SYSTEMS REFORM

Evaluation of Systems Reform in the Annie E. Casey Foundation Mental Health Initiative for Urban Children

FINAL EVALUATION REPORT

May 2000

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

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May 2000 • Tampa, Florida

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This publication was produced by
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Louis de la Parte Florida Mental Health Institute Publication #180, Tampa, Florida

Recommended citation for the report:

Gutierrez-Mayka, M., Joseph, R., Sengova, J., Uzzell, J. D., Contreras, R., Friedman, R. M., & Hernandez, M. (2000). *Systems reform in the Annie E. Casey Foundation Mental Health Initiative for Urban Children: Final evaluation report.* Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Preparation of this product was supported in part by a grant from the Annie E. Casey Foundation for evaluation of the Mental Health Initiative for Urban Children (Award # 92.2802). The opinions stated herein are those of the authors, and do not necessarily reflect those of the Annie E. Casey Foundation.

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

We are especially thankful for the thoughtful input of Michael Grady, Patrick McCarthy, and Mareasa Isaacs from the Annie E. Casey Foundation. Sheila Pires and Kathy Dennis, members of the Technical Assistance team also provided helpful comments and insights. The organization of the content—as well as its clarity—were greatly improved through their suggestions. Thanks are also due to all the Mental Health Initiative's stakeholders in Boston, Houston, Richmond and Miami who shared the valuable information which has served as the foundation for the impressions and findings reported herein.

A final thanks goes to Cindy Liberton and Julie Almeida of the Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute, University of South Florida, who were responsible for the design of the report, its layout and production.

For more information about this report or the Evaluation, contact Marcela Gutierrez-Mayka at 813/974-0079. To obtain additional copies of this publication, call the de la Parte Institute's Technical Publications office at 813/974-4404; reference publication number 180.

INTRODUCTION

Background

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-sensitive mental health services to children in high poverty, urban communities, and to work with states to improve the policies and practices supporting these services.

A key aspect of the design of the MHI was its focus on high poverty 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 1999 Kids Count Report produced by the Annie E. Casey Foundation, there are 9.2 million children nationally who are growing up with multiple risk factors including absence of a parent, low parental education, low socio-economic status, unemployed or underemployed parents, welfare assistance, and lack of health insurance coverage (p. 6). 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[1] , the implications of these statistics for their future health and well-being are sobering.

In addition to environmental stressors, in the United States today, increasing numbers 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, another key element in the MHI's design was to target a broad population of children at-risk, while incorporating features from system reform initiatives specifically targeted at children with serious emotional disturbances and their families. 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

[1] The 1997 Kids Count report projects a growth between 1996 and 2005 in the number of African-American children by eight percent, 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.

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.

A final feature that contributed to the uniqueness of the MHI was its emphasis on the importance of delivering services that were responsive to the culture of the target communities and its 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 maximize the impact of the neighborhood-level demonstration and improve the chances for statewide adoption of the model, and out of recognition of the effect that state and local level policy decisions have on the lives of neighborhood residents.

National Context for the MHI's Implementation

During the span of the MHI, there were important developments taking place in the mental health field across the country, and in the broader field of children's services. These developments, directly or indirectly, had implications for the overall well-being of children and families, and, potentially, for the effectiveness of the MHI.

Health Care Financing

Probably the most far-reaching changes have been those in the health care field. Both in the private and the public sector, there has been a major movement towards increased use of some type of managed care approach to financing, instead of the traditional fee-for-service approach. For example, while only 9.53% of enrollees in Medicaid were covered by managed care in 1991, just prior to the start of the MHI, that figure had risen to 40.1% by 1996, according to data from the Health Care Financing Administration (HCFA). By early 1998, nearly all states were engaged in some health care reform activity involving Medicaid (Pires, Armstrong, & Stroul, 1999).

The impact of these changes on outcomes for children cannot yet be determined. Also, it cannot yet be determined if the reduction in costs that resulted from decreased use of hospitalization and shortened lengths of stay has been a true cost reduction or a shift in cost to other child-serving systems. It does appear, however, that the movement towards managed care in Medicaid has contributed to increased access to at least basic mental health services; decreased utilization of inpatient psychiatric hospitals; increased use of short-term therapies; and a greater range of services being offered. However, it has also made it more difficult for individuals and their families to receive care for the necessary length of time to address their needs.

At the same time managed care was being implemented, the Balanced Budget Act of 1997 amended the Social Security Act to create Title XXI, called the State Children's Health Insurance Program (SCHIP). Congress provided $20.3 billion to support this program which is designed to expand health insurance for low-income children who are not eligible for Medicaid.

Despite the addition of SCHIP, the American Academy of Pediatrics reported in 1999 that 11 million children (14.8%) remain uninsured. The number of children without any health insurance is actually increasing, despite the introduction of SCHIP. The increase is attributed to the fact that the cost of health insurance has risen so much over the past 15 years that low-income employees are unable to afford it or it is no longer as likely to be included as a benefit of employment (Kronick & Gilmer, 1999). Another reason for the increase in the number of children without health insurance, according to Klein (1999), is welfare reform, discussed in the next section.

Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created a major social change impacting upon the lives of millions of children and their families by reforming the federal public assistance program. Also called Temporary Assistance for Needy Families (TANF), this change in federal policy has imposed limits on the length of time during which a family may receive cash benefits. It

essentially has changed cash assistance from an open-ended entitlement to a temporary benefit during which time recipients must be engaged in employment or job training. The program provides states with flexibility to exempt some families from the time limits in instances of special need. In most states, considerable supports and services have been provided to assist families to secure work. These include assistance with transportation, health care, and child care.

While preliminary studies indicate that 44% to 70% of former welfare recipients are finding jobs, it is too early to know what the long-term impact of this change will be, how it is affecting the quality of life in low-income families, and what the impact will be when the economy is not as strong as it currently is. It is clear, however, that TANF has contributed to a major short-term reduction in caseload size. As families have left, they have also often lost their health insurance benefits which came to them through Medicaid. Also, the switch from an entitlement program to a time-limited benefit tied to work has increased reporting and monitoring requirements, resulting in change in the nature of the relationship between government and low-income families.

In addition to TANF, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 made significant changes to the criteria for eligibility for children's SSI disability benefits. The law established a stricter definition of "disability," and mandated reviews of many children who had been previously declared as eligible and were receiving benefits. According to the Bazelon Center (1999), approximately 243,000 of the one million children receiving SSI were affected by the new eligibility definition, and over 115,000 low-income children had their benefits terminated through the review process. These benefits often represented a sizeable portion of the family income.

Comprehensive Community Mental Health Services for Children and Their Families Program

The Children's and Communities Mental Health Services Improvement Act of 1992 created a new federal program to support the expansion of community-based systems of care for children with serious emotional disturbances and their families. This program started in 1993 with $5 million, and in 1999 had a budget of $78 million. Through this program, which is operated by the Center for Mental Health Services (CMHS), 45 sites around the country have received five year grants to expand their service capacities, provide a broad array of mental health and related services, provide services in the cultural context that is most appropriate to their citizens, and involve families fully in the planning and treatment process. Grants have been given to entire states, counties and/or cities, and to neighborhoods, especially those in low-income urban areas (e.g., Mott Haven, NY; East Baltimore, MD).

Child Welfare

In 1997, The U.S. Congress passed the Adoption and Safe Families Act (ASFA). This legislation essentially builds on prior child welfare legislation (P.L. 96-272) in seeking to protect the safety of children, promote adoption and other permanent placements, and support families. However, the balance between child safety and family preservation in this Act differs from prior legislation. This legislation clearly and emphatically states that the number one priority in child welfare must be child protection. While states are still expected to make a reasonable effort to preserve or reunify families, there is a greater focus on removal of children in order to protect their safety. No data on the impact of ASFA is available yet.

Juvenile Justice

In large part, the 1990s have been a time of increased punitiveness within the juvenile justice system, with an increased focus on incarceration, and on juveniles being directly filed to adult court. This shift is also accompanied by a weakened belief in the possibility of rehabilitation, and the consequent reduction of rehabilitative opportunities for juveniles.

Another trend in juvenile justice over the last decade has been the explosion in the number of children entering the system, mostly tied to the increased enforcement of drug-related offenses committed by residents of low-income neighborhoods. It is esti-

mated that 100,000 youth are incarcerated on any given day (Faenza, 1999). This increase in population has led to overcrowded facilities, and a reduction of funding geared for services in favor of more jail construction dollars. In fact, it is reported that 60% to 70% of youngsters in state and local juvenile justice systems have mental health or substance abuse problems, and that services for these children are woefully lacking (Faenza, 1999).

Implications

Overall, in spite of the strong economy that has characterized much of the 1990s, the policy changes that have taken place have created considerable anxiety and uncertainty for families. This is especially true in neighborhoods of the type served by the MHI, and for systems and providers.

The changes described above represent a new relationship between government and low-income families; one that can be described as more adversarial. As the government's traditional image as a provider of supports and resources shifts to one of guardian, enforcer and punitive agent, efforts to form partnerships between formal agencies and residents of low-income communities will become increasingly more difficult.

Moreover, the resources of families are not only stretched thin in important areas, but the ability of families to depend on these resources has diminished with changes in welfare, in health care, and in SSI. Under these conditions, it is the families with individuals with special needs (i.e., adults or children) who are likely to fare the worst, and need the most support.

Finally, despite increases in certain federal programs that benefit a limited number of communities, the resources available to providers are few. Systems and providers have also had to adjust to new ways of doing business due to changes in important policies, such as the increased use of managed care, and the change in focus in the child welfare system brought about by ASFA.

At the same time as these changes are taking place in the policy environment, the demographics are reflecting a rapid increase in the number of children of color, a growth in the number of adolescents, and a disproportionate number of children of color in inner-city neighborhoods who are at special risk. On the one hand, all of these new trends have provided a special challenge to the MHI in its effort to create partnerships between formal systems at the local and state level and neighborhood residents. On the other hand, it has also accentuated the importance and relevance of the MHI as one model to strengthen families and communities, in order to improve outcomes for children.

MHI Planning and Implementation

Originally, six states were awarded $150,000 planning grants in July 1992. Based on the results of their planning, four of the states—Florida, Massachusetts, Texas and Virginia—were awarded $3 million grants over a four year period to implement their plans from 1994-1998. The expectation was that successful reforms would be sustained by the states and/or other mechanisms when Foundation funding ended. The neighborhood sites that each state worked with were the following:

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

For implementation purposes, the MHI involved a three-pronged approach: service design and delivery, neighborhood governance, and systems reform. Each of these domains was further operationalized into strategies created by partnerships of state, local and neighborhood stakeholders based on broad benchmarks 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.

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 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; and
- Emphasize parent education and involvement.

Neighborhood Governance

At the neighborhood level, the initiative called for the development of a governance structure to provide administrative oversight and fiscal accountability for the project. The governance structures were to include leaders and key stakeholders from every part of the community, including government officials, community leaders, professionals and decision makers from all child-serving agencies, residents, and consumers of services.

Another unique aspect of the MHI was building state-local-neighborhood partnerships. At the state level, the initiative sought to foster the coordination of mental health and other child-serving agencies—for example, child welfare, juvenile justice and schools —and to develop new funding strategies. At the local level, the initiative strived to promote interagency cooperation in program development and financing in order to create a system of care at the neighborhood level.

Systems Reform

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 reforms 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.
- Changes in policies, regulations and funding mechanisms to support sustainability and generalize 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.

Evaluation and Reporting

The Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida, was contracted by the Annie E. Casey Foundation to conduct the 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. The evaluation did not focus on documenting outcomes, but rather on understanding changes that took place in the implementation process.

Qualitative methods were used to describe the different stages of implementation in the area of service design and delivery, neighborhood governance, and systems reform (see Appendix A).

The findings of the evaluation are the subject of a three volume set of reports, one for each implementation area, plus an additional Executive Summary report that will provide an abbreviated discussion of the longer pieces. The present report covers the findings related to Systems Reform.

In the following sections, we provide a description of the most significant systems reform that directly resulted from the implementation of the Mental Health Initiative for Urban Children in the four host sites. The report is organized as follows:

Cross-Site Summary of Systems Reform Implementation: Brief discussion of shared and unique issues identified across the four MHI sites.

Stakeholders' Views on Lessons Learned: The section summarizes the various perspectives of key groups of MHI stakeholders on the successes and challenges in systems reform. Their insight on what could have been done differently is presented in the form of "Lessons."

Case Studies of Systems Reform Efforts in Florida, Massachusetts, Texas and Virginia: This section presents findings on systems reform accomplishments and challenges in each of the four sites. The individual site discussion begins with a brief description of the community where the MHI was implemented in the state. The following description addresses the features of the pre-implementation environment which led the Casey Foundation to select it for the MHI. The discussion concludes with specific examples of systems reform that occurred in the site as a result of MHI implementation.

Appendices

A. *Methodology:* Provides a brief description of the various qualitative methods utilized to gather data on systems reform in the four MHI sites.

B. *Additional State Reforms:* Descriptions of reforms that occurred in each of the sites that were consistent with the philosophy of the MHI, but were not necessarily tied to its implementation. These include legislation impacting children's mental health, state implementation of federal laws impacting children and families, and more local developments that shared a common vision with the Casey Foundation in terms of how services to poor children and families in urban areas could be improved.

C. *References:* Provides complete citations for works cited in the text, as well as resources used in the preparation of the report.

SECTION

ONE

Cross-Site Summary of Major Reform Achievements and Challenges

Cross-Site Summary of Major Reform Achievements and Challenges

Today, there is widespread agreement that adequately meeting the needs of disadvantaged children and their families requires fundamental reforms in the systems designed to serve them. Although the MHI did not call for specific structural or functional changes, it identified four critical areas that needed to be addressed in any reform efforts:

- 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.
- Changes in policies, regulations and funding mechanisms to support sustainability and generalize 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.

The present cross-site analysis was derived from the descriptions of reform efforts undertaken by the MHI sites in these four areas and summarized in the last section of this report. This section represents the evaluation's attempt to draw generalized conclusions on the trends and common reform themes across sites.

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 between neighborhoods and state and local stakeholders. An initial lack of trust among partners, and differing visions for the Initiative slowed down progress and service implementation. Eventually, though, the various governing configurations in the four sites led to increased levels of local control and shared authority with neighborhood residents.

The final governing structures in all boards were faithful to the original design of 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 the Foundation was pursuing when it designed the MHI. Without the state's involvement, the local MHIs are now functioning as community-based organizations with strong resident leadership, but whose chances to impact major policy decisions at the state level have greatly diminished.

The MHI's philosophy of resident-driven service design embedded in its 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 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.

Stakeholders agree that the development of this 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 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, 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 other 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" (e.g., 24 hours a day, 7 days a week) support systems. Miami has even 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.

A final accomplishment in the area of service systems reform comes from the example set by Houston in pioneering the involvement of a grass-root minority community organization in the managed care scene. People in Partnership (PIP), which is Houston's governing board and a nonprofit organization, applied with the state to become a Medicaid provider of mental health and addiction treatments 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 join the managed care world. Although the model is still new and significant barriers have been encountered, particularly around accreditation, the opportunity to learn from this experiment makes it a primary example to inform systems reform.

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 with necessary flexibility 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.

The cross site analysis could not establish a trend in this aspect of systems reform. In other words, the 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 relied on 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 where the FRC is located 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 com-

munity agency can match, and at no cost to the program other than 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.

In the area of policy, accomplishments were fewer, but 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 this area of the state established a contractual relationship with an organization whose board is made up of a majority 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 while a permanent person was being recruited for the position. As a rule, state employees are not allowed to serve on boards of organizations with which the state contracts.

Personnel policies were also re-examined by the state and local providers involved with the MHI. In the case of the state, the 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.

The city'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 discarded as a failure. Rather, they need to be followed and studied as a significant 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 cross site analysis of the MHI data collection effort found only modest examples of system reform. The accomplishments that did occur related specifically to the sites' ability to capture baseline information, and the impact data collection had on the state, local and neighborhood levels.

By gathering data on service, placements, and the cost of out-of-home placements for children, the MHI secured the first baseline measures of these sta-

tistics at a neighborhood level for the target communities. 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.

Another unexpected outcome of the data collection piece was the identification of important structural barriers. Some of the most significant ones are the 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. This knowledge is a critical first step toward improving information utilization in system reform endeavors.

A final accomplishment was the increased awareness many MHI stakeholders now have of MIS and other data issues. In particular, resident stakeholders in the four MHI sites now have a better understanding 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, 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.

The second 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[1]. In addition duplication of state level intake processes still remains a problem.

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. 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 has yet to become fully operational. Richmond is still in the process of developing its client tracking system.

Conclusions

The Mental Health Initiative for Urban Children had an ambitious reform agenda in a field, children's mental health, where important changes are taking place all across the country. The MHI's originality and promise came from its focus on children and families from low income urban neighborhoods, a population facing multiple challenges related to their living environment. At the completion of the initiative, we can say with certainty that the Foundation's focus was the right one. The life experiences of children in these communities places them at much higher risk for involvement with systems (e.g., mental health, juvenile justice, child welfare, special education) that are unprepared to give them and their families the support they need to succeed.

[1] One exception is noted in Houston, which at some point during MHI implementation could access the Department of Social Services data system through the Integrated Database Network. The services were suspended, but there are plans to re-establish this link again sometime in the future.

We can also assert, that neither the Foundation, nor the partners in the different states where the MHI was implemented anticipated the complexity and demands of the task they had set to accomplish. Most stakeholders involved in this project agree that the five year time frame was insufficient to see the kinds of results the Foundation anticipated during the life of the initiative. Moreover, the MHI's reform agenda called for simultaneous efforts on a variety of fronts (e.g., community involvement and governance, service design and delivery, MIS, systems integration, sustainability, etc.) making it almost impossible to dedicate the time, energy and commitment that each one required to succeed.

To the question of whether the MHI delivered the reforms that were expected when it was designed, we must give a mixed answer: "yes," "no," and "it's too early to tell."

Clear successes can be claimed in the area of partnerships. The MHI's mixed governing entities modeled new types of relationships between state and local agencies, and neighborhood residents, and created new networks whose potential impact is yet to be seen. Stakeholders at all levels recognize that the personal experience of working to accomplish the MHI's goals changed them, more specifically, left them more open to trust one another, better able to communicate with each other, and more aware of each other's strengths. In the site case studies at the end of this report we present examples of how this model has already spread outside the MHI.

Another unquestionable fact is that the MHI has been a leadership incubator for the four communities involved. In all instances, new leaders have been uncovered and nurtured. Moreover, experienced leaders have been given an opportunity to enhance their knowledge and abilities gaining more visibility outside the boundaries of their community, and a stronger, more assertive voice with which to advocate for their peers at the local and national levels. The long term impact these residents can have in improving conditions in their communities cannot be underestimated.

In terms of reforms related to service delivery, the main contribution of the MHI is the idea that a service strategy (i.e., Family Resource Centers) which emphasizes supporting families' basic needs for housing, employment, education, recreation, spirituality and cultural identification can be an effective mechanism to address children's mental health needs and prevent their future involvement with formal systems. This idea has implications for how community-based mental health services are marketed and packaged, and ultimately, for the achievement of positive child and family outcomes.

The notion that trained community residents can make important and unique contributions to a family's mental health is another legacy of the MHI. The ramifications of this concept tie into development of human capital, expanded community and individual networks, additional services and supports to families, and improved cultural competence and accessibility. The reverse side of this coin is that the full potential of professional/para professional partnerships was not realized in the MHI because of the failure to achieve significant policy changes to support them.

Finally, the success in promoting policy and fiscal reforms, and in the development of management information systems (MIS) to support the service strategy can be considered small compared to what the Foundation expected to see in this area. The sites provide some relevant examples of accomplishments in personnel and contracting policy changes and some promising financing strategies, including managed care and the Time Dollar Bank. Most stakeholders believe expectations in this area were set too high to begin with, and the time allowed was too short.

To its credit, the MHI did infuse new policy and fiscal knowledge for all stakeholders involved. The project provided numerous opportunities to learn from consultants, conferences, and visits to innovative programs. Similar resources were made available in the MIS area. How individuals apply these ideas to practice or incorporate them into policies that result in true reforms is something we may have to track for a long time to come.

SECTION

T W O

Stakeholder's Views on Lessons Learned from Systems Reform

Stakeholder's Views on Lessons Learned from Systems Reform

Large, complex initiatives like the MHI can have impact in many ways. The most direct impact is the changes that are brought about in the immediate communities that are the actual sites for the program. However, large initiatives also have the potential to have impact on the broader field of which they are a part. They can do this both through specific benefits that accrue from the initiative, and from new learning that takes place as a result of the initiative.

This section summarizes the most relevant lessons learned from implementing systems reform in the MHI. Rather than distilling our own lessons from the individual sites' experiences with systems reform, the evaluation team decided to go back to key stakeholders across the various groups involved with the MHI, and ask them to share what they learned through the unique roles they played in the initiative.

The evaluation team held a series of focus groups in the last year of the grant's implementation to capture the views and perspectives of the various stakeholder groups. These included: residents, local and state level representatives, MHI staff and service providers, technical assistance and evaluation teams, and Foundation representatives (see Appendix A). The questioning routes for the discussions were the same for all groups and asked participants to reflect on achievements and challenges, and to suggest changes that would have facilitated the implementation of systems reform.

The lessons derived through this methodology were then grouped by the evaluation team under four major headings.

1. "From the Top Down"— This set of lessons responds to the initiative's assumption that to achieve large and sustained change, it was essential that the state level be strongly involved, that it help create the conditions for success at the neighborhood level, and that it learn from that so that meaningful system reform would take place.

2. "From the Bottom Up"— The lessons in this grouping reflect a second key assumption that changes occurring at the neighborhood level as a result of the MHI implementation could be used as a demonstration to inspire reform in other communities, and to share with others around the state or the country.

3. "Innovative Practices"— These lessons refer to the broader issues of innovative service delivery and evaluation approaches employed in the MHI.

4. "Management Information Systems"—The last set of lessons deals with the development of management information systems and its impact on systems reform.

Each lesson is preceded by narrative that provides the necessary context for interpreting what was learned. The specific lessons represent the collective wisdom and particular insights of the stakeholder groups as the evaluation team captured them through the focus group process. They are provided here as a reflection on what the MHI accomplished and the challenges it faced, and as suggestions on how similar efforts could be improved in the future.

From the Top Down

State Oversight Caused Unexpected Challenges During Early Implementation

Stakeholders at the neighborhood and state and local levels agreed that the Foundation's choice of the state as grantee created considerable obstacles in meeting MHI objectives for systems reform. They mentioned that the state's inflexible bureaucratic requirements and slow pace 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.

LESSON

Stakeholders suggested one way to overcome the barriers imposed by selecting the state as the MHI grantee may have been the designation of an existing community-based organization (CBO) as grantee. Such an organization should have had a strong track record of success and high visibility in the target community, as well as connections with and the trust of the state. Initial funding could have gone to expanding the CBOs most effective programs. Eventually, funding levels could have increased to accommodate more comprehensive efforts that involved collaborations with other CBOs and state and local agencies.

Moreover, state level stakeholders admitted that they felt accountable to the Foundation for the administration of the initiative's funds. The state's lack of experience in involving residents from poor neighborhoods in the way the initiative called for, resulted in its initial reluctance to delegate responsibilities or base its actions on local input. This 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. As a state level stakeholder pointed out: "*When the initiative began to focus not so much in building mental health services, or expanding the service array, but was really creating these issues of neighborhood governance and sharing the power and resources and all of that, I think those state bureaucracies became very uncomfortable with that.*"

Lack of Political Continuity Weakened Support for the Initiative

Stakeholders identified the changing levels of state commitment to supporting the systems reforms goals of the MHI as another significant obstacle. This was primarily due to the loss of original players who had been instrumental in bringing the project to their respective states and their replacement with others who did not have the same level of personal investment. All sites experienced changes of leadership in critical state positions from Governors to Mental Health Commissioners, and department heads.

LESSON

The stakeholders' consensus was that sites that weathered this challenge did so through support from "champions" who were in less vulnerable positions, but still high enough in the system to command attention and trust. Stakeholders suggested some effective champions may be found in the business community because of its economic power, networks and connections, and leverage in demanding accountability from politicians. Nurturing and involving these types of champions from the beginning may have helped counteract the impact of the lack of political continuity on state social policy and programs.

The case of Miami was cited as an example of the role a group of champions played in transferring control from the state to the local level through its Neighborhood Governance Board. As board members themselves, a County Administrator, a Department of Children and Families planner and division head, and the director of a local child advocacy group helped make the transition a reality by strongly advocating the NGB's administrative competence to state officials.

Governments Respond Better When Financial Responsibility is Shared

> If the public sector had had a larger financial stake in the MHI, its commitment to the initiative would have been reinforced. According to stakeholders, this could have afforded the opportunity to develop agreements that would have been maintained regardless of changes in the political landscape.
>
> LESSON

Stakeholders representing the state judged that state and local governments did not have sufficient incentives to become heavily involved with the MHI. In their opinion, the fact that these entities were not required to match the Foundation's funding resulted in diminished motivation to invest their time and human resources in implementing a complex initiative such as the MHI. Agency administrators also felt that compared to their own massive budgets, the Foundation's investment in addressing an important social problem was minimal, and they doubted the MHI's capacity to maintain state partners at the table.

The Disadvantages of Relying on a Single Bureaucracy

> Stakeholders concurred that an alternative to using the same point of entry in all sites could have been a customized approach. The selection of the point of entry could have been based on an assessment of the role that different state agencies concerned with child and family well-being played vis-à-vis the mental health needs of children and families in that system.
>
> LESSON

Three of the four MHI states placed the initiative within the state Department of Mental Health[1]. Some stakeholders felt that while the decision made logical sense given the focus of this initiative, it overlooked the fact that state Departments of Mental Health often have very little clout and power of their own to involve other key partners. Therefore, they may not have been capable of producing the kind of meaningful change the project envisioned.

State level representatives also felt that the choice of the Departments of Mental Health as the single grantee narrowed the focus of the MHI, and alienated other state agencies (e.g., Juvenile Justice, Child Welfare) that were needed in order to address the significant cross-system issues impacting this population of children.

[1]Texas placed the grant with the State Health and Human Services Commission.

Finally, stakeholders in the field of children's mental health acknowledged that this system is less likely to encounter children of color than either Juvenile Justice or Child Welfare.

This approach would have identified Juvenile Justice, Child Welfare, Special Education, or a combination of them, as valid systems over which the MHI could have been overlapped. It would also have made it easier to identify minority children and families in need of additional mental health services and supports, and would have provided an opportunity to increase the focus on cultural competence in these systems, an area of the MHI which stakeholders consistently rate as weak.

LESSON

This group of stakeholders proposed using a social marketing campaign or some similar means to promote a clearer understanding of the concept of systems reform. This would have helped develop consensus and set direction for all levels involved in the MHI. The providers specifically noted that to avoid confusion, the choice of services and their delivery strategy at every level should have been consistent with and supportive of the stated goals for systems reform.

The Different Meanings of Systems Reform

To the service provider stakeholder group, the lack of consensus around the meaning of "systems reform" posed special challenges. According to these informants, the fact that individuals involved with the MHI in different capacities were able to speak the jargon of systems reform did not necessarily mean they understood the concept or how to translate it into practice.

Providers were 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 the goals of systems reform at higher levels. The MHI provider partners asked: "*What services should be delivered to affect whatever systems reform was going to happen? And, who is supposed to clarify that?*"

From the Bottom Up

The MHI's intention to promote statewide systems reform by starting with geographically defined neighborhoods in partnership with state and local agencies, had both positive and negative implications.

Improved Relationships with Neighborhoods

According to various stakeholder groups, one encouraging effect of the MHI was to remove 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 in local governing boards and attending various neighborhood functions, these officials gained a renewed understanding of community issues.

> Once state and local administrators interact on a frequent and consistent basis with community members, they become "neighborhood champions" who are strong and effective advocates for poor families. Although these changes may occur at the individual rather than the system level, the potential policy impact of strategically positioned individuals who share a common philosophy of community involvement, should not be underestimated.
>
> LESSON

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."*

"It's (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, for instance, in Boston with community policing…block groups that really watch for safety in the neighborhoods."

State and local stakeholders admitted 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. Examples of new initiatives and programs which include service consumers in their advisory committees or boards along with state and city agencies were shared by representatives of the four sites.

Opposing Views on the Value of Neighborhood Pilots

Stakeholders were consistent in identifying the increased attention the MHI brought on inner-city neighborhoods as one important impact of the initiative. However, informants were divided with regard to the likelihood that broad system changes would result from focusing on one neighborhood per state.

> Pilot projects are essential in showing how the philosophy behind a model such as the MHI can exert a real—world impact. There was some sense among stakeholders, although not necessarily a consensus, that it would have been helpful to have more than one neighborhood site per state in order to more successfully engage state officials in the MHI. The experience gained from piloting the initiative in these neighborhoods could have had a broader impact on systems reform.
>
> LESSON

Those favoring the pilot project approach cited the example of the Miami and Boston sites, where different aspects of their service strategies have been adopted by state and local agencies as models for use in other relevant areas. More skeptical stakeholders expressed their concerns in the following terms: "*We want state reform but we are trying to drive it through one geographic area, and that is a problem…it was too narrow in terms of driving state reform.*"

Reforms Through the Eyes of Neighborhood Residents

In contrasting the perspectives of the different stakeholder groups, it was apparent that neighborhood residents saw the impact of the MHI through a more positive, and perhaps more personal lens. Furthermore, they felt that, although not as meaningful to outside stakeholder groups, the changes represented major accomplishments to residents. These informants mentioned three significant benefits of implementing the initiative in their communities:

LESSON

Local communities have different expectations of change compared to those of state and local agencies and to some extent, the Foundation. Effective systems reform can occur from the top-down or the bottom-up…or both. Using neighborhood models to generate statewide reform may not be the best approach in the short run, but their positive impact on children and families cannot be tossed aside. Neither can the potential to effect more comprehensive reforms through the power of their success.

- The opportunity to unite around a common cause and be empowered by that unity.
- A greater interaction and coordination of services among community-based organizations, which are becoming more family-centered and focused on collective strengths.
- The lessening of the stigma attached to mental health by community residents.

Unity 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 that what they ever even imagined in regard to the community piece. We are more together across the board.*"

The resulting empowerment also made residents feel they had a stronger voice in policy decisions concerning programs and services that directly impacted their communities. They felt that these had more relevance to everyday life than state policies.

Moreover, residents agreed that community-based organizations were interacting more with each other, coordinating services, and co-locating in the community, while becoming more family-centered and strength-focused. They were partnering with local residents in actual service delivery to families in the neighborhood. The positive effects of this collaboration between professionals and residents was another example of reforms that were felt at the community rather than the system level.

One stakeholder described the change this way: *"At the community—based level, we have made a reality what true systems reform is."*

Another stakeholder says that simply listening to the community is a positive step: *"Having the administration of our lead provider agency coming in to the Board every month and talking about who they're serving, how they are being served with numbers and details…I call real system reform. Having them being questioned by us and having to respond because they're not used to that."*

Empowerment of Community-Based Minority Providers

According to resident stakeholders, the MHI has provided valuable assistance to some minority provider agencies in the targeted communities, most notably by increasing their technological, structural, and administrative capacities. A similar desire by different state agencies to enhance the minority provider base has also changed how they define Affirmative Action. In Boston, for example, RFP applicants must now specifically outline their strategy for improving this base.

One informant explained the significance of this reform: *"Now we are looking at new language in Affirmative Action that says you must help build capacity among minority agencies. That was never there before."*

Lessening the Stigma

Resident stakeholders believe that MHI's impact on attitudes about mental health was a major accomplishment in itself. As a result of their involvement with the MHI in their respective communities, many residents now have a clearer understanding of issues around children's mental health and this has lessened the stigma associated with it. Furthermore, they expanded the narrower concept of mental health as understood by practitioners to include a general sense of well-being for the entire family, not just the impacted child. Residents are now more willing to advocate for prevention and support services rather than treatment and institutionalization.

LESSON

More attention should have been given as to how the MHI could apply neighborhood experiences to drive positive change at the system level. Effective models need to be identified and/or developed to accomplish the following objectives:

- Delivering mental health services to minority populations and dealing with issues of race, class, and power differentials.
- Strengthening minority service agencies.
- Broadening the definition of mental health to be more in tune with community perceptions.

Innovative Approaches

Development and Support of New Service Delivery Models

> The task of improving mental health for children and families in a community setting may require deviating from the traditional mental health approaches most comfortable to practitioners, but less meaningful to consumers. Responding to community residents' broader view of the roots and causes of mental health problems with innovative and flexible service delivery models may result in benefits beyond those originally expected.
>
> LESSON

Stakeholders representing the technical assistance team believed that one of the contributions of the MHI to the broad children's mental health field was its support and encouragement of service delivery models and approaches that were 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 variety of services ranging 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," the 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.

Ethnographic and Utilization Approach to Evaluation

> In the evaluation of complex community-based initiatives where process is as important as outcomes, evaluation designs may need to rely more heavily, at least until outcomes are ready to be measured, on qualitative methodologies. The evaluation design must also be geared to inform implementation decisions and suggest areas in which technical assistance is needed.
>
> LESSON

Stakeholders representing the Foundation, technical assistance teams, and various individuals who closely followed the implementation of the MHI specifically addressed the approach to the Initiative's evaluation as an example of change for the field. The evaluation emphasized gathering practical information that could be used to assist during implementation rather than focusing almost exclusively on outcomes as many evaluations do. The evaluation also used approaches to gathering information from individuals representing different perspectives that had strong roots in the discipline of anthropology and qualitative field methods.

Some of the methods of information gathering and summarizing were not only useful to the MHI but have already been used elsewhere. This includes family-centered interviews in which numerous individuals describe the needs and interventions 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.

Diversifying the Family Movement

There was consensus among stakeholders that one of the important benefits of the MHI to the children's mental health field was its role in supporting the Federation of Families for Children's Mental Health through giving it a meaningful and important function in the program. In particular, through its focus on families of color in the MHI, the Foundation contributed to the diversification of the Federation. Resident stakeholders from all sites have attended Federation conferences and trainings, have 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.

LESSON

The diversification of the family advocacy movement to embrace more people of color is necessary if minority children are to be reached with meaningful and culturally competent mental health services. Moreover, the leadership skills parent advocates develop can be applied to addressing other issues impacting their families and communities.

Implementing Management Information Systems

MIS an Unfamiliar Territory to Stakeholders

The realization that stakeholders at all levels had limited knowledge and expertise in this area was a significant finding. Inexperience and a lack of true understanding about management information systems and related issues was a problem for stakeholders at the state, local and community levels.

LESSON

Stakeholders from all levels of the Initiative need more vigorous technical training and support before and during implementation of MIS reform. Training must be flexible and tailored to accommodate the various levels of expertise and knowledge of individuals involved.

A state representative admitted: *"… 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 this fact: *"I think that the intent of MIS is good…this was something new that nobody had done, so we were trying…"*

Residents serving on the MHI's governing boards were expected to work closely with professionals on decisions regarding MIS. Just as the state and local level stakeholders, they openly admitted their inexperience and acknowledged being largely unprepared for implementation of this particular aspect of the Initiative. One such resident reported, *"I was asked by my board president to chair the MIS committee. I had no knowledge, none whatsoever, about what I was doing."*

Stakeholders Differ Regarding the Types of Data that Should be Collected

LESSON

More involvement of sites in determining the types of data and how it should be collected is imperative if sites are expected to take ownership in the process. Furthermore, trying to homogenize data indicators across sites may hinder the assessment of the service array of individual sites, particularly at the neighborhood level.

While the 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. There was general dissatisfaction with the type of data that had been collected but each level of stakeholders appeared to have a slightly different perspective on what should have been done.

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 collecting the same type of data for all sites. They also felt this strategy would have made it possible for sites to capture information on what they were actually doing—i.e., Family Resource Centers services and activities, and more prevention and intervention type services.

From the provider perspective, the MHI placed too much emphasis on information about state funds, while little or no effort was made to collect measurements of the contributions of community-based providers.

From the Foundation and technical assistant perspectives, the sites were expected to collect information that was not only need-based but also strength-based. TA and other stakeholders felt that this had not happened in the MHI, and suggested that the management information systems needed to be more strength-based.

State Philosophies are Difficult to Change

A common experience across MHI sites has been that state agencies do not 'buy into' the concept of making data readily available to local community-based agencies. While many state agencies provided data, this did not impact their overall attitude toward sharing it. Confidentiality and other issues related to state agencies' historical organizational culture made them reluctant to share their data with community-based providers.

LESSON

Progress in getting agencies to fundamentally change their philosophies and way of thinking towards sharing data is a very gradual process. Sporadic change in agency actions should be not necessarily be interpreted as an indication of a change in philosophy but rather as a response to a specific stimulus. The benefits of an integrated MIS system need to be consistently highlighted to all stakeholders.

From the providers' perspective, there are at least two main benefits to having access to this type of information: 1) service needs and utilization patterns of families involved in multiple systems could be more easily identified, and 2) the need for duplicative intake processes for these families could be reduced.

A resident's overall assessment of the progress made in this area of information sharing was as follows: *"So again, the lesson learned for me is that while we have a very extensive data collection piece, the state didn't buy into it. So, we were never able to dial up into the state's MIS system, to extrapolate information and data from there to use on the local level."*

SECTION

THREE

Case Studies

FLORIDA

- **East Little Havana Site Profile**
- **Systems Reform in Florida**
- **Highlights**

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.

[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.

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 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.

SYSTEMS REFORM IN FLORIDA

Pre-Implementation Environment

An Ideal Climate for Change in the Sunshine State

The innovative reforms the Annie E. Casey Foundation was hoping to encourage through its Mental Health Initiative already enjoyed strong support within Florida. This became increasingly apparent when key state and local stakeholders were interviewed by the Foundation's site selection team back in 1992. Among the factors that impressed the interviewers most was the level of visionary leadership. Devon Hardy was Chief of Children's Mental Health Services in Florida during the site selection process, and he explained why the state was a good candidate to become an MHI site: "It [the MHI] meshed exactly with his [Governor Chiles'] campaign promises, meshed with his legislative initiatives with children and families, meshed with his effort to decentralize HRS [Department of Health and Rehabilitative Services] to enable decision making to be done at the community level. So, this was actualization of a lot of stuff that he had been talking about and committed to do."

The strong commitment to interagency collaboration was another significant foundation for reform already present in the state. For instance, the mental health and education systems had established the Severely Emotionally Disturbed Students Multiagency Network (SEDNET). Their partnership was considered to be a model for other states, and it also encouraged other alliances at the local level. An example is the Family Service Planning Teams (FSPTs), which targeted children with multiple problems who might otherwise require residential placement. FSPTs made it possible for parents to work closely with local community agencies in planning, developing and implementing effective services for their children.

The Full Service School Initiative was another case in point. These grants encouraged the integration of health, education, and human services at or near schools. The joint involvement of private agencies, the Department of Children and Families, and other public agencies, made it possible for these Full Service Schools to operate as family service centers offering mental health therapy, before and after school programs, adult literacy courses, and coordinated case management. In addition, public assistance eligibility workers were able to provide school-based services.

Public funding of Florida's early intervention and prevention programs illustrate another feature of the supportive environment the Casey Foundation encountered in the state. Two specific indicators of the state's commitment were Healthy Start (serving pregnant teenagers and their babies) and the Supplemental School Health Program (providing primary health care at local schools). In addition to this general emphasis on preventive measures in health and education, local Children's Services Councils were created and local voters were permitted to approve the levying of up to .5 mil in taxes to support early intervention and prevention services for children and families in individual counties.

The strong belief in prevention was also at the heart of a statewide effort to reduce the role of institutions in providing mental health care to children in Florida. In fact, at the inception of the MHI, Florida was one of the few states in the country where a reduction in state support for residential care was accompanied by an increase in early intervention programs and in the number of children served (Betty King, Site Visit Report, March 1992). Other

Miami's neighborhood governance board, "Abriendo Puertas," illustrates the kind of partnership between residents and state, local and agency representatives that is seldom seen between those levels of stakeholders.

examples of the transition from institutional to community care are the statewide Family Preservation/ Family Support Program (providing intensive in-home services and crisis counseling), the "Bring Our Children Home" Campaign, and the "Building Futures for Florida's Children" Initiative.

Reforms Resulting from MHI Implementation

A retrospective look at the accomplishments of the MHI in East Little Havana reveals numerous examples of reforms that occurred as a direct result of the initiative's implementation between 1993 and 1998. The impact of some of these reforms has been felt in various aspects of state, local, and community functioning, and are already observable in projects outside the realm of the MHI as well as outside of East Little Havana. This section discusses the changes and their implications.

Increased Local Control, Leadership and Shared Authority with Neighborhood Residents

Strengthening Relationships between Public Systems and Neighborhood Stakeholders

Miami's neighborhood governance board, "Abriendo Puertas," illustrates the kind of partnership between residents and state, local and agency representatives that is seldom seen between those levels of stakeholders. Despite a difficult beginning slowed down by lack of trust, language and cultural barriers, and differing visions, the board evolved into a viable organization driven and led by its resident majority with a supportive group of non-residents who were willing to see things through the eyes of the neighborhood.

The kind of commitment that led to the group's viability is illustrated by the process resulting in the board's full autonomy from the state. Originally, the state's office of Alcohol Drug Abuse and Mental Health (ADM) routed the Casey grant to East Little Havana through Miami-Dade County, which acted as the fiscal agent. While the initiative's governing board, "Abriendo Puertas," had some decision-making authority over the use of the grant money, the process was hampered by county policies regarding procurement, personnel, contracting, travel, and other matters. The resulting double layer of bureaucratic red tape between the state and the county slowed the Board's work, making it difficult to maintain the original focus on grassroots participation.

All this began to change when Abriendo Puertas obtained 501 C 3 status in 1998. It then requested the right to administer funding from the Casey Foundation directly instead of using the state and county as intermediaries. County and district representatives who had served on the Board from the beginning of the MHI supported the changes, vouched for the board's ability to fulfill fiscal responsibility, and were instrumental in getting the transition approved. As a result of this transition, the governance board now develops its own budget, programs, policies and procedures, and is better able to meet community needs because of local residents' input into the process. An Executive Director was hired to carry out the board's programs and administer the grant.

Miami-Dade County Administrator Jim Mooney, who has been on the board for five years, was instrumental in making the decentralization possible. In his view, "*The major accomplishment [of the Board] is that the Board has begun to become more independent*

“From the beginning, the priority of the local initiative was centered around prevention and early intervention.”

from government and to take more responsibilities for its own life, its own accountability, and its own management."

The Family Council, an independent, resident-only organization that elects community representatives to serve on the Abriendo Puertas board, is another mechanism that has promoted partnerships with residents. The group has been a breeding ground for resident leaders. The Family Council has a small budget of its own which it develops and administers to fund various community-oriented projects. The organization also links with other resident volunteer groups in East Little Havana to address shared community concerns.

The example set by Abriendo Puertas in its efforts to be more inclusive of residents and provide opportunities for meaningful involvement in decision-making inspired similar reforms around the state. The Team Florida interagency council, which oversees the implementation of the federal Family Preservation/Family Support legislation, requires that all neighborhood family centers receiving federal funds develop governing structures similar to Abriendo Puertas. The MHI's state coordinator involvement with Team Florida is credited with the adoption of Casey's consumer-driven philosophy and its dissemination to other sites.

Prevention and Early Intervention

A Comprehensive Vision for Families

From the beginning, the priority of the local initiative was centered around prevention and early intervention, as the local initiative vision statement reflects:

"A system of care which provides children and families the full range of services to enable them to successfully live at home with a supportive family in the community and to do well in school."

The vision was reinforced in 1995 when the MHI developed its version of the elements of a reformed system of care. The document outlined the following objectives:

- Organize a collaborative effort by community schools and early intervention programs so that all children are prepared to complete the primary grades physically, mentally, and emotionally.
- Assist families in obtaining information and meeting their basic needs by establishing a community support network.
- Expand access to mentoring, tutoring, and recreation programs that encourage the prevention of substance and drug abuse, delinquency and gang membership, teen pregnancy, and dropping out of school.
- Increase usage of preventive health care services in the neighborhood, particularly in the areas of prenatal and well-child care.
- Enable families to utilize available supports and services before the onset of a major crisis by developing culturally competent mechanisms.

Each of these objectives has been translated into service strategies and specific programs for children and families from East Little Havana. The details on service delivery will be the subject of another report.

Implementation of a High Quality Community-Based Service Delivery Approach

State and Local Plans Incorporate MHI Service Philosophy

Even before programs were up and running in East Little Havana, the MHI was influencing the state's thinking and approach to services. The strongest connection between the MHI's principles and state-

> We [the state's ADM office] do not write any policy any more that does not address the family's preferences, their experience, their environment…

fostered reforms was in the area of children's mental health. Evelyn Shelley, Behavior Management Analyst with the Children's Mental Health Division of the Department of Children and Families, who with others helped prepare Florida's MHI application back in 1992, believes the process instilled a new awareness that has shaped state policy ever since[1].

Before MHI principles were fully understood by administrators, she notes that the role of families and the community in determining mental health policies was minimized. Since then, however, exposure to the Foundation's philosophy has resulted in these elements being consistently factored into planning and policy considerations. According to Ms. Shelley: "*We [the state's ADM office] do not write any policy any more that does not address the family's preferences, their experience, their environment…*"

Another example of front-line practice reform impacted by the presence of the MHI in Florida relates to an emphasis on community involvement. In response to the federal Family Preservation Initiative, District XI had to develop a specialized Family Preservation and Family Support Plan for Miami-Dade County in 1995. This five-year plan involved the collaboration of parents, child and family advocates, local residents, and providers along with state and local agencies. Four members of the Advisory Board that guided the process were closely tied to the MHI, and through their input, the perspective of the Casey Foundation was incorporated into the final plan. In fact, the Casey Mental Health Initiative for Urban Children is cited on page 4 of the plan as "a champion of the basic tenets of family focused practice."

The plan calls for neighborhood family centers in seven high-risk communities, all modeled after the MHI's Abriendo Puertas Family Resource Center in East Little Havana. The principles guiding service delivery include:

- Universal access for children and families needing services.
- Collaboration.
- Parent involvement in the planning process.
- Building on community strengths.
- Cultural competence.

According to Sylvia Quintana, an ADM administrator for the District: "*The idea was to re-create the Abriendo Puertas program in other communities…and bring the Casey experience to other sites.*"

A final example of the MHI's influence on program planning in District XI comes from the Life Zone Project which was started in January 1996. Project designers emulated the MHI vision in responding to local needs, integrating services, involving local residents, and applying management information systems (MIS). Technical assistance by Foundation consultants in developing the MIS proved critically useful to district administrators.

The project divides District XI into 13 Life Zones in order to assess health and social service needs, seek appropriate budget allocations to meet those needs, and integrate required services in each zone. Because of the presence of the MHI in East Little Havana, Life Zone Six was designed to overlap the boundaries of the Casey project.

[1] In Florida, the Casey Foundation issued its grant to the Florida Department of Health and Rehabilitative Services (HRS), which since then has changed its name to the Department of Children and Families. The Department has 15 district offices and a main office in the state capital of Tallahassee. Because of this decentralized configuration, operational control of MHI was diverted from Tallahassee to the HRS District XI office (Dade and Monroe Counties), which has jurisdiction over the target neighborhood of East Little Havana in Miami.

“This co-location arrangement represents the first time East Little Havana residents have access to mental health services in a non-threatening, family friendly and culturally competent setting.”

Abriendo Puertas Leads the Way in Culturally Competent Front-Line Practice

The Florida MHI has successfully adopted and replicated nationally recognized service models and developed innovative practices of its own. Its Family Resource Center (FRC), Abriendo Puertas, is patterned after centers serving low income, minority residents in other urban areas in the country, and constitutes the main service delivery strategy. The Center has served East Little Havana residents since 1997, and is located in the heart of the community for maximum convenience. It is a vehicle for those who can benefit from prevention and early intervention, promotion, family preservation and support, and intensive services. More importantly, it provides services to foreign undocumented families who do not qualify for government assistance.

While Abriendo Puertas provides services under each category listed above, it continually adds programs and activities in response to the expressed wishes and recognized needs of residents. Some are run entirely by neighborhood volunteers, such as the Arts and Crafts classes. New supplies and materials are purchased from proceeds earned through the sale of these crafts.

The Center sets another example through its emphasis on cultural competence. Every Center sponsored activity celebrates the diverse ethnic traditions of East Little Havana residents. All FRC services and information are presented in Spanish and English. Staff members are bilingual and bicultural, and are joined by volunteers who add their special knowledge of the community. Local residents also offer community outreach expertise and serve as family support volunteers. This active involvement further enhances the cultural competency of the FRC in serving community needs.

Co-location Promotes Unique Collaborations

When the local initiative teamed up with Miami Behavioral Community Mental Health Center to bring intensive mental health services into the FRC through a multi-year federal grant, therapists and case managers from Miami Behavioral were relocated to the Abriendo Puertas FRC. This co-location arrangement represents the first time East Little Havana residents have access to mental health services in a non-threatening, family friendly and culturally competent setting.

The co-location also meant that trained mental health professionals are now supposed to partner with community outreach volunteers trying to connect needy families with services offered at the Center. An evaluation of services provided through the Family Preservation grant revealed, among other things, the untapped potential of these community volunteers to strengthen the work of the professionals. This finding, in turn, prompted the development of a training curriculum known as “Equipo Training.”

Professionals and trained volunteers called “Madrinas and Padrinos” (i.e., Godmothers and Godfathers) are brought together for an intensive training on how they can benefit each other’s work with at-risk families. In the process of discovering their respective strengths, they learn new and creative ways to address family needs that would not have surfaced had they worked in isolation. They also learn to respect and value each other’s contributions and to extend this respect to the families with whom they work.

Equipo’s policy of inviting families who receive services and supports to reciprocate by becoming volunteers who subsequently help other families in need establishes another precedent as a mechanism for the development of human capital.

“This new arrangement represents one of the first instances in which a state agency contracted with a non-profit organization whose board includes a majority of residents from a poor community.”

The Equipo Training model now has been presented at one state and three national conferences by teams of professionals and natural helpers from Abriendo Puertas. The Center for Children's Mental Health Services is already preparing to apply the Equipo Training model in some of its urban sites.

Policies, Regulations and Funding Changes

State and Local Policy Changes Support the Neighborhood's Vision

The MHI in Florida offers several meaningful examples of systems changes that state and local stakeholders undertook in support of the neighborhood's goals. One of the most significant ones is the transfer of control over the MHI grant from the state to the Abriendo Puertas board described in the previous section. This new arrangement represents one of the first instances in which a state agency contracted with a non-profit organization whose board includes a majority of residents from a poor community. Furthermore, the expedited time table to transfer grant control to the neighborhood (i.e., one month) is a record for state bureaucracy.

Additional state administrative policies had to be re-examined in response to the independence of Abriendo Puertas. For instance, when the MHI's Executive Director resigned from her position, the state honored Abriendo Puertas' request to allow an ADM district administrator who had worked closely with the MHI for several years, to become the Interim Director. As a rule, state policy does not allow a state employee to serve on boards of agencies with which it contracts. Thanks to the MHI precedent, the state is now allowing another one of its employees to serve on the board of a contracted organization.

The state made another exception to allow the board to set its own criteria for hiring the new Executive Director. With the previous Director, the county's job description had been used. A board committee composed of a majority of residents and the Interim Director developed a list of candidate qualifications. The same committee wrote the questions that were in the candidates' interview, and made the final recommendations to the full board. The end result was a compromise between what neighborhood residents thought was needed to best serve the interest of the community, and the state's desire to have a strong administrator in charge.

The county also made administrative changes to facilitate the implementation of the MHI. As the state designated fiscal agent prior to Abriendo Puertas' taking control over the grant, the county used its own policies and procedures to administer funds. When it became obvious that the bureaucracy was working against the MHI's goal of neighborhood involvement, an effort was made to simplify things. In particular, payment and travel reimbursement policies were expedited to accommodate neighborhood residents' participation in national meetings and conferences. The county also lent the MHI one of its accountants to serve as administrative officer. This person's familiarity with county regulations greatly simplified an otherwise cumbersome process.

A final example of local reform undertaken as a result of the MHI implementation relates to changes in personnel and reporting policies to support the service design. As previously mentioned, Abriendo Puertas partnered with Miami Behavioral Community Mental Health Center for a federal Family Preservation/Family Support grant. The partnership involved the co-location of Miami Behavioral therapists and case managers at the Family Resource Center. Furthermore,

“Abriendo Puertas establishment of a Time Dollar program as part of the FRC has created a unique system of reciprocity where services and supports are exchanged by participating residents.”

the team work required by the work in Equipo did not fit the agency's traditional job descriptions. The old "Individual Case Manager" title was replaced by a "Family Support Specialist" position. The Family Support Specialist works with the entire family based on a family service plan. Reporting requirements have also changed to reflect work with the family as opposed to just the target child. The clinically-oriented and restrictive Medicaid menu of services has been replaced with flexible services tailored to the specific needs of each family. The Family Specialist's efforts to coordinate with other providers working with the family are now viewed as "part of the job." According to the person holding the position: "*My job is much more flexible and I have more freedom to work with the family as a team.*"

Creative Strategies Lead to Fiscal Sustainability

Abriendo Puertas has been proactive in its efforts to ensure the sustainability of its programs after the Casey grant is over. In addition to securing various federal and local grants to cover services and operating expenses, the organization has obtained donations and in-kind contributions amounting to thousands of dollars. Miami-Dade County, for instance, sublets Abriendo Puertas two office suites for $1, instead of charging the actual rental cost of $62,000 per year. It also pays for utilities. Monetary donations from individuals and corporations have totaled over $25,000 in the last year alone.

Private corporations donate food, clothing, furniture and toys for families who come to the FRC. Individuals and local service organizations provide free tickets to special events for Abriendo Puertas' youth group members as well as toys for the holidays. A local hospital has hosted Christmas parties with gifts for every child in attendance for two consecutive years. A local health clinic has donated space to conduct trainings and meetings.

Other creative strategies include the use of volunteers to support activities and the operation of the FRC. An art instructor donates painting lessons for children twice a week and offers a furniture recycling class to adults once a week; a puppet class instructor donates two hours a week; Pro-Personas Mayores (Alliance for Aging) has three staff members working 20 hours a week each as receptionists, one offers sawing classes; students from Florida International University and the Miami Institute of Technology assist in planning, implementation and evaluation activities as part of a class or internship.

Events co-sponsored by Abriendo Puertas and the Family Council have raised money for additional activities. A very successful flea market was conducted in 1999 and another one is being planned.

Finally, Abriendo Puertas establishment of a Time Dollar program as part of the FRC has created a unique system of reciprocity where services and supports are exchanged by participating residents. Volunteers donate their time to support activities at the Center (e.g., food bank, child care, clean up) and other community organizations. In return, they are entitled to receive goods, services and supports when they need them. Although the monetary value of these exchanges has not been calculated, 8,699 volunteer hours have been logged so far.

“The development of the Initiative's internal MIS is the area that has shown the most progress”

Management Information Systems and Effective Use of Information

The goal of integrating data bases across neighborhood, local and state levels was not fully accomplished in Miami. However, some promising steps in that direction were undertaken and continue to be supported by the Abriendo Puertas Board.

The development of the Initiative's internal MIS is the area that has shown the most progress. Before selecting a software package for client tracking purposes, the site went through a process of mapping the flow of clients through the various programs offered at the Family Resource Center (FRC). FACTORS (DOS version) software was found to be the best package for tracking clients served at the FRC. This system compiles demographic information, and monitors participation in FRC activities. It also has the capacity to maintain case management notes which can be entered by staff.

After two years of preparation, six FRC staff members now utilize the system and have received FACTORS training. A database administrator maintains the system.

The information captured by FACTORS can be shared across the different programs that are housed in the center. This is important in service delivery because program staff are able to use the system to obtain information about family members who may be using different programs.

Although the FRC system is not connected with any state information system, some attempts are being made to integrate data collection at the local level by adopting common computerized intake forms. Miami Behavioral Health Center, a private non-profit agency holding the contract to provide Family Preservation/Family Support under a federal grant, has agreed to create a form to track services rendered to clients by its staff co-located at the FRC. This form separates clinical from demographic information in an effort to maintain client confidentiality. The section capturing services is shared with the client tracking coordinator at the FRC who uses the information to create reports on the various aspects of service provision.

In addition to the client tracking system, Miami was also able to establish a database that tracks the Time Dollar program. Time Dollar is a program whereby people exchange volunteer hours for goods and/or services (e.g., food, clothing, baby sitting, transportation). The database keeps track of the volunteers' hours, and summarizes individual "accounts" and activities on a monthly basis.

HIGHLIGHTS OF SYSTEMS REFORM IN FLORIDA

Pre-Implementation Environment

- Visionary leadership
- Strong commitment to interagency collaboration
- Public funding of early intervention and prevention programs

Reforms Resulting from MHI Implementation

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

  Abriendo Puertas Neighborhood Governance Board receives Casey funds directly from the state.

  The Family Council, a grassroots group initiated by the MHI, trains new leaders to serve on the governing board and advocate for their community.

  Team Florida requires all neighborhood family centers receiving federal Family Preservation/Family Support funds to develop consumer-driven governance structures patterned after Abriendo Puerta's board.

- Prevention and early intervention

  The local initiative develops and implements a comprehensive vision emphasizing prevention and early intervention.

- Implementation of a High Quality, Community-Based Service Approach

  Abriendo Puertas Family Resource Center (FRC) becomes a model for centers funded through the Family Preservation and Family Support Plan for Miami-Dade County.

  East Little Havana is designated as a Life Zone project by the Department of Children and Families in District XI. The MHI's guiding principles are incorporated into the Life Zone implementation.

  Abriendo Puertas FRC develops community-based, culturally competent, and family-centered programs with input and participation from residents.

  Co-location of mental health professionals at the FRC leads to new collaborations with community volunteers.

  The Equipo Training model developed for Abriendo Puertas brings professionals and natural helpers together to improve family outcomes.

- Policy, Regulations, and Funding Changes

  Local initiative obtains federal and local grants to ensure sustainability

- Management Information Systems and Effective use of Information

  Integration of databases across neighborhood, local and state levels was not accomplished.

  Internal MIS has been developed to track client flow and activities at the FRC.

  Time Dollar Bank established its own database to administer volunteer hours.

MASSACHUSETTS

- **Mission Hill, Highland/ Washington Park and Lower Roxbury Communities Site Profile**
- **Systems Reform in Massachusetts**
- **Highlights**

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.

[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.

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 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.

[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).

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

SYSTEMS REFORM IN MASSACHUSETTS

Pre-Implementation Environment

The Mental Health Initiative for Urban Children found a willing partner in the Commonwealth of Massachusetts. Each embraced reform objectives with similar philosophies, accounting for the Casey Foundation's choice of Boston as an MHI site. The pre-implementation context in the State of Massachusetts included an emphasis on service integration and coordination, data utilization in policy decisions, preventive services, and family and community inclusion in service delivery.

During an initial Foundation visit to Massachusetts in 1992, service integration and coordination were found to be two important themes in service delivery. Several projects with this specific focus were already underway in the state at the time. One of them was the Healthy Boston Coalition, which was being spearheaded by the Boston Department of Health and Hospitals with additional support from the Kellogg Foundation. Its goal was to encourage collaboration between local agencies and increase their degree of integration, especially in service delivery and fiscal matters. Additionally, the Coalition sought to coordinate the activities and resources of municipal agencies and departments. Funding was secured from federal, state, and private sources.

The state's Executive Office of Health and Human Services had also started its own interagency planning committee focused on children's services. Committee representatives came from Education, Health and Human Services, and Public Welfare. A similar group was assembled by the Office of Children's Services for the purpose of reviewing and referring children with multiple agency needs.

The state's willingness to deliver more coordinated and integrated services was also evident in the FY 1992 Budget. The Department of Mental Health was called on to design a model for enhancing interagency coordination of services to at-risk children and adolescents, and to develop a pilot project for Metro-Boston. This model would blend funding among agencies and facilitate a shared mission.

The climate for change in the state was further exemplified by the way the state was beginning to collect and use data in policy decision making. Even though it was not yet possible to integrate client tracking systems, both the legislative and executive branches realized the value of a Management Information System that could collect, compare and analyze cross agency data.

Another factor that showed Massachusetts was committed to reform was its overall focus on prevention, early intervention and community-based care. This stood in sharp contrast to traditional service delivery approaches which tended to focus on inpatient services, hospitalization, and placements outside the home. With budget cuts affecting several agencies, the state had to close some institutions, and transfer patients to less costly community alternatives that were based on the nationally recognized Ventura Model.

There were other indications that Massachusetts favored the adoption of a more preventive approach. Legislation provided insurance coverage to children up to the age of six. Other changes included furnishing a full range of mental health services to children in Head Start along with improved parenting and support services. A new Early and Periodic Screening, Diagnosis and Treatment Planning (EPSTD) program featured mental health screening, along with health screening and a broad range of other benefits.

“Resident involvement in decisions regarding service delivery can be traced to the initial selection of the lead service agency for the MHI.”

A final indicator of the state's congruency with the MHI's philosophy was a strong emphasis on family and community inclusion in service delivery. At this time, Massachusetts was beginning to grapple with the issues of "community voice" and "community ownership" in service delivery. Both the Metro-Boston and Healthy Boston Initiatives actively encouraged family representation and participation. In addition, the Parent/Professional Advocacy League (PAL) was functioning as a hub for parent advocacy groups. PAL's goal was to improve collaboration between parents and professionals, promote advocacy, and provide a support network for parents.

Reforms Resulting from MHI Implementation

The Mental Health Initiative coincided with a general willingness to undertake reform in Massachusetts, and its implementation from 1992-98 reinforced this path. By emphasizing the importance of neighborhood residents' involvement, community-based programs, and inter-agency collaboration in the reform process, the Initiative demonstrated that actions taken on the local level could exert an impact far beyond their original intent.

Increased Local Control, Leadership and Shared Authority with Neighborhood Residents

Roxbury Unites For Families and Children, Inc. (RUFC) was the governing structure created to guide the implementation of the Initiative. Stakeholders at the state, local and neighborhood level communicated and interacted through RUFC for the span of the MHI. A direct result of that interaction was the strengthening of leadership capacity among residents, and a move toward more shared decision making, particularly around service delivery.

Residents Help Decide How to Best Meet their Needs

Resident involvement in decisions regarding service delivery can be traced to the initial selection of the lead service agency for the MHI. At the urging of RUFC resident board members, the state, as the Foundation's grantee and contracting entity, agreed to change its Request for Proposals' (RFP) review policy. Typically, only state employees participate in a proposal review process. In the MHI's case, however, the state allowed residents from the MHI neighborhoods which would receive the contracted services to participate in the selection of the provider agency. Later, another exception was made to include residents in the selection of the client tracking system to be purchased per MHI contract.

These changes in policy established a precedent for parent and consumer involvement in review groups with various state agencies. Moreover, the MHI experience led the Department of Mental Health to make a special effort to seek involvement from minority consumers in decisions regarding service contracts.

Through these and other opportunities afforded by their interaction with state and local levels, residents were able to voice legitimate concerns regarding service delivery. As a state representative reflected: *"They have managed to get their issues on the policy table at the state level."*

Service providers also learned to listen and be accountable to the resident-led governing board. In a significant departure from the way they traditionally operated, Children Services of Roxbury (CSR), the lead agency for service delivery, had to provide

> The board is a force to be reckoned with.

monthly updates and reports on their progress to RUFC. At times, the agency's actions were questioned or halted all together by the board. In the words of a resident Board member "*The board is a force to be reckoned with*" and maintained that "…*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.*"

The state's and providers' efforts to involve residents in the decision making process, however, were not always successful. Some state and provider level stakeholders believed that active resident involvement slowed down the implementation process because of the need to educate, inform and negotiate issues with residents before activities could be undertaken. These beliefs became a significant barrier to service delivery in the MHI in Boston.

Residents' Lobbying Attracts Funding for Their Neighborhoods

The leadership skills that some RUFC's resident board members honed through their involvement with the MHI were also evidenced in their successful lobbying efforts on behalf of their communities. Thanks to the residents' engagement of the support of Roxbury's state representative, the legislature allocated approximately three million dollars for four successive years to support RUFC's cause. The money was used to finance the site's service delivery strategy. This represented the first time such a large amount of money was allocated by the legislature to serve designated neighborhoods within the city.

While all stakeholders agree that this precedent was a significant achievement for a grass-root organization, unanticipated obstacles interfered with its long term success. Stakeholders at the state level speculated that the task of managing such a large amount of money may have distracted the attention of the board and weakened other components of the Initiative. They also felt that RUFC had insufficient administrative and fiscal experience to manage the state's allocation. Ultimately, these challenges resulted in the suspension of the allocation and discontinuation of services.

Resident Board Members Expand Their Influence Beyond the Neighborhood.

One additional significant benefit of resident involvement in the MHI was their exposure to new ideas, models, and strategies to promote the types of reforms that would lead to better services. Through participation in training events sponsored by the Foundation, interaction with the Foundation's technical assistance team, and attendance at national conferences, both as participants and presenters, residents' confidence and visibility grew. As a result, a few RUFC Board members were invited to join local and national advisory boards and consumer advocacy groups, such as the Federation of Families for Children's Mental Health, the National Association for Families with Basic Needs, the National Industrial Cooperatives of America, the Annie E. Casey Foundation's Latino Consultative Group, and Boston's Public Housing Task Force.

Prevention and Early Intervention

Preventing Recidivism Becomes an Important Service Priority

Data collected during the application phases of the MHI in Massachusetts revealed that there were nearly 800 children from the targeted neighborhoods who were in out-of-home placements outside their communities. These statistics prompted the state after the Foundation awarded its grant, to target these

> …we were in the neighborhood, we were culturally competent and family-centered, all our folks were parents and we used community providers. People borrowed from us…we made a start on the journey…

children to bring them back home to their communities and prevent them from going back into placement or becoming further involved in the juvenile justice, mental health or child welfare systems.

The site's response to this priority was the "Roxbury Returns Project" (RRP). The project was coordinated by a Strategic Management Team (STM) comprised of state officials from the Departments of Mental Health, Social Services, Youth Services, and RUFC board members and staff. The STM identified children under the custody of state agencies who could benefit most from the community-based services provided under the MHI. The program was successful in bringing at least thirty children home from placement. However, after one year in operation, the STM stopped meeting and the program was discontinued. Despite its limited impact, the creation of the STM as a case identifying and referring mechanism, and the collaboration of the state agencies involved with a community-based program with significant resident input is an important precedent for future attempts.

Implementation of a High Quality Community-Based Service Delivery Approach

A Break From the Traditional Way of Serving Families in Massachusetts

There is no doubt that the MHI brought about an increased awareness among all stakeholders of the value of keeping children and families together in their communities, and put new ideas forward on how to do this in partnership with community residents. As a stakeholder from the state described it: "*We kind of led the way. We did this when nobody else was doing this. In Massachusetts, we did a lead agency with the network, we did wraparound programming, we tried to have quality assurance and utilization management…we were in the neighborhood, we were culturally competent and family-centered, all our folks were parents and we used community providers. People borrowed from us…we made a start on the journey…we were the groundbreakers…we started the movement.*"

In developing a vision for service delivery for three distinct neighborhoods, RUFC adopted the best practice approaches in the children's mental health field, including services that were sensitive to race and culture, and accessible and available to those who needed them. This was unprecedented for many residents who had been forced to seek assistance outside of their community and who were for the most part served by individuals who did not share their social background, race, or culture.

RUFC's service strategy also combined professional and para-professional (resident) staff. Resident board members working in the service design committee believed that families would respond better to teams of professional workers with knowledge about agencies and clinical training and para-professionals with knowledge and understanding of community dynamics, and social, racial and economic barriers faced by their clients. Although the approach was implemented, it ran into difficulties because it did not have a strategy to get the two groups to work cohesively as partners on the same team.

Unfortunately, the service strategy in Boston did not survive the end of the Initiative. Operating three independent centers involved many formidable administrative challenges including managing and brokering power between stakeholders from the state, local and neighborhood levels. The loss of the Legislature's allocation combined with inadequate sustainability plans contributed to the closing of the FRCs.

“The FRC model, for instance, has been modified and repeated in projects undertaken by other State agencies.”

The philosophy behind the way services were delivered by the MHI, however, seeded new ideas about the way services can be delivered to low-income, minority families living in urban areas. The FRC model, for instance, has been modified and repeated in projects undertaken by other State agencies. The Department of Public Health (DPH) has a total of seven Family Resource Centers managed by parents that have been established across the state through the Children's Trust Fund. Another DPH center based on this model helps with the development of healthy babies and the empowerment of parents. In addition, the City of Boston has also applied the MHI Family Resource Center model to create Family Opportunity Centers as sites to train and assist job seekers. Selected schools are also using the model for parent education and information.

MHI Promotes Cultural Competence and Strengthening of Minority Providers' Service Capacity

In a few areas, the MHI affected overall attitudes of state agencies. An objective of the MHI in Boston was to increase and strengthen minority-based organizations located in the targeted neighborhoods. Although these expectations were never fully realized, the Initiative has been credited with pushing the notion that established minority community-based organizations should be an important aspect of service delivery reform. The MHI also provided a backdrop for more open discussions with the state about cultural competence in service delivery. The state responded by requiring that all applicants for state social services funding address issues relating to improving the minority provider base and cultural competence. One state informant reported on this important change: *"Now we are looking at new language in Affirmative Action that says you must help build capacity among minority agencies. That was never there before."*

Policies, Regulations and Funding Changes

Flexible Funds Provide Resources for Families

The MHI was responsible for a introducing the concept of flexible funding in service contracts. Under the MHI, the state contract with service providers authorized the spending of flexible dollars that could be used to purchase anything a family needed, from time in an inpatient unit, to furniture for the house or a membership at the YMCA. This flexible wrap-around funding mechanism was a significant departure from the traditional contracts that purchased established services for specific needs from a narrow list of what providers could offer.

The Department of Mental Health's flexible fund contract with the MHI's lead agency was the first time this model was used in the state. Since then, the Department of Social Services has adopted it, and DMH is in the process of expanding it to other programs.

Management Information Systems and Effective Use of Information

The Boston site, like the other MHI sites, did not meet the Foundation's expectation that armed with accessible, accurate, and easy-to-understand data, stakeholders at the different levels would be able to make more informed service delivery decisions. This was partly due to challenges related to retrieving service utilization information and linking local and state level data systems.

The site however, took the first step in being able to effectively use information by successfully setting

> The Department of Mental Health's flexible fund contract with the MHI's lead agency was the first time this model was used in the state.

up its own client tracking system which operated until the FRCs were closed down toward the end of the MHI. The system was purchased under the guidance of Cambridge Resource Group[1], with some assistance from the Department of Mental Health and input from the Board. It supported client intake, case management activities, assessments, treatment and planning notes, as well as demographic information on families served through the FRCs.

The programmatic data generated through the local MIS was shared with board members and other stakeholders. This sharing represented a change from the established path followed by state and local providers who did not routinely provide community representatives access to this type of information. Furthermore, the fact that some resident Board members were actively involved in data collection and Management Information Systems issues facilitated open discussions of consumer concerns about confidentiality, 'child labeling', duplicative intake processes and other factors relating to service utilization that often resulted in significant consumer burden.

A final accomplishment related to data collection had to do with the MHI's emphasis on obtaining data by zip code. In preparing the application to the Casey Foundation, Massachusetts was able to identify 800 children from the three targeted neighborhoods who were in out-of-home placements outside the boundaries of the communities where they lived. The geographical distribution by neighborhood was obtained from the children's residential zip code. Following the MHI's example, the head of the Executive Office of Health and Human Services for the state has adopted the concept of looking at city-wide statistics by zip code. The Targeted City Project seeks to project trends for the next 10 years in eleven cities across the state combining state and city data. The goal is to use these micro-level statistics to better target social and other types of programs to areas with the most need.

[1]Cambridge Resource Group was the local consulting firm contracted to assist the site with data collection and MIS related issues.

HIGHLIGHTS OF SYSTEMS REFORM IN MASSACHUSETTS

Pre-Implementation Environment

- Strong commitment to service integration and interagency collaboration.
- Shift in mental health service provision philosophy from inpatient to prevention, early intervention and community care.
- Valued family involvement in service delivery.

Reforms Resulting from MHI Implementation

- Increased Local Control, Leadership and Shared Authority with Neighborhood Residents.

  Residents participate in service delivery decisions and through the Request for Proposal (RFP) process help choose the lead service agency.

  Residents lobby legislature for $3 million for four consecutive years to sustain the Initiative.

  Residents participate on other local and national advisory boards.

- Prevention and Early Intervention

  Preventing recidivism becomes an important service priority and Roxbury Return Project brings children in placement back home.

- Implementation of a High Quality Community-based Service Delivery Approach.

  MHI provides a non-traditional way of serving families providing easily accessible, culturally-competent and family-friendly services.

  Although the FRC no longer exist, the MHI community-based FRC model is adapted and used by the Department of Public Health, the City of Boston and others.

- Policies, Regulations and Funding Changes.

  MHI helps the state broaden its definitions for allowable expenses for family services and flexible funding pools are created.

- Management Information Systems and Effective Use of Information.

  The site does not fulfil the goal of effectively using data in service delivery decisions. However, as an important first step stakeholders purchase the 'Sociomedics' client tracking system which compiles data on case management activities, assessments, treatment and service utilization.

  Residents are routinely informed about service utilization, caseloads and other statistical data.

  Resident participation in MIS development is credited with facilitating open discussions on confidentiality, 'child labeling,' and duplicative intake processes.

TEXAS

- **Third Ward Site Profile**
- **Systems Reform in Texas**
- **Highlights**

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

[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."

children and youth. Additionally, there are four "Magnet" programs including one Vanguard program.

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 (NACP). 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.

SYSTEMS REFORM IN TEXAS

Pre-Implementation Environment

In 1992, the Annie E. Casey Foundation site assessment team recommended locating a Children's Urban Mental Health Initiative in Texas, both because of the need for improvement of children's services in the state and because improvements were being undertaken. Specifically, they spoke positively of the Governor's support and the strong leadership and competent staffing in the state mental health agency.

Central to their expectation for improvement was the strong leadership promised by then-Governor Ann Richards. Dr. Pat Cole, Richard's representative in meetings with the Foundation, was described by one of the site team members as *"savvy about the … initiative [which] creates an important level of assurance of support and understanding from the Governor"* (Pires 1992, p.1).

Cross Agency Coordination for Children with Multiple Needs

Texas' commitment to improving the coordination among state agencies serving the same children was an important precursor of systems reform noticed by the Foundation. The Children and Youth Services State Coordinating Committee was created in 1987 to help state and local agencies serve children with problems that required a joint response.

Texas Family Code § 264.003 (formally Texas Human Resources Code §264.003), enacted at the time, required state agencies to maintain a memorandum of understanding (MOU) so that services could be provided to children who might otherwise "fall between the cracks." Input from private service providers and children's advocates helped shape the MOU, which was adopted by several agencies including the Departments of Human Services and Mental Health and Mental Retardation, the Education Agency, Juvenile Probation Commission, and the Youth Commission. The most current MOU also includes the Department of Protective and Regulatory Services, and the Interagency Council on Early Childhood Intervention.

In 1989, the Children and Youth Services State Coordinating Committee became the Commission of Children, Youth, and Family Services. One of the Commission's work groups continued the implementation of the MOU. The Community Resource Coordination Groups model (CRCGs) was piloted in four communities and following the pilot, the work group prepared to implement it statewide. During 1991 and 1992, one-fifth of the state's counties initiated CRCG's. As of December 1996, CRCG's were available to all 254 Texas counties.

According to a number of surveys, evaluations and data reports from local CRCG members, the initiative has been well received, and CRCG's appear to be improving coordination of client services between agencies.

Consolidating State Human Service Agencies

Eleven separate agencies shared responsibility for providing human services in Texas until the passage of State House Bill 7 in 1992. Governor Richards then

“In 1990, the Texas Legislature created the first line item for children’s mental health services by funding five demonstration projects.”

created the Health and Human Services Commission[1] to centralize control over these diverse agencies.

This umbrella organization coordinated budget requests, streamlined funding, and coordinated service planning and implementation, including strategies such as co-location of offices (service centers).

Improving Mental Health Care to Texas Children

State leaders have worked throughout the 1990’s to improve the state’s mental health related services for children. In 1990, the Texas Legislature created the first line item for children’s mental health services by funding five demonstration projects. Two years later, it appropriated money to the Texas Department of Mental Health and Mental Retardation (TXMHMR) for implementation of the Texas Children’s Mental Health Plan (TCMHP).

Representatives of the Casey Foundation praised the legislation because it required, “*…collaboration … of all agencies and … embodies the CASSP principles of service integration, interagency networking and family empowerment, and goes beyond traditional mental health programs in requesting a strong drug treatment component to respond to the realities of the 1990s*” (King 1992, page 1).

Twenty-nine centers were funded that year to serve persons from birth to 17 who had an official psychiatric diagnosis, were at risk for removal from home, or attended a special education class at school.

[1]The Health and Human Services Commission reviews and approves lease requests for new and existing office locations of the eleven health and human services agencies to assess co-location potential. The division maintains a database of all health and human services locations in the state. HHSC and the health and human services agencies work to co-locate office locations as existing leases expire. Activities are coordinated through the Co-Location Workgroup.

Reforms Resulting from MHI Implementation

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

Reciprocal Relations Bring MHI Neighborhoods Closer to Local Partners

The MHI has set an example for the state in terms of re-evaluating the contributions of neighborhood organizations to the enhancement of local services. Loss of support at the state level stemming from the change in governors early on in the Initiative prompted the Texas MHI to forge links between the city, county, and legislative delegation and the target neighborhood, known as the Third Ward. For instance, the Mayor of Houston and the Mayor Pro-Tem, as well as other elected officials, are emphasizing neighborhood organizations as a way of promoting grass roots change, service provision, and extra-electoral representation in city government. The Executive Director of People in Partnership (PIP), the governing entity for the MH—specifically because of the organization’s experience with grass roots development—has been made part of a task force formed by the Mayor to promote such organizations throughout underserved areas of the city. The stated purpose of this (aside from increasing local support for the city government) is to use local resources to help solve local problems.

The opportunities to interact afforded by the MHI has created a two-way awareness. Just as city officials are more interested in grass-root efforts, resident PIP members, local directors of state agencies, and service-

In order to foster leadership development, FAN members received training in community outreach and education.

related groups have also become more aware of relevant city and county government officials, and their new or ongoing projects. This knowledge helps ensure that input from local stakeholders will be taken into account as meaningful policy changes are considered.

Resident Input Channeled through the MHI

The growing influence of local residents in the Initiative parallels changes within People in Partnership (PIP), the MHI governing body in Houston. Noteworthy examples include:

- Replacement of the original provider-driven neighborhood governing board (NGB) membership with residents recruited from, and elected by, the neighborhood itself.[2]
- Development of the Family Advocacy Network (FAN) in 1994, and its growth in strength and effectiveness. In order to foster leadership development, FAN members received training in community outreach and education. As one neighborhood resident described: *"…they are educating and letting [residents] know that as neighborhood people, they do have power and if they have problems they can do something about it."*
- FAN facilitation of a training partnership between PIP staff and Texas Southern University. The "Friends of the Family" training program builds capacity and focuses primarily on neighborhood residents, although service providers may also attend. The program develops and enhances skills that assist graduates in serving neighborhood families and enhances their own personal development and their readiness to assume leadership positions in the Initiative. Two training cycles have been completed up to now.
- Creation of a local Provider Network to re-connect providers with the Board. This allows providers in and around the neighborhood to learn about MHI goals and principles. The Network Chair sits on the Board of Directors and serves as a liaison between providers and the Board. As PIP prepared to bid for participation in the managed care referral system, Provider Network members formed the core of providers to which they would refer.
- Establishment of the Inter-Agency Council (IAC), whose members are drawn from local directors of state agencies. While intended to build bridges to these agencies, a higher degree of local collaboration and cooperation currently exists through the IAC than is found officially at the state level.
- Participation in the American Federation of Families (PIP staff and board members), which awarded the FAN special recognition for outstanding service.

Prevention and Early Intervention

A Community-Based Diversion Program for Adolescents at-Risk

Of the various service strategies applied by the PIP, the one with the greatest impact on prevention and early intervention has been a diversion program for adolescents at risk for out-of-community placement. This program—operated under a contract with the Department of Juvenile Justice—involves juveniles who have been court ordered to participate for a year in a weekly program of activities and discussion, and sup-

[2]This Board was disbanded in 1995 and a new Board was elected in a neighborhood election in 1996. Providers and state agency representatives largely lost the right to vote with the Board, except in cases where providers were also residents and could serve on the Board in that capacity.

> In my lifetime, this is the first time this many partners have sat down together to build something. In the past, they have only come together to criticize something.

port groups aimed a reintegrating them into society while they continue to live at home and attend school. Over a hundred youths have completed the program and their recidivism rates are far lower than rates in comparable forms of diversion and rehabilitation.

A counselor works with program participants so that they can avoid self-destructive behavior and further encounters with the police. What makes this program innovative is that the counselor is a charismatic local man, working within the Community Resource Center, and the youths in the program are also from the neighborhood. The positive results of the program have led Juvenile Justice officials to encourage similar community-based programs elsewhere.

Implementation of a High Quality Community-Based Service Delivery Approach

Setting the Example on Cultural Competence

The MHI in Texas has set some important precedents in terms of applying the CASSP service principles to practice, especially in terms of cultural competence.

By stressing the value of cultural diversity and the understanding of what cultural competence represents, the MHI has set an example for others to follow. For instance, the Child Protective Services (CPS) Agency in Harris County sought advice from People in Partnership concerning ways to increase the number of minority foster and adoptive parents. In March and May of 1998, PIP sponsored two roundtable discussions where stakeholders and community representatives worked on possible solutions. The resulting plan called for lobbying the local legislative delegation, and educating them on the need to enact a law to encourage adoptions by minority foster parents. Since CPS cannot undertake lobbying efforts as a state agency, PIP assumed that responsibility. Its strong relationship with the neighborhood's state representative elicited a promise to support this proposed legislation in upcoming sessions. The eventual outcome remains uncertain, but the local CPS staff is optimistic.

Similarly, the trained FAN volunteers who are residents of the Third Ward bring their extensive knowledge of issues affecting consumers of services and their community at large into their advocacy on behalf of families. Their type of cultural competence cannot be taught.

Local Collaboration and Coordination Increased

As the former MHI State Coordinator said during a 1998 interview: "*In my lifetime, this is the first time this many partners have sat down together to build something. In the past, they have only come together to criticize something.*" She considered this improved dialogue to be a major step in systems reform, a sentiment echoed by local directors of state agencies. Two of them contended that interagency collaboration is found only at the local (but not the state) level, despite "bureaucratic statements" to the contrary by agency staff in Austin.

Earlier cooperation was sporadic, and depended on the existence of personal ties between staff members in different agencies. However, it is now routine for agencies to sign letters of intent which outline how their services will complement one another. The influence of the MHI in this process is unclear, but a consensus of interviewees agreed on its value as part of a general change of consciousness that has been developing in the 1990s.

“The Executive Director of PIP proposed that its provider network could be used as the base for a Medicaid provider pool.”

Another change tied to the MHI is seen in the manner in which PIP is seeking to expand their resource base by redirecting their focus from the large state bureaucracies to development of their own local service systems through its managed care contract, and by advocating for needed human resources. In the words of the Chair of the Inter-Agency Council (IAC), what is needed is “community entrepreneurship.” He suggested that local officials in state agencies who regard the Initiative positively, state and federal legislators, and county commissioners should receive regular information concerning success stories and other forms of advocacy from staff and MHI board members alike.

Finally, PIP has also done a very good job of bringing together providers and community activists to mobilize in support of the Third Ward. In 1992, a group of service providers and community representatives applying to the Casey Foundation formed a community-wide organization known as “The Community Cloth.” Relationships between PIP and The Cloth have changed over time. During some periods as PIP struggled with issues of balance between professionals and residents, there was complete separation between the two organizations, though both had grown in response to the same initiative. Nevertheless on several occasions, The Cloth has joined with PIP in neighborhood activities, publicizing and dramatizing adult literacy programs, turning out participants in PIP’s elections and on other occasions. In all this, the Cloth has never provided direct services or received Casey funds.

Policies, Regulations, and Funding Changes

Managed Care in a Community Setting

As Texas developed its system for channeling Medicaid funds into a managed care framework providing mental health and addictions treatment to the poor, it became apparent that there was an opportunity for the MHI to make use of its grass roots expertise to direct this funding stream to the neighborhood.

In 1997, a PIP administrator gave this account of how ongoing financial support might become available: *“We’ve applied for our Medicaid provider number to funnel dollars to the service strategy. I think that’s going to be real critical to provide dollars into the provider network. I think that will really allow us to delineate what are administrative functions and what are service dollars.”*

The Executive Director of PIP proposed that its provider network could be used as the base for a Medicaid provider pool. PIP could then act as a managed care broker, referring children and their families to appropriate mental health services provided in their own communities. Funding of all non-Medicaid services would have to be found elsewhere.

Putting the managed care idea into practice has required a great deal of persistence and learning. PIP instituted a software package to do the Medicaid billing for the members of its provider network, and provided some case management services on its own. After gaining agreements with up-stream care managers to broker services, however, a major problem presented itself in the need to qualify local providers as Medicaid providers. This has required not only learning on the part of the PIP staff, but also learning on the part of providers.

“To accommodate the managed care contract, PIP has re-organized into two operational sections, Behavioral Health Services, and Family Development.”

Unfortunately, only very few of the original local service providers have been able to meet Medicaid requirements. As a result, while the PIP has been able to retain control over referrals, its provider network has lost importance. For those community-based organizations that PIP was able to credential and certify, however, it represented the difference between extinction and survival.

Funding Wraparound Services

To accommodate the managed care contract, PIP has re-organized into two operational sections, Behavioral Health Services, and Family Development. Behavioral Health Services is the Medicaid managed care arm of the organization. However most of the previously existing services, including the Family Resource Center and the VISTA contract (which has provided for outreach services and other forms of assistance, but which will be discontinued at the end of the present year) are in the Family Development section.

It is not yet clear how much revenue will be available for wraparound services from the managed care program. The Executive Director believes that separate funding will always be required for Family Development activities. A fundraising capability is being developed along with the pursuit of grants and other program-specific funding sources. Fortunately, continued funding for the Family Development section has been secured from the local Hogg Foundation, which is active in children's mental health programs.

Other Sources of Revenue

The increasing role of the PIP as a player in local service provision activities also portends additional funding opportunities from a variety of sources. The Executive Director, continuing the remarks quoted above, addressed this issue: "*The training consortium (referring to PIP, Texas Southern University, and the Friends of the Family training) is really at a point now where it can be an income-generating mechanism.*" In fact, today, managed care contracts with HMOs include a budget line item to bill for the services of para professionals trained with the "Friends of the Family" curriculum.

Management Information Systems and Effective Use of Information

The MHI in Houston never developed a formal management information system. This was unfortunate because early in the Initiative a thorough needs assessment was conducted, and this would have provided a useful bench mark with which to begin. Three major barriers stand out and should be considered for the sake of future initiatives.

The first factor is the nature, and context, of services and service provision. Many of the activities of PIP were one-time educational or community involvement projects, which did not lend themselves to the kind of case tracking one normally thinks of for this kind of information storage and use; or they were the kind of political or organizational activities that are difficult to record and quantify. In the Family Resource Center, because there were no fees for services provided, there was little incentive even to keep client charts, much less lists of clients seen and services provided, many of which were (and are) not easily quantifiable.

The second factor is the immediacy of contact with residents in the neighborhood. Due to the strong involvement of residents in the Initiative, there may have been a sense that needs were already known, and that quantitative data was unnecessary or even misleading. Related to this issue is the fact that the sys-

> ...the systematic collection and analysis of data to continuously improve services was not seen by neighborhood residents as a natural path to services.

tematic collection and analysis of data to continuously improve services was not seen by neighborhood residents as a natural path to services.

Finally, given the other two factors, it is understandable that, given the urgency of carrying out the Initiative in five years, and the priorities of the people involved, MIS would be put off until a future time when other, more pressing issues had been taken care of.

HIGHLIGHTS OF SYSTEMS REFORM IN TEXAS

Pre-Implement Environment

- Strong leadership provided by the governor and heads of key state agencies.
- Cross-agency coordination for children with multiple needs

  The Commission of Children, Youth, and Family Services created in 1989 assists state and local agencies to coordinate local service delivery.

  Local Community Resource Coordination Groups (CRCG) were piloted in 1989. As of December 1996, CRCG's were available to all 254 Texas counties.
- Creation of the Health and Human Services Commission as an umbrella organization for service planning and implementation
- The Texas Children's Mental Health Plan (TCMHP) was implemented in 1992.

Reforms Resulting from MHI Implementation

- Increased Local Control and Shared Authority with Neighborhood Residents.

  People in Partnerships is in the process of gaining total control over its own funding and earnings.

  PIP's Family Advocacy Network (FAN) fostered local leadership development by training residents to do community outreach.

  Through the Inter-Agency Council, the new Provider Network, and the dual roles of some Board members (as residents and providers), providers have been brought into dialogue with residents as never before.

  Collaborative training of Friends of the Family volunteers by PIP Staff and Texas Southern University.

  PIP's Executive Director serves in the Mayor's task force for promoting grass-root organizations throughout under served areas of the city.
- Prevention and Early Intervention

  Under contract with the Department of Juvenile Justice, PIP runs a diversion program for adolescents at risk for out-of-community placement.
- Implementation of a High Quality Community-Based Service Delivery Approach

  PIP sponsored discussions and lobbied the state legislature to increase the number of minority foster and adoptive parents in Harris County.

  The MHI encourages local collaboration and coordination among local agencies. The "Community Cloth," a neighborhood-based organization created in response to the MHI, is still a vocal entity in the Third Ward.
- Policy, Regulations and Funding Changes

  PIP has assumed the role of managed care broker for child and family services in the Third Ward under the state's Medicaid program. PIP is working with its local provider network to deliver these services.

  Revenues from Medicaid reimbursements are expected to fund additional services under PIP's Family Development umbrella.

  PIP has obtained a five-year grant from the Hogg Foundation for Mental Health to cover family development services.
- Management Information Systems and Effective Use of Information

  Texas' MHI never developed a formal MIS. Barriers included: MHI activities did not lend themselves to quantification (e.g., advocacy); feeling that since needs were already known, quantitative data did not have much to add; other MHI activities competed for staff's time and effort.

VIRGINIA

- **East End Site Profile**
- **Systems Reform in Virginia**
- **Highlights**

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.

[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.

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

SYSTEMS REFORM IN VIRGINIA

Pre-Implementation Environment

Tremendous support for reform existed at the state, local, and neighborhood levels even before the Annie E. Casey Foundation considered sites for its Urban Mental Health Initiative. Virginia's readiness and support for MHI reforms were determined in 1992, based upon three major criteria: capacity to plan and manage; priority placed on Children and Adolescents Service Systems Project (CASSP) principles for systems of care reform; and capacity to support urban neighborhood-based initiatives. Virginia's receptive environment further led to the selection of Richmond's East District as a target neighborhood.

During his term, Governor Douglas Wilder's commitment and leadership capacity paved the way for MHI funding. His record was cited in a report prepared by a team of Foundation consultants: *"Outside his state, he is known as a governor who understands decategorization and systems change. His willingness to take on special interests, notably the medical establishment, and to take risks is a major strength. He clearly understands and supports the Casey initiative, not only in terms of Virginia, but from a national perspective."*

The Commonwealth's support of collaboration in providing services was demonstrated by its creation of an Interagency Consortium on Children's Mental Health in 1987. As a result, a Memorandum of Agreement was formally signed by the Departments of Education, Mental Health, Mental Retardation & Substance Abuse Services (MHMRSAS), Social Services (DSS), and Youth & Family Services. Another cooperative reform endeavor began in 1990 with the creation of the Council on Community Services for Youth and Families. The Council was dedicated to reducing reliance on institutional care, limiting its cost, and improving community services for children with emotional or behavioral problems. Council representatives included the highest level administrators from agencies that served children, along with community leaders from both the private and public sectors. The Council's interagency approach demonstrated how costs could be controlled and services improved through the use of about $3.4 million in state funding.

Prior to the MHI, the need for early intervention and prevention services was reflected in the state's mental health plan for children. It targeted at-risk children between the ages of birth and 7, as well as those with Severe Emotional Disturbance (SED). This change reflected an understanding of how using a preventive approach with at-risk children would favorably impact the budget. Other proposed changes in service delivery called for setting up a legislative trust fund to support prevention services beginning in 1993. A site team reviewer offered this description of the reform: *"They are moving their system away from out-of-home group care towards community-based and in-home care. They have a Council on Coordinating Prevention, which is coordinating efforts across departments."*

Major efforts were undertaken to restructure children's services so that more responsibility would flow to individual neighborhoods through the City of Richmond, thereby enhancing the role of families in services. Virginia's new service delivery agenda was committed to making sure families were sufficiently involved, and its objectives were strongly acknowledged by the Casey Foundation Selection Team in 1992: *"Virginia has both a statewide parent advocacy group and 30 local parent support groups, including one in Richmond."* In applying the CASSP principles, the state developed support from parents and advocacy

> At the state level, the site was praised for developing parent support and advocacy networks, and for involving families in systems change.

networks while involving families in the systems change process. An excellent relationship between state and local officials also generated maximum representation from the City.

Richmond's readiness for reform was demonstrated by the city's involvement in interagency collaboration efforts, as well as through significant grassroots family initiatives in the East District. An example of this readiness at the city level was the formation in 1990 of the Large Portfolio, a coalition comprising administrative representatives from public and private human service agencies. Departments participating in the Large Portfolio included the departments of Social Services, Health, and Juvenile Justice. The Assistant City Manager for Human Services became its direct supervisor, and the Portfolio group became responsible for building cooperation between city agencies and private agencies in the areas of service planning and service delivery. City officials even went further than this to also organize the Local Interagency Service Project, through which different localities could receive joint funding to coordinate interagency services.

By the end of 1992, the City of Richmond was promoting the neighborhood team process in order to help residents assume a lead role in determining future policies. It also maintained neighborhood control of advocacy efforts. This led to the formation of Civic Associations where residents began discussing their specific concerns, which were then shared with the City Manager.

Residents also showed their commitment to becoming more involved in neighborhood governance. In 1992, residents formed their own chapter of the Federation of Families for Children's Mental Health, called the Parent Resource Network (PRN). The resident-led Urban Neighborhood Initiative Board became the foundation for the Youth and Family Programs Committee (YFPC), a subcommittee of the East Team Board, which in turn became the MHI's governing entity.

At the state level, Virginia received high recognition for developing parent support and advocacy networks, and for involving families in systems change. Parents served on virtually all of the major policy and planning groups at the state level. Locally, parent involvement was mandated by the legislation that reformed the service delivery system.

Reforms Resulting from MHI Implementation

MHI reforms focused primarily on shared authority with neighborhood residents and leadership development, interagency collaboration, availability of qualified staff, and family involvement in services. The following section summarizes the main accomplishments and challenges faced by the site.

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

Community Participation Creates Strong Partnerships

The MHI governance process in Richmond created meaningful partnerships between residents, city, and agency representatives in the East District. Residents' participation in the various partnerships helped increase their knowledge of systems, the governance process, and service delivery. This knowledge, in turn, enhanced their natural leadership skills. Similarly, outsiders exposed to this new type of partnership learned important lessons that have been applied

“The Strategic Partnership Team (SPT): it was charged primarily with responsibility to serve as “a vehicle for the community,” and help “facilitate increased resident decision-making.”

beyond the scope of the MHI. Examples of successful collaborations with residents include:

The East Team Board (ETB): The MHI's neighborhood governance body was established in 1994 as the neighborhood decision-making body with capacity to manage and be accountable for administering resources in the East District. The East Team Board includes representatives from the following entities: East District residents/parents, the East District Family Resource Center (EDFRC), Public Safety Committee Board, State Department of Social Services, Richmond Department of Community Development, Redevelopment and Housing Authority, Service Provider Network, and Parent Resource Network (PRN).

The Strategic Partnership Team (SPT): Formed in 1996 and recognized as the core local neighborhood governance advisory group or “recommending body,” it was charged primarily with responsibility to serve as “a vehicle for the community,” and help “facilitate increased resident decision-making.” Stakeholders represented on the SPT are: the East Team Board, Service Provider Network, East District residents/parents, the City/East District Initiative, State DMHMRSAS, PRN, and EDFRC. One resident referred to the SPT as “the entity that is in place that facilitates the partnership,” because “all of the stakeholders who are involved with the initiative are at the table making decisions for the community.”

The East District Family Resource Center Board (EDFRC): conceptualized and set in motion in December 1995, it was designed based on the MHI governance model. The EDFRC Board comprises representatives from the PRN, Youth and Family Support Committee, East District residents, City, State, service providers, churches and public school system. When the Family Resource Center became fully operational on November 6, 1998, it began functioning as a community-based and family friendly service hub, providing East District children and families access to consolidated services.

Parent Resource Network (PRN): The PRN was started in 1992 by seven East District residents and the Urban Neighborhood Initiative Board as a Chapter of the Federation of Families for Children's Mental Health. The PRN soon became the vehicle for resident participation in the MHI's service delivery. Membership of the PRN includes: seven neighborhood coordinators representing the communities of Chimborazo, Creighton, Fairfield, Fulton, Mosby, St. John, and Whitcomb; a Senior Project Manager, Youth and Family Support Program Administrator, and the East District Manager. The PRN has expanded its role outside the MHI to become an effective advocacy voice on a variety of issues impacting the East district.

Of these various partnerships, the one between the city and community residents seems to have been the most productive. As one resident described it: “*The city and community partnership has strengthened itself. We have gone through our periods of dissatisfaction with each other and worked through those. Now we have a group that is willing to even in the hard time, come together and have the conversation, and that's a strong point for our community here.*” Although the MHI called for strong involvement from the state, this relationship did not fully materialize. Residents felt the main reason for this had to do not so much with lack of will, but with not having “*…the right person at the table…there has to be a very conscious effort from the citizens to go and talk directly to, I guess [the Department of] Mental Health Mental Retardation Substance Abuse Services; sit down and talk to someone who can*

“The MHI experience, with its focus on inclusion, rather than exclusion, changed the way in which neighborhood residents related to each other and to outsiders.”

really make the decisions, and make sure what comes back to us are actually the wishes of the Department."

Residents Promote Inclusiveness and Rally Around Community Issues

The MHI experience, with its focus on inclusion, rather than exclusion, changed the way in which neighborhood residents related to each other and to outsiders, and gave voice to groups that had traditionally been left out of the decision-making process. The East Team Board's present composition, for example, reflects diversity across age, race and gender groups. The current treasurer is the Board's youngest female member; the Board's legal counsel and attorney is a White female, while the chair of the Board is an African American female.

Similarly, the SPT membership, which traditionally included mostly older, more experienced or academically qualified adults, has expanded to incorporate all who have skills and talents to share. A unique feature of the SPT today is that it includes young people from the community who have traditionally been excluded from the governing experience. The diversification of the SPT furnished a broader platform for residents to join in the MHI, and a positive forum for airing differences and addressing specific group issues.

Another major contribution of residents related to applying the concepts of governance and representation learned from the MHI to broader neighborhood matters. When the federally funded Vernon Harris Health Clinic in the East District was shut down for poor performance, a group led by some prominent PRN, EDFRC and East District Team Board representatives started lobbying congressmen and City Council representatives to reopen the facility which had provided accessible health services for their children and families. They won a major administrative battle with the formation of a Health Clinic Board patterned mainly after the EDFRC Board and committee structure. They then successfully recruited board members from several East District neighborhoods, had the clinic renovated and reopened for services in 1999. With this effort, residents not only succeeded in improving the quality of life for their neighbors, but they also identified and mentored new leaders in the East District.

The PRN was also the local brainchild behind formation of the EDFRC in Richmond, the subsequent support EDFRC received from the City, as well as current sustenance of its programs. The PRN was strongly represented on the Family Resource Center Planning Committee (FRCPC), and particularly instrumental in helping secure the City's property at 2405 Jefferson Avenue for use as the new FRC, because of its central location, availability and proximity to the bus route.

A final illustration of the critical role residents involved with the MHI have played in the larger community context is provided, once again, by the PRN. In 1996, the PRN successfully mobilized and transported 220 children and families to the "Stand for Children" march in Washington, DC to advocate on behalf of East District children and families. According to one of the PRN organizers, those neighborhood children and their families learned a lesson on advocacy and leadership that will impact their community beyond the span of the MHI. The PRN also used its leadership role in support of other neighborhood programs serving East District children and their families, such as the Mosby Middle School's Youth Development Program and Parent Resource Center, and the Garfield F. Memorial Child Fund.

“The EDFF model was the catalyst for another effort by the city to make services more comprehensive, accessible and better integrated.”

Prevention and Early Intervention

Collaborative Strategies Enhance Service Coordination

The MHI focus on prevention and early intervention generated a mix of services that addressed a wide range of family needs beyond those of the focal child. This approach involved serving children with early signs of behavioral problems, and keeping them at home with their families. As a result of the MHI, the East District Initiative launched policy implementing a new model of family case management in 1997. The inter-agency program, called “East District Families First” (EDFF) included the East District Initiative, Youth and Family Support Programs/UMHI, Department of Social Services, Spectrum–Family First Initiative of the Department of Juvenile Justice, Lead Safe Richmond, Virginia Cooperative Extension, Child Support Enforcement, Healthy Start and the Richmond Community Action Program (R-CAP). The collaborative chose to focus on low-income and predominantly African American families in the East End District, where fathers were absent. EDFF’s case management philosophy and practice interpreted prevention in the holistic sense of family preservation. The case management program targeted:

- First-time parents with children less than 3 months old;
- Women pregnant for the first time;
- Families with children at-risk for placement outside the home, or those who had returned from outside placement within the last 60 days;
- Non-custodial parents; and
- Families with children with behavioral problems that may result in court involvement.

In addition, the EDFF child screening and thorough assessment process involved not only the target child, but his/her family, service agencies and providers. Following assessment, EDFF set stringent prevention/intervention guidelines and requirements in the implementation of the child/family service plan including attendance at parent education classes; school attendance monitoring for children; family mediation service; family recreation; home visitation support; father’s support group; prenatal counseling; family nurturing activities; and father employment.

The inclusion of fathers, their male surrogates or equivalents in the service planning and delivery process gave additional strength to this case management philosophy of better facilitating successful child prevention/early intervention outcomes in the East District. One challenge faced, however, was serving the significant number of incarcerated parents of the focal children and youth. Another significant setback to EDFF was the small number of frontline staff handling the numerous and complex caseloads.

The EDFF model was the catalyst for another effort by the city to make services more comprehensive, accessible and better integrated. Under this approach, four different agencies (i.e., Richmond’s Housing Authority, Department of Social Services, Department of Health, and Department of Juvenile Justice) redeployed staff to reside and work in the four Churchill housing developments—Whitcomb, Creighton, Fairfield, and Mosby—located in Richmond’s East End. Staff included nurses, social workers, benefit specialists and juvenile justice workers.

A final example of how the MHI inspired reform in other systems involves the Healthy Families Richmond Program. In keeping with the service philosophy espoused by the MHI, Healthy Families began providing inten-

“Findings from the evaluation’s examination of intensive services in the MHI suggest that the accessibility of these and other services and of the provider network may have played a role in enabling children to remain in the least restrictive setting appropriate for them.”

sive in-home preventive and educational support services to enable East District's first time parents to successfully raise their children and create healthy families, and to foster well informed communities.

In terms of integration, the Healthy Families Richmond was placed under the MHI's Local Coordinator in the East District service building. This, in essence, marked the first major step in service integration and coordination across human services in the East District.

Implementation of a High Quality Community-Based Service Delivery Approach

Consolidating Access to Community Services

A significant accomplishment of Richmond's MHI was its expansion on an already existing, albeit disconnected, selection of public and private services located in the East End. The MHI focused on access by utilizing a community-based service delivery approach with consolidated access to integrated/coordinated services, all located within the East End District geographic area.

Bus routes connect residents of target communities such as Whitcomb, Creighton, Fairfield and Mosby with the services they need. Also, primary service agencies involved in the initiative such as Richmond's 13th District Juvenile and Domestic Relations Court, Department of Social Services, Child Protective Services-2nd Response program, and mental health clinics at Virginia Commonwealth University are all located in the East End. The EDFF, the EDFRC, and the PRN, described in the previous sections, are three additional mechanisms to improve access and service integration. Findings from the evaluation's examination of intensive services in the MHI suggest that the accessibility of these and other services and of the provider network may have played a role in enabling children to remain in the least restrictive setting appropriate for them, usually in their own homes or neighborhood with their caregivers (2nd round FES 1999).

Cultural Competence Enhanced Through Resident Participation in Service Delivery

As with the other sites, the MHI in Richmond recognized the value of using local community resources in service planning and delivery, including frontline and management staff residing in the community to ensure a culturally competent system of care. The utilization of local community expertise and neighborhood resources also meant the development of professional and paraprofessional working teams in service delivery.

The EDFF case management program and the EDFRC are two models especially noteworthy for their success in delivering culturally competent services. EDFF is staffed essentially by present and past local residents of the East District devoted to serving neighborhood children and families. Its case managers and assessment workers are predominantly African American and serve their own community in ways that are responsive to their family values, life styles and belief systems.

Since its opening in 1998, the East District Family Resource Center (EDFRC) has become a safe haven and cultural hub for neighborhood residents. One resident described EDFRC as “a community spot” which serves some of the most basic social and health needs of East District residents. The newly remodeled Center offers a convenient and user-friendly facility where residents can come for assistance with a range of basic needs including: food, health, educational tutoring, parenting, employment skills, and recreational

“To support the implementation of the EDFF, the City agreed to accept new job descriptions and salary ranges for EDFF staff, a policy that is reflective of the new emphasis on working with entire families rather than with individuals.”

activities. In keeping with its inclusive philosophy, the Center celebrates holidays reflecting various traditions in the community such as Islam and Christianity, and events significant to its largely African American participants. The atmosphere of the center's family lounge was described by a resident as a place "where families can come and just shoot the breeze". (April 1999 FRC Monthly Report).

Finally, the Parent Resource network (PRN), which predated the MHI, contributed its strong culturally sensitive, family-driven and community-based practices to service delivery and community empowerment activities. Its advocacy efforts on behalf of the East End were described earlier. As part of the planning committee for the EDFRC, PRN members stood behind the hiring of a minority contractor to renovate the property where the center would be housed. It also created the first micro-enterprise in the community in the form of a catering service operated by local residents, specializing in traditional African American dishes.

Policies, Regulations and Funding Changes

Richmond implemented changes in policy and regulations, and continues to explore creative funding strategies that set important precedents for systems reform beyond the MHI. Among the most visible were reforms related to redeployment of existing funds, hiring policies, and co-location of services. More recently, the Richmond MHI has been considering ways to draw new dollars through managed care strategies.

Policies Change in Support of More Community-Based, Neighborhood-Driven Services

In the previous section, the EDFF model was described as an example of service integration. It represents a paradigm shift in service delivery policy, namely:

- from the single individual to the entire family;
- from being one-dimensional to being holistic;
- from a deficit to a strength-based orientation; and
- from duplicative, uncoordinated, to integrated/coordinated services.

To support the implementation of the EDFF, the City agreed to accept new job descriptions and salary ranges for EDFF staff, a policy that reflects the new emphasis on working with entire families rather than with individuals. MHI funds were used to supplement City dollars for salary increases.

The assignment of a PRN representative to the multi-agency EDFF team was another example of policy reform, reflecting the importance attached to resident involvement in service design and delivery. The fact that the City has invested in the model and is reproducing it with other city agencies speaks to its commitment to a permanent shift in the way it delivers social services.

Similar personnel innovations were required to staff the FRC. All key job descriptions were created from scratch using models from FRCs all over the country. Residents from the East End sat on hiring panels for all FRC positions, and some residents who had been involved with the MHI as volunteer PRNs were hired as staff.

“Following Houston’s lead, the East District Initiative (EDI) has been in negotiations with local HMOs to obtain contracts to provide comprehensive case management services to city residents following the EDFF model.”

Redeployment and Refinancing Improve Sustainability of MHI

The City committed significant resources in support of MHI inspired plans to add and integrate services in the East District. The main example of this is again, the EDFF model. Each of the agencies contributing staff to EDFF continues to pay for the salaries and benefits for a total of close to $200,000. The City now also funds the Family Resource Center from its general budget allocations for a total of $86,000 a year. The East District Center operations are also funded through the city as are the salaries of the East District Manager and other support personnel.

To sustain the achievements of the MHI after the formal end of the initiative, Richmond has been exploring new ways of attracting funds. Following Houston’s lead, the East District Initiative (EDI) has been in negotiations with local HMOs to obtain contracts to provide comprehensive case management services to city residents following the EDFF model. If the HMOs accept the proposal, service capacity would be increased by adding new staff and replacing existing positions that were lost due to loss of funding.

Another strategy for sustainability has involved securing grants from local foundations to support the expansion of programs at the FRC, and soliciting contributions from businesses in the East End. A furniture manufacturer located in the community, for instance, has donated the furniture for the FRC building and made other cash contributions.

Management Information Systems and Effective Use of Information

An important accomplishment of the MHI in this site was getting the city of Richmond interested in integrating information systems across various agencies. As reported in the site’s 1995 Self-Assessment Report, the newly formed Human Services Automation Committee pooled resources from the Annie E. Casey Foundation, Richmond Employment Training and Education Network (RETEN), and the City’s general Fund in order to develop the Integrated Human Services Information System (IHSIS). Agency staff received training on various software and operating systems in anticipation of this new integrated system. Data Collection requirements to support the monitoring of outcomes, individual family budgets, and a detailed accounting of service dollar spending were also developed for the city’s primary human service agencies. Although the full service and systems capacity for data collection, tracking and utilization of information across human service agencies anticipated in the beginning has not be reached, the MHI has helped facilitate the city’s efforts in the right direction.

HIGHLIGHTS OF SYSTEMS REFORM IN VIRGINIA

Pre-Implementation Environment

A strong favorable political climate and commitment to interagency collaboration existed at state and local levels.

A significant shift occurred in state mental health plan and service delivery policy from inpatient/out-of-home placement to early intervention prevention and community-based/in-home care.

Families formed a chapter of the Federation of Families for Children's Mental Health, paving the way for increased family empowerment and leadership capacity.

Reforms Resulting from MHI Implementation

- Increased Local Control, Leadership and Shared Authority with Neighborhood residents.

  The MHI inspired Strategic Partnership Team (SPT) served as a core governance and local advisory group as well as a vehicle promoting resident participation and resident decision-making.

  Strong partnerships were created among East District residents, city and agency representatives with benefits for all groups involved.

  Residents' involvement in the various partnerships promoted inclusiveness across age, gender, and racial groups.

  Residents strengthened their leadership capacity and became more effective advocates on behalf of their community.

- Prevention and Early Intervention

  EDFF's holistic family case management practices shifted from treatment to a prevention/early intervention focus serving the entire family, with an emphasis on re-involving absentee fathers.

- Implementation of a High Quality Community-Based Service Delivery Approach

  East District Families First (EDFF) family case management program and East District Family Resource Center (EDFRC) provided community-based, family-centered/integrated and coordinated/culturally competent services to all residents.

  EDFF and EDFRC are both centrally located, easily accessible to all East District residents, and are predominantly staffed by longtime residents or East End neighbors.

- Policies, Regulations and Funding Changes

  The City agreed to accept new job descriptions and salary ranges for EDFF staff to accommodate working with entire families rather than with individuals. MHI funds were used to supplement City dollars for salary increases.

  A PRN representative was assigned to the multi-agency EDFF team reflecting the importance attached to resident involvement in service design and delivery.

  The EDI is trying to contract with local HMOs to provide comprehensive case management services to city residents following the EDFF model.

  Grants from local foundations and contributions from local business have provided additional funds.

  The City of Richmond continues to support the FRC, EDFF and other staff positions assigned to the East End.

- Management Information Systems and Effective Use of Information

  As a result of the MHI, the City created the Human Services Automation Committee with matching funds from the MHI to develop the Integrated Human Services Information System (IHSIS).

  Agency staff receive training on various software and operating systems, and the data to be collected is identified.

  Implementation of the IHSIS is still pending.

APPENDICES

- **APPENDIX A: Methodology for Systems Reform Analysis**
- **APPENDIX B: Additional Systems Reforms**
- **APPENDIX C: References**

APPENDIX A
Methodology for Systems Reform Analysis

Sources of Information

Each evaluation team member responsible for a site was in charge of summarizing the major system reform efforts for their site. Each site analysis was based on information retrieved from two or more of the sources listed below:

- In-person interviews with stakeholders from the State, Local, Provider and Resident levels conducted during the MHI implementation period.
- Telephone interviews with key site stakeholder or policy representatives conducted in 1999.
- Web sites developed by state agencies, policy analysts, and advocacy groups.
- Document Review (site reports, foundation reports, evaluation reports and other relevant literature).
- Lessons Learned Focus Groups.

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

Informants for the telephone interviews were identified by the evaluation team in consultation with the Foundation and technical assistance staff. 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.

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, many pertinent documents have been written by the sites, the Evaluation team, the Foundation, site consultants and others in the children's mental health field. These documents were reviewed to provide both background information and reform information. Some of these documents provided references to other potential data sources.

Lessons Learned Focus Groups

The lessons learned from the implementation of the Mental Health Initiative were derived from four focus groups conducted at the project's closing conference held in May, 1999.

Three of the focus groups were organized according to stakeholder type, and mixed representatives from all four sites. The 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 through 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.

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—Description 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 may have been omitted in this analysis.

APPENDIX B

Additional Systems Reforms

- **Additional Systems Reforms in Florida**
- **Additional Systems Reforms in Massachusetts**
- **Additional Systems Reforms in Texas**
- **Additional Systems Reforms in Virginia**

Additional Systems Reforms in Florida

MHI Philosophy Reflected in State and Local Reforms

During the five years of the MHI implementation in Florida, a number of significant reforms took place in the fields of Mental Health and Special Education. Some of these efforts were undertaken by the state legislature responding to advocates' demands and federal laws. Other reforms were initiated by state agencies in an attempt to become more accountable and improve outcomes for children and their families.

These reforms reflect the MHI philosophy in their values and objectives, and indirectly supported the Foundation's agenda of meeting the mental health and emotional needs of children, regardless of the system with which they were involved. The following discussion focuses on state and district level reforms that shared the MHI's tenets, but were not necessarily prompted by it.

Mental Health

A System of Care for Florida's Children

A major turning point in the field of mental health that impacted state and district policies in Florida came with the passage of the Comprehensive Child and Adolescents Mental Health Act in 1998. Although revisions to children's mental health legislation had been proposed in the past, none had passed. In preparation for the 1997-98 legislative session, the Senate Committee on Children, Families and Elders spearheaded an effort to introduce new revisions. The committee's staff had strong support from the Chief of Children's Mental Health at the Department of Children and Families, the Florida Council of Community Mental Health Providers, and the Louis de la Parte Florida Mental Health Institute. The language of "systems of care" and the Child and Adolescent Service System Program (CASSP) principles were incorporated into the proposed legislation which was supported by both houses as well as by the Governor.

Local districts are now mandated to apply CASSP principles in the care of children with mental health problems (i.e., child and family centered planning, need and strength based, culturally competent, integrated, and community-based services, and emphasis on early intervention and prevention). As a result, any private provider with a state contract must furnish performance outcomes, offer diversified services that include assessment and planning, and follow established case management standards. The bill also calls for a state-wide information and referral service to be developed.

The mental health reform agenda was also strengthened through the leadership of the state's office of Alcohol, Drug Abuse, and Mental Health (ADM). The Office has adopted the concept of a system of care for children with emotional disorders and consequently, has undertaken the closure of child and adolescent units of the state mental health facilities in favor of less restrictive community-based treatment alternatives.

The Department is also breaking new ground in consolidating mental health and substance abuse data, outcome measures, and Medicaid information statewide. In response to the state's Government Performance and Accountability Act of 1994, outcome measures were developed by the ADM program office as part of its 1996-97 budget request to the Legislature. The following performance measures were established for children's mental health: functional scores, time spent in the community, school attendance, and juvenile justice involvement.

Finally, ADM is the driving force behind the creation of the Florida Institute for Family Involvement. This organization is a state-wide network of family members who have come together to better advocate for children's mental health issues.

District XI Redeploys Funds and Maximizes Federal Entitlements to Bring Children Home

In 1992, while the MHI was beginning to call attention to the issue of children in out-of-home placements, a lawsuit forced state officials to implement the "Building Futures for Florida's Children" program to bring children with severe emotional disorders from institutional placements back to their own communities.

The ADM District office saw this as an opportunity to reduce the considerable costs of these residential placements and relieve a serious budget deficit. ADM began to assess how children in mental health facilities outside the district could either be returned to their natural families or placed in more appropriate homes (e.g., specialized foster care). To date, this action has reduced the number of most restrictive and expensive residential beds in the district from 256 to 80. It has also developed procedures to discourage the unnecessary out-of-home placement of children with mental health needs outside the community, added wraparound services and made specialized placements available, and provided training to parents to encourage family reunification.

The reforms initiated by the ADM District Office not only reduced the deficit, but also drew attention from other agencies facing the same dilemma. In 1998, the Department of Juvenile Justice (DJJ) began collaborating with ADM, adopted some of its procedures, and contracted with the same providers so that children in its care could return home. The local school system is also applying ADM strategies along with increasing services at school and contracting specialized placements as needed.

On another front, ADM led the way in improving mental health coverage for Medicaid recipients. In addition to broadening care options for children, the current package allows for more in-home, community-based services as well as intensive therapeutic services provided to children in placements outside the home (e.g., specialized therapeutic foster care). These services allow ADM, in partnership with the Agency for Health Care Administration, to serve many more children with serious emotional disturbance while enabling them to remain in their community.

Special Education

Cross-System Collaboration Meets the Needs of Children with SED

As mentioned earlier, Florida set a precedent for systems reform through the establishment of an alliance between the state's education, mental health, child protection and juvenile justice systems. The Severely Emotionally Disturbed Students Multiagency Network (SEDNET), established in 1980, is the only specialized network of its kind in the country. Its longevity is due to the Network's ability to respond to changing local needs, federal and state mandates, and to the dynamic leadership of state and regional advisory boards.

SEDNET assists local school districts in meeting the needs of students with serious emotional problems through a cost-shared, collaborative planning and service coordination approach. It currently operates in 1,000 schools statewide. Its $2.2 million budget allows community mental health centers to place staff on school campuses, where they provide crisis intervention and teacher consultation along with group and individual counseling services.

Presently, SEDNET is organizing regional meetings across the state to discuss the changes brought about by the passing of the Individuals with Disabilities Education Act of 1997 (IDEA 97), and is also presenting best-practice examples to local educators working with this group of children.

Additional Systems Reforms in Massachusetts

MHI Philosophy Reflected in State and Local Reforms

During the past five to six years, Massachusetts has undertaken a series of reforms which share philosophies that were embraced by the MHI. The following section highlights reforms that support philosophies that are similar to MHI in their fundamental principles and beliefs.

Mental Health

Family Input Gains Acceptance by State Agencies

One of the MHI objectives for systems reform was to "develop the neighborhood capacity to function as full and equal partners with the state and local government and service providers in designing and managing the new delivery system." (Benchmarks Document, 1995: p. 21). In Massachusetts, the concept of including parents and residents as a critical element in delivering services has made tremendous strides.

Specifically, the family movement has prompted the Department of Mental Health (DMH) to employ parents as partners and coordinators in every one of its areas, and to include them in request for proposals (RFP) review teams. The Department of Social Services (DSS) and the Department of Youth Services (DYS) are undertaking a similar participatory approach. As a result, these agencies are also issuing RFPs that are more family-friendly and family-centered.

Another example of parent inclusion can be found in the Collaborative Assessment Program (CAP), a multi-agency collaborative program that partners with parents. As one state official explained: "*I can tell you a few years ago we wouldn't have a parent sitting there…now we have them and it's no problem.*"

Managed Care Enhances Array of Services Available to Families

In Massachusetts, managed care has emerged as a fiscal and service strategy that supports many of the same improvements favored by the MHI. The two-prong managed care approach adopted in the state supports a system that can provide a wide array of health and mental health services to families. This strategy is consistent with one of the service objectives of the Initiative that is aimed at providing comprehensive care for families in the target neighborhoods.

The specific characteristics of Masshealth/Managed Care in Massachusetts ensure that all Medicaid-eligible clients under age 65 are enrolled. This program includes the Primary Care Clinician Program (PCCP), which features clinicians who provide primary care and preventive services. They also serve as gatekeepers through their authorizations of secondary care. Under this plan, patients needing mental health care are referred to mental health managed services. The second component is the Medicaid HMO program, which provides a full range of health services to all registered clients (including mental health care).

Another common element that managed care practices share with the MHI can be found in the service structure, operations and practices. Managed Care in Massachusetts has affected the way state agencies operate, and has resulted in greater use of utilization management and quality assurance techniques. Under this system data collection and reporting are high priorities, as is the development of appropriate Management Information Systems. These components are consistent with MHI reform objectives, which also call for changes in standards, techniques, regulations, and staff training along with changes in the way systems use and manage data (Benchmarks Document, 1995: p. 11).

Managed care has also utilized a lead agency and a network of providers structure, a concept that was envisioned and at least partially implemented by the MHI in Boston. The MHI in its service implementation model employed a lead service agency, Children Services of Roxbury, but was less successful in establishing a strong network of providers.

Child Welfare

Common Works Model Focuses on Less Restriction

The Department of Social Services (DSS) and the MHI share a focus on reducing the length of time children in their custody spend in residential settings. DSS has adopted the managed-care type model, the "Common Works," which moves children from the most to the least restrictive placements through "step-down" programming, utilization management, and quality assurance. Similar to the managed care structure discussed under Mental Health, the Common Works also designates a lead provider and uses a network of residential providers.

Education/Special Education

Building a More Family-Friendly System

Overall, Education and Special Education reforms in Massachusetts share a common theme with the MHI. Like MHI, some of these reforms are shifting their focus from serving children in more restrictive, residential out-of-home placement settings to less restrictive, familiar classroom settings.

The Massachusetts Education Reform Act was passed in 1993, but its impact only began to be felt once state officials approved the Department of Education's five-year plan for education in 1995. The plan called for increased and more equitable school funding, greater accountability for student learning, and statewide standards for students, educators, individual schools, and school districts.

This reform package included the Family Support Network, which encouraged the development of programs that support children at the neighborhood level. One state official explained: "*They (school system) are joining the other state agencies. Actually, it's a pretty exciting time, they are making more of an effort to keep families and children in community settings.*"

State lawmakers in Massachusetts have addressed the special education needs of children more specifically through their approval of Chapter 766. In essence, Chapter 766 helps to minimize potential stigmatization and maximizes the child's development in less restrictive surroundings. More emphasis is being placed on allocating prevention and intervention resources. The school system is also engaged in developing a Special Education program that will utilize classroom support as opposed to large residential support.

Juvenile Justice

Redeployment of Funds Improves Services for Children

A joint project to coordinate the purchase and delivery of services was undertaken by the Department of Mental Health (DMH), the Juvenile Court Department, and the trial court of the Commonwealth. This project embraces many aspects similar to those incorporated in the MHI, including an emphasis on interagency coordination and collaboration, and the use of high quality standardized agency practices as a means of improving service delivery.

For instance, the consolidation of procurement efforts represents a significant change in terms of fiscal expenditures, coordination and collaboration, and ensures a more efficient service delivery system for children and families.

The purpose and roles of each partner were defined in an Interdepartmental Service Agreement (ISA) covering Clinical Assessment, Treatment, Counseling, and Community Referral/Liaison Services for children and their families involved with the Juvenile Court. In practical terms, this allows DMH to purchase necessary services for the Juvenile Court Clinics on the Court's behalf. The Department also can manage procured services for the Juvenile Court.

This joint venture helps avoid duplication of effort since DMH and the Juvenile Court each have a tradition of providing these services. The Court can continue to determine the nature and quality of services provided by the Juvenile Court Clinics, but it can also benefit from DMH's experience in procuring and

managing service contracts. The use of standardized practices and guidelines are an important part of this reform strategy and as one state official reported: "This will allow a more consistent implementation of services for children and families."

Cross-Systems Reforms

Interagency Partnerships Promote Collaboration in Massachusetts

An important theme that has emerged in the state of Massachusetts over the past six to seven years has been the concept of interagency collaboration. In addition to reforms that have occurred within individual systems, Massachusetts has been establishing cross-system reforms. This idea of cross system reforms is consistent with the MHI philosophy which supports the notion that systems need to coordinate and integrate their services in order to effectively and efficiently provide resources to children and families.

In the past six years, human service agencies have coordinated their efforts with notable effectiveness. The Collaborative Assessment Program (CAP) has been especially visible in implementing a "single-door entry" philosophy. Participating agencies include the Department of Mental Health, Department of Social Services, and Medicaid. CAP's goal is to divert children into community-based services rather than placing them outside the home. This program has been operating in the Southeast for over two years and takes a wrap-around approach involving multiple agencies to serve children and families while allowing a 30-day period for assessment. To date, CAP has served over 300 children, with about 50 children coming from each of the state's six regions.

The Managed Care movement in Massachusetts has also improved collaboration between agencies. For instance, an interagency agreement between the Department of Mental Health, Department of Social Services, and Division of Medical Assistance defines the specific roles and responsibilities in a partnership. Under the agreement, a lead agency and network of providers is established. In addition, all of DMH's emergency and acute care cases have been turned over to the Division of Medical Assistance. This collaborative agreement has helped to clarify roles and facilitate service delivery.

Additional Systems Reforms in Texas

MHI Philosophy Reflected in State and Local Reforms

Mental Health

Integrated Funding Maximizes Resources

A fragmented and categorical funding strategy has historically been employed by public agencies serving children in Texas. Since 1992, state officials realized that children with multiple needs could not be adequately served unless these agencies shared resources and curbed their dependence on costly institutional placements.

This challenge was initially addressed in 1997 by the Texas Integrated Funding Initiative. The project was supported by a grant from the Robert Wood Johnson Foundation Mental Health Services for Youth Replication and by the Department of Mental Health & Mental Retardation. It was intended to develop local service delivery systems for children with multiple needs. These systems are family-based, accountable for outcomes, and designed to maximize federal, state, and local funding opportunities. The Initiative is currently operating as a pilot project in Travis County, Brown County, the Riceland region (south of Houston), and the Dallas area.

Family-Centered Practice Keeps Children at Home

The Department of Mental Health & Mental Retardation built its "Families Are Valued Project" from the experiences of a previous initiative ("All Kids Belong in Families"). The initiative targeted children with disabilities and provided a range of supportive services so that they could remain with their families. The concept of permanency planning was strongly emphasized. It involved the establishment of local family collaboratives to help nurture children, and assist with the reunification of children who had been placed outside the home and when needed, the placement of children in other family environments. Additional elements included community-based respite care, information and referral services, and emotional supports, as well as the coordination and planning of services. Special attention was also paid to supporting families of children with disabilities through shared parenting arrangements, long-term foster care placements, and adoption services. Three urban sites received grants for "Families are Valued" pilot projects along with one rural location.

Medicaid Managed Care Expands Mental Health and Substance Abuse Services

Three pilot programs funded by Medicaid are currently providing mental health and substance abuse treatment. The State of Texas Access Reform (STAR) program provides acute medical and behavioral health services in several sites across Texas. Its clientele is primarily women and children who are already receiving Medicaid benefits.

Cross-Systems Reforms

Setting the Stage for Flexible Funding

Wraparound services require flexible funding. During the MHI implementation, state-level supporters of the Initiative investigated the possibility of blending funds across agencies. However, they found that this would be prohibitively time-consuming and expensive. A reliance on multiple funding sources (including the federal government) was a factor, along with the impact of special legislation and the complexities associated with earmarked taxes and entitlements. Despite this conclusion, the state is still trying to deal with the problem. The Commissioner

of Health and Human Services is outspoken about his support of the concept and claims to be working toward its adoption.

The state's commitment to blending funds is exemplified by the Texas Integrated Enrollment and Services (TIES). TIES' purpose is to integrate eligibility determination and service delivery for multiple health, human services, and workforce programs. The collaborative is planned to include some of the state's largest programs—Food Stamps, Temporary Assistance for Needy Families (TANF), Primary Health Care, Women's Infants and Children (WIC), many Medicaid programs, the Job Training Partnership Act and Employment Services.

Goals, priorities, and the overall direction for TIES were established by the Texas Legislature in HB 2777. Staff from the Departments of Human Services and Health, the Texas Workforce Commission, and the Health and Human Services Commission are jointly developing and implementing a plan to integrate many of their services. If successful, a major hurdle will be erased toward the possibility of creating a flexible funding system.

Additional Systems Reforms in Virginia

MHI Philosophy Reflected on State and Local Reforms

The Virginia legislature enacted changes consistent with MHI philosophy and systems reform in areas of mental health, child welfare, health care, juvenile justice, and special education. Several of these initiatives and programs were implemented simultaneously with the MHI. The Legislature mandated policy reforms at the state, local, and neighborhood levels under the *Code of Virginia*, which summarizes every state law. This appended section describes some of the most salient examples of reforms complementary to the Urban Mental Health Initiative in Richmond.

Mental Health

Emphasis on Prevention and Early Intervention for At-Risk Children

Virginia's 1993 Comprehensive Services Act (CSA) established a framework for guiding, restructuring, and financing services for children with severe emotional and behavioral problems. It set up a $78.8 million funding pool and trust fund that consolidated nine funding streams across four agencies. While this strategy was intended to reduce out-of-home placement expenditures, it was especially consistent with the MHI principle to keep at-risk children at home.

The Comprehensive Services Act also supported the MHI principle of interagency collaboration, by helping to build and facilitate several state and local interagency management teams. These teams consisted primarily of local service providers and caregivers: the State Executive Council (SEC), the State Management Team (SMT), the Community Policy and Management Team (CPMT), and the Family Assessment and Planning Team (FAPT), all of which had representation across state, local and neighborhood entities.

CSA also emphasized prevention and early intervention through community-based programming, parent and resident involvement, organized participation within the target neighborhood, and local control. Amendments were made to the commonwealth's legal code so that the State Executive Council (SEC) could oversee the coordination of these efforts. The SEC also promoted a comprehensive community-based planning process for prevention and early intervention services.

The Children's Services Unit of Virginia's DMHMRSAS began conducting its own prevention planning, evaluation, and monitoring of services. This demonstrated a strong commitment to reform that was accompanied by a partnership between the Department and prevention directors from forty community service boards. These partners worked together to plan and implement comprehensive community prevention activities. In addition to the parents and youths with a vested interest in these types of reforms, other participants included local service agencies, schools, government, law enforcement, business and social organizations, and the faith community. A needs assessment process was introduced similar to the MHI inspired EDFF family assessment process that identified risk factors in adolescent behavior such as substance abuse, delinquency, teen pregnancy, school dropouts, and violence. Specific child and family needs were then addressed through services that were evaluated and verified through state and local data for each community.

DMHMRSAS also reportedly sponsored two other initiatives designed to assist neighborhood children and families: "Better Beginnings for Virginia's Children" and "Project Link." Special attention was paid to providing services to the children of young unwed mothers. These services emphasized family support (most notably geared to pregnant teens and

teen parents starting new families), and promoted improved life and health outcomes for neighborhood families in general.

Mergers Promote Service Access and Availability for Families

A desire to establish a neighborhood-based service delivery system had prompted the City of Richmond to undertake complementary reforms in 1991. Though it happened prior to implementation of the MHI, this effort represented a reform in service delivery venue from inaccessibility/unavailability to a community-based, and culturally sensitive location. The city felt that East District children and families would receive better health and mental health care as a result of changes in service delivery venue. That same year, a citizen's committee began planning *"the establishment of a test site for a neighborhood-based Community Resource Center…"*

In an attempt to address these changing priorities, then Assistant City Manager Dr. George Musgrove convened a Large Portfolio subcommittee early in 1990, although the Portfolio itself did not get off the ground until much later. It consisted of directors and staff from City agencies, along with representatives from United Way, non-profit organizations, hospitals, the religious community, neighborhood teams, local universities, and other interested parties. Their strategy called for establishing these key elements: Family Resource Centers (FRC), Family Case Management teams, community liaisons, and community level governance. Its implementation brought together agencies that served children, while ensuring that mental health services would be available and accessible to East District residents (especially at-risk children and youth).

Education/Special Education

Collaboration Increases Responsiveness to Families

The state General Assembly passed landmark legislation (SB 1199 – School Division Participation in Medical Assistance Services), mandating service integration and coordination through a Memorandum of Agreement between the Superintendent of Public Instruction (DPI) and the Director of the Department of Medical Assistance Services (DMAS) or their designees. The law related to the special education health services provided by school divisions to public school students. By specifically defining their relative roles, it appeared to exemplify the state legislative tenet requiring two state departments to jointly promote improvements in health services to at-risk children and youth. To maximize inclusion of at-risk children and their families, DPI and DMAS were specifically required to communicate with each other, school division personnel, and school board representatives on a regular and consistent basis.

Juvenile Justice

Emphasis on Community-Based Correctional Services that are Family-Centered

Virginia's General Assembly enacted the Comprehensive Community Corrections Act for Local Responsible Offenders on March 24, 1999. This act gives *"any city, county, or combination thereof"* the authority to establish community-based services for juvenile offenders that are not incarcerated in local correctional facilities. The legislation specifically requires alternative programs to be provided for offenders who are either convicted, sentenced by, or receive services through a court such as the Richmond Juvenile and Domestic Relations District Court, a service partner of the EDI.

In efforts to prevent recidivism, these programs and services focused on community service, home incarceration with or without electronic monitoring, and probation supervision, along with substance abuse assessment, testing and treatment. Provision was also made for local day reporting center programs and services, local halfway houses that temporarily care for adults placed on probation, and public inebriate diversion programs. Each would be provided under contracts arranged with qualified agencies such as the publicly funded Department of Social Services East District Families First case management, and the Family Resource Center, or private agencies such as Memorial Child Guidance Clinic.

APPENDIX C
References

INTRODUCTION

Citation

American Academy of Pediatrics. (Nov., 1999). *State Activity in Response to Title XXI (SCHIP)*, [On-line]. Available: http://www.aap.org/advocacy/newplans.htm

Annie E. Casey Foundation (1999). *Kids Count 1999 data book: State profiles of child well-being.* Available from The Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202.

Bazelon Center (Jan., 1999). *Status of children's SSI redeterminations*, [On-line]. Available: http://www.bazelon.org/ssiupdat.html.

Faenza, M. M. (1999). NMHA unveils new ideas for 1999. *The Bell, 2.*

Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1998). Prevalence of serious emotional disturbance: An update. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental Health, United States, 1998*, 110-12. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Friedman, R. M., Katz-Leavy, J. W., Manderscheid, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States*, *1996*, 71-89. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Kronick, R. & Gilmer, T. (1999). Explaining the decline in health insurance coverage, 1979-1995. *Health Affairs, 18*, 30-47.

Pires, S. A., Armstrong, M. I., & Stroul, B. A. (1999). *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families—1997-98 State Survey*. Available from the Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL, 33612.

Resources

McCarthy, P. (n.d.). *A mental health initiative for urban children: A program of the Annie E. Casey Foundation Child and Adolescent Health Domain*. Unpublished manuscript.

Health Care Financing Administration. (Sept., 1997). *Children's Health Insurance Program*, [On-line]. Available: http://www.hcfa.gov/init/kidssum.htm

National Conference of State Legislatures. (Nov., 1997). *Analysis of State Legislation Enacted in Response to the Adoption and Safe Families Act, P. L. 105-89*, [On-line]. Available: http://www.ncsl.org/programs/cyf/asfa.htm

Children's Defense Fund. (Nov., 1997*). Summary of the Adoption and Safe Families Act of 1997 (H.R. 867)*, [On-line]. Available: http://www.childrensdefense.org/safestart_pass3a.html

Children's Defense Fund. (n.d.). *Progress Report: Implementing the State Children's Health Insurance Program (CHIP),* [On-line]. Available: http://www.childrensdefense.org/

CASE STUDIES

Florida Systems Reform

Citation

King, B. (1992). *Mental Health Initiative for Urban Children, Site Visit Report: Miami*. Unpublished manuscript.

Texas Systems Reform

Citation

King, B. (1992). *Mental Health Initiative for Urban Children, Site Visit Report: Texas*. Unpublished manuscript.

Pires, S. A. (1992). *Mental Health Initiative for Urban Children, Site Visit Report: Texas*. Unpublished manuscript.

Massachusetts Systems Reform

Citation

Annie E. Casey Foundation. (1995). *Benchmarks*. Unpublished manuscript.

APPENDIX B

Additional Systems Reforms in Florida

Resources

Florida Council for Community Mental Health. (n.d.). *Key Provisions of the 1998 Comprehensive Child and Adolescent Mental Health Act* [Fact Sheet]. Available from the Florida Council for Community Mental Health, 316 East Park Ave., Tallahassee, FL 32301.

Florida Department of Children and Families. (n.d.). *Children's Mental Health*, [On-line]. Available: http://sun6.dms.state.fl.us/cf_web/adm/cmh2.html

Florida Department of Children and Families. (n.d.). Children's Mental Health: Who We Are, [On-line]. Available: http://sun6.dms.state.fl.us/cf_web/adm/au_1.html

Florida Legislature Online Sunshine. (n.d.). *Senate Bills 1998 Session. S 352: Foster Care/Privatization*, [On-line]. Available: http://www.leg.state.fl.us/session/1998/senate/bills/billinfo/html/sb0352.html

Lipson, D. (1996). *Managed care programs: Developments affecting children. Florida,* [Revised Draft]. Prepared for the Annie E. Casey Foundation. Unpublished manuscript.

Armstrong, M. (1999). *Report to the legislature: Expected impact of the child health insurance program on ADM operations*. Available from the Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612.

State of Florida Department of Education. (1996). *Annual Report 1994-1995: Multiagency Network for Students with Severe Emotional Disturbance (SEDNET).* Available from the Florida Department of Education, Turlington Bldg., 325 West Gaines St., Tallahassee, FL 32399-0400.

Additional Systems Reforms in Massachusetts

Resources

Web sites for the State of Massachusetts:

Commonwealth of Massachusetts, *Official Home Page*, [On-line]. Available: http://www.state.ma.us/

Massachusetts Department of Public Health, Bureau of Family and Community Health, Division of Maternal, Child and Family Health, *The Children's Medical Security Plan*, [On-line]. Available: http://www.state.ma.us/dph/cmspweb.html

Massachusetts Department of Education, Resources and Information, Publications and Videos, *Chapter 766 Regulations: Chapter 5: Programs*, [On-line]. Available: www.doe.mass.edu/doedocs/766CH5.html

Additional Systems Reforms in Texas

Resources

State of Texas. (n.d.). *Proposal to the Annie E. Casey Foundation Mental Health Initiative for Urban Children from the State of Texas*. Unpublished manuscript.

Texas Health and Human Services Agency. (1998). *Health and Human Services Coordinated Strategic Plan for Fiscal Years 1999-2004*. Unpublished manuscript.

Texas Health and Human Services Commission. (Feb., 1999). *Innovations in health and human services: Report to the 76th Legislature on streamlining and simplifying delivery of services*. Unpublished manuscript.

Additional Systems Reforms in Virginia

Resources

City of Richmond. (1991). *Citizen report, a strategic plan for the future: Richmond tomorrow*. Unpublished manuscript, City Manager's Office, Richmond, VA:

Commonwealth of Virginia DMHMRSAS. (February 1, 1995). *Virginia's Urban Mental Health Initiative: Bi-annual progress and expenditure report of August 1, 1994 through January 31, 1995* [Draft]. Unpublished manuscript, Richmond, VA.

East District Initiative. (1994, April). *East District News: Community and City News and Information That Matters, (1)*3. Richmond, VA.

Johnson-Seabrook, D. (1999). *Monthly report: April 30*, 1999. Unpublished manuscript, East District Family Resource Center, Richmond: Virginia.

Kay, P. & Sengova, J. (1998). *Neighborhood governance in Richmond: A developmental analysis, Year 4*. Available from the Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, 13301 Bruce B. Downs Blvd., Tampa, FL 33612.

Parent Resource Network. (1995). *Orientation manual*. Unpublished Document, East District Center, Richmond, VA.

Virginia's Urban Mental Health Initiative Interim Strategic Planning Team. (February 7, 1997). *Virginia/City of Richmond Urban Mental Health Initiative: 1996 Self-Assessment Report* [Draft]. Unpublished manuscript, Richmond, VA.