SERVICE DEVELOPMENT

Service Development in the Annie E. Casey Foundation Mental Health Initiative for Urban Children

FINAL EVALUATION REPORT

June 2001

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

University of South Florida
USF

Service Development in the Annie E. Casey Foundation Mental Health Initiative for Urban Children

FINAL EVALUATION REPORT

Prepared by

Ruby Joseph, M.P.A.

Marcela Gutierrez-Mayka, Ph.D.

Joko Sengova, Ph.D.

J. Douglas Uzzell, Ph.D.

Ricardo Contreras, M.A.

Mario Hernandez, Ph.D.

Robert M. Friedman, Ph.D.

June 2001 • Tampa, Florida

University of South Florida
USF

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

This publication was produced by
The Department of Child and Family Studies
The Louis de la Parte Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807
For more information, call 813/974-4637
or visit the Website: http://www.fmhi.usf.edu/cfs

Louis de la Parte Florida Mental Health Institute Publication #186, Tampa, Florida

Recommended citation for the report:

Joseph, R., Gutierrez-Mayka, M., Sengova, J., Uzzell, J. D., Contreras, R., Hernandez, M., & Friedman, R. M. (2001). *Service Development 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.

TABLE OF CONTENTS

Acknowledgments

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

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

We are especially thankful for the thoughtful input of Patrick McCarthy and Mareasa Isaacs from the Annie E. Casey Foundation. 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 Ruby Joseph at 813/974-9339. To obtain additional copies of this publication, call the de la Parte Institute's Technical Publications office at 813/974-4404; reference publication number 186.

PREFACE

The evaluation findings of the Mental Health Initiative for Urban Children (MHI) are the subject of a three-volume report series which respectively cover each of the three implementation areas (*i.e.*, ***systems reform, service delivery and governance***).

Each implementation report comprises a detailed and abridged version. The Executive Summary of evaluation findings completes this three volume series and provides a summary discussion of highlights of MHI.

This document is focused on the service delivery component of the Initiative. The introduction provides background to the Initiative and gives a brief synopsis of the three implementation areas. The main body of the report is organized into the following sections:

- Cross-site Summary of Service Delivery Implementation: This section provides a discussion of shared and unique service strategies identified across the four MHI sites. It also includes the evaluation findings from the Family Experience Studies, and focus groups, which were used to assess the quality and effectiveness of site service intervention strategies. This section focuses on accomplishments and barriers relating to overall service implementation as well as direct service delivery.
- Stakeholders' Views on Lessons Learned: This section summarizes the various perspectives of key groups of MHI stakeholders regarding the successes and challenges of implementing service strategies. Their insight on what could have been done differently is presented in the form of lessons.
- Case Studies: The case studies provide detailed descriptions of service delivery strategies in Boston, Houston, Miami and Richmond: These discussions include:
  - ➤A developmental overview of service delivery from pre-implementation to post-implementation.
  - ➤Description of each site's service implementation strategy and service accomplishments and challenges.
  - ➤Summary of sites' post-implementation accomplishments and future service aspirations.

Appendices

A. *Methodology* provides a description of the various qualitative methods utilized to gather data on services in the four MHI.
B. *Site Logic Models* provides the Initial Logic models for MHI implementation developed by each site.
C. *Additional Service Information* comprises supplemental information such as utilization and outcome data and other relevant site documents related to service delivery.
D. *References* provides complete citations for works cited in the text as well as resources used in the preparation of the report.

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-focused mental health services to children in high poverty, urban communities, and to work with states to improve the policies and practices supporting these services. Six sites submitted proposals and four sites were selected for implementation:

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

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

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

For the reasons mentioned above, another key element in the MHI's design was to target a broad population of children at-risk, and incorporate unique features from other system reform initiatives specifically targeted at children with serious emotional disturbances and their families.[3] The MHI therefore embraced the philosophy of providing community-based, individu-

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

[2] The 1997 Kids Count report projects a growth between 1996 and 2005 in the number of African-American children by eight 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 6% (Annie E. Casey Foundation, 1997). For the same time period, a decrease of 3% is projected in the number of Caucasian children.

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

alized, strength-based, culturally-competent services in a comprehensive way. In addition, there was a strong emphasis on collaboration among public service providers to implement systemic funding and policy reforms in support of services.

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

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

Neighborhood Governance

The governance structure was aimed at developing and strengthening partnerships between representatives from the state, local and community level stakeholders involved in the Mental Health Initiative. 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 major child-serving agencies, residents, and consumers of services.

A key goal of these governance strategies was to ensure that community residents had input and ownership in all major aspects of implementation of the MHI and that the governance structure itself had administrative oversight for the project.

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

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 that 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.

- Emphasize parent education, support and involvement.

In order to achieve this service vision, the Mental Health Initiative required the sites to develop services to address two main issues of service availability and access. Service availability was related to strengthening the existing array of services and supports available to children and families within the target neighborhood areas. Service access included developing a system that would assist residents to gain easy admittance into programs and allow them more opportunities to utilize services. Service access also included increased outreach and integration of services and supports.

The Foundation further identified three broad service areas as being critical to any service support system. These areas were **universal supports**, **targeted prevention supports** and **intervention supports.**

- ***Universal*** supports included services that were available to all families within the target neighborhoods and in general did not require any particular eligibility criteria. These services included services such as job training, summer camps for children, and advocacy.
- ***Targeted prevention*** services were those services that were available to children who had a specific risk factor such as low birth weight or attention deficit disorder (ADD) or exposure to violence. Services in this category included tutoring, mentoring, skills building, and financial assistance.
- ***Intervention*** services provided supports to families who had identified problems and conditions such as mental or emotional disturbance. These services were for children who already had an identified problem and such services were aimed specifically at trying to alleviate these problems. These services included inpatient services, residential placements, counseling, group and individual therapy and therapeutic medication.

Each of the four sites responded to the service vision of the MHI by implementing their own service strategies that addressed these two broad areas of access and availability. Although the overall vision remained the same for each of the sites, the specific objectives and operationalization of the service vision were unique for each site. This meant that while all sites had some elements in common, there were other aspects that set each target site apart from the other.

In order to provide context from which sites developed their individual service strategies national evaluators used focus groups to review two domains:[4]

- Quality of life in these four communities
- Residents' perceptions regarding their community's service system prior to MHI implementation.

Neighborhood Context: Quality of Life

As a result of the focus groups held at the beginning of implementation, community residents from the four sites identified several challenges which included the following:

- ***Drugs*** - Residents complained that parts of their community and neighborhood parks were 'overrun by drug addicts.'
- ***Violence*** - Participants gave descriptions reflecting the violence in their communities: "*We live in a war zone, so you basically have to keep a sharp eye on our little ones.*"
- ***Safety Issues*** - Many residents felt afraid and unsafe: "*It's like a battlefield. You never know when to run and when to move. I mean, you're scared.*"
- ***Unemployment*** - Participants identified unemployment as a major cause for concern.

Other challenges were site specific such as the problems facing the Miami site with its large numbers of undocumented immigrants or Boston's monolingual, Spanish residents who encountered language barriers which negatively affected service delivery.

These challenges were compounded by high levels of poverty that contributed to the sense of isolation that many families felt. The focus groups also identified community strengths and resources such as the strong, positive, role of the church and a deep sense of community spirit among some families. These

[4] Focus groups were conducted during the initial phase of implementation and reported on the quality of life and service system. Focus groups described the residents' perceptions about services at the beginning of MHI before site's developed their service systems. (See Appendix D-References).

strengths could not combat the numerous challenges that existed within these communities and some focus group participants reported needing more social, mental health and recreational supports.

Neighborhood Context: Quality of Services Prior to MHI Implementation

Participants in the focus groups identified several limitations and challenges related to services provided through some of the state and local human service agencies. These challenges included the following:

- Inaccessible Services
  - ➤ Long waiting lists for services.
  - ➤ Lack of awareness about available services.
  - ➤ Residents often had to travel outside their communities to access services.
  - ➤ Strict eligibility criteria made it difficult for the 'working poor' to qualify for much needed services.
- Unavailable Services
  - ➤ Inadequate recreation and youth develop ment activities. In particular, residents noted that they needed safe parks and other places for children to play.
  - ➤ Poor Collaboration among Agencies result ing in intake processes that are repetitive.
- Negative Staff Attitude Towards Service Users–Residents complained of being 'looked down on' and disrespected.
- Lack of Cultural Competence–Residents in all sites noted that services needed to be more culturally competent. This was particularly an issue in Boston and Miami.[5]

Evaluation and Reporting

The Annie E. Casey Foundation contracted with the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida to conduct the national evaluation of the MHI. Overall, the general evaluation strategy was a process oriented, formative evaluation designed to answer a series of significant questions regarding implementation. The evaluation did not focus primarily on just documenting outcomes but also focused on understanding and describing the changes that took place in the implementation process.

The national evaluation, among other tasks, was responsible for reporting on the development of service strategies across sites and evaluating the direct services provided as a result of MHI implementation. Focus groups and Family Experience Studies (FES) were the two primary methods used to evaluate direct services provided as a result of MHI implementation.[6] The major findings from the FES can be found in the cross-site summary section.

On a macro level, the evaluators also used focus groups with stakeholders from all levels of the Initiative (i.e. , state, local, provider, and community levels) as a primary evaluation method.[7] These stakeholder focus groups assessed the accomplishments and challenges and lessons learned associated with overall implementation of the MHI.

The findings of the evaluation are the subject of a three-volume set of reports, one for each implementation area. Each implementation area report comprises both a detailed comprehensive version as well as summarized version. The Executive Summary which is the final evaluation report provides a summary discussion of the three MHI implementation areas of **Systems Reform**, **Service Delivery** and **Governance**.

[5] In Boston and Miami cultural issues were of great significance because these sites had many foreign born, mono-lingual Spanish speakers who did not have bilingual staff to assist them.

[6,7] See Appendix A–Methodology.

SECTION

ONE

Cross-Site Summary of Service Delivery: Accomplishments and Challenges

Cross-Site Summary of Service Delivery: Accomplishments and Challenges

The sites can be cited as the impetus for several accomplishments related to improving the delivery of mental health and support services to children and families in Boston, Miami, Houston and Richmond. These accomplishments came along with challenges and although sites were able to overcome some of these challenges, there are others which sites continue to work through.

The cross-site summary of the four sites' service strategies includes:

- An Overview of Common Service Strategies in the MHI Sites
- Service Delivery Accomplishments and Challenges in the Mental Health Initiative
- Conclusions

Consistent with the needs expressed by neighborhood residents in the focus groups, the MHI design emphasized both service availability and accessibility. Availability issues were to be addressed by strengthening the array of services and supports available to children and families in the target neighborhoods. Accessibility issues involved outreach to the families in the target communities and ensuring that services were easy to obtain. There was also an overall expectation that through a seamless array of services, the MHI goal of "…improving the life chances of children and youth in the four target neighborhoods…"(Benchmarks, 1995: pg. 1) would be obtained.

The Foundation therefore suggested that sites consider three core service categories. The first set of services, *Universal Supports*, included services that were available to all families within the target neighborhoods and in general did not require any particular eligibility criteria. The second set, *Targeted Prevention services*, were those services that were available to children who had a specific risk factor such as low birth weight, or exposure to violence. The third set of supports, *Intervention services*, were supports to families who had identified problems with mental or emotional disturbances and had been diagnosed with disorders such as Attention Deficit Hyperactivity Disorder (ADHD), or determined to be Severely Emotionally Disturbed (SED). These services were aimed specifically at trying to alleviate identified problems of children who had already been diagnosed.

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

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

7. Capacity to be sensitive and responsive to cultural and ethnic differences (Benchmarks Document: 1995, pg. 3, 4).

Overview of Common Service Strategies in the MHI Sites

The four sites developed their service strategies using the seven guiding principles listed above and the identified service needs of their target residents.[1] With the help of technical assistant providers each of the sites carefully researched various service model options that might possibly meet their site's service needs. Interestingly, all four sites independently arrived at service strategies that included three major service components:

- Family Resource Centers
- Community Outreach
- Intensive Case Management

Family Resource Centers

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

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

MHI sites chose family resource centers as a service strategy because these incorporated characteristics that made it possible to address important issues of service accessibility and convenience. The FRC concept was also able to address cultural competence issues and provided an opportunity for families to address some of their mental health needs in a comfortable and welcoming environment.

In general, the Family Resource Center model was able to address these concerns and the four sites established centers that had the following common features:

- A convenient location within the target communities;
- A mixed and varied array of universal, targeted prevention and intervention support services;
- Staff and services that reflected cultural-competence
- Family and resident input in the service design and implementation; and
- Less stigmatizing place to address mental health concerns.

The first common feature of the family resource centers was their convenient location within each of the target neighborhoods. All sites felt that covenience was essential to effective service delivery. In the Boston site, where three distinct neighborhoods comprised the MHI target area, one family resource center was located in each community. Prior to implementation of services, residents from the four sites had complained of having to go outside their neighborhood in order to obtain mental health and other social services. By establishing family resource centers within their respective neighborhoods the sites were able to significantly address the issue of service inaccessibility.

In addition to being conveniently located, the FRCs represented a place where residents felt welcome and comfortable. Many of the residents in initial focus groups had complained of being disrespected and reported feeling generally unwelcome at many service agencies. By providing a family-friendly atmosphere in the centers, all sites were successful in helping to make families feel more welcome.

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

A second consistent feature of the family resource centers was that each site's center provided a broad mix of universal and targeted prevention services and intervention services. In Houston, this range of supports included services such as housing, employment, and transportation, literacy training for adults and parenting skills training. In Boston, services provided included daycare, job training and employment, summer camps, parenting education classes, after school program services, parent advocacy and tutoring. Some non-traditional services such as buying household equipment for families and providing food baskets and turkeys at Thanksgiving were also part of the rich mix of services provided through the family resource centers at this site. In Miami, the broad array of services included the Time Dollar Volunteer program, seminars and educational training for parents, hospital and recreational services for families, immigration services and a youth support group. In Richmond, the family resource center provided behavior modification training for parents and parenting enrichment, family support and advocacy for accessing other social service programs, and educational and vocational support for families.[2]

Within their broad array of services and programs, the sites had common programs and areas of emphasis such the family development services. Such programs supported family empowerment and overall family functioning, recreational, educational and other developmental supports for parents and their children.

The third consistent feature of these family resource centers was that they all attempted to respond to cultural competence issues. Each site hired family resource center staff members who represented the culture and ethnicity of the families in their respective neighborhoods. Many of the para-professional staff were also long-time residents who had a deep understanding of residents in the target areas. This approach of including para-professional staff who could identify and relate better to families represented a change from more traditional staffing patterns of human service agencies that tended to hire more professional and clinical staff. Residents appreciated this change in staffing and felt that the para professional staff at the family resource centers were generally culturally-competent.[3]

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

A final feature of the family resource centers that were developed at the MHI sites was related to the idea of providing a place where families could obtain mental health services that was less stigmatizing than traditional mental health facilities. Because of the stigma normally associated with needing and seeking various mental health services, residents wanted to have a facility were they could obtain mental health services without feeling 'degraded' or 'ashamed' as they did when seeking mental health services from more traditional mental health facilities. As a result, the family resources centers in the target neighborhoods were successful in providing a less stigmatizing environment for families who needed mental health support.

[2] For more detailed service information see individual case studies.

[3] See focus group reports conducted after implementation of site service strategies-Appendix D– References.

It is important to note that while this section of the report focuses on the major service trends that were common to all four sites, each site established its own unique service delivery system. Individual site centers were unique either in the way they provided their own special blend of services or in their selection of a distinctive service component. These service differences represent, innovative strategies and are discussed in depth in the individual site case studies.[4]

Some examples of these site specific innovations include Houston's Juvenile Probation Program, where the site addressed some of the juvenile justice problems facing young African-American males in a distinctive manner. This program, focused on youths in the probation system, provided an innovative way of supporting troubled youths within a peer setting. The program became a successful diversion program. Also, because Houston's family resource center, unlike the other three sites, was housed within an elementary school, services offered through this center included support services for children who experienced in-school suspensions. This site is service strategy also included a managed care component which helped the site secure some financial sustainability beyond the life of the Initiative.

Another example can be found in Boston, where 'tracking' services represented a very creative and unique way of supporting at-risk youths. This innovative program allowed youths who were at risk or had experienced some problems to be matched with a tracker–an adult who was culturally-competent and could identify with that youth's situation. This individual provided support and monitored the identified youth's activities. Trackers were used as mentors and companions for youth who had experienced some type of mental health, juvenile justice or school behavioral problems. As an intervention strategy, Trackers represented a preventive approach for serving at-risk youth.

In the Miami site, a youth group was responsible for helping to provide and coordinate youth activities. This group was involved in many innovative social projects and received recognition for its assistance in painting a local child care center. This creative way of working with youths made the Miami youth program unique.

Richmond's 'Men of Vision' program helped promote the stronger presence of males in families and demonstrated a unique component of the site's service design. This program was particularly important because it was the only program that specifically targeted adult males.

The family resource centers emerged as a viable service strategy where residents in the target neighborhoods could receive a variety of services that were culturally competent and more easily accessible. The centers also served to reduce stigma often associated with mental health in these communities. The family resource centers emerged as one of the strongest components of sites' service delivery implementation.

Community Outreach

With services in place, sites recognized that they still needed ways to inform community residents about the resources available. Sites also realized that in order for their service strategies to be truly successful they needed to be more engaged with community residents as well as the community at large. Therefore, each of the sites developed a community outreach component as part of their service delivery strategy. These outreach services had the following goals:

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

All four sites focused on trying to provide information and referral, and to connect their service strategy to the target community at large. As a way of sharing information about services with residents and connecting their services to families living in the target communities, the sites developed some type

[4] See individual case studies for detailed discussions on comprehensive sit- specific service strategies.

of information and awareness campaign. This was implemented through newsletters, word of mouth and/or testimonials from residents who had actually used some of the services. Some of this information and referral also was provided by staff employed at the local family resource centers as they interacted with family members and residents.

In addition, sites established more formal ways to provide outreach and connect to the community at large. For example, the Houston site was able to train a group of residents to provide outreach and information services to families in their target neighborhoods through the federal Volunteers In Service To America (VISTA) program.[5] The 'Vistas' comprised a group of para-professional residents who provided outreach and information services to families in Houston. In addition, the Family Advocacy Network (FAN), closely connected to the Initiative in Houston, also performed a family advocacy role.

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

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

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

In addition, some communication and outreach activities were conducted through the governance boards in Boston and Miami. The parent and youth committees at these sites were able to provide outreach and service information informally to families in these neighborhoods.

Information and referral and outreach to the community at large were important aspects of community outreach in all four sites. Throughout implementation sites continued to work through strategies that would ensure that outreach and information regarding available services was effectively maintained. Reviews about the effectiveness remained mixed with some strategies like the informal strategies used in Boston and Miami through the family resource specialists being extremely successful at providing in-depth, comprehensive and detailed information to a relatively small number of residents. Other strategies such as the VISTAs program in Houston were more successful in reaching a large number of residents.

---

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

[6] East District News: April 1994: Vol.1. No. 3, p.7 -Appendix D-References.

[7] Madrinas/Padrinas translated to mean "God-mother and God-father" are natural helpers in the community who assist families.

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

[9] See Miami site case study.

Connecting with other community-based agencies was another community outreach goal, and sites tried to work with these agencies. However, only two of the sites were successful in actually working in partnership with other community-based mental health centers. In Richmond, a connection and working relationship was formed with Memorial Child Guidance Clinic and Miami was able to develop a working partnership with the Miami Mental Health Center. While attempts were made, neither Boston nor Houston was successful in developing this type of relationship with another community mental health center.

The final component involving engaging families in service delivery was effected through the governing boards which provided a vehicle through which the sites were able to keep families connected with the site's overall service strategy.[10]

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

Intensive Case Management

Another common feature of sites' overall service delivery strategy was an intensive case management component. This included the organization and management of services for children and families in the following categories:

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

Services provided within this component included wraparound support services for targeted children and their families, and involved the management of a variety of intensive services.[11] These services included but were not limited to the following:

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

Although all four sites provided some type of intensive case management services, three of the four sites did not make this a major emphasis. Case management services in Houston, Miami and Richmond primarily focused on case management supports for at-risk children. The Boston site was the only one that specifically targeted their case management to children with severe emotional and mental health problems and their families. This site initiated the Roxbury Return Project (RRP). The goal of this program was to bring children back into their community providing case management and wraparound supports to help them transition back to their families and communities effectively.

Staff who were part of the intensive case management or family resource center teams played a role in managing, organizing and coordinating services for families. In addition, some of these staff were involved in providing additional support functions such as advocacy and parent empowerment. The four sites used a combination of para-professional and professional staff to provide these services.

In Boston, the family 'reunification team' and family resource specialists provided case management support for families in the target neighborhood. In Richmond, the East District Families First case management model comprised both para-professional and profes-

[10] To see various ways in which family members were connected to the service development and implementation review Neighborhood Governance Reports–Appendix D- References.

[11] See individual case studies for specific case management services provided at each site.

sional staff. In Miami, the 'Equipo training–one of the innovative aspects of the Miami service strategy–was responsible for training case managers (professionals) and natural helpers as partners to help support and strengthen families. Finally, Houston's team of clinical and para-professional staff provided clinical support and case management for families in need.

Service Delivery Accomplishments and Challenges in the Mental Health Initiative

Accomplishments and challenges emerged in two main areas: Those successes and challenges relating specifically to sites' *direct frontline services* and those relating to *overall implementation* of the MHI service delivery component.

Accomplishments of Sites' Direct Frontline Services

Findings from the national evaluation provide information on accomplishments and challenges of sites' frontline services and service delivery strategies. It should be noted that the national evaluation was formative in nature and did not focus on individual family outcomes. Rather the evaluation was focused on service delivery models in each site and their effectiveness. The assessment of the quality of each site's service model was evaluated using focus groups and Family Experience Studies (FES).[12]

Collectively, the focus groups and FES offer an evaluative assessment of how successful the *direct services* provided at the sites were in reaching certain key principles. The FES[13] specifically assessed the degree to which the services provided by the sites were:

- individualized,
- family-centered,
- culturally competent,
- community-based,
- integrated and coordinated, and
- individualized.

The focus groups also assessed issues of family satisfaction with the quality of services.

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

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

One of the most concrete accomplishments of service delivery was the fact that the four sites were successful in creating family resource centers that were located within the target communities. In Richmond site, the family resource center was referred to as a 'community spot'; in Boston during the early implementation stage, each of the three neighborhoods (i.e. Mission Hill, Highland/Washington Park and Lower Roxbury) had their own neighborhood-based center; Houston's family resource center was housed within an elementary school in the Third Ward; and Miami's Abriendo Puertas, 'opening doors' family resource center became a fixture in the heart of the East Little Havana community. Overall, the long-term success and viability of these centers has been very positive. Today, with the exception of the Boston site where the MHI did not survive beyond the implementation phase, the community-based family resource centers are still operating and expanding within these communities.

The family experience study findings at baseline and follow-up suggest that the provision of support services for the MHI through community-based FRCs has had a positive effect on service accessibility. Findings from the focus groups and the FES further indicate that, in

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

[13] Detailed information on FES findings can be found in FES evaluation reports- Appendix D-References.

general, families were satisfied with the accessibility of universal and targeted prevention services provided through the FRCs. In addition, case managers' willingness to visit families at home and keep flexible schedules also contributed to families' satisfaction with the accessibility and convenience of services.

Cultural-competence: Services value diversity, acknowledge and work with the underlying cultural dynamics of the community and family, and adapt services to meet the needs of culturally and ethnically diverse groups within the community.

Another accomplishment achieved by the sites' service models was their sensitivity to racial and cultural differences. This sensitivity to race and culture was demonstrated in the way sites' staffed their programs and in the types of support services provided. In all four sites, there were deliberate considerations to ensure that workers reflected the racial and cultural diversity of the communities being served.

Sites took steps to ensure that their staff were 'professional' and 'culturally-competent,' and each site responded by hiring both para-professional and professional/clinical staff. In Boston, staff teams comprised both licensed clinical staff as well as para-professional workers who were from the target communities and reflected the racial composition of the families in the three neighborhoods. In Miami, the 'Equipo' training helped formally train professionals and natural helpers to work together as partners and this pairing helped improve cultural competence of service providers and other professional staff. Houston's pairing of para-professional and professional staff was accomplished through 'VISTAs', who were para-professionals that did outreach to the community, and other staff with Doctorate degrees and/or people who were licensed clinical workers, who provided clinical service support. The para-professional/professional teaming in Richmond occurred both in the Parent Resource Network (PRN) and East District Families First Case Management model (EDFF). Here para-professional staff complemented other case management staff who had more clinical expertise and extensive human service system experience.

Services offered through the sites' delivery systems also were structured to respond to family background and culture and were more sensitive to the families' needs. For instance, case managers/family resource specialists and other critical staff were willing to meet families in their familiar home settings as opposed to having families come to the center. Staff also showed flexibility in scheduling meeting times to accommodate family work schedules. This meant that staff were also willing to meet families at times other than during the traditional hours of 8:00 a.m. to 5:00 p.m. In addition, many staff shared their personal cell phone numbers and pager/beeper numbers with parents and caregivers to ensure that they could be reached in the event of an emergency. These different strategies used by sites were more responsive to the needs of their target families than other more traditional service systems.

In addition, FES findings reveal that in the two sites, Boston and Miami, where language was a critical issue, bilingual staff were assigned to work with the Spanish families. This was an important step because some of the families in these two communities are monolingual Spanish speakers. Others who are bilingual still preferred to speak Spanish, their first language. Clearly, having staff that could accommodate these families made their services more culturally-competent.

In addition, FES showed that these sites also demonstrated a willingness to consider factors such as religion, family structure, values and beliefs as important factors in service planning and delivery. A few case managers in all four sites acknowledged that they had voluntarily taken the initiative to learn more about their clients' family background and values in order to better serve them. Many of these family members confirmed that they felt understood and respected by these same case managers.

Another way services tended to be more culturally competent in all four communities was shown through the diverse and multiple roles which many of the staff were willing to play in order to effectively serve families. Many case managers were advocates for

their families, and also played the role of supportive friend. These staff provided a wide range of informal services which included the following:

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

While some of these activities fell outside their professional case management obligations, these workers realized that for many of these families this type of support was often very important to family functioning. As such, these services responded more readily to the family needs and were more competent in responding to the culture, background and circumstances surrounding their target families.

Family-Friendly: Services are provided in an atmosphere or environment that is comfortable and conducive to interaction between family and providers.

Although this quality was not tracked specifically through the FES, residents during the initial focus groups identified this as an important issue. These initial focus groups indicated that traditional service systems were less sensitive to the families' needs and that services were generally provided in unfriendly environments. Following the implementation of services, a second set of focus groups revealed that family members generally felt that services were being provided in 'family-friendly, nurturing environments.' This finding was particularly true for the family resource centers where it appeared that the friendly atmosphere was created in part by staff with whom families could identify. For instance, in Boston families described the atmosphere in one of the family resource centers as 'welcoming' and 'friendly'. In Richmond, a stakeholder described this friendly atmosphere in terms of the center being a 'community spot.'

Family-Centered: Services are dictated by the needs of the child and family, are based on the family's strengths, and are provided in a manner which maximizes opportunities for involvement and self-determination in planning and delivery.

Services delivered through site case management models met with more modest success with respect to family-centeredness. Evidence of family-centeredness was seen at both baseline and follow-up mainly through the 'family-advocacy' role that staff played. Also, the FES suggested that, at follow-up, case managers had made some progress in providing a more family-centered approach to service delivery. While the integration of this principle was far from complete, each site had made some progress in this area. In the initial baseline study, most of the services were found to be more child than family-focused. At follow-up, the three sites had begun to place much more emphasis on working with other members of the child's family and taking a more comprehensive approach to solving problems. For example, at the time of FES follow-up in three communities (Boston, Richmond and Miami), sites had begun taking a more family-centered approach to service delivery, looking not only at the needs of the target child but also at the needs of other family members.

In addition, to ensure that this family-centered approach was being implemented, at follow-up some of the sites had developed a more comprehensive approach to service delivery. In Boston for instance, the site took a multi-agency approach to working with children who were returning home from out-of-home placement. Through the site's Roxbury Return Project, families were able to benefit from the collective insight and input of experienced agency staff from major service agencies, such as the Department of Mental Health (DMH), Department of Youth Services (DYS), and the Department of Social Services (DSS).

Richmond had also initiated a more comprehensive approach to its family assessment process. This assessment process included the Family Assessment Planning Team (FAPT). Family members were permitted to invite whomever they chose to be part of the FAPT. This was significant because other individuals that supported the family could be included in the service assessment process.

Miami's use of natural helpers was another example of site's willingness to expand and build on the notion that services to families should incorporate a broader more comprehensive support system.

This approach also showed that in order to be family-centered plans must be built on each family's strengths and this often means appreciating and including extended family members.

Overall, sites continue to make progress in this particular area of service delivery. It seems reasonable to expect that future services will continue to embrace family-centeredness as a core service feature.

Challenges and Barriers of Sites' Direct Frontline Services

There is little doubt that many of the accomplishments outlined above represented milestones in direct service delivery for these sites. However, the sites had difficulty realizing all of the principles of service delivery outlined in the benchmarks. The FES found that in two areas, *individualization* and *integration and coordination*, adoption of key principles for service delivery was generally weak.

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

The sites demonstrated less impressive results regarding the principle of individualization of services. At baseline, a consistent finding across the four sites was that case documentation (i.e., the service/treatment plan) was incomplete and mostly child-focused. Written plans did not adequately reflect the extent of existing family needs, and service goals rarely addressed life domains. Also, at baseline, all four site service systems were weak in designing service plans that were able to fit the unique needs and potentials of the child and family. There was also little or no connection between the identified goals and the utilization of any child and/or family strengths.

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

Some progress with respect to individualization of services was noted at follow-up as sites responded to findings from the baseline study. For instance, during the second round, FES evaluators found that sites had improved in their ability to connect service goals identified in individual family case plans to the different life domains. They also found that case managers had made more attempts to ensure that the needs of families were identified and addressed in the service plans. In addition, these service plans that had more complete and detailed documentation.

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

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

Integration and coordination of services between service providers was found to be weak during the initial and follow-up FES. In both studies case managers were the only ones who were consistently linked to the providers within a child's local service support system. Although many families in the FES had multiple service providers, these providers often had never spoken to or met one another. These providers for the most part were providing services for these families independently with minimal consideration being given to other services that child may have been receiving from other agencies.

At baseline and follow-up, evaluators suggested that there was a need to improve communication and coordination between various service providers involved in providing services for a particular child or family.

Integration and coordination between sites' service systems and other agency staff was difficult primarily because many larger agencies responded to different agency-specific guidelines and criteria. Be-

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

Further Successes and Achievements of MHI Service Implementation

In addition to the accomplishment's discussed previously, other successes were noted in the overall implementation of the service delivery component of the MHI. In order to assess these benefits, evaluators conducted focus groups with all major stakeholder levels. This included technical assistants, foundation staff, providers, and neighborhood, local and state representatives. In addition, document reviews and a limited number of stakeholder interviews provided critical information for this analysis.[14]

MHI Includes Families in Design and Implementation

Other impressive results were accomplished with respect to way sites included families in the overall implementation of the service component of the MHI. The four sites deserve recognition for including and incorporating resident and family perspectives. This integration achieved in part through the Neighborhood Governing Boards (NGB) which formed a critical part of the MHI design. Sites included family and resident perspectives primarily through governing boards, and other working committees, which played a role in service design and implementation. Many residents were in favor of establishing a service system where services were consistent with the identified principles outlined earlier.

In addition to resident participation in service implementation through the NGBs, sites had other innovative approaches to parent and family inclusion. In Richmond for instance, through the PRN, residents were able to actively participate in planning the design of the East District Family Resource Center. This site [which preceded the Initiative], made the PRN, an integral part of planning services, and used the group to help develop the Family Resource center. Houston's unique integration of family and resident input was seen in the development of the 'Friends of the Family' Training curriculum. Miami's use of community residents in its outreach program and development of a resident advisory group are additional examples of how residents played a critical role in service development during the MHI. In Boston, for the first time, residents were a part of the Request for Proposal Process (RFP) and took an active role in deciding which agency would be awarded the lead agency service contract for their communities.

The inclusion of residents in service design and this special focus on having a 'family-oriented' service foundation was an excellent way of ensuring that family and resident values remained central to service delivery. With families and residents at the core of the conceptualization and design of the service model, it is expected that direct services will continue to become more culturally competent and family-centered.

Other Site Specific Successes

Other accomplishments have come from individual sites and reflect special ways in which the sites have pioneered philosophies or service strategies that are on the cutting edge of human service delivery. Some of these successes resulted in part because each site designed its service strategy to address its own site-specific needs.[15] The following are just some of the noteworthy site accomplishments, a more comprehensive discussion of accomplishments can be found in site case studies.

[14] See Methodology-Appendix A.

[15] See individual case studies for unique site accomplishments.

Miami

MHI Responds to Site Needs that Fall Beyond the Mental Health Definition

In Miami, the site broadened its definition of mental health to include areas that would help address its own community's needs. Immigration issues were one of the main concerns that residents had identified in initial focus groups. With many families being 'undocumented', employment was a big problem in the area. The site responded to this need and used some of its MHI funds to contract with the Florida Immigration Advocacy Center (FIAC).

MHI Integrates the Concept of Extended Family

This site was instrumental in developing the 'Equipo' training in direct response to some of the shortcomings and challenges in its case management model. This training had an exceptional method for training professionals and natural helpers to partner with families. It was anticipated that 'Equipo' would also help bring about a shared sense of responsibility towards outcomes which would in turn, improve families' chances of meeting these outcomes.

Houston

Managed Care Broker Helps Sustain Initiative

Like Miami, Houston showed similar sensitivity to its own specific circumstances and capitalized on the managed care environment that came into existence in Texas in 1997 The site modified its overall service strategy during the mid to latter phase of implementation to become a Medicaid managed care coordinator. This was the site's bold attempt to respond to its external environment and at the same time secure financial sustainability for the Initiative. The site's strategic posturing of PIP enabled the organization to receive its Medicare and Medicaid provider number and makes the Houston site a leader in expanding the role of a community-based organization to administrative broker in a managed care service environment. This site also provides a noteworthy example of how communities can use their organization to provide a fiscal strategy that contributes significantly to its sustainability and survival.

Richmond

Residents Play An Instrumental Role in Service Delivery

Richmond was innovative in its approach of incorporating the PRN into its overall service implementation. The site skillfully integrated this existing entity, into its own MHI service strategy. The site recognized the value of having para-professional residents working with families in the community, and in at least one instance hired an individual who was part of the PRN to become part of the team of case managers supporting the East District Families First (EDFF) case management model. In addition, this site should be credited for utilizing residents to accomplish meaningful goals as was seen in the pivotal role that residents played in preventing a local health center from being closed down.

Boston

MHI Leads the Way For More Resident Participation

Although services in the Boston site did not survive beyond implementation of the MHI, the site can be recognized for the impressive way it included residents in service delivery design. Residents at this site participated in the Request For Proposal (RFP) process and were instrumental in ensuring that affirmative action language was subsequently put into RFPs. The significance of this contribution is that minority agencies now stand a much better chance of receiving government contracts. In addition, the site was also able to effectively engage family members in lobbying and securing millions of dollars from the legislature. These funds were used to support services for residents in the three target communities.

Implementation Context: Issues and Challenges Affecting Overall Service Implementation

There were several broad issues that made implementation of the service component of the Initiative challenging. These issues spread across all four sites and highlight some of the significant challenges and barriers that were part of the general context of service implementation. These challenges elucidate how difficult it is to develop and implement the notion of neighborhood-based services even when substantial amounts of funds are allocated to implementation. The implementation obstacles encountered by the MHI sites validate the challenges and difficulties that have been and still continue to be faced by other community mental health centers across the nation.

The major challenges to service implementation experienced by MHI sites include the following areas:

- Flaw in MHI Design
- Broad Work Scope of the Initiative
- Poor Collaboration between Initiative Stakeholders
- Difficulty in Collecting Management Information Systems Data

Flaw in MHI Design

A consistent problem in effective service delivery was related to the fact that the MHI did not have a clear strategy for shaping the role that community mental health centers (CMHC) or other critical providers of services for children with Severe Emotional Disturbances (SED) could have in implementing site's service strategies.

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

Broad Work Scope of the Initiative

Another consistent problem recognized by stakeholders was related to the work load demands of the Initiative onsite staff and stakeholders. The stress of implementing services was often compounded with other competing work assignments and responsibilities that were related more specifically to systems reform and governance. In these circumstances, service delivery was sometimes put on hold as sites dealt with other systems reform and governance issues.

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

Poor Collaboration between Initiative Stakeholders

Another major implementation barrier was related to collaboration between stakeholder entities. A number of barriers contributed to the collaboration problems that existed among stakeholders, site neighborhood service systems and other 'traditional' state and local agencies. These barriers include the following:

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

Difficulty in Establishing Working Relationships Between the Various Site Stakeholders

The Mental Health Initiative brought together state, local and community residents and prescribed that these three entities cultivate and maintain a working relation-

ship in order to implement the Initiative. However, collaboration was generally an uphill task and difficult to maintain because of the following factors:

- Historically these groups of people, i.e., community residents, local service providers and state and local agencies, did not work together.[16]
- Stakeholder groups and entities had different views and perspectives and did not trust each other.
- Lack of clarity in the stakeholder roles and the differing stakeholder perspectives regarding service design and delivery.[17]
- Different 'learning curves' of stakeholders which some state, local and provider representatives felt slowed down the service process.

Different Work Philosophies and Hiring Practices of Neighborhood Service Systems and Traditional State and Local Human Service Agencies

True collaboration between the site service systems and the state or local agencies was also affected by the incompatible service philosophies held by each group. The incompatibility between site service systems and traditional service systems played itself out in terms of how services were to be delivered and who should be hired to provide these services. Traditional systems tended to be more inclined to respond to federal mandates, while site neighborhood systems were more family focused and strength-based in their approach. Traditional systems also tended to hire clinical professional staff to provide services while site service systems were more open to staffing their family resource centers and case management models with para-professionals. These fundamental differences negatively affected collaboration between these organizations.

In Boston, for instance, larger agencies like the Department of Mental Health, the Department of Social Services and the Department of Youth Services lacked confidence in the site's community-based service staffs' capacity and ability to serve children requiring intensive services and interventions. Therefore, these agencies were reluctant to refer their clients to the local service system for support. This lack of confidence also affected direct service delivery because agencies were sometimes unwilling to collaborate and communicate with case managers at the local sites or incorporate some of the more innovative strategies that were being implemented at the sites.

Incompatible qualification problems manifested themselves a little differently in Houston. At this site, the People In Partnership's (PIP) provider network had been set up as a potential pool of providers to whom PIP (in its new role as Managed Care Coordinator) could make referrals. Unfortunately, most of these local providers in the network failed to meet the accreditation standards for receiving Medicaid privileges. As such, many of these neighborhood providers could not initially be used as a referral source.

Difficulty in Collecting Management Information Systems Data

Another major implementation obstacle faced by sites involved collecting out-of-home and service utilization information. Collecting comprehensive data on service utilization was one of the major goals of MHI service component. However, because this was an extremely difficult task, sites were not very successful in accomplishing this goal. The sites failed to accomplish this particular goal because they depended on the staff of larger human service systems to retrieve this information for them. Staff from these human service agencies found it difficult to provide the neighborhood-specific data that local neighborhood systems requested. Neighborhood specific data was generally inaccessible because many of the agencies did not maintain neighborhood-specific databases. Other agencies that dit not maintain computerized systems found it extremely difficult and time consuming to retrieve this information. In addition, many agencies did not have the personnel to devote to this task.

[16] See neighborhood governance study report for detailed analysis of governance strategies developed by sites.

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

Furthermore, in some instances where data were available, many agencies were reluctant to release this information to sites because they did not trust these neighborhood systems with confidential information. In addition, because these agencies generally had a different service philosophy than the site systems, they were somewhat skeptical about sharing this type of sensitive information.

As such, data collection efforts to secure neighborhood specific information on placements and service utilization were undermined, and although sites did make efforts to report and collect this information their efforts were not as successful as originally anticipated.

However, sites were moderately successful in tracking service utilization of their own local neighborhood systems through their established local client tracking and management information systems.

Although it is reasonable to assume that all four sites during one phase or another encountered several of these challenges, they were able to successful work through them and provide services in their communities. These challenges have not prevented Houston, Miami and Richmond family resource centers from continuing to operate. These sites have, in fact, found ways of overcoming many of these challenges. While institutional barriers and philosophies still remain an issue, the sites have made some progress in working with more traditional agencies.

In terms of bridging the philosophical differences between their neighborhood-based service systems and traditional service agencies, sites have found it beneficial to accommodate some of the mandates and rules that guide these agencies. The sites have hired a combination of para-professional and professional staff to provide services. By taking this more balanced approach they have been able to earn the respect of traditional agencies who have since become more open to collaborating with them. Some sites like Houston, have spent time and resources to ensure that some of their local community agencies are accredited and this has put them in a better position to obtain Medicaid privileges and become more competitive.

Also, as implementation of the Initiative progressed, stakeholders became clearer about their roles and learned to work more productively with other stakeholder entities. Better working relationships could more effectively implement services.

Finally, many sites have continued to operate because they have explored sustainability options for securing additional funding and grants from state government and private foundations such as the Casey Foundation and the Hogg Foundation.

Conclusions

The analysis of service implementation indicates that sites' service systems accomplished the two major goals of service availability and accessibility. Through their three-pronged approach to service delivery involving family resource centers, outreach services, and intensive case management, sites were able to increase the number of services available to families hereby strengthening the array of services and supports. Sites were also able to ensure that these supports and services were easy for families to obtain and that the services were generally provided within the target communities.

Reviews on the sites' success in accomplishing the seven critical benchmark areas (outlined on pg. 11 & 12) are mixed. Strong success was achieved in two of the seven areas (#7 & #4). There were modest gains made in one area (#6) where sites were initially quite weak they have now begun to show progress. Sites have been less successful in four other areas (#1, #2, #3, & #5) primarily because these areas deal more specifically with children with serious emotional or behavioral problems which most sites did not focus on.

All four sites showed the most success in ensuring that direct services were sensitive to and responded to the cultural and ethnic differences (#7). Evaluation findings rate cultural competence in relation to direct services as being high. Sites were also successful at creating a continuum of services within a less restrictive environment (#4). Most of their service systems were based on strategies that were implemented within the family and/or community settings.

Initially, sites had had limited success in engaging families as full partners in planning and providing services for their children (#6). At the individual family

level, families appeared to have had a minimal role in the design and delivery of services. However, evaluation studies conducted during the latter phase of implementation show that sites had begun to make progress in this area and had started involving parents much more in the development of their service plans.

With the exception of the Boston site, sites did not focus primarily on children with serious emotional or behavioral problems. The Boston site developed an intervention for these children (#1) by incorporating services for the severely emotional disturbed children and children in out-of-home placement as a major part of their direct service strategy. This was done primarily through the Roxbury Returns Project (RRP) aimed at bringing children back into the community from placement.

Houston, Miami and Richmond placed much less emphasis on this category of children. This shift seemed to be intentional as sites moved away from providing extensive intensive intervention to providing more targeted prevention and universal services. As MHI implementation progressed, sites began to view mental health in very broad terms, and began to focus more on providing various supportive, prevention type programs such as camps, tutoring and training programs. At the same time intensive intervention services became less of a priority.

Sites also had limited success in providing case management services that ensured coordinated assessments and planning, service delivery and supports for transitions within the continuum of care (#5). In general evaluation findings suggest that coordination between site case managers and other human service systems was relatively weak. This was partly because other service systems responded to mandates and guidelines which were often in conflict with the philosophy and principles of the site's case management and service philosophy. Therefore, the sites generally did not fair well with regard to having collaborative coordinated assessments and planning of services to support children and families.

Relatedly, sites also failed to develop an integrated array of services across agencies and programs (#2).

Consequently, sites did not develop highly individualized services and supports for families with children who have serious emotional or behavioral problems (#3). Even in Boston where there was a focus on this category of children, evaluation findings indicate that this site was not very successful in tailoring its services to truly fit the needs of each unique family. This may have been due in part to the fact that there was a limited amount of resources available and therefore, staff were more inclined to provide families with services from the menu of services that were available.

It should be noted however, that the evaluation analysis does indicate that overall sites were successful in implementing an array of universal, prevention support services provided primarily through the family resource centers. The choice to emphasize on universal and targeted supports in lieu of more intensive services appears to be intentional.

Sites deserve special recognition because they achieved broader accomplishments beyond the seven core areas discussed in the previous paragraphs.

By implementing the MHI, sites created an environment that promoted parent, family and resident inclusion as an integral part of the site's service implementation design. This type of approach fostered communication between families and other professionals at the state, city and community-based organization levels. Site teams successfully engaged many families from low-income, minority communities and provided them an opportunity to assist in determining what their service system should look like and which agency should provide those services. Site Neighborhood Governing Boards provided a vehicle through which family members could participate in this type of decision making and represented an innovative approach to family inclusion in service delivery. Some stakeholders suggested that this type of inclusion is critical to ensuring that direct support services are family-centered and culturally competent.

Another accomplishment resulting from family inclusion is the great sense of pride and fulfillment reported by many residents. The family resource centers that are still delivering services in Houston, Miami and Richmond represent concrete evidence of the contributions and hard work of residents. These residents have made a difference in the way services are now being delivered in their communities.

The contributions of these residents also have a broader impact. Families from the four target communities have not only presented their implementation experiences at national conferences, they also have become involved in other local and national Boards such as the Federation of Families. Many family members have become involved in peer-to-peer training, sharing their ideas with others in similar roles. As such, families in communities throughout the United States can be motivated by the individual and collective achievements of the families that have represented the four MHI communities.

At the national level, the MHI service implementation model can serve as a prototype for other national service models. Other communities and stakeholders who are involved in initiatives or programs similar to MHI, which involve extensive resident inclusion and participation in service design and delivery, may benefit from some of the lessons learned from implementing the MHI. The Initiative has shown that this type of approach can be implemented and can provide useful examples of what works and what does not work.

SECTION

T W O

Stakeholders' Views on Lessons Learned from Service Delivery

Stakeholder's Views on Lessons Learned from Service Delivery

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

This section summarizes only the most relevant lessons learned from implementing services in the MHI. Rather than distilling our own lessons from the individual sites' experiences with service delivery, 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 Methodology-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 from implementation of services through the Mental Health Initiative can be categorized under three major headings:

- Inclusion of Residents in Service Delivery –Pros and Cons
- Complexity of Service Implementation
- Other Implementation Lessons

Inclusion of Residents in Service Delivery–Pros and Cons

This set of lessons responds to the initiative's mandate of family and resident inclusion in the design, delivery and implementation of services. The lessons reflect on the 'benefits of resident involvement in service delivery' and the 'challenges of resident involvement in service delivery.'

Inclusion of Residents in Service Delivery–Pros

The following subsections review the three main benefits that emerged as a result of resident inclusion in service delivery.

- Residents Make Services More Culturally-Competent and Family-Centered
- Residents Provide a Holistic View of Mental Health
- Family Involvement Boosts Consumer Knowledge and Confidence

Residents Make Services More Culturally-Competent and Family-Centered

LESSON

The inclusion of residents in service delivery made it easier for stakeholders at all three levels to design services that were based on the perspectives of family members. Family input was a valuable tool for ensuring that services were culturally competent and family-centered.

On a macro implementation level as well as the direct service level, service strategies were culturally competent and reflected the families' cultural backgrounds and perspectives. Families were able to give input into service design through the governance structure and its committees. These families helped design services that were more in line with what families wanted rather than what providers thought they needed. Stakeholders at the various levels agreed that there was value in having resident involvement: "*I think that the strategy (of involving parents) is the strength, that it is being determined by the parents what services are going to be needed.*"

Family input and feedback were also partly responsible for the sites' hiring of paraprofessional staff. These staff were usually from the target neighborhoods and could more readily identify with families. In Miami and Boston, for instance, individuals who could speak Spanish were hired to better serve the monolingual Spanish speakers in these neighborhoods.

Although sites were far from fully implementing the concept of family-centeredness, they made some progress in providing services that include families in the planning and delivering of their case plans. By the end of the Initiative, the sites' case management models had begun responding not only to the needs of the target child, but also addressing some of the needs of other family members.

Some stakeholders at the provider level however, cautioned that community and family input by itself was not the optimal approach. Providers warned that for services to be truly effective: "*Its really has to be a combination, not the government dictating (what is needed) and not just the neighborhood dictating.*"

Residents Provide a Holistic View of Mental Health

LESSON

Community residents provided a broader, more holistic definition of mental health. Their inclusion in service delivery ensured that providers and other state and local stakeholders had a realistic view of the scope of the families' perceptions regarding their 'mental health' needs.

One of the benefits of having residents as part of service delivery was that they helped to redefine what mental health meant to residents in the target neighborhoods. There was a distinction between residents' definition of mental health and the state, provider and other non-community stakeholders' definition of mental health. This distinction was reflected succinctly in the residents' emphasis on more preventive and supportive services, as opposed to the provider/state emphasis on more intervention and intensive type services. In general, providers' definition of mental health was narrower, and more clinically-based. In contrast, residents described their mental health in terms of overall mental well-being. This definition of the mental health meant that they were very concerned above providing preventive type resources such as food baskets at Thanksgiving and camp and recreational activities for their children. While families seemed to realize that traditional services such as counseling and therapy were important, such services were clearly seen as less of a priority than preventive, universal services and supports.

By the end of the Initiative the gap between the two definitions was getting smaller. The state and provider agencies began to accommodate the broader more flexible view of mental health identified by the families. However, it is clear that without family representation this focus on less intensive, preventive support services would have been much more limited.

Family Involvement Boosts Consumer Knowledge and Confidence

LESSON

Residents who were involved in the design and implementation of their site's service delivery model, became generally more knowledgeable, informed and confident. Residents became more aware of their rights as consumers and developed a stronger consumer voice.

Stakeholders stated that some of the residents involved in the Initiative had grown and developed in their knowledge about human service systems. Others had experienced some professional growth and advancement. Some residents became computer literate and MIS savvy, others developed contacts and links with state agency staff, while others moved on from being just community residents to being para-professionals providing services. These examples mark the strides that residents made as a direct result of their participation in the MHI service development process.

With increased family involvement and more consumer knowledge about services, families were more confident about their rights as consumers of service and this placed them in a stronger position to effect service changes. One resident reiterated the need for families to make their own service choices: "*We need to move the family to where they want to go and not where the professionals think they ought to go.*"

Inclusion of Residents in Service Delivery–Cons

The following subsections review some of the challenges that resulted because of resident inclusion in the sites' service design. The three challenges include the following factors:

- Traditional Systems are Difficult to Change
- Para-professional Staff Are Not Trained to Provide Clinical Services
- Community-Based Agencies Are Not Equipped to Compete in the Managed Care World.

Traditional Systems Are Difficult to Change

> Although including family perspectives in service design led to the development of more culturally-competent and family-centered services within the MHI, it was much more difficult to change service delivery in traditional, bureaucratic, state and local human service agencies.
>
> LESSON

Many of the state and local providers had a 'traditional' way of providing services that involved limited or no family involvement. In contrast, the newer service models designed through the Initiative emphasized the family's role in service design and implementation. During MHI implementation it was clear that a number of traditional agencies with whom many of the family resource centers and case management staff collaborated were not prepared to change the way they delivered services to families in these four communities. Some residents even complained that *"we (community) were never able to get the state agencies to follow through."*

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

Second, some state and local service providers were unconvinced that these MHI models were capable of providing certain services effectively. In Boston, for example, the Department of Mental Health (DMH) and the Department of Social Services (DSS) did not feel that the case management support staff, which at that time comprised mainly para-professional staff, had the ability or expertise to effectively manage families that required intensive intervention. These agencies were, therefore, initially quite reluctant to refer their clients for case management support at the FRCs and chose to continue serving these children themselves.

Para-professional Staff Are Not Trained to Provide Clinical Services

Para-professionals were used in all four sites and represented a unique aspect of the sites' service strategies. The Family Resource Specialists in Boston, the Parent Resource Network in Richmond, the Friends of the Family Training Curriculum in Houston, and the Madrinas/Padrinas in Miami were all important components of services in these four sites. However, it was clear that para-professional supports could not completely replace clinical or psychological expertise and other social work experience and training.

LESSON

Although para-professionals served a unique purpose, it was necessary to complement their services with those of trained professionals with clinical background and experience. Para-professional staff could not effectively provide the clinical and professional support services that many of the families needed.

Stakeholders at the state level reported that these para-professionals could not support a service strategy on their own, and maintained that trained clinical staff were vital to effective service delivery. One stakeholder made this assertion:

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

A demonstration of this type of sentiment occurred in Boston when some state agencies refused to refer their families to the case management team at the FRCs who initially had been predominantly para-professionals. These agencies argued that the case management staff was simply not qualified to treat these families.

Interestingly, resident stakeholders had a different view about the role and need for para-professionals, and emphasized their importance to effective service delivery: " …*Para-professionals are aware of the true needs and they are undervalued."* While it may be true that agencies have yet to utilize the full potential of para-professionals, their skepticism regarding a para-professional's ability to provide the type of intensive case management that professional staff can provide is understandable.

Community-based Organizations (CBOs) Are Not Equipped to Compete in the Managed Care World

LESSON

Many of the minority, community-based providers involved in the MHI did not have the training and organizational capacity and/or status that was necessary for them to successfully compete for government contracts. This meant that these organizations needed technical assistance to help them pre-qualify to become Medicaid eligible and/or qualify for other government contracts.

The para-professional staff helped to ensure that services were culturally appropriate and family-centered. However, in the beginning some of the community-based organizations involved in the MHI failed to meet certain standards necessary for them to compete in the managed care environment. This meant that the staff was either not licensed or did not have the necessary professional qualifications as clinicians or social workers. As one state representative concluded: "*It (service delivery) is a serious business and we were naïve not to train the community and community providers in this industry. It is a serious industry, it is being taken over by the managed care world and we have not prepared folks to be able to enter and participate in that world...So a lot of small providers simply could not respond (to the RFP) because they could not qualify.*"

The situation that occurred in Houston when many of the providers within that site's provider networks failed to meet Medicaid eligibility standards, also demonstrated how a lack of organizational capacity and preparedness can negatively impact service delivery. At this site, stakeholders had to work diligently to get some of the providers within the MHI provider network certified so that they could become Medicaid eligible. A state representative concluded that, "*No managed care company is going to do business with you as a representative of service providers if nobody has a degree and nobody has a license.*"

Complexity of Service Implementation

Complexity of Initiative Design

These lessons arose mainly because of the Initiative's multi-faceted and complex nature. The Initiative involved three main components representing *systems reform, service delivery and governance*. Each of these three areas required working with different groups of people at the state, local and community levels and each area had its own goals. Sites were expected to accomplish these goals simultaneously. This was a difficult undertaking and five major lessons emerged as a result of MHI's complexity. These are:

- Confusion Over The Board's Role Affects Service Delivery
- Decision-Making Power Is Tied too Strongly to Control of Funds
- Technical Assistance Becomes a Priority in Service Delivery
- Multi-faceted Nature of MHI and Complexity of Service Implementation Cause Delays in Service Delivery
- Community Organizing Aspect Needs Separate Funding From Service Delivery

These lessons can provide useful information for other sites involved in similar projects and initiatives.

Confusion Over The Board's Role Affects Service Delivery

Consultants and representatives from the state and local levels felt that the goal of the governance strategy with regard to service delivery and implementation was not clearly defined. Some state and local stakeholders also felt there was confusion because residents had never been clearly told what their role was to supposed to be: "*…we were not clear about really what was the expectation of the parents, what should the parents do?…"* These state and local representatives appeared to think of the Board in terms of being an advocacy and advisory group.

LESSON

Stakeholders in the Initiative, i.e., state, provider, community, and consultants, believed that the role of the NGB either as an advisory, monitoring, advocacy, or decision-making entity should have been more clearly defined from the beginning of the Initiative. Generally, stakeholders at the state, local and community levels did not agree on what the neighborhood governance boards were actually supposed to be doing. This confusion cost the Initiative in terms of time, relationship building and service development.

In contrast, residents across sites did not appear to see themselves as having merely an advocacy role, instead these residents agreed, at least in theory, that the Board had a decision-making role to play. However, in reality, residents had different views about how successful their Boards had been in influencing service delivery at their site. For instance, some residents felt that their resident Board members had been responsible for making service design decisions. Other residents felt that overall, residents in their particular site had had much less influence in making any service decisions:*" (only) a few of the recommendations made by parents were listened to."*

Decision-Making Power is Tied Too Strongly to Control of Funds

Stakeholders at the provider level generally stated that decision-making power was in the hands of the grantees–i.e., the state and therefore, since the governing board was not in control of money, the residents had less leverage and less decision-making power. Some residents seemed to agree with this notion that money translated into decision-making power. One resident reported that as far as the residents were concerned, *"money and resources were available but not accessible."* Not surprisingly, these residents also reported that they had not had many opportunities to make service decisions.

LESSON

Some stakeholders at the provider and community levels believed that the governing board had a limited decision-making role because they did not control the funds. These stakeholders believed that decision-making power about services rested primarily with the grantees.

The implication here is that if residents do not have access to the resources then their ability to make service decisions will be limited. Residents recognized this and so it was not surprising that when the Miami Board was able to gain direct control of some of the MHI funds, resident stakeholders considered this to be a major accomplishment.

Technical Assistance a Priority in Service Delivery

Stakeholders stated that the timing of technical assistance was often inappropriate. These stakeholders reported that in some of the sites technical assistance came too late. On these occasions instead of helping stakeholders at the sites with the service design, consultants were often engaged in trying to 'undo' or 'fix' some of the inappropriate decisions that sites had already made. They suggested that allowing the sites to decide when they needed technical assistance sometimes resulted in these sites formally requesting assistance when they were already in crisis.

LESSON

Technical Assistance was a top priority in service implementation. Providing technical assistance to local providers and stakeholders was essential for effective service implementation. Consultants seemed to agree that providing technical assistance to the sites at the appropriate time was a challenge–sometimes assistance was provided too late and at other times began too early. Consultants also felt that more local technical assistants should have been identified, trained, and mentored earlier on in the Initiative.

However, they also reported that there had been times when their assistance had come too early. For example, some consultants reported that perhaps technical assistance training on services was a bit premature and introduced too early on in the Initiative when sites where not yet quite ready to handle these services.

Consultants further reflected that in most sites MHI had not developed an effective pool of local technical assistants who would have been more accessible to the sites and in a better position to provide the necessary follow-up. The value of such a strategy appeared to be validated by a provider who reported that his site had needed more technical assistance around service delivery. This provider reported that technical assistance had been piece meal: "*We got it in pieces, we got a little of governance, and we got pieces of culture…*"

The proper timing of technical assistance and the development of a credible pool of local technical consultants were critical elements needed to support effective service delivery. These factors become even more relevant when one considers how important issues of para-professional staff training and organizational capacity building were to the MHI's community-based service systems.

Multi-faceted Nature of MHI and Complexity of Service Implementation Cause Delays in Service Delivery

Sites had to prioritize their tasks and assignments and the four sites spent the initial phase of implementation developing their governance vision and strategy. The Initiative was well into the implementation phase when sites were able to offer services to the residents through their MHI service models.

LESSON

In a multi-faceted initiative such as the MHI, stakeholders had to juggle competing tasks and assignments. It was often difficult to maintain and implement all MHI strategies of governance, systems reform and services at the same time. In addition, the service strategy itself was complex and this led to a delay in sites delivering services to community residents.

Consultants believed that the issue of when to provide services was important. These stakeholders stated that services could not have been started before a site was developmentally ready, but recognized that a lengthy delay in service delivery could result in residents losing interest and withdrawing from the Initiative.

In addition, consultants agreed that although the family resource center concept was a useful strategy in providing mental health services, its complexity made it difficult to implement. They reflected that perhaps it would have been best to start the service component of the Initiative with more concrete, and less complex activities.

Community Organizing Aspect Needs Separate Funding From 'Service Delivery'

The multiple tasks related to governance, service delivery and systems reform created time and resource management challenges. State and local representatives agreed that they had at times had to shift resources and time between competing duties related to these three areas. As one local representative suggested: *"I think that the community organization needs to be funded separately from service delivery…there needs to be a linkage between the two, but if we are going to change power relationships within the neighborhoods then that has to be a separately funded and targeted focus…"*

LESSON

Some stakeholders at the state and local level felt that community organizing (i.e. getting residents organized and involved in the Initiative and service design) and actual service delivery needed to be funded separately. These two activities required considerable time and resources and stakeholders felt that things would have worked more effectively if separate resources had been allocated for each of these tasks.

Other Implementation Lessons

The three lessons discussed in this section also have a direct bearing on front-line service delivery. These lessons include:

- Service Outcomes Could Not Be Accomplished Within Implementation Time Frame
- Culturally-Competent Evaluators and Technical Assistants (TA) Facilitate Service Implementation and Monitoring
- Consultants' Expanded Roles and Innovative Techniques Facilitate Service Implementation

Service Outcomes Could Not Be Accomplished Within Implementation Time Frame

Stakeholders at all levels agreed more careful consideration should have been given regarding the amount of time that would be required in order for sites to realize the full benefits and potential of their site strategies. They reported that perhaps more focus should have been placed on interim short-term outcomes. Stakeholders agreed that the five-year time frame for the Initiative was not enough time for the sites to accomplish some of the long-term outcomes for children in the target communities.

LESSON

Sites generally did not have defined measurable interim outcomes and tended to assign more long-term outcomes to their service models. Many of these outcomes were not reached during the implementation phase because the length of time allotted for the Initiative was too short.

Culturally-Competent Evaluators and Technical Assistants (TA) Facilitate Service Implementation and Monitoring

The Casey Foundation deliberately set out to organize technical assistance and evaluation teams that were reflective of the MHI communities. The benefits of including TA and evaluation that are culturally-competent had a direct effect on service implementation as well as the evaluation of the sites' service strategies. The presence of people of color in evaluation and technical assistance teams made it easier to work in the target communities. As one technical assistant put it: "*When we went into Hispanic neighborhoods, …we tried to get Hispanic people in those neighborhoods.*" In addition, because the evaluators were culturally-competent, residents opened up and shared information about the weaknesses and strengths of their site service models in a way that would not have been possible if staff had not been culturally-competent.

LESSON

The MHI ensured that both its technical assistance and evaluation staff had diverse cultural backgrounds. Technical assistants and evaluation staff were culturally matched to the communities they worked in. This made it easier for consultants to provide assistance and for evaluators to monitor and evaluate services.

Although matching racial and cultural background of the technical assistants and evaluation staff was not the only important aspect of evaluation and technical assistance, it represented an important step in ensuring that the cultural diversity of the sites was respected.

Consultants' Expanded Roles and Innovative Techniques Facilitate Service Implementation

LESSON

MHI benefited from the innovative ways the Foundation used its technical assistants and evaluators in the overall implementation and service delivery. Some technical assistants and evaluators dual role in MHI design as well as its implementation had a positive impact on services. In addition, innovative approaches taken by consultants helped facilitate service delivery.

While consultants normally perform specific technical services and evaluation tasks and assignments after a project has been designed and in operation, in the MHI, some consultants were a part of both processes. Consultants believed that the Casey Foundation's approach of incorporating them as part of the decision-making process earlier on was not only innovative, but also had a positive impact on overall implementation. Being involved as part of the decision-making process increased their level of commitment to ensuring the successful implementation of the Initiative.

In addition to having this type of expanded role, technical assistants were also innovative and flexible in their approach to helping sites. Although the proper timing of technical assistance was noted as a challenge, their flexibility in responding to site needs was impressive. At times technical assistants were very proactive in their approach while at other times they responded specifically to sites' requests. This approach allowed technical assistants to be both proactive and responsive to sites' needs, and represented a change from the more systematic way of providing technical support at scheduled intervals.

Some consultants felt that sites were given too much autonomy in deciding their sites' technical assistance needs. These consultants felt that they could have had an even more directive role and prevented the sites from "floundering." However, there is little doubt that technical assistants played a leading role in steering sites towards the Family Resource Center model as a possible service delivery option, and that the FRC strategy was a major MHI accomplishment. The results of this proactive leadership on the part of the TAs are the family resource centers in Houston, Miami and Richmond, which provide needed supports and services to families.

The evaluation component also played an important role in service implementation. Some evaluation staff, like some of the TA staffing, also had been involved in the conceptualization of the Initiative. The evaluation's approach to assessing service implementation was also helpful. This meant that it provided improvement-oriented evaluation data. These data provided sites with information that allowed them to reflect on and modify their service strategies. An example of the value of this type of evaluation was seen in Miami when the site developed the "Equipo" training in direct response to some of the findings of the national evaluation's Family Experience Study.

However, consultant stakeholders contended that evaluation reports could have been timelier. They suggested that if these reports had been more timely, they would have been more prepared to respond to and assist sites as they implemented their services.

Although the evaluation and technical assistants had their share of challenges they provided meaningful support to the sites. Their commitment and support helped the sites design and deliver culturally-competent, family-centered services for residents in the target communities.

SECTION

THREE

Case Studies

FLORIDA

- **East Little Havana Site Profile**
- **Overview of Service Development in Miami**
- **Service Delivery Strategy in Miami**
- **Highlights of Service Development in Miami**

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.

OVERVIEW OF SERVICE DEVELOPMENT IN MIAMI

Pre-Implementation/ Planning Phase

In 1992, the state of Florida outlined an ideal service array of local and state resources to be provided through a holistic neighborhood service system in their application to the Casey Foundation. Under this system, *"services would be available in the home and school, in or near the neighborhood, provided by culturally competent service providers who value family preservation, and with services available at times that families can most easily access them*" (There are Children Here; Billy's Story. A Proposal to the Annie E. Casey Foundation, State of Florida, April 1992; p. 24).

The array of services proposed included health, substance abuse, and mental health services; child welfare; vocational rehabilitation; income support; legal; pre-school programs; full service schools/family service centers; economic development; community development; and transportation. The proposal also referred to the provision of innovative packages of overlay and wraparound services and ensured *"maximal pooling and flexibility in the use of funds and resources being provided to residents of the selected neighborhood"* (ibid, p. 26).

In 1993, prior to the implementation of a comprehensive service plan, the MHI's resident-driven board (i.e., Vecinos en Accion or VEA) chose to focus on increasing recreational opportunities for children in the neighborhood. VEA worked with the Department of Children and Families District Office to pay for sport coaches at the Jose Marti Park in the heart of East Little Havana (ELH). It also provided a summer program for youth with assistance from the county's Department of Youth and Family Development. The county also provided staff to work at the VEA office, offering information and referrals to families that were approaching the board for crisis assistance.

In March 1994, a partnership between VEA, service providers, Dade County Public Schools, the Department of Children and Families (then Health and Rehabilitative Services), and the Children's Services Council began the task of outlining the MHI's service design strategy. The resulting plan was called "Elements of a Reformed System of Care." The Vision statement for the proposed system was:

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

The Elements of this system of care involved three primary areas:

- **Community organization**: outreach to residents and linkages with existing community organizations, the faith community, and civic organizations to identify community needs and develop advocacy mechanisms to meet them.
- **Prevention and early intervention activities**: Expansion and enhancement of social networks which occur naturally in the community through a network of 'Madrinas' and 'Padrinos' acting as link persons, and the creation of a Family Center where local agencies can offer integrated services and basic supports to parents.
- **Services and supports for multi-need families**: Services targeted to children and their families with need for multiple interventions over time, particularly those with mental health needs. These services would be delivered by a multi-agency team working in collaboration with the Madrinas and Padrinos and offering individualized interventions and crisis management.

> …the Abriendo Puertas Governing Board strengthened and incorporated to become a non-profit organization with 501(C)3 status.

Implementation

The Abriendo Puertas Family Resource Center opens in East Little Havana

True implementation of services began in 1995. In collaboration with Miami Behavioral Health Center, a non-profit mental health provider, the MHI was awarded a Family Preservation/Family Support grant to support the "Equipo Familiar del Barrio" (Neighborhood Family Team). The $240,000/year grant renewable over four years involved the collaboration of several local agencies who would co-locate at the Family Center. Services included were information and referral, outreach, case management, family and individual counseling, therapy, intensive mental health services, family preservation and support services, and recreation and cultural activities. The grant included sub contracts with Family Builders (intensive family preservation), Regis House (substance abuse programs for youth), and Legal Services of Greater Miami (immigration seminars).

The MHI also leveraged Casey funds to obtain an Americorps grant to bring Legal Services of Greater Miami to serve families in ELH. This was significant because many residents were in need of legal services primarily to deal with immigration issues.

In addition, Casey funds were matched with 93-94 Dade County Public Schools monies to support programs in two full service local elementary schools: "Florida First Start" offered family skills building and prevention for families with children age birth to 48 months; and All Aboard provided tutorial mentoring program for children in grades K-1.

The "Madrinas and Padrinos" community outreach program was developed and volunteers were trained. This program involved community residents who volunteered to provide outreach to families in need and connect them with service providers who were connected to the MHI.

Other developments at the site included 'Concilio de Familias', a resident advisory group to the MHI's Neighborhood Governing Board that was formed in 1996. The group is open to all residents of ELH and fulfills several different functions. These include advisory to the Board, resident leadership training, advocacy on behalf of community children, improved employment and economic opportunities for residents, and development of support networks for families with children with special needs and those facing child abuse or domestic violence issues.

As implementation of the MHI continued, the Abriendo Puertas Governing Board strengthened and incorporated to become a non-profit organization with 501(C)3 status. Abriendo Puertas began several different activities aimed at providing services for residents in the target community. For instance, in 1996, Abriendo Puertas obtained a three year contract from the Alcohol Drug Abuse and Mental Health Office (ADM) of the Florida Department of Children and Families District XI. This contract was to provide prevention services and programs at the Family Resource Center. The $100,000 a year grant funds the following prevention activities: Children's Cultural Circle; Abriendo Puertas Community Newsletter; Computer Tutoring; Painting Classes; and FRC staff salaries.

Another contract was obtained from the Shared Services Network (SSN) to provide services through IDEA '97 funds. The $40,000 are used to cover salaries for a community organizer and parent coordinator whose jobs center around increasing parent and community involvement with the local schools in East Little Havana, and to support community outreach activities. The grant is renewed yearly.

“The Casey Foundation contracted with the Time Dollar Institute to implement the program in ELH.”

In addition, during this period Abriendo Puertas began to use part of the MHI funds to contract with the Florida Immigrant Advocacy Center (FIAC) to provide much needed individual immigration consultation to residents of ELH.

Another important development that occurred at this time was the addition of the Time Dollar and Food Bank component. The Casey Foundation contracted with the Time Dollar Institute to implement the program in ELH. Time Dollar requires participants to accrue hours doing volunteer work that can subsequently be exchanged for services or food.

As the family resource center continued to develop and expand it became clear that staff needed to be well trained and subsequently an intensive training model was developed in 1998. The first Equipo Training was conducted with both professionals and ‘Madrinas’ and ‘Padrinos’. The purpose of the training was to better integrate formal and informal supports available to families who are served through the Equipo Family Preservation/Family Support grant.

Post Implementation

With the official ending of the MHI in December 1998, Abriendo Puertas has continued to thrive. In 1999 a local resident and long time volunteer and board member of Abriendo Puertas was hired as a part time volunteer coordinator to oversee the Time Dollar and Food Bank operation.

The Family Council has also received a $40,000 allocation from the Casey Foundation to fund and support its own activities in the community and a second Equipo training has been offered to another group of volunteers and professionals.

It seems clear that services will continue at this site for sometime into the future and sustainability of the services seems assured as the site continues to produce evidence that services are working effectively for residents in East Little Havana.

SERVICE DELIVERY STRATEGY IN MIAMI

This section provides an in-depth discussion of Miami's service strategy discussed under the umbrella of **Abriendo Puertas Family Resource Center** and highlights major **Service Issues and Challenges**. The discussion closes with a summary of how **Abriendo Puertas FRC Thrives into the New Millennium**.

In the 1994 document "Elements of a Reformed System of Care" which outlined the MHI's service strategy, three primary areas were identified for implementation:

- **Community organization**: outreach to residents and linkages with existing community organizations, the faith community, and civic organizations to identify community needs and develop advocacy mechanisms to meet them.
- **Prevention and early intervention activities**: Expansion and enhancement of social networks which occur naturally in the community through a network of Madrinas and Padrinos acting as link persons, and the creation of a Family Center where local agencies can offer integrated services and basic supports to parents.
- **Services and supports for multi-need families**: Services targeted to children and their families with need for multiple interventions over time, particularly those with mental health needs. These services would be delivered by a multi-agency team working in collaboration with the link person(s) and offering individualized interventions and crisis management.

Miami's overall service strategy included these three elements which were placed under the physical umbrella of the Abriendo Puertas Family Resource Center. The center opened its doors in 1996 and its service philosophy was consistent with the philosophy of the MHI. Abriendo Puertas Family Resource Center has been successful in implementing a seamless continuum of services which includes *promotion and universal supports, targeted prevention, family preservation and support, and intensive services*. A strong emphasis was placed on accessibility and availability to families of East Little Havana (ELH).

Findings from the focus groups conducted in Miami in 1997 as part of the MHI evaluation provided information on some of the early accomplishments of the Abriendo Puertas FRC. The data collected at that time suggested that the promotion, prevention, and treatment categories under which programs were organized were not really mutually exclusive. Several focus group participants were involved in more than one category and stated that as the range of services increases, they will extend their involvement into other areas. This finding points to the successful implementation of the concept of a "seamless continuum of services" which was part of the original vision for the MHI in Miami.

A major accomplishment also identified through the focus groups is related to FRC's family friendly atmosphere and culturally-appropriate approach to service delivery. Focus group participants spoke of having a sense of familiarity and comfort whenever they are at the center and with providers, and of the of their increased sense of self-confidence as a result of the positive interaction. Participants spoke of the FRC as "*a place where they can go for assistance, where they can express their fears, where they can link with the rest of the community and seek mutual support.*" (Contreras et al. 1997).

The following section describes the different services and programs delivered through Abriendo Puertas. It is organized according to level of intensity, starting with the most community-oriented services and ending with the more intensive support programs. The program descriptions also center

> The Council's mission is: To promote unity among parents in ELH community where families can benefit from all the resources…

around accomplishments, innovative program features, and relative impact on community residents. The section also addresses some challenges related to service implementation and concludes with the accomplishments that have occurred after the official ending of the MHI.

Abriendo Puertas Family Resource Center

Promotion and Universal supports

These services are available to all families in the ELH target area and respond to several of the needs identified by community residents during the MHI's planning phase including: children's educational and recreational opportunities; child care; adult employment; job training; and legal and immigration advice.

Community Residents Become the Backbone to Abriendo Puertas' Service Delivery Strategy

The provision of promotion and universal services relies heavily on the contributions of ELH residents. Residents are involved in a variety of ways. The Family Council, for instance, is a family-run organization whose members reside in East Little Havana and are willing to participate and collaborate in community development activities. The Council has an Executive Committee and as of August 1999, had a membership of 142.

As stated in its by-laws, the Council's mission is: *"To promote unity among parents in ELH to create a community where families can benefit from all the resources, in all aspects of life, including physical, moral, spiritual and economic, in order to ensure a better future for themselves and their children."*

Seven work areas have been created to carry out the Council's mission:

- Involvement with the Casey Mental Health Initiative through participation on service related decisions to ensure that services provided at the Abriendo Puertas FRC are of high quality and appropriate to meet the needs of residents;
- Improvement of parenting and community leadership skills among residents;
- Identification and mobilization of resources to support youth development;
- Creation and improvement of employment opportunities and development of links with the ELH business community;
- Development of support mechanisms for families, particularly those with children with special needs, and those impacted by child abuse and domestic violence;
- Collaboration with parent organizations in local schools; and
- Establishment of links with other community-based organizations such as PTAs, Crime Watch groups, churches, tenants councils, child care centers, etc.

The Family Council's efforts have significantly enhanced the capacity of Abriendo Puertas to offer promotional services to all residents of ELH. In 1998,

- Recruitment of 30 residents to take child care accreditation classes.
- 10 members of the Council graduated from the Community Leadership Program, a series of seminars designed to improve community involvement.

To expand Abriendo Puertas' linkages with community-based organizations and local businesses, a Community Organizer was hired in 1998.

- A youth group was developed and funds were made available to them to support their activities. The youth do volunteer work with community-based agencies in ELH. Different recreational and educational outings for the youth took place during the year.
- Collaborative partnerships were established with local churches, schools, businesses, and other citizen driven groups. A partnership with the San Juan Bosco Church resulted in the location of a housing consultant at the FRC to assist residents with housing issues, one of the most pressing needs of many ELH residents.
- Council volunteers provided child care for parents attending activities at the FRC, supervised all special events held at the FRC and coordinated volunteers required before, during and after the event.
- Through its Nations Committee, the Council conducted special activities and celebrations aimed at promoting cultural awareness and tolerance among ELH residents.

Another way in which residents are involved in services is through the Time Dollar Bank. Through this program, all participants registered in an FRC program "contract" for services by agreeing to provide volunteer hours to support the center's activities and to help meet community needs. The FRC does not charge fees for any of its services. Volunteers earn "Time Dollars" which allows them to "purchase" or exchange volunteer time for services they may need. An additional benefit for participants is that the performance of volunteer community work strengthens the application of residents seeking U.S. citizenship. A quote from a participant in a focus group supports this finding: "*There is high unemployment in the neighborhood. We need services to provide training for parents. The first thing they ask you when you look for a job is: 'What can you do?' Many don't know how to do anything.*"

A Volunteer Coordinator was hired in 1999 to coordinate the activities of the Time Dollar and Food Banks. This person is a long time community resident and ex-member of the Abriendo Puertas Board. As of fall 2000, 8,699 volunteer hours had been logged by 187 ELH residents at Abriendo Puertas.

Information and Outreach Promote Abriendo Puertas' Services

A key to the success of promotional and universal supports is a well-informed community. The goal is to increase awareness of the services offered by Abriendo Puertas, and connect families to other services and supports available in the community. To that effect, a monthly informational bulletin is disseminated throughout the community, to neighbors, providers, funding sources, etc. In addition to articles of general interest, the newsletter includes articles aimed at prevention of delinquency, substance abuse, and other topics of interest to families and residents. Funds for the production and distribution of the newsletter come from a grant from Dade County School's Shared Services Network and from District XI's ADM Office substance abuse prevention award.

Staff and volunteers who work closely with Abriendo Puertas are also trained to provide information and referral to any family who approaches them for assistance. Displays located in the waiting area of the FRC contain informational brochures about services offered at the Center as well as elsewhere in the community. An Intake Coordinator also provides initial screening and referral to participants.

To expand Abriendo Puertas' linkages with community-based organizations and local businesses, a Community Organizer was hired in 1998. Some of the entities with which the organizer has developed collaborative relations include: Miami-Dade Cultural

To promote closer ties among FRC participants, monthly gatherings are held to celebrate children's birthdays, national and religious holidays.

Affairs Council, The Miami Herald, Arts and Entertainment Partnership, AARP, Sun Trust Bank, Kiwanis of Little Havana, Fannie Mae, Census Bureau, and the Latin Chamber of Commerce.

The links with other community organizations also allow FRC staff, board and Family Council members to advocate on behalf of the families and children from the neighborhood through their participation in various committees of state and local agencies. Examples of some of those activities include: participation in the Human Services Coalition; Community Voices; Champion Our Children Initiative (early childhood); Informed Families; Child welfare providers meetings; and Community Relations Board, Census 2000.

An Emphasis on Education Permeates Promotional Services

As already indicated Abriendo Puertas is very committed to community participation at all levels of its service strategy. In response to continuous feedback from residents about the need to offer educational opportunities for adults and children alike, a variety of courses and training events are offered at the FRC addressing issues of interest to residents. Presentations are offered throughout the year by FRC staff on topics such as Leadership Training, Conflict Resolution, Madrinas/Padrinos (informal service providers), etc. Legal Services, Inc. offers seminars on a variety of legal topics of relevance to ELH's residents (e.g., tenant rights).

Courses are also offered throughout the year on computer literacy, English language skills, Arts and Crafts, and other subjects that vary depending on what residents want. The skills acquired in these classes have improved participants' chances of obtaining employment. For instance, the Arts and Crafts classes participants have sold their work in local gift shops; the three levels of computer classes have prepared participants for clerical jobs at the FRC and other community businesses. A special achievement has been the child care course in Spanish taught by approved faculty. The goal is to enable participants to secure the training necessary to work in child care related positions. In 1998, 30 people took classes required for licensing as child care providers and obtained the necessary certification. The new child care slots resulting from these certifications can help alleviate the long waiting lists for accessible and affordable child care in ELH.

For children, tutorial supervision is offered after school to help them improve their academic standing. Members of the youth group volunteer their time tutoring younger children and can receive tutoring themselves if they need it.

Recreational and Hospitality Activities Bring People Closer Together

To promote closer ties among FRC participants, monthly gatherings are held to celebrate children's birthdays, and national and religious holidays. Food for the events is prepared and served by volunteers. Outings and field trips for children and adults are also organized in response to the lack of recreational opportunities in the community. A quarterly flea market, fully organized and run by volunteers with assistance from staff has been very successful in terms or attracting new families to the FRC, offering opportunities for meeting new neighbors, and also bringing revenue to parent activities. For these and all other activities where parents are involved, temporary age-appropriate child care is offered to allow them to participate and benefit from all FRC programs.

“In 1998, the Youth Group received recognition for its assistance in painting a local child care center.”

Targeted Prevention and Support Services

These services are available to families with risk factors associated with poverty, community safety issues, lack of access to services, immigration status, unemployment, etc. All of these risk factors were identified through the MHI evaluation's first round of focus groups conducted in 1996 as impacting residents of ELH (Gutierrez-Mayka and Hernandez, 1996). Under this umbrella, activities are targeted to resident groups with specific needs and/or interests.

FRC's Youth and Child Oriented Programs Fill Important Service Gap in ELH

In 1996, participants in the evaluation focus groups shared concerns about the unavailability of safe and accessible recreational opportunities for their children. A worried parent gave the following example: *" Apparently the kids are going to play pool, but they are selling them drugs. The waitresses in the coffee shops sell drugs…"*

In response to these concerns, Abriendo Puertas sponsored a youth group to address the needs of youth 13 to 21 years of age who are residents of East Little Havana. The Youth Group identifies its goals and plans and coordinates preventive and social activities accordingly. The group's activities are coordinated by the Youth Group Coordinator in collaboration with parent representatives and Abriendo Puertas staff.

In 1998, the Youth Group received recognition for its assistance in painting a local child care center. The youth also offer tutoring to younger children. To ensure that the needs of youth are properly addressed, the group elects a representative to the Abriendo Puertas Board of Directors and participates in the decision-making process with the adults.

A variety of activities called "Children's Cultural Circle" are offered to younger children from the neighborhood. Programs are designed to assist children with the identification and appropriate expression of feelings; prevention of alcohol, drug and tobacco use; self-esteem; and health promotion. Examples of some of these activities offered to children include Puppet Theater and Puppet Making, Painting Classes, Story-Telling Hour, outings to art shows, museums, etc., and contests (such as drawing and painting). All these activities, in addition to various celebrations, are offered after school.

New and At-Risk Parents Benefit from Parenting Education

A variety of services and activities are designed to enhance parenting skills, including dissemination of information about early childhood development and about healthy family activities. These classes were organized in response to parent feedback, captured in the evaluation focus groups, that they wanted more education activities regarding preschool children and family issues as opposed to only focusing on at-risk teenagers.

The "Seven Family Encounters" are an example of these types of activities. Seven meetings are held for up to 10 participants. Topics include child development, discipline, household budgeting, stress management, and promotion of healthy family interactions. Additionally, infant and child stimulation activities disseminate information about the needs of infants and young children as well as adult-child interactions to help maximize child development (e.g., building visually stimulating crib toys). The parenting classes offered have allowed parents who have open cases with the Department of Children and Families due to child abuse or neglect to fulfill the Department's requirement for parenting education in a convenient and family-friendly environment.

A pool of money is available to assist families in financial crisis that could jeopardize their stability.

Help with Immigration Issues Enables Residents to Provide for their Families

During the MHI planning phases, immigration issues were identified as a major obstacle faced by residents of ELH who did not have legal status or had been unable to obtain work permits. As one parent participant in the focus groups conducted by the evaluation in 1996 stated: *"The majority of persons who live in ELH are not legal residents. My daughter who was not born here cannot even get a social security number."* Without the necessary documentation families in ELH cannot support themselves, and are deprived of much needed health and social services. As a result of this pressing need, Abriendo Puertas is using MHI funds to contract with the Florida Immigration Advocacy Center (FIAC). This agency provides individualized immigration consultation, updates residents on changes in immigration laws and regulations, and assists them with their immigration related issues.

Early Screening of Families has Strong Preventive Power

For families who come into the FRC requesting specific assistance for their problems, professionals and/or natural helpers called "Madrinas and Padrinos" perform family assessments. These assessments allow the identification of strengths and needs of the family in order to develop an initial service plan. A case coordinator ensures that services are coordinated for all family members. This individual also ensures that services are accessed in a timely and effective manner, and that service gaps and duplication are avoided. A pool of money is available to assist families in financial crisis that could jeopardize their stability.

Family Preservation and Support Services

These services are targeted to families presenting severe risk factors that could lead to their children being removed from the home due to child abuse and/or neglect. These risk factors may include: adults lacking parenting skills, homelessness, domestic violence, chronic unemployment, substance abuse, or having an open case for child abuse or neglect with the Department of Children and Families. The strategy for providing services to these families has been supported by a three-year renewable federal Family Preservation/Family Support grant. Miami Behavioral Health Center partnered with Abriendo Puertas to secure the funds, and acts as the fiscal agent.

An initial evaluation of the services provided under this grant (e.g., Family Experience Study described earlier) revealed several challenges. These included a lack of effective coordination and collaboration between the formal, professional providers (e.g., case managers, and therapists) and the FRC-based Madrinas and Padrinos, a team of volunteer community residents trained to do outreach and assessment. An innovative training curriculum was subsequently developed to address this gap and is now being implemented at Abriendo Puertas.

Innovative Training Strengthens the Concept of a Family Neighborhood Team

Abriendo Puertas' EQUIPO is a system of service delivery composed of the Madrinas and Padrinos, and a group of service providers that work together to provide a comprehensive continuum of care for children at risk of being removed from their homes and their families.

“The EQUIPO professionals and natural helpers work as partners with the families they serve. Relationships are based on mutual respect, shared responsibility for outcomes, and trust.”

The service providers are either co-located at the FRC or provide services at other sites in the neighborhood. The formal service providers include a Family Support Specialist, a Case Manager and a Therapist, and are coordinated by Miami Behavioral Health Center.

The EQUIPO professionals and natural helpers work as partners with the families they serve. Relationships are based on mutual respect, shared responsibility for outcomes, and trust. Interventions are focused on meeting needs identified by the family itself, and finding solutions that build upon family strengths and social supports and resources. These responses are augmented by those resources available through the Madrinas and Padrinos and professional service providers.

Formal mental health services available to EQUIPO participants include individual, play and/or family therapy, home visits, and intensive family service coordination. Other required services, such as psychiatric evaluations, domestic violence and/or substance abuse treatment are provided through other departments of Miami Behavioral Health Center. Program participants may also be served through the promotion and prevention activities offered by the FRC.

Abriendo Puertas EQUIPO formally integrated the existing Madrinas and Padrinos network with the service providers in August 1998, following completion of an innovative service and training design. The objectives of EQUIPO Training are to increase the capacity to serve families, and to improve effectiveness of service delivery. EQUIPO Training's philosophy represents a shift in traditional case management and service delivery philosophy. The summary shown in Table 1 illustrates the shift that the training has produced.

Table 1: Traditional Services Vs. Abriendo Puertas Services

Traditional	Abriendo Puertas
Clinical Model	Clinical and Natural Supports
Professional Control	Partnership with Families
Culturally "Blind" or Inappropriate	Culturally Relevant and Competent
Institution Based	Community Based
Provider Focused	Family Focused
Individual Centered	Family Centered
Deficit Based	Strengths Based

A training curriculum written in Spanish and English is geared to train an initial collaborative group of professionals and natural helpers. The curriculum was designed to serve as a 'train-the-trainer' manual so that experienced trainees can prepare new cohorts without having to depend on outside technical assistance to do it.

Intensive Services

These services are provided through Miami-Dade County's Family Builders Program to families who have open cases with the Department of Children and Families due to substantiated findings of child abuse or neglect. Family Builders provides time-limited, intensive services including case management, home visits, therapy, psychiatric evaluations and consultations, medication management, and referral and follow up.

> The family-centered focus of AP's intensive services is hard for agencies to adapt to…

Service Issues and Challenges

The success of Abriendo Puertas in developing a continuum of services which are accessible and culturally appropriate for the residents of ELH has not been without challenges. In fact, the very success and rapid expansion of programs at the center has overwhelmed the center's staff and the physical capacity of the building to accommodate participating families. Since many of the programs, particularly the promotion and prevention oriented ones, are not funded separately, but are instead run by center staff whose positions are paid for by the MHI funds, each time a new activity is added to the center, the staff's load increases.

An interesting challenge is tied to the success of the FRC in assisting families with their immigration-related needs as part of their goal to improve local residents' self-sufficiency. Through a subcontract with the Florida Immigration Action Center, many participants at Abriendo Puertas have been able to obtain working permits and find jobs. As a result, they have reduced their voluntary hours at the Center. The involvement of Madrinas and Padrinos, in particular, has decreased in the last few months due to a strong economy and the fact that people were now able to take advantage of it.

A third issue impacting the delivery of services relates to Abriendo Puerta's collaborations with more traditional social service agencies operating in the community. The family-centered focus of AP's intensive services is hard for agencies to adapt to, particularly when they are used to billing for individualized interventions in order to obtain federal reimbursements. This system's challenge has been partially addressed through the work of EQUIPO, but institutional obstacles still remain.

A final barrier faced in service implementation concerns limitations to serving participants who are not legal residents in this country. Health services are the most difficult to obtain, in particular for adults.

Abriendo Puertas FRC Thrives Into the New Millennium

Since the official end of the MHI in 1998, Abriendo Puertas has been actively expanding its services and seeking new funding to support their programs. Some of their significant accomplishments follow:

Designation by the Annie E. Casey Foundation as one of the sites for the Neighborhood Transformation/Family Development Initiative. The first phase of the new initiative is already under way in 20 sites around the country. For the year 2000, the Foundation provided $50,000 for an expansion of the Equipo training, and $10,000 to expand the Time Dollar program in ELH as part of the Neighborhood Transformation initiative.

The Families Count: National Honors Award: According to the Foundation's President, Abriendo Puertas was chosen because *"it exemplifies the Casey Foundation's efforts to build strong families in tough neighborhoods by providing the resources and supports to help families and their kids succeed."* The $500,000 grant will be awarded to Abriendo Puertas, Inc. and the governing board will have total discretion as to how the monies are allocated over the next three years.

Other post-implementation developments related to service delivery include the physical expansion of

> Abriendo Puertas has become an active player in the discussions around the privatization of the foster care system in Florida…

the FRC which was made possible due to the Foundation's extended support. The additional space has allowed for the creation of a larger child care room, a computer classroom, and additional office space for center staff.

In response to the board's goals to support the volunteer and youth efforts, additional staff were hired in 1999. A community resident and long time board member of Abriendo Puertas became the FRC's first Volunteer Coordinator. This position has responsibility over the Time Dollar and Food Bank operation. In addition a full time Youth Coordinator hired by Regis House, a subcontractor under the Equipo grant, was located at the FRC to organize and support youth activities.

Over the last 12 months, Abriendo Puertas has been concentrating on strengthening its partnerships with local businesses and civic organization in ELH. As a result of the latter efforts, the "Brothers to the Rescue" organization permanently loaned four computers to Abriendo Puertas to be housed at the FRC. Representatives of the business and civic community have also taken seats on the board, FRC participants have benefited from donations from local businesses, and the local church of San Juan Bosco has placed a full-time housing specialist at the FRC.

Abriendo Puertas has become an active player in the discussions around the privatization of the foster care system in Florida and the role that Family and Neighborhood Resource Centers can play. As a Family Preservation/Family Support site through the Equipo grant, Abriendo Puertas has modeled new approaches to family support in a community-setting. The Equipo Training has been conducted with staff at other sites using community residents and professionals as co-trainers.

Abriendo Puertas Family Resource Center has been getting national attention as a model program for community-based services. The Center has been visited by representatives from three Children's Mental Health Services grantee organizations from sites in Seattle, WA, Tampa, FL, and Detroit, MI. Representatives from the Kellogg Foundation also toured Abriendo Puertas. At the local level, the new head of the Department of Children and Families District XI requested a visit and expressed his wish to have family resource centers patterned after Abriendo Puertas distributed throughout the district. The last group of visitors were representatives of a family support program in Medellin, Colombia.

According to utilization data provided by Abriendo Puertas, as of 1999, the center has had 1,693 families and 4,054 participants.

HIGHLIGHTS OF SERVICE DEVELOPMENT IN MIAMI

Pre-Implementation/Planning Phase

- In the 1994 document "Elements of a Reformed System of Care" which outlined the MHI's service strategy, three primary areas were identified for implementation:

  Community organization, prevention and early intervention activities, and services and supports for multi-need families

Service Delivery in Miami

- Abriendo Puertas Family Resource Center

  Abriendo Puertas Family Resource Center is the umbrella where a variety of services are provided.

  The service vision was translated into a seamless continuum of services including promotion and universal supports, targeted prevention, family preservation and support, and intensive services.

Promotion and Universal Supports

- Community Residents Become the Backbone to Abriendo Puertas Service Delivery

  Residents are involved in the Family Council which is composed of family members residing in East Little Havana who are willing to participate and collaborate in community development activities.

  Residents get involved in service delivery through the Time Dollar Volunteer Program. The FRC does not charge fees for any of its services. Volunteers earn "Time Dollars" which allows them to "purchase" or exchange volunteer time for services they may need.

- An Emphasis on Education Permeates Promotional Services

  Seminars, Tutoring and Training are offered throughout the year by FRC staff on a variety of topics relevant to the needs and interests of the community. Courses are offered throughout the year on computer literacy, English language skills, Arts and Crafts, and other subjects of interest to residents. Tutorial supervision is offered after school to help children improve their academic standing.

- Targeted Prevention and Supports Services

  Targeted services are available to families with risk factors associated with poverty, community safety issues, lack of access to services, immigration status, unemployment, etc.

- FRC's Youth and Child Oriented Programs Fill Important Service Gap in ELH

  The Youth Group helps coordinate preventive and social activities. Youths tutor younger children and assist in other social activities such as painting a local child care center.

- New and At-Risk Parents Benefit from Parenting Education

  Through the Parent Education program a variety of services and activities are designed to enhance parenting skills, including dissemination of information about early childhood development and about healthy family activities.

- Help with Immigration Issues Enables Residents to Provide for their Families

  Individualized immigration consultation is provided through a contract with the Florida Immigration Advocacy Center (FIAC) to update residents on changes in immigration laws and regulations and assist them with their immigration related issues.

Family Preservation and Support Services

- These services are targeted to families presenting risk factors severe enough that could lead to their children being removed from the home due to child abuse and/or neglect.
- Innovative Training Strengthens the Concept of a Family Neighborhood Team

  Abriendo Puertas' EQUIPO–Family Neighborhood Team: Abriendo Puertas' EQUIPO is a system of service delivery composed of the Madrinas and Padrinos and a group of service providers that work together to provide a comprehensive continuum of care for children at risk of being removed from their homes and their families.

Intensive Services

- These services are provided through Miami-Dade County's Family Builders Program, to families who have open cases with the Department of Children and Families due to substantiated findings of child abuse or neglect.

MASSACHUSETTS

- **Mission Hill, Highland/ Washington Park and Lower Roxbury Communities Site Profile**
- **Overview of Service Development in Boston**
- **Service Delivery Strategy in Boston**
- **Highlights of Service Development in Boston**

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

OVERVIEW OF SERVICE DEVELOPMENT IN BOSTON

Pre-Implementation/ Planning Phase

Boston's proposal to the Foundation in 1993 responded to the numerous service needs in the three target communities. The goals of this proposal included the following areas: developing a resource hub to promote and facilitate mental health service delivery; developing a comprehensive parent education and skill building program; establishing a support program that focuses on self-advocacy and empowerment; preventing out-of-home placements; and reintegrating children with serious emotional disturbance back into their community. These goals were to be accomplished through the implementation of four pilot projects.[1]

Implementation Phase

The four pilot projects were never implemented but the overall philosophical vision remained fundamentally the same. The site's major service goals resurfaced as follows:

- providing culturally sensitive services
- improving family advocacy
- reducing out-of-home placements and
- providing a comprehensive array of support services for residents

The first year and a half of implementation was dedicated mainly to organizing the governing board, Roxbury Unites For Families and Children Inc. (RUFC)[2] and developing an operational vision for the Initiative. By late 1994, however, after some technical assistance and extensive research and investigation, the Family Resource Center model began to emerge as the primary service strategy of choice.

Family resource centers are envisioned as a solution to service problems

The site's service strategy was developed by two primary stakeholders, the Department of Mental Health (DMH), which was the state agency responsible for overseeing the implementation of MHI and the Roxbury Unites For Families and Children (RUFC) Governing Board. It included two main aspects–the Family Resource Center (FRC) and the development of the Minority Business Enterprise Development (MBE) program. The Family Resource Center model was successfully launched in 1995. The MBE program however, was not fully launched, perhaps, in part, because of the MHI's wide scope, which forced stakeholders to prioritize. The MBE program consequently had very limited success in reaching its goals of establishing a broader minority base and improving government contracts to minority agencies.

The Family Resource Center model was aimed at achieving the service goals previously outlined. In addition, the FRC model was expected to address some of the problems identified by residents who had participated in focus groups conducted in late 1994. In these groups, residents had complained of needing a place that was readily accessible and where

[1] Community Health and Education and Training Project, Family Support Program, the Placement Prevention and Reintegration Team and the Diversity Project Paradigm. Proposal submitted by the city of Boston, Commonwealth of Massachusetts to the Annie E. Casey Foundation–Mental Health Initiative for Urban Children (June 1993); (See Appendix D- Site References).

[2] RUFC comprised representation from neighborhood residents, state, city and provider agencies.

> Case management services were provided by para-professional and professional staff teams through the family resource centers.

families felt comfortable. They had also complained that services were fragmented and culturally inappropriate and had reported that there were insufficient preventive intervention type services.[3]

The Family Resource Center model established in Boston was comprised of three centers with one center being located in each of the three target communities of Mission Hill, Highland/Washington Park and Lower Roxbury. The three centers opened to the public sequentially within a five-month period between November 1995 and March 1996.

The specific operational goals of the centers were focused on providing a mix of services in the following categories:

- *Universal* services that were available to anyone from the three neighborhoods irrespective of whether or not they had problems.
- *Targeted prevention services* or early intervention services aimed at certain at-risk families.
- *Intervention* services geared towards children who had more severe emotional and mental health problems and who were more likely to be involved in one or more human service systems.

An important feature of Boston's service strategy was that it incorporated the *case management model* which specialized in providing case management supports primarily for families requiring intensive intervention services. *Case management services* were provided by para-professional and professional staff teams through the family resource centers.

Stakeholders at the site were dedicated to ensuring that the services provided by the family resource center or the case management model were accessible, culturally and linguistically competent, integrated and coordinated, and provided in a family-friendly environment.

Sustainability Plans Fall Through

Several challenges affected the operation and service provision of these three family resource centers. For instance, leasing problems were a consistent issue for some of the centers. The FRCs also had some 'image' problems associated with the perception that their staff lacked professional expertise and credibility. There were also administrative challenges associated with implementing an Initiative of this scope and magnitude. In addition, in some instances, stakeholders had competing interests and objectives and this had an effect on the way they prioritized services. Finally, and perhaps most importantly, in the latter part of the Initiative, the site had the challenge of securing funds that would assure the continuation of services beyond implementation (see section on Service Issues and Challenges).

The evaluation findings from the second round of focus groups with residents who had used FRC services revealed that families were generally satisfied with the quality of services provided through the centers.[4] However, because of some of the problems previously mentioned, the centers began to close. In 1999, the last of the three centers was shut down after the state discontinued its funding. The site's anticipated segue for services, the Multisystemic-therapy (MST) model also came to an abrupt halt that same year when the state failed to allocate funds for that model's service delivery component.

[3] A report on Parents' Perceptions of Life and Services (September 1995). Gutierrez-Mayka, Joseph and Hernandez. (See Appendix D-Site References).

[4] Residents Perceptions of RUFC' Family Resource Centers (March 1997) Joseph and Gutierrez-Mayka (See Appendix D-Site References).

“Their vision for service implementation now appears to be based in the Special Education system.”

Post Implementation

Parent /Parent Consultant Partnership in Special Education - An Alternative Service Strategy

With MST no longer a viable service option and all three family resource centers closed, the Boston site has had to regroup. The site is now focusing on Board development and is trying to establish its governing Board as a family organization. Their vision for service implementation now appears to be based in the Special Education system. Under this new plan, parent consultants will work with approximately four hundred families helping them through the Individualized Educational Plan process. Stakeholders believe that Special Education is often an entry point for identifying children who may benefit from early intervention. With $220,000 funds still to be accessed through the Casey Foundation, stakeholders expect that this new plan will be realized.

SERVICE DELIVERY STRATEGY IN BOSTON

Roxbury Unites for Families and Children, Inc. (RUFC) represented the governing entity developed as part of the Mental Health Initiative (MHI). RUFC included representatives from the three target neighborhoods, the state, city and local provider agencies. Together with key stakeholders like the Department of Mental Health and the city of Boston, RUFC designed the overall service strategy that was adopted in Boston. Children Services of Roxbury (CSR) was awarded the lead service agency contract in August 1995 and became responsible for service delivery implementation in the site.

This section provides a detailed report on the two major components of the site's primary service strategy, the Family Resource Centers (FRCs) and the Minority Business Enterprise Development Program (MBE). It also highlights major Service Issues and Challenges and concludes with a short discussion of the site's Service Aspirations in the Year 2000 after the end of MHI implementation.

Family Resource Centers

The FRC's design attempted to respond to and alleviate many of the challenges and problems related to service delivery through larger human service agencies. These issues identified by residents who participated in focus groups conducted during the fall of 1994 included: inaccessibility of services (services were generally outside the target area), a lack of culturally or linguistically sensitivity of services, and a general service unresponsiveness to the needs of low-income families.[1]

Children Services of Roxbury (CSR), the site's lead service agency began to implement the site's family resource center model by creating three family centers- one in each of the three communities, hiring staff and providing support services to families in the target neighborhoods.

Boston's service strategy was reflective of the foundation's long range vision of "strengthening the array of services and support" and "developing a system to ensure access outreach and integration for services and supports" (Benchmarks: p.1, 1995).

The FRC model was initially successful in the following areas:

- Providing a broad mixed array of support services,
- establishing a organizational structure that helped maintain effective service delivery,
- focusing on children who were in out-of-home placement, and
- establishing services that were community-based, culturally-competent, family-centered and family-friendly.

FRCs Provide a Mixed Array of Support Services to Neighborhood Families

During their operation the FRCs offered a broad mix of services which included these categories: *Universal services, Targeted Prevention services and Intervention services*.[2]

[1] A report on Parents' Perceptions of Life and Services: A focus on Mission Hill, Highland/Washington Park and Lower Roxbury Communities in Boston, Massachusetts–Gutierrez-Mayka, Joseph and Hernandez (September 1995); (see Appendix D–References).

[2] For a comprehensive list of services -See RUFC Service Activity Report–Appendix C.

> Targeted prevention services were geared towards early intervention for at-risk children and families.

Universal Services

Universal services were provided to anyone who lived in one of the three neighborhoods regardless of whether or not they had any type of problems. These services included day care, job training, employment training, summer camps for children, parent advocacy, parenting education, after-school program services and wrap-around information and support links.

Targeted Prevention

The targeted prevention services were geared towards early intervention for at-risk children and families. These type of services were aimed at supporting the family so that the situation of the child and/or parent would not deteriorate to point where they needed to become involved in formal social or human service systems, or experience out-of-home placement. Such services were aimed at specific groups or types of families and targeted prevention services were characteristically more intensive in nature than universal services. These services included but were not limited to tracking services[3] mentoring, parent aides, tutoring, skills building, parent support groups and advocacy services. Non-traditional types of supports such as buying clothes or household equipment for families or providing turkeys for families in need during Thanksgiving were also part of a host of different targeted prevention services provided at the centers.

Intervention services

Intervention services were generally provided through the site's *case management model*, which was an important feature of the site's service design. The case management model was focused around specific categories of children. These included:

- Children and families with severe mental or emotional problems.
- Children who were already receiving services through one or more of the larger human service systems (Juvenile Justice, Mental Health, and Special Education).
- Children who were in out-of-home placement; and children who were returning home from placement.

Intervention services at this site included individual and family counseling, therapy, case management support services, transitional services, and crisis services.

Services captured in RUFC's summary service activity report dated February to July 1996[4] represent the range of services provided through family resource centers and case management model. Along with the network of provider codes,[5] these documents provide some indication of the scope of the site's services.

Organizational Structure Key to FRC Success

The ultimate organizational structure that emerged within the FRC model contributed to effective service delivery. However, this structure developed over time and was created partly in response to external factors.

In 1995, Children's Services of Roxbury (CSR) began to implement the site's service plan. It successfully opened the first center in the Mission Hill in November 1995. The second center followed a few months later in January 1996 in Washington/Highland Park, and the Lower Roxbury center opened in

[3] Trackers are adult companions who monitor and support a specific child. They sometimes share similar characteristics and interests with the child they are tracking.

[4] See RUFC Service Activity Report - Appendix C

[5] See RUFC Network Service Codes -Appendix C

> In April 1997, the state Department of Mental Health mandated that Children's Services of Roxbury produce approximately 20 service outcomes by September 1997.

March 1996. In addition, neighborhood residents and other stakeholders were successful in lobbying the state legislature and received $3 million dollars towards providing services at the centers. This lobbying is particularly significant since residents were an integral part of this effort.

Although it appeared that things were off to a great start, by mid 1996 talks of discontinuing the state's $3 million financial support surfaced. Centers were told that they needed to produce tangible service outcomes, such as clinical improvement of the children's emotional and mental health, and increase in the number of children returned to their communities. In April 1997, the state Department of Mental Health mandated that Children's Services of Roxbury produce approximately 20 service outcomes by September 1997.[6]

This mandate forced the FRCs to shift emphasis from universal and prevention services to more intensive intervention services. For the first year and a half the centers had concentrated mainly on providing targeted prevention and universal types of services such as camps, job training and employment. The new emphasis on intensive intervention services was put into effect primarily through the Roxbury Return Project (RRP).[7] This program provided intensive case management and wraparound supports for children coming home from placement.

In order to provide intensive case management and wraparound support services for this group of children, it became critical to ensure that FRC staff had the professional competencies to do the work. Furthermore, state agencies like the Department of Mental Health and the Department of Social Services were already stating the FRC staff did not have the professional training to serve families who needed intensive services.

In October 1996, CSR began to address this problem and reorganized the FRC structure in order to improve staff resource capacity. Some reunification specialists were laid off and other more experienced staff were reassigned to the new 'reunification team'. This team became responsible for providing more intensive intervention family support and providing wraparound supports for children returning home to their community under the RRP. The team included a Licensed Clinical Social Worker and four reunification specialists with either Bachelors or Masters degrees. In addition, a clinical supervisor and Ph.D.-level candidate coordinated and supervised all staff. The para-professional family resource specialists continued to provide case management for families who required less intensive interventions.

Subsequently, the FRC's became staffed with teams of para-professional and professional coworkers and improved their professional capability. This gradually helped boost the image, credibility and reputation of the centers. With the centers fully staffed with qualified clinical professionals and para-professionals, stakeholders at the provider and state level claimed that the site was successful in surpassing the state's mandated outcomes by the deadline date of September, 1997.

[6] See Table of State Mandated Outcomes–Appendix C

[7] Roxbury Return Project was aimed at returning children from out-of-home placement back to their families and communities.

“The Roxbury Return Project’s goal was to return children safely back to their families and communities by providing intensive intervention services.”

FRC’s Case Management Model Responds to Families in Crisis and Out-of-Home Placement

As stated in the previous section, the state’s mandate focused on certain specific outcomes and this resulted in the centers providing more intensive services to clients who were already in crisis or facing significant challenges. These services were provided through specific programs and supported by a case management model. One such program, the Roxbury Return Project (RRP), was a subcategory of the statewide Collaborative Assessment Program (CAP), and involved collaboration between the Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Social Services (DSS), the Boston Public School (BPS) system, Children Services of Roxbury (CSR) and Value Options/ Behavioral Health.[8] The Roxbury Return Project’s goal was to return children safely back to their families and communities by providing intensive intervention services. These services included evaluative assessments, counseling, clinical consultation and psychological testing, wraparound support services, crisis and emergency services. Wraparound services also sometimes included tracking services, family and individual counseling, information provision and referrals, and conducting reunification assessments.

The case management model with its para-professional and professional staff teams, was responsible for providing these services. However, some intensive intervention services were provided by other state, local, and community-based agencies. The FRC family reunification specialists at the centers were responsible for coordinating all services associated with the children in the Roxbury Return Project.

The unique pairing of professionals and para-professionals can be considered one of the site’s accomplishments because it helped make the case management model more effective. The reunification team and family resource specialist teams comprising clinical and para-professional staff made it possible for families to get both clinical and family support. This organizational set up also allowed families to reap the benefits of having culturally competent para-professional staff supporting them and advocating on their behalf.

Another accomplishment directly related to the RRP was the development of the “grand rounds” process which became an important part of the program. The grand rounds process was aimed at providing a comprehensive review of the most intensive FRC cases and allowed the family reunification specialists an opportunity to debrief with the clinical coordinator and other representatives of key agencies (i.e., DMH, DSS, DYS, and BPS). This process resulted in the development of useful strategies for dealing with the families requiring intensive intervention services. The grand rounds process helped the FRCs to provide families with the necessary supports needed for their children’s reintegration into their communities.

FRC’s Adoption of System of Care Principles Results in Resident Satisfaction

The services provided through the Family Resource Centers were reflective of principles similar to the CASSP[9] principles. In particular, they were ***community-based, culturally and linguistically competent, family-centered and family-friendly***. Resident consumers in the second wave of focus groups

[8] For more information see Report Boston report on accomplishments submitted to the Casey Foundation (August 1996)-Appendix D-Site References.

[9] The National Institute of Mental Health’s Child and Adolescent Service System Program.

“The staff were identified as being respectful and courteous.”

conducted in December 1996 reported that these centers had many appealing qualities. The qualities identified by these residents contrasted sharply with those voiced by residents who participated in the initial focus groups conducted in fall, 1994.

One of the main benefits identified by residents was that FRC services were accessible and community-based. During the initial implementation phase one center was located in each neighborhood. The presence of these centers within these communities was considered an accomplishment because it made resources and supports very easy for residents to obtain. Even after some centers were closed the other resource centers were still relatively accessible to residents from the three target communities. In addition to the convenient location of the centers themselves, residents also praised FRC staff for being accessible: *“One thing that I can say is that if they are not in at the time and you leave a message they will get back to you.”*

Other accomplishments of the Family Resource Centers were related to attention to cultural competence issues. All centers hired culturally and linguistically competent staff. The fact that staff at these centers came from these neighborhoods made it easier for them to identify with and understand the circumstances faced by many of these families.

Another accomplishment was noted in the family-friendly atmosphere of the resource centers. The staff were identified as being respectful and courteous. Families in the second round of focus groups[10] who had received services from the centers reported that they felt understood and respected by staff. Different focus group participants made claims such as:

“*I feel at home*” (i.e., at the center)

“*I feel comfortable…*” or

“*They don't look down on you…*”

This differed from what residents had stated during the initial focus groups, when they had complained of the cultural insensitivity of many agencies whose front-line staff generally had little in common with the families they served. Residents in the initial focus groups had very negative impressions about quality of services provided by the larger human service agencies and had complained about staff being discourteous and disrespectful: “*They sit there and look at you like they're better than you.*”[11]

Success was also seen in the staff's tendency to provide a family-centered advocacy role for many families. Findings from the second set of focus groups revealed that many families had received advocacy and support services from the centers. Families reported that they trusted and relied on their family resource specialists: *“She was there at every meeting... whatever I need, they are right there for me…if they can help me or give me some type of resource they'll do it.”*

A final strength of the centers expressed by residents was flexibility in the types of services provided for families. In addition to providing the usual traditional services like counseling and case management, centers occasionally assisted families in non-traditional ways. This included buying food and clothing, purchasing a washing machine for a single father of twin babies and assisting with bills. This represented a welcome change from the traditional services provided through larger government agencies that tended to be more categorical in nature.

[10] Residents' perceptions of RUFC's Family Resource Centers in Mission Hill, Highland/Washington Park and Lower Roxbury, March 1997, Ruby Joseph, M.P.A., Marcela, Gutierrez-Mayka, Ph.D. (See Appendix D- References).

[11] A report on parents' perceptions of life and services: A focus on Mission Hill, Highland/Washington Park and Lower Roxbury Communities in Boston, Massachusetts–Gutierrez-Mayka, Joseph and Hernandez (September 1995); (see Appendix D- References).

RFPs are now written in a way that has allowed more doors to open for minority agencies in application for government contracts.

Although these centers were ultimately closed (see Service Issues and Challenges), one can argue that overall, FRC as a service strategy pioneered some of the best practices and approaches to delivering mental health services at the neighborhood level. The FRCs enjoyed some success during early implementation providing culturally and linguistically competent, community-based, family-friendly and readily accessible services for children and families in the target neighborhoods. Comments from families in the second set of focus groups underscore these sentiments and leave little doubt that residents who had received services from these centers during early implementation were very satisfied.[12]

Minority Business Enterprise Mentorship Development Program

MBE Program Helps Raise Cultural Awareness Through the Request For Proposal (RFP) Process

The second component of service delivery in Boston centered on establishing a Minority Business Enterprise network comprised of local providers. The goal of this aspect of service delivery was to establish a mentoring relationship between some of these organizations and other long-term, contracted health and human service agencies. Although the Cambridge Resource Group, a team of local consultants took the initial step of providing an inventory of all the local, community-based providers in the three neighborhoods, the MBE program was never fully implemented. The reason for this could lie in the fact that providing direct services to residents was given a higher priority.

This particular strategy was successful, however in promoting recognition of the importance of cultural competence in government contracting with local community-based providers. While MHI's aspirations of strengthening the minority provider base did not materialize, it was successful in ensuring that the language of subsequent Request For Proposals (RFP) was geared towards encouraging more minority participation. RFPs are now written in a way that has allowed more doors to open for minority agencies in application for government contracts.

Service Issues and Challenges

Several challenges presented obstacles for service delivery implementation in general, and family resource center operation, specifically. The cumulative effect of all these challenges eventually resulted in the closing of the centers. Service implementation challenges included:

- Tensions in stakeholder relationships
- Wide scope of the Initiative
- Fiscal sustainability issues and
- Administration and operational challenges

Tensions in Stakeholder Relationships

Tensions in stakeholder relationships which existed from time to time made service implementation difficult. Part of the tensions arose because different stakeholder entities had different expectations regard-

[12] Residents' Perceptions of RUFC's Family Resource Centers in Mission Hill, Highland/Washington Park and Lower Roxbury, March 1997, Ruby Joseph, M.P.A., Marcela, Gutierrez-Mayka, Ph.D. (See Appendix D–References).

“Board input was sometimes perceived at the service provider level as counter-productive to overall service delivery effectiveness.”

ing the stakeholder roles.[13] For instance, Board input was sometimes perceived at the service provider level as counter-productive to overall service delivery effectiveness. These sentiments stemmed from the fact that while some state and provider stakeholders viewed the Board as having a monitoring role, some Board residents perceived themselves as having decision-making power.

Wide Scope of the Initiative

MHI implementation required that stakeholders work on multiple tasks at the same time. It was extremely challenging for the site to develop and form working relationships (governance), engage in systems reform efforts, develop plans for sustaining its service model, lobby for state funds from the legislature, and provide services in three different hubs all at the same time. Understandably, equal emphasis could not be placed on all aspects and prioritization of these multiple tasks often impacted service delivery.

Fiscal Sustainability Issues

One of the biggest challenges of implementation was related to providing alternative strategies to fund services beyond the implementation phase. Although stakeholders at this site had successfully lobbied the legislature for $3 million for several years, by the end of the Initiative the site was not able to secure any state funding. In addition, by the end of the Initiative none of the sustainability plans previously envisaged had materialized. Alternative strategies, such as the Multi Systemic Therapy model did not occur because the site was not able to secure the financial backing of the state.

[13] Three sets of evaluation reports on neighborhood governance development in Boston provide detailed descriptions of working relationships between different stakeholder over the life of the MHI.

Administration and Operation Challenges for FRC

The challenges that directly affected FRC operation included leasing problems, and a poor FRC image.

Leasing Problems

One of the first problems was related to difficulties in obtaining reasonable leasing sites as permanent locations for the centers. The very first problems arose in 1998 when after operating for two and a half years, the Mission Hill family resource center was forced to relocate because of exorbitant leasing costs. Similar leasing obstacles continued to plague the family resource centers throughout the Initiative. This resulted in changes and moves that were disruptive to the implementation and service delivery process.

Poor FRC Image

Another barrier to service implementation was related to staffing Family Resource Centers with para-professionals. In the beginning phase of service implementation families felt understood and appreciated, and endorsed the help provided by the para-professional staff. However, in contrast, other state agencies felt that these same para-professionals were not equipped to serve families who had children with serious mental health problems. The lack of credibility regarding para-professional staff affected the image of the FRCs, and many agencies like the Department of Social Services (DSS), Department of Youth Services (DYS) and Department of Mental Health (DMH) were reluctant to refer their clients to the FRCs for services. Although steps were taken to resolve these issues by hiring professional and clinical staff, the damage to the FRCs reputation during the initial phases of service delivery did represent a significant challenge.

> Residents are still dedicated and committed to providing services for families in their communities.

It can reasonably be assumed that the combination of these factors contributed the FRC service strategy's failure to survive in Boston. However, although all three centers have closed, resident stakeholders remain committed to helping children and families. RUFC is now developing a new service vision that involves providing assistance to families through the Individual Educational Plan process.

Service Aspirations in the Year 2000

RUFC Poised to Make a Difference Through Special Education

With the centers closed and the Initiative officially over, in the year 2000 resident stakeholders have gone back to the drawing board. Stakeholders at the neighborhood level plan to reorganize a parent organization and are envisioning a different service design.

This new service plan will be funded through $220,000 that has already been allocated but not yet released by the Foundation for Board development. RUFC's workplan and budget call for the hiring of eight parent consultants who will work with families within the Special Education system. The eight parent consultants will assist families involved in the Individual Education Plan process. Each parent consultant is expected to participate in at least fifty sessions and this implies that approximately four hundred families will be served through this new service strategy. Stakeholders feel that the educational system is an important entry point for many juveniles and children with mental health, emotional and behavioral problems. They believe that the education system is often the first system that children enter prior to being referred to other service systems such as juvenile justice or child welfare. The Board also believes that working with parents and their children in the educational system may have implications for other service systems.

This service strategy is a diversion from the original FRC concept, but it illustrates that residents are still dedicated and committed to providing services for families in their communities. One can speculate that the lessons learned from the MHI will help guide their future efforts.

HIGHLIGHTS OF SERVICE DEVELOPMENT IN BOSTON

Implementation

- The Family Resource Centers emerge as the strategy of choice and focus on providing culturally-sensitive services, improving family advocacy, reducing out-of-home placement and providing a comprehensive array of support services.

Service Delivery Strategy in Boston

- Site strategy includes the Family Resource Center Model and the Minority Business Enterprise Development Program (MBE).
- FRC model is fully implemented with one center located in each of the three neighborhoods; while MBE is less successful in its implementation.

FRCs Provide a Mixed Array of Support Services to Neighborhood Families

- FRCs respond to family needs by providing a mixed array of services including *universal* (e.g., child care), *targeted prevention* (e.g., parent advocacy) and intervention services (e.g., counseling).
- Case management model targets intensive intervention services.

Organizational Structure as a Key to FRC Success

- Teams comprising professional and para-professional staff improved services to residents.

FRC's Case Management Model Responds to Families in Crisis and Out-Of-Home Placement

- FRC case management supports the Roxbury Return Project.
- The "grand rounds" meeting process provides a useful tool in providing coordinated Wraparound services involving the Department of Mental Health (DMH), the Department of Social Services (DSS), the Department of Youth Service (DYS) and Boston Public Schools (BPS).

Adoption of System of Care Principles Results in Resident Satisfaction

- Feedback from residents who had used FRC services indicate family satisfaction with respect to services being community-based, culturally and linguistically competent, family centered and family-friendly.

Minority Business Enterprise Program (MBE)

- MBE is not successful but paves the way for more cultural awareness in the Request For Proposal (RFP) process.

Service Issues and Challenges

- Leasing problems and poor image affect service operation while tensions in stakeholder relationships, scope of Initiative and sustainability issues affect overall implementation.
- The challenges eventually result in the three family centers being closed down.

Service Aspirations in the Year 2000: RUFC Poised to Make a Difference Through Special Education

- RUFC reorganizes into a parent organization that will focus its service goal on working with parents with children in Special Education.

TEXAS

- **Third Ward Site Profile**
- **Overview of Service Development in Houston**
- **Service Delivery Strategy in Houston**
- **Highlights of Service Development in Houston**

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 (NAACP). Additionally, there are organizations that provide recreational services to youth, including an amateur boxing association, a community artists' collective, a community music center, the YMCA and the YWCA.

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

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

OVERVIEW OF SERVICE DEVELOPMENT IN HOUSTON

Pre-Implementation/ Planning Phase

The first step in planning for service delivery was to develop a set of guiding principles that effectively translated the concepts of the Annie E. Casey Foundation Initiative for Urban Children's Mental Health Stuff into operational terms appropriate for the Third Ward. Major goals included a single entry point into the system, responsiveness to specific community needs and strengths, development of a capacity and opportunity for grass-roots control of the system, and a family-focused approach (including both traditional and non-traditional families) to enhancing the wellness and dignity of children and families. The state of Texas was in the early stages of modifying its children's service delivery system, and officials applying for the Casey grant proposed to bring order to the existing services environment, beginning with a comprehensive needs assessment followed by planning and coordination. The general goal was to develop a system of care that would be based on the guiding principles mentioned above, with emphasis on multi-faceted community development and prevention.

A primary objective was to establish Family Resource Centers (FRC) with co-located services. The service area was divided into four quadrants, and it was envisioned that such centers would operate in each of the four quadrants of the community. It was also envisioned that the centers would be based in a variety of settings (schools, churches, recreational facilities, etc.) and that they would be linked functionally, allowing for both convenience and specialization. Emphasis was placed on hiring local residents, both degreed and non-degreed, to serve wherever possible, and providing training which would sharpen skills of staff and assure their understanding of the principles being promoted.

Implementation

As soon as the Third Ward neighborhood was awarded a planning grant in late November of 1992, a Charter Neighborhood Governing Board was formed, consisting largely of service providers and others who had been meeting as a "Coffee and Conversation Group" throughout 1992. This organization conducted a needs assessment and community survey (December 1992–January 1993), and focus groups. With these data, a plan for a local initiative was completed, and Texas was selected as a site in August.

In October, a neighborhood governing board (NGB) was formed to implement the grant. This board was not incorporated and it was arranged that the local chapter of the Urban League would serve as fiscal agent to receive and administer funds. The interim board established a Casey Policy Council in January of 1994. A year later, a Family Resource Center (FRC) opened at Douglass Elementary School. It had one therapist from the Harris County Mental Health and Mental Retardation Authority (MHMRA), two caseworkers from Texas Work Force Commission (TWFC), staff from Communities in Schools, Houston (CISH) and a parent coordinator, paid for through Casey project funds.

Development of the Family Resource Center

"Family development services" have continued to be provided at the single FRC established throughout most of the grant period, while a variety of training and neighborhood mobilization initiatives have been carried out. Between 1994 and 1997 the MHI went through a major reorganization, the state's Governor, who had personally welcomed and supported the initiative, was replaced, and the NGB

> PIP is committed to outreach and involvement in community affairs, central goals of the Initiative.

struggled unsuccessfully to find a strong and reliable leader at the highest state level. The more serious internal organizational problems were resolved in 1996, and the process of incorporation as People in Partnership (PIP) was begun near the end of that year. By early 1998, People In Partnership had received its 501(c)3 designation.

Development of the organization went through many reversals of fortune, all of which were resolved, but not without cost in time, energy, creativity, and money. Throughout it all, services continued to be provided, and local exigencies were met, with innovative and effective responses.

Sustainability Opportunities Shape Service Strategy

The organization's early shift from on-site provision of services to service brokerage expanded when the state turned to managed care for its Medicaid health services for children in families with low incomes. When the state contracted with several HMOs to manage children's Medicaid services, in Harris county, PIP was positioned to be an advocate for innovative care role, continuing to monitor quality of services. At the same time, PIP desired to carve out a network broker, using Medicaid income to sustain itself financially after the end of the Casey grant.

Universal Services Make a Difference

PIP was committed to outreach and involvement in community affairs, central goals of the Initiative. Its Provider Network proved to be a vehicle for re-orienting providers to the Initiative's goals and preferred methods. PIP and the Interagency Council also were active in gaining local (i.e., county, city, legislative delegation) support for the initiative, crucially replacing the waning state support. Meanwhile, it had initiated several activities that have sustained the process of outreach and renewal in the community. For example, PIP is playing an increasingly important role in shaping the city's dealings with citizens who are dispossessed and living in poverty.

A *Friend of the Family* training program, co-created with parents and implemented in association with nearby Texas Southern University, has trained local residents to become effective para-professionals within various family service systems. Each graduate of that program is potentially both a valuable contributor of informal services and a force for change and renewal in the community.

Post Implementation

In 2000 PIP was lean and flexible, delivering services, but also capable of opportunistic growth and development. Family Development services provided at the FRC and other community sites are currently funded by the Hogg Foundation.[1] Traditional and innovative clinical intervention continues under direction of the Director of Behavioral Health Services, with Medicaid paying for an increasing number of services. To accommodate this shift of emphasis, PIP has re-organized, with one branch of the organization carrying out Behavioral Health Care and the other providing Family Development services. A third section handles administration.

The service design that has been adopted in the Houston site has evolved in response to both internal and external factors. The general goal has been to

[1] The Hogg Foundation is a Texas-based foundation long involved in children's mental health programs as well as contracts with the local workforce board for youth employment services and TANF training programs.

SERVICE DELIVERY STRATEGY IN HOUSTON

develop a system of care that is strength-based and family-focused, with a single-entry point. Nevertheless, the need to sustain services beyond MHI implementation and the consequences of Managed Care environment have affected how the site chose to design and implement its service system. The current service design is comprised of two major components: The Family Resource Center and the Medicaid Managed Care Provider Group. These two components perform separate but interdependent roles within this service design.

The discussions that follow highlight service implementation challenges and accomplishments. This section discusses the Family Resource Centers as a major service strategy. It also addresses some Parallel Developments in the form of activities and services that emerged as spin offs of some of the original supports provided through the Family Resource Center. The section also describes the site's Medicaid Managed Care Broker feature. A section on Service Challenges precedes the final summary of PIP Services in 2000.

Family Resource Center

The Family Resource Center was operated in partnership with the Houston Independent School District (HISD), the Douglass Elementary School PTO, Communities in Schools, Houston (CISH), the Texas Workforce Commission, neighborhood providers, Volunteers in Service to America, and the Family Advocacy Network (FAN). The family resource center that exists today was just one of four such centers that the MHI had anticipated opening.

This center opened its doors to Third Ward residents beginning in October of 1994. The staff structure at that time included one therapist from the Harris County Mental Health and Mental Retardation Authority (MHMRA), two caseworkers from Texas Work Force Commission (TWFC), staff from Communities in Schools, Houston (CISH), and a parent coordinator. The center's emphasis was on provision of services to families, from counseling and case management to general assistance in problem solving. A computer installed at the FRC was networked with the county's central human service records. Consequently, a staff member was able to check services already received by a given family and use that information with other computerized resources to find further services, such as short-term financial relief of various kinds. However, because services at the FRC did not require disclosure of this information, and families thought of it as intrusive, this resource suffered from under-utilization. At present this technology is no longer available at the site.

The center offered a mixed array of supports and services for residents in the Third Ward. A primary service category of universal type services identified as "family development" services represented a major portion of services provided at the center. Family development services helped families meet a wide range of needs including housing, employment, transportation, and money management. Parents and children also received counseling, training in problem solving and effective communication, parenting, and (where needed) literacy training for adults. In short, the family development workers helped families learn or acquire anything deemed necessary to raise children effectively. Since many of the "family development" services were aimed at solving problems that made it difficult for families to raise and support their children, these services assumed as many forms as there were families. Although we will continue to refer to the FRC as the Douglass Elementary Center, in actual fact, its activities occurred at several sites. These sites

> Intervention supports include weekly support groups, supportive intervention with children…and classroom presentations on problem solving and building of self-esteem.

included the local YWCA–an important local landmark in the community's rich history of civil rights activism–as well as at local churches, community centers and Texas Southern University.

Although the rubric of *family development* covers most activities of the FRC, the center provided a variety of more general outreach, prevention and intervention services. The most important of these services and programs are discussed in the sections that follow.

FRC Provides Support for Children with In-school Suspensions

With the location of the center within an elementary school it is not surprising that some of the services were targeted towards children having problems within the school itself. These services provided intervention supports to children who already exhibited some negative behaviors in school.

Throughout its existence, FRC and PIP staff provided resources and expertise in the development of parent involvement strategies, teacher training and after-school tutorials, as well as service emphasis on early intervention. Each year PIP offered 3-5 teacher workshops to expand knowledge and skills in intervention for children and caregivers experiencing situational crises compounded by poverty.

Beginning in 1998, emphasis was placed on 35 school children with frequent referrals to In-School Suspension. Intervention supports included weekly support groups, supportive intervention with children, parents and teachers, and classroom presentations on problem solving and building of self-esteem. During the first year of operation this program provided approximately 50 children with a variety of activities, including, art, videography, field trips, and tutoring.

School-focused services also included development and implementation of several expressive arts activities for youth and adults. First implemented as a multi-site program which served over 200 youth in 5 community centers, the program sub-contracted with five arts organizations. In 1995, the Arts Series served 175 children attending Douglass Elementary and their parents.[2]

Although direct evaluation of outcomes of these services has not been conducted, the overall out-of-school suspension rate has decreased in Douglass Elementary since PIP's involvement began, and scores on the state achievement exam increased by more than 20 percent in each academic area between 1996 and 1998. The belief is that PIP has at least contributed to these outcomes, both directly and by working in concert with the school administration and staff to encourage school attendance, early intervention and parental participation.

Family Stabilization as an Integral Intervention Strategy

Family stabilization and crisis support for children and their families was included in the FCR's overall strategy of family development. FRC staff served an average of 125 walk-in visitors each month who received counseling, information and referral (provided in partnership with United Way of the Texas Gulf Coast), and other services.

From 1997 through 1998, a co-located Department of Human Services (DHS) staff member worked one day weekly helping an average of 4 to 6 families to establish

[2] Figures based on sign in sheet and family development service report.

> This juvenile justice program has emerged as a highly successful diversion program for youths.

eligibility and become re-certified for public assistance. Due to the demands of welfare reform and high case loads at the central DHS office, this on-site service is no longer available, though referrals can still be made preferentially to that worker. On Thursdays, a co-located member of staff from the Texas Workforce Commission assisted applicants with work readiness, job search, and referral activities, achieving job placement for approximately 30 percent of candidates referred. Annually, an average of 75 adults were provided intensive job search support through this co-located position.

Other intervention services included counseling, information and referrals, and case monitoring for families who used services offered by the FRC. PIP had two care coordinators and Friend of the Family staff, each of whom carried a caseload of approximately 30 children/adolescents and their families. From 1997-1999, the PIP staff team served approximately 350 individuals annually through care coordination services. An additional 1,200 individuals per year attended various workshops, family fun activities and drop-in services.[3]

Juvenile Justice Program Strengthens Youths

Another intervention program was started early in 1995, in collaboration with the Texas Department of Juvenile Justice. In this program a PIP provider network member and staff work with an average of 7-10 neighborhood youth weekly who are on Juvenile Probation. Members of the program graduated after a year of participation or upon completion of their probation period. The consistent impact of the program has been seen in an increase of school attendance by participants and a 25 percent decrease in their recidivism rate, based on state Department of Juvenile Justice records. Within the five years of operation, 150 youth participated in at least two sessions, with over 80 youth completing the year-long program.

This juvenile justice program has emerged as a highly successful diversion program for youths. Focus groups conducted by the national evaluation in 1998 indicated that youths found this intervention strategy very useful. The program, coordinated with the Department of Juvenile Justice and funded through private foundation dollars, allows neighborhood youth to participate in support group services in their own neighborhood. The youths meet weekly with a charismatic program facilitator who works with them on decision making and problem solving and takes the boys on educational and recreational outings monthly. The resulting reduction in recidivism (mentioned above) among the adolescents has gained praise from DJJ and there are plans by the Department to replicate the program.

Time Dollar Exchange

The Time Dollar Exchange program was initiated in partnership with Ujima Community Volunteer Services, SHAPE Community Center, and the Cuney Homes Resident Council. This member-to-member exchange program was designed as a tool to support numerous community volunteers and to assist in the neighborhood placement and documentation for individuals in welfare to work programs and court-mandated volunteer time. It continues to be developed with SHAPE Community Center as a lead partner.

[3] Data based on family development services reports and Behavioral Health Care Unit reports (1999)- Appendix D–Site References.

“The Friends of the Family (FOF) training program is unique, particularly because the curriculum was co-designed by parents from the Third Ward.”

Parallel Developments

Over the course of time, the original Initiative has spun off related and quite valuable activities. The MHI provided a setting for desirable activities to take place that were not part of the original implementation plan, but have come about as a result of the Initiative's groundwork. We have discovered that small actions can ramify into large effects, and it is important to acknowledge their part in the cascade of local events following implementation of the Casey Initiative in Houston.

Volunteers In Service To America (VISTA) Provide Universal Services for Third Ward

We consider it important to mention the actions and effects of the VISTA volunteers who worked with PIP on the Initiative. Under the family development umbrella, VISTA was able to offer universal services to Third Ward residents. From 1995 to 1999, the VISTA program allowed up to ten community residents to work with People in Partnership to participate in outreach, community resource mapping, and coordination of community events. VISTAs were located with community partners in each of the quadrants, as well as in the Douglass FRC. They co-facilitated focus groups, assisted with drug prevention education, health fairs, holiday food and gift drives, tutoring, PTA/PTO activities, civic club clean-ups, and other activities with over fifteen local organizations. Unfortunately, due to contract limitations and funding problems, VISTA staff may be lost, and PIP is actively trying to address this issue so that the critical services that the VISTAs perform will not disappear.

Community Residents Benefit From the Friends of the Family Training Program (FOF)

PIP has continued to take seriously its commitment to outreach and involvement of the community. The Friends of the Family (FOF) training program is unique, particularly because the curriculum was co-designed by parents from the Third Ward. This program, in collaboration with nearby Texas Southern University, has trained local residents and assisted families in finding practical, professional solutions to their problems. FOF offers a 60-hour curriculum of interactive skill-building workshops designed to strengthen families and thereby strengthen the community. Leaders in the field of human services facilitate the workshops in partnership with the Texas Southern University School of Social Work. Completion of the training certifies the graduate as a “Friend of the Family.” Continuing Education Units (CEUs) are earned and the participant can become a member of the PIP provider network. Training also is provided monthly to staff, provider network members, and partners.

This educational opportunity, offered by PIP each year, has several benefits. It indirectly affects outreach and self-help in the neighborhood and helps to prepare parents to participate in the Provider Network. More basically, it provides participants an opportunity to learn some useful skills that help them better care for themselves and their families. The FOF program has been used as a state example for training and employing para-professional case workers.

Since its inception in 1997, three groups of participants have completed the program, with a total of 27 graduates. At a focus group of FOF partici-

“In 1998, through a Family Resource Coalition grant, over 40 community members came together to discuss and design supports for kinship care.”

pants conducted by the national evaluation in 1998, graduates of this program gave moving and eloquent testimony to the importance of this training. Participants recalled that as a result of this training they had been able to help their neighbors and stated that their own personal sense of efficacy, competence and dignity had improved because of the knowledge they had gained through this program.[4]

Roundtable: Protecting Children and Supporting Families

PIP has successfully incorporated grass-roots participation and control, and ‘bottom-up’ participation in solving the problems of children and youth in low-income populations in Houston. PIP’s visibility has given the organization a role in the community that exceeds the original implementation plan. PIP responds to requests for participation in local affairs, and serves as a source of community input. This type of community input is believed to enhance the likelihood of securing funding for future projects.

A case in point developed last year, when the Department of Protective and Regulative Services approached PIP to assist in recruiting participants in the community for their foster parenting plan. Although the resulting community focus group was convened to address recruiting foster and adoptive families, it primarily brought greater attention to the increasing number of families in kinship care relationships. Kinship caregivers, defined as “individuals who step forward and take responsibility for rearing a child when the child’s parents are unable to do so,” were viewed by PIP as the natural community response, deserving public system support.

In 1998, through a Family Resource Coalition grant, over 40 community members came together to discuss and design supports for kinship care, and to discuss its impact on foster care and adoption programs. The planning committee included parents, as well as representatives of the Department of Protective and Regulatory Services, Black Child Development Institute, Family Outreach Services and Special Kids Incorporated. PIP’s roles as organizer and host made these meetings possible. PIP also sponsored a legal fellow to help facilitate meetings and research kinship care legislation.

FRC Services Create a Ripple Effect for the Third Ward Residents

It is also essential to remember that these Initiatives do not occur in a vacuum. A major factor in the success of PIP, beyond its Casey mandate, was that it was embedded in a long, proud heritage of African American community and personal development, persisting in the face of major social and political obstacles. Services provided by People in Partnership have had a ripple effect on the neighborhood, partly because of its history of activism and autochthonous development. Home to both a leading African American University (Texas Southern University) and one of the very few African American teaching hospitals still active in the United States (Riverside General), the neighborhood includes professionals and business people as well as the poor.

Outreach to poorer residents and their inclusion in Friends of Family seminars, membership on the board of directors, employment as regular staff or VISTA workers in the Initiative, and participation in the Family Advocacy Network have increased the awareness of many residents of the existence and need for services. MHI has also helped inform residents about how to seek and obtain the services they need.

[4] The Hogg Foundation has recently funded the publishing of the FOF workbook as a curriculum tool.

“In the Spring of 1998, PIP received its Medicare and Medicaid provider number.”

However, in a very real sense, the outreach has also been directed to the historical institutions and long-established community centers, which now have come to see all residents as vital partners in changing outcomes for the community as a whole. The point is that in the wake of the Initiative the neighborhood appears to be a setting where children and their families are more likely to get services they need than was the case in 1992.

Medicaid Managed Care Broker

PIP's Role as Medicaid Managed Care Coordinator

As indicated in the overview of service development, neighborhood providers and some public agencies began to express the concern that the MHI was developing into a competitor, almost from the time the FRC first opened its doors. In response, PIP immediately began shifting away from provision of services that had traditionally been afforded by clinicians. Instead, the organization focused on the Initiative's goal of organizing and energizing a cadre of local clinicians and an infrastructure which was connected with ordinary residents of the neighborhood. This became clear with the self-assessment process which began in 1995-96. The resulting Project-Wide Work Plan, based on the Casey "benchmarks," articulated this shift of overall strategy.

Though already in place, this process was accelerated in 1997 by MHMRA's relocation of its therapist to another site, and the state's use of Medicaid managed care as a means of improving children's health services. When the state invited bids for managing children's Medicaid services, PIP began positioning itself to become a participant in that activity as a means of sustaining itself financially after the end of the Casey grant. In the Spring of 1998, PIP received its Medicare and Medicaid provider number with plans of operating as an innovative provider group with a network of local clinicians.

Service Issues and Challenges

Managed Care Coordinator Creates Some New Obstacles

As the Initiative positioned itself to broker services through the Medicaid Managed Care Program in Texas, it faced many organizational and management problems. Not the least of these was the problem of working with (and without) members of the Provider Network who were para-professionals or professionals without full certification or documentation.

PIP's Provider Network of local service providers, already affiliated with the PIP board, was originally seen as forming the core of providers to whom the organization, in its guise as Managed Care Coordinator, would refer. This was one of the strengths of the Initiative: It was able to link up local providers with neighborhood families in need of services, thereby benefiting both provider and recipient of services. PIP staff began in 1997 and early 1998 helping these service providers to become certified as Medicaid providers. Unfortunately, the majority of the original Provider Network members lacked credentials for Medicaid privileging. Additional community providers had to be mobilized and accredited.

> A traditional electronic management information system was never fully developed.

Need for New Methods of Evaluation; Difficulty of Quantifying Non-Traditional Family Development Services

Reviewing the past six years or more of Houston's involvement in the Casey Initiative, the one thing that stands out is that far more services were provided than the evaluators or most technical advisors knew.

Because non-traditional, individualized, pro-family services ("universal" services in the Casey Foundation's terms) have not yet become commodities as traditional services have, they do not lend themselves easily to traditional counting and accounting. When evaluated at all, these general family-building services are more likely to be systematically evaluated by outcome information than by process information. Furthermore, lack of professional charting made it difficult throughout the Initiative to demonstrate the extent of services actually being provided, much less their effectiveness. A contemporary electronic management information system was never fully developed and even if it had been, it would have been difficult to fit family development and universal services into traditional categories and documentation processes.[5]

Family development services were provided from the time the FRC opened, but their effect has never been well documented in the traditional method of recording items of service delivery and persons or families served. Focus groups conducted at the site, however, provided a rich anecdotal picture of the effective assistance being provided to families who are in need of training and informal counseling. These groups also provided information on a wide range of less traditional supports being offered through PIP.

PIP Services in 2000

The Managed Care arm of PIP has secured funding to provide services in the coming years. It appears that the family resource center will continue to operate and provide less traditional services primarily aimed at the type of family development services that strengthen and support families, including parenting classes and other family supports. As anticipated, some of the family development services provided are being funded through private foundations.

People in Partnership now functions as a source of energy and innovation in the local community as a whole. It continues to pursue its central activities while also remaining poised to take advantage of other opportunities for service as they arise. For example, in 1999, the local offices of the Department of Human Services were mandated to become more involved in utilizing community-based organizations within the health and welfare systems. PIP continues to serve on the Medicaid Regional Advisory Council, State Commission on Alcohol and Drug Abuse sub-committees, and have a parent representative on the Texas Integrated Funding Initiative planning committee. Additionally, the Executive Director of PIP was asked to sit on a citywide taskforce on local participatory government due to the Initiative's experience with neighborhood organization. In these and more subtle ways the organization continues to increase its influence and the effect of the Initiative on the quality of life of children and their families.

[5] Drop-in services at the FRC continue to be documented as visits, where within the course of two hours, the visitor is helped, as well as becoming a helper to someone else. Similarly, FOF graduates informally assist neighbors, relatives, and others without documentation submitted to the agency.

“Many of the implementation services continue and some are even expanding.”

The process of obtaining Medicaid accreditation for Third Ward providers during implementation of MHI had been long and difficult. However, by 1999 the new Behavioral Health Division of PIP began receiving and coordinating Medicaid referrals. This is the arm of the organization that brokers traditional clinical services to children and their families in Third Ward and nearby neighborhood. The Family Development services are provided directly by the Family Development section and are now funded by the Hogg Foundation. The Behavioral Health unit also works with managed care organizations to expand the types of services that are purchased and authorized.

Many of the implementation services continue and some are even expanding. In 1999, the FRC support to elementary children continues to include the 5th grade girls of the school, providing support group activities with an emphasis on the transition into junior high school. Based on the service report from the Behavioral Health Care Unit of PIP, each year approximately 22 to 30 female youth participate in the year-long program, and there are plans to expand and introduce a male specific component.

The expressive arts program which first occurred during implementation (1995) has most recently evolved into after school programs conducted by the partners (volunteers and staff). During the first year of operation as a free standing after school program (i.e. in 2000), 56 children with a variety of activities, including, art, leadership training and tutoring.[6]

The needs of at-risk youth led PIP to seek a summer youth employment contract that was funded through federal investment act funds. This program successfully served 53 youth in 1999 with a focus on entrepreneurship and included several local CBO in sub-contracting relationships.

Support for protecting children and families started through the roundtable discussions continue and there is now a core group of 12 kinship care families who continue to work with People In Partnership. The group is developing specialized parenting training and services to meet the needs of families in kinship care relationships. The group has met with their state representative to encourage recognition of this definition of family by state family services.

[6] Data based on sign in sheet and family development services report.

HIGHLIGHTS OF SERVICE DEVELOPMENT IN HOUSTON

Service Development in Houston

- An early goal of the Initiative was not so much to create traditional services as to coordinate traditional services that were already available, beginning with a comprehensive needs assessment followed by planning and coordination.

Family Resource Center

- A Family Resource Center (FRC) opened at Douglass Elementary School within a year of the formal beginning of the Initiative. It had one therapist from the Harris County Mental Health and Mental Retardation Authority (MHMRA), two caseworkers from Texas Work Force Commission (TWFC), and staff from Communities in Schools, Houston (CISH).
- Reduction of on-site provision of traditional services resulted from withdrawal of early state support, which had included co-location of providers.

FRC Provides Support for Children with In-School Suspension

- Beginning in 1998, emphasis has been placed on 35 school children with frequent referrals to In-School Suspension. Intervention supports include weekly support groups, supportive intervention with children, parents and teachers, and classroom presentations on problem solving and building of self-esteem. During the first year of operation this program provided approximately 50 children with a variety of activities, including, art, videography, field trips, and tutoring.

Juvenile Justice Program Diverts Male Youth

- An intervention program is developed in collaboration with the Texas Department of Juvenile Justice. A PIP provider network member and staff work with an average of 15 neighborhood youth who are on Juvenile Probation. Members of the program graduate after a year of participation. The consistent impact of the program has been seen in an increase of school attendance by participants and a 25 percent decrease in their recidivism rate, based on state Department of Juvenile Justice records.
- The Time Dollar program has been initiated in partnership with Ujima Community Volunteer Services, SHAPE Community Center, and the Cuney Homes Resident Council. This member-to-member exchange program is designed as a tool to support numerous community volunteers and to assist in the neighborhood placement and documentation for individuals in welfare to work programs and court-mandated volunteer time.

Parallel Developments

- A Friends-of-the-Family training program in association with nearby Texas Southern University has trained local residents to become effective para-professionals. Each graduate of that program is potentially both a valuable contributor of informal services and a force for change and renewal in the community.
- Community development, including development of grass roots capabilities for planning, providing, and gaining funding for services, has been a major achievement of the initiative and should be considered a service in its own right.
- From 1995 to 1999, the Volunteers In Service to America (VISTA) program allowed up to ten community residents to work with People in Partnership to participate in outreach, community resource mapping, and coordination of community events. VISTA's were located with community partners in each of the quadrants, as well as in the Douglass FRC. They co-facilitated focus groups, assisted with drug prevention education, health fairs, holiday food and gift drives, tutoring, PTA/PTO activities, civic club clean-ups, and other activities with over fifteen local organizations.

Medicaid Managed Care Broker

- PIP's Role as Medicaid Managed Care Coordinator

  Early on, the organization shifted focus from on-site provision of services to brokerage of traditional services and on-site "family development" activities, including case management and what are usually referred to as "wraparound services."

  This focus paid off when the state turned to Medicaid managed care for health services for children in families with low incomes. When the state invited bids for managing children's Medicaid services, PIP was positioned to play a managed care role, thus continuing to monitor quality of services and at the same time using the income to sustain itself financially after the end of the Casey grant.

Service Issues and Challenges

- Many more services were provided in the Casey Foundation's participation in the program than may have been apparent to many of the TA staff. This was due in part to PIP's inability to develop a traditional management information system (MIS). This, in turn, is partly due to the fact that current MIS models are inappropriate for the non-traditional (and non-commodified) services which were the hallmark of the initiative.

PIP Services in 2000

- While funding of traditional mental health services has been paid for through Medicaid, non-traditional services at the core of the initiative do not generate revenue, and are currently being paid for by the local Hogg Foundation.

VIRGINIA

- **East End Site Profile**
- **Overview of Service Development in Richmond**
- **Service Delivery in Richmond**
- **Highlights of Service Development in Richmond**

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 multi-service 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.

OVERVIEW OF SERVICE DEVELOPMENT IN RICHMOND

Pre-Implementation/ Planning Phase

In 1992, Virginia's grant planning committee showed tremendous excitement about applying for the Casey Foundation's Mental Health Initiative grant. The state hoped that funding would assist greatly in developing: *"an improved mental health delivery system that is pervasive, family-centered, neighborhood based, culturally appropriate, and interdisciplinary"* (II Proposed Approach: p.2). Virginia chose Richmond's East End Planning District as its target locality for implementing the Casey East District Initiative (EDI), because that district ranked highest statewide in indicators of risk factors for potential mental health problems facing urban children and adolescents.

The pre-implementation phase began early in 1993, with the planning-grant activities focused on: refining EDI goals and principles; narrowing target populations; determining which services it should develop; organizing the governing structure; hiring staff; promoting collaboration among existing service agencies; and creating linkages and communications between components of the EDI. The proposed structure of the EDI was to include: a neighborhood governing structure; parent resource network; consortium of state, city, provider, advocacy and parent groups; and Executive Committee of the Council on Community Services.

The stated mission of the EDI was to promote a culturally competent system of care at the East District neighborhood level that addressed the needs of youth and their families. Planning involved placing special emphasis therefore, on youth at risk of not reaching their full potential, through creating the right environment that would positively affect their lives. The EDI placed priority on assisting families reach their full potential through community involvement in the development of coordinated social, emotional, cultural, spiritual, recreational and educational programming. It proposed a neighborhood service system that would include: grassroots identification of service barriers; partnering with neighborhood residents to design and deliver services that best met their assessed needs; and providing community based and culturally competent services. It initially planned that the East District Family Resource Center (EDFRC), and East District Initiative (EDI) Center would both house MHI services and programs, as well as provide families easy access to those services within their own neighborhoods.

Implementation Phase

Though it emerged early in 1992, it was the Parent Resource network (PRN) that first signaled service development and reforms in Richmond. The PRN was created when seven East District residents with strong dedication toward ensuring active parent participation in the community empowerment process came together from the communities of Chimborazo, Creighton, Fairfield, Fulton, Mosby, St. John and Whitcomb, and formed their local chapter of the Federation of Families for Children's Mental Health. The Network provides or facilitates a number of services including supports for families in crisis, community referrals, advocacy, improved communication between parents and youth serving agencies, the local Micro-Enterprise Initiative Caters II, described as "*the primary UMHI community food provider.*"

> The multi-service center served as the main venue for decentralized and co-located services…

East District Families First (EDFF) Case Management Programs Provide Services for Community Residents

The next step in the Mental Health Initiative implementation was the grand opening of the newly remodeled East District Center building, located at 701 N. 25th Street, on Saturday May 7, 1994. The multi-service center served as the main venue for decentralized and co-located services, as well as a "mini City Hall" bringing services closer to neighborhood consumers. The East District's Families First (EDFF) family case management model was launched late in 1997. The EDFF model of case management had been developed formally a year earlier in 1996 by East District service providing agencies, at both city and state level.

East District Family Resource Center (EDFRC)–A Tangible Community Resource

On September 28, 1998, the East District Family Resource Center (EDFRC), which had been first on Richmond's development agenda, opened its newly renovated facilities located at 2405 Jefferson Avenue in the East District, after many delays and at the very end of the Foundation's funding. The FRC (for short) was designed as a community-based and family friendly service hub, providing East District children and families access to consolidated services. Other FRC services included: re-organizing the Youth and Family Support Programs, and placing the Healthy Families Richmond program under the Local Coordinator to ensure its full integration into the FRC. In essence, this became the first major step toward service integration and coordination across human service agencies in the East District.

Post Implementation Phase

The EDI has continued working toward sustaining many family-centered, neighborhood based, culturally appropriate, and interdisciplinary programs and services launched during the MHI. It is also currently engaged in forging new partnerships with local and external entities through funding drives that will improve the lives of East District youth and families. Major funding drives have included writing and submitting grant proposals to public and private agencies.

SERVICE DELIVERY STRATEGY IN RICHMOND

This Section describes Richmond's service strategy in detail by discussing four major service implementation components: Parent Resource Network (PRN); the East District Initiative (EDI) Center; the East District Families First Case Management (EDFF); and the East District Family Resource Center (EDFRC). The section also highlights Service Issues and Challenges and gives a synopsis of the site's service strategy after implementation in the final subsection, Richmond Builds on Momentum Established by MHI.

Virginia chose Richmond as its target locality for planning and implementing the Annie E. Casey Foundation Urban Mental Health Initiative because the East End Planning District had ranked highest statewide in a 1993 survey of risk factors for potential mental health problems facing its urban children and adolescents. Risk indicators were obtained from data collected on education, juvenile justice, health and vital statistics, social services, mental health, substance abuse, and other demographic data. Interviews with parents, formal and informal community leaders, city officials, and other professionals also revealed severe mental health challenges faced by children and their families in at-risk urban population areas of Richmond, especially the East District. After implementation began, the MHI in Richmond's East End District became popularly known as the East District Initiative (EDI). To date, EDI services and programs have served thousands of residents in the East District.

Service delivery strategies in Virginia were subsequently designed to "*strengthen the array of services and supports available to children and families within the (East District) neighborhood.*" EDI hoped to develop a comprehensive system of supports for families, that ensured the availability, accessibility and integration of human services. In addition to *targeted prevention* and *intervention* services designed to address the needs of at-risk children and families, services were also designed to provide *universal supports* for all East District children and their families. Developing such services, however, also meant securing 'buy-in' and commitment from key local players involved in the MHI, including human services agencies, neighborhood residents, public and private organizations.

The service delivery strategies involved four major components: the Parent Resource Network (PRN), a family support and child advocacy network; the East District Initiative (EDI) Center, housed in a building located at 701N. 25th Street, which was chosen as the ideal location for decentralizing and co-locating services in the East District; East District's Families First Case Management Model (EDFF), a pilot model of family case management that would be family-centered, individualized and culturally sensitive; and the East District Family Resource Center (EDFRC), a center that provides universal services. Collectively, these strategies demonstrated Richmond's general orientation and commitment toward improving both availability and accessibility of services and supports for all East District families and children.

Parent Resource Network (PRN)

Parent Resource Network focuses on Universal Services in the East End

The Parent Resource network (PRN) is a local advocacy group and Chapter of the Federation of Families, formed in 1992 by seven community residents representing Chimborazo, Creighton, Fairfield, Fulton, Mosby, St. John and Whitcomb. Though it did not originally develop as an MHI inspired initia-

“Staffed essentially by long time East District residents, the PRN worked mostly at grass roots level, providing supports for families in crisis.”

tive, the PRN quickly became an integral part of the overall service strategy, as well as a vehicle for providing and facilitating a number of important universal services in the East District.

Staffed essentially by long time East District residents, the PRN worked mostly at grass roots level, providing supports for families in crisis by making referrals to lead professional agencies such as EDFF and EDFRC. The PRN used its own resources to help children and families. Its staff had long experience in family and community issues, and provider skills that were later learned primarily from MHI inspired neighborhood governance and family/professional experiences at local and national level. One learning experience that PRN staff gained from training conducted in 1997 by Survey Research Laboratory staff at Virginia Commonwealth University was how to conduct focus groups. PRN members also utilized their learned parent/family advocacy skills to provide families with access to youth serving agencies, such as Richmond's 13th District Juvenile and Domestic Relations Court, and the school system. East District children and families also looked upon the PRN as a popular food and financial needs provider. The Network is known among East District families as "*the primary UMHI community food provider*" serving the food needs of poor families through its privately funded Micro-Enterprise Initiative, Caters II.

The PRN also played a big role in providing universal supports and outreach through other community-based programs. Such supports included the Mosby Middle School-based Youth Development program and Parent Resource Center; the Garfield F. Memorial Child Fund; the East District Family Resource Center and other informal outreach services to East District children and their families. The PRN serves hundreds of East District residents through outreach alone. The group was instrumental in the formation of the EDFRC, and later became active in promoting continuing City support for FRC programs, and their sustainability efforts. One of its greatest family advocacy efforts was demonstrated in 1996, when it undertook the *"mobilization and transportation of 220 children and families to the Stand for Children March in Washington DC,"* to give them first hand learning experience in future advocacy and leadership roles.

The PRN has continued to grow in its child and family advocacy roles, as well as become even more active in partnering with formal service providers and East District parents.

East District Initiative Center

Co-Location of services provides one-stop services for East District residents

After extensive renovations were completed in 1994, the East District Center building (formerly the East End Social Services Building), located at the corner of 25th and Main streets opened its doors to MHI services, including a number of universal, prevention/intervention services and programs. A Finance Department window where residents conveniently paid their utility and tax bills also moved in. This helped combat the problem of transportation which residents faced with the services that were located in downtown Richmond. A Food Stamp intake window was also opened to make it easier for families to collect stamped coupons without having to ride a bus to Richmond's center city. A new information corridor was introduced to provide residents with information about city/community programs, services and events. The offices of the East District Manager/Local Coordinator and staff (including the Youth and

“The Richmond career Advancement Center was also located at the center, and provided intervention services through utilization of job/ career assessment, training and placement resources.”

Family Support Programs, Healthy Families Richmond Program), the Virginia Cooperative extension, the Annie E. Casey Foundation Urban Neighborhood Mental Health Initiative (including EDFF and the Fatherhood project), and Churchill Neighborhood Inc. all opened for business. The steady flow of families and residents in and out of the building during most business hours suggests that the services provided at the center were available and accessible.

Other essential family focused programs that moved into the East District Center included the intensive in-home educational program, the East District Youth Summer Camp/Scholarships program serving East District youth, ages five to eighteen, who were at high risk for serious problems. Over the life of the MHI, at least 500 children participated in various summer camp programs that provided invaluable new experiences, as well as much needed respite for families. The Youth Summer Camp program continued its own variety of prevention/intervention programs including Camp B.A.N.G (Building A New Generation), Youth Services Corporation.

Richmond's family preservation goals kicked into high gear when the City Department of Social Services co-located its services to the East District Center. It provided direct case management services under EDFF, and other direct benefits through its network of social workers. As part of Virginia's Welfare Reform efforts, DSS along with other local agencies began working in partnership with the Child Support Enforcement agency to assist with legal paternity rights issues, and administer child support obligations on behalf of custodial parents caring for children. This effort was of great benefit to families in dire need of financial resources to cover most child expenses, and other family/household needs.

Another noteworthy program, the Richmond Career Advancement Center was also located at the center, and provided intervention services through job/career assessment, training and placement resources.

East District Families First Case Management (EDFF)

SERL-VCU "Logic Models" help change EDFF Case Management Service Philosophy

East District Families First (EDFF) family case management programs kicked off in 1996, as a result of an MHI inspired interagency collaboration at both city and state level. This collaboration brought together programs and service resources from the East District such as the Youth and Family Support Programs/UMHI, Social Services, Spectrum–Family First Initiative, a state Department of Juvenile Justice agency, Lead Safe Richmond, Virginia Cooperative Extension, Child Support Enforcement and the Richmond Community Action Program.

Later that same year, as part of a joint MHI Casey Foundation-East District Initiative subcontract, the Survey Research Laboratory (SERL) at Virginia Commonwealth University (VCU) started its local EDI evaluation program. The four major components of the SERL evaluation focused on coordination, clarification of program goals and objectives, history and development of the EDI, and collaborative survey. SERL's development of several "logic models" also helped shape EDFF case management practice. The model helped to show how programs theoretically work, identified clear goals and measurable objectives, and monitoring processes (East District Evaluation

> The SERL logic models helped detail basic steps toward family outcome assessment in EDFF case management.

News, September 1997, No.1; VCU Team Leader Memo: Jordan, 1997). The SERL logic models helped detail basic steps toward family outcome assessment in EDFF case management, including development of a screening tool for child/family assessment.

Collaboration among Agencies Strengthens EDFF

Other personnel from various agencies assisted the relatively small pool of front line EDFF staff and consortiums, through what appeared to be locally arranged partnerships. For example, Virginia Commonwealth University graduate students assisted with various prevention and intervention service activities through internships. Hope In the Cities (HIC), a local consortium and non-profit provider group, also contributed a Fatherhood Employment Coordinator (FEC) to work in partnership with the EDFF Fatherhood Coordinator. This collaboration seemed especially important to EDFF, since it offered them a trained professional free of charge who would enhance their focus on including parents (particularly fathers) in service intervention. The joint team of coordinators also provided educational training for fathers about their children's special needs, stressing the importance of male parent supervision in helping to keep and raise their children at home. Working in partnership with these other organizations helped to strengthen the quality of services provided through EDFF.

As previously indicated, the Survey Research Laboratory (SERL) at Virginia Commonwealth University (VCU) played a major role in developing logic models for EDFF. However, this was done through collaboration with EDFF's Family Case Management Team (FCMT). One logic model was developed for each of EDFF's target groups which included the following:

- first-time parents (prenatal or with an infant 3 months or younger)
- 17-year-old children or those younger and at risk of out of home placement, or returning home in 30 days
- 17-year-olds or younger with behavioral problems
- non-custodial parents, especially fathers desiring to reunite with their children.

In addition, these models were consistent with the FCMT's overall goal and philosophy which was: "*…to empower families to become self-sufficient through a family-focused partnership that is responsible, nurturing, no-deficit, culturally relevant, strengthening and holistic.*"

Through these partnerships EDFF was also shifted from a deficit or 'needs-based' approach to a more 'strengths-based' approach. This partnership also helped case management move away from individual service planning to family service planning. As such, EDFF case management services started focusing on the child's entire family and not just the child at risk, incorporating the philosophy that "*the Family is the client, not the individual!*"

EDFF Provides Intensive Case Management

EDFF provided intensive case management services as well as prevention and intervention services. These included individual and family therapy, especially for families with serious mental health issues; in-home respite support services to keep children at home; housing assistance to keep families together; coverage for physical health needs; and financial assistance benefits. Local agency mental health counselors from Virginia Commonwealth University and the City of Richmond's Behavioral Health

> The Family Case Managers (FCM's) were responsible for coordinating and implementing family-centered and individualized services.

Authority's Mental Health Truancy Substance Abuse Assessment program also provided preventive services for high-risk children, conducting home and office visits to help children increase their resiliency and protective factors. Other service agencies involved in prevention and intervention services included the following: Richmond's 13th District Juvenile and Domestic Relations Court, Department of Social Services, Child Protective Services-2nd Responder Program, and Department of Education's After School Program.

The overall service strategy adopted through EDFF included two critical aspects that positively affected service delivery. These were the careful delineation of staff roles and responsibilities and strong collaboration with other local agencies. For example, EDFF Family Case Assessment workers (FAWs) were specifically responsible for the formal initial assessment and documentation of the child and family's needs, using the Denver II: DA Form 5694, a universal screening tool and needs assessment instrument recommended by SERL. On the other hand, the Family Case Managers (FCMs) were responsible for coordinating and implementing family-centered and individualized services, after planning and approval of case plans by the families at the Family Case Assessment Planning Team (FAPT), is now called the Guiding Individual Families to Self Sufficiency (GIFTS) team. Membership on the GIFTS team was very inclusive and usually comprised EDFF staff, family members and their support network, and human service agency representatives directly involved in their cases. EDFF's successful service focus on involving various family support networks–especially, biological/adoptive fathers who had been incarcerated–deserves special recognition.

East District Family Resource Center (EDFRC)

East District Family Resource Center hailed as a "community spot" for families and residents

The East District Family Resource Center (EDFRC) was initially designed as a community-based and family friendly service hub, providing East District children and families access to consolidated services. Contrary to initial expectations, however, the EDFRC did not open for services in the East District until November 6, 1998, at the very end of MHI funding. According to residents, much of the delay in opening the center was due to construction anomalies that seemed to be beyond control of the EDI. Once it became fully operational it was described as "*a community spot that residents would feel comfortable in, where they would have a place to go and get their service needs met…*"

In contrast to the EDFF model that focused more on intervention and prevention supports, once it finally got off the ground in 1998, the FRC provided an extensive array of universal and preventive services for children and families in the East End.

FCR Provides Services to East End Residents

EDFRC appears to have accomplished a great deal in a relatively short time, especially in provision of universal services and supports to the East District. One of its very first accomplishments was the successful acquisition of city property 2405 located at Jefferson Avenue and remodeling it into a new FRC facility. Informal site contacts also reported that many East

Caseload problems were also an issue for some EDFF front line staff who were pooled from the integrated team of DSS social workers.

District residents liked the idea of hiring a minority contractor to remodel the newly acquired FRC facility. Renovation were accomplished through a $50,000 pre-development work authorization fund from the MHI, and $275,000 renovation grant from the Jackson Foundation. Residents believed that securing this property would ensure that East District families and residents would have relatively easy access to services and programs.

Similarly, in the area of local job service, the FRC began recruiting and training East District residents as certified Asbestos Abatement removers and Minor Demolition workers in 1997 so they could be employed at the Center. It also launched a job training interior design program for residents, anticipating that the Center would open that same year, even though it did not, due reportedly to internal problems meeting the contractual completion timeline.

EDFRC improvised case management services informally, doing the referrals, checking out on available resources for families' and residents' housing needs. Through such improvisation, the FRC increased both its family assistance capacity (non-clinical case management services), and ability to team with trained professionals.

Service Issues and Challenges

The consensus among residents was that partnerships throughout the Initiative were relatively slow to develop. This was partly due to the fact that it was difficult for representatives from the different state, local, provider and neighborhood levels to work together. It was a challenge to establish interpersonal relationships among people who often were working together for the first time. In addition, early discord between state, local and neighborhood entities did not help create the needed collaboration or integration and coordination of programs and services across service agencies.

Consumers and providers both seemed to agree that effective services were being provided to most East District residents and families. However, serious shortages were noted in the number of clinical frontline staff. A provider stated that at the EDFRC "*People are getting good activities, they're getting some services but they're not getting the full range of services that FRC should provide because they have no case managers.*"

Caseload problems were also an issue for some EDFF front line staff who were pooled from the integrated team of DSS social workers. These workers had multiple case loads and dual assignments from EDFF and DSS family case files. In a few instances, they also had carry-over assignments from Richmond's Juvenile and Domestic Relations Court. These multiple case loads, along with the limited number of staff carrying them, made it virtually impossible for the agency to effectively serve targeted high-risk children and families of the East District.

In planning the MHI, case management services theoretically were the responsibility of EDFF and EDFRC programs that were originally designed to serve the mental health needs of the area's children, youth and their families. Unfortunately, both entities began full service operation a couple of years apart with very little firm ground on which to build collaboration, integration and coordination.

There also appeared to be some fundamental confusion in delineating service roles of EDFF staff from those of EDRFC staff, such as addressing family issues of maternity/paternity, first-time parental care

East District Initiative staff seem empowered and motivated by the MHI experience, and continue to seek new funding opportunities to sustain their site's programs…

giving, family reunification, etc., versus provision of services for deep end cases. That confusion was apparent in this informal interview with a site observer: "*EDFRC programs are very limited, you have to be pregnant or have a child under a certain age but the folks that come in that need housing and really mental health stuff, they can't be seen by them. And so the FRC staff doesn't have a case manager.*"

Despite these challenges, the future appears to look good with all four service program components. EDI continues to secure needed funding to provide easily accessible, culturally competent, and family-centered services to its East District residents.

Richmond Builds on Momentum Established by MHI

Richmond has been involved in several post-implementation activities. It secured additional funding of $150,000 from the Casey Foundation for the year 2000, and local government funding of $86,000 in 1999, and was successful in securing other private agency grants. These additional resources have helped to sustain and support the East District Initiative after implementation and continue to help strengthen MHI initiated programs and services that are being provided to East District residents.

As the East District Manager summed it up in a recent interview,[1] "*We are building on the momentum of the initiative.*"

The East District Initiative staff seem empowered and motivated by the MHI experience, and continue to seek new funding opportunities to sustain their site's programs and launch new ones. The site has engaged in cross-site consultation and collaboration for program funding and sustainability with other sites like Houston. The experiences of the Houston's managed care model have helped guide the Richmond site as it explores HMO managed care funding options that might help support the East District Families First (EDFF) case management model.

In another recent landmark step, the EDI introduced intensive, home-based family case management services in its four target neighborhood housing projects (Whitcomb, Creighton, Fairfield, and Mosby housing development projects in Churchill). These services were made possible by a $28,000 funding from the City of Richmond, with an additional federal grant to the city through its Health Department. The direct services are provided by an integrated family case management team, the newly created Healthy Families unit comprising staff re-deployed from the various EDFF collaborating agencies. Through this innovative program, residential units, along with state, federal funding and other essential service logistics, are provided for the case management staff to live permanently within these communities and serve families.[2]

The site has also been successful in refunding the local health center which had previously lost its funding: "*The de-funded Health center has been refunded; this is the Vernon Harris Health Clinic, and it also now has a board…MHI was a catalyst for it…*" [3]

[1] Telephone Conference Interview with East District Manager on March 20, 2000-Appendix D-References.

[2] Telephone Conference Interview with East District Manager on March 20, 2000-Appendix D-References.

[3] Telephone Conference Interview with EDFF Supervisor on August 29, 2000-Appendix D-Site References.

“The East District Family Resource Center has also experienced significant growth and development in its services and programs.”

The East District Family Resource Center has also experienced significant growth and development in its services and programs since the end of the MHI. In its April 1999 monthly report, for example, the EDRFC listed on its menu a large variety of services: Parenting enrichment and support services that provide opportunities for parents to explore behavior modification and management models, and crisis intervention to assist families to reach their goals. It listed family case management services assisting families with financial, educational, and/or social needs; intake services to enhance/support residents' access to social services assistance programs; and outreach services aimed at visibility and increasing knowledge and awareness of FRC programs.

EDFRC also had a super pantry to enhance residents' nutritional well-being through integration of nutrition education, emergency food, alternative food purchasing and specialty cooking classes. There are auxiliary services to enhance members' participation in Center programs; health and exercise especially for women, infants and children to improve their physical and medical well being; and a career closet offering employment counseling services to enhance residents' employment opportunities. Education services include computer and vocational training classes, while child care and family development provided opportunities to East District families to ensure individual and family success. In addition, the 'Men of Vision' program promotes a stronger male presence in East District families. A community club encourages peer-to-peer support, and provides resources/information to senior members.

Another addition to East District's post-implementation services involved a United Way funded Teen Education Empowerment and Nurturance (TEEN) program Center that opened July 6, 1999. The TEEN Center was located on the lower level of the newly renovated Health Clinic across from the East District Center building, and is operated by East Team Board members and supervised by their current chair under United Way funding requirements. The Center serves young teen mothers or first-time parents, providing them with pre-natal as well as post-natal skills and opportunities for mainstream education and possible careers. Also on its service menu are substance abuse prevention with a post-test component, "Great Expectations" which is administered after 8 weeks. This post-test component includes "teaching abstinence or postponing teen sexual activity, art lessons, teen trauma and counseling.

The TEEN Center is currently partnering with several agencies, especially since it experienced funding cuts from United Way this year. Some of those partners that also assist with funding include Virginia Health Center, a non-profit organization; Richmond Planned Parenthood and City Police; Department of Parks and Recreation; Dr. Fred Black of Summit, etc. To date, the center has served nearly 100 teenage mothers since it opened its own facilities in 1999 in the basement of Health Clinic. The Mental Health Initiative was also partly instrumental in getting funding for the TEEN Center, making it an added resource in the East District community.[4]

In terms of scope of this site's array of services, to date EDFF has served a total of 193 children/youth, 110 of who were first-time (teen) parents, and 83 court ordered cases.[5] A total of 144 of these individuals were served during MHI implementation (1993-1998).

[4] Telephone Conference Interview with East District Manager on March 20, 2000-Appendix D-References.

[5] Telephone Interview with East District Neighborhood Governance Team Board Chair, August 31, 2000.

“More recently data for the month ending July 2000 demonstrates significant increase in utilization of these services and programs.[6]”

East District Family Resource Center (EDFRC) utilization figures for the month of April 1999 indicated the following:

- Total membership–370 residents with 26 new members;
- 1,296 total visits by East District residents, including 166 volunteer members and 929 program-based members;
- 201 non-members;
- 35 residents served under the “career clothes closet;”
- 71 in “food emergency;”
- 30 in the child care/child waiting area program;
- 27 served in transportation and 1 computer graduate.

More recently data for the month ending July 2000 demonstrates significant increase in utilization of these services and programs:[6]

- Total membership of 751 residents;
- 2,566 total visits including 2,269 members and only 297 non-members, mostly WIC program recipients;
- 255 residents received emergency food;
- 395 went to the child care/child waiting area program;
- 51 residents graduated from the FRC computer class.

Recent post-implementation interviews conducted with EDI staff, however, reveal that there are still some challenges in the area of service integration and coordination. Providers continue to work on establishing healthy communication and interaction for better service provision in the East District.

[6] Brief telephone interview with EDFRC Administrator, August 29, 2000-Appendix D-Site References.

HIGHLIGHTS OF SERVICE DEVELOPMENT IN RICHMOND

Pre-Implementation/Planning Phase (1993-1994)

- EDI pre-implementation/planning grant phase focused on developing services and programs that would provide families easy access to services within East District residential neighborhoods, especially the Whitcomb, Creighton, Fairfield, and Mosby housing development projects in Churchill.

Service Delivery in Richmond

- EDI implementation strategy involved: The Parent Resource Network (PRN) a family support and child advocacy network; the East District Initiative (EDI) Center building as ideal location for decentralizing and co-locating services in the East District; East District's Families First case management program (EDFF), a pilot multi-agency family case management program that was family-centered, individualized and culturally sensitive; and the East District Family Resource Center (EDFRC), providing universal services.

Parent Resource Network

- Parent Resource Network focuses on Universal Services in the East End

  Staffed essentially by long time East District residents, the PRN worked mostly at grass roots level, providing supports for families in crisis through referrals with the lead professional agencies (EDFF and EDFRC), and providing access to youth serving agencies, such as Richmond's 13th District Juvenile and Domestic Relations Court, and the school system.

East District Initiative Center

- Co-Location of services provides one-stop services for East End residents

  After extensive remodeling, the East District Center building (formerly the East End Social Services Building), located at the corner of 25th and Main Streets opened its doors to MHI services in 1994, including a number of universal, prevention and intervention services and programs (such as Finance Department, Food Stamp Healthy Families, Fatherhood project, Churchill Neighborhood Inc.)

East District Families First Case Management Model

- SERL-VCU "Logic Models" help change EDFF Case Management Service Philosophy

  The EDFF family case management model deserves particular attention for its inclusion of various family support networks, especially biological/adoptive fathers (many incarcerated), in planning and delivering services to their high-risk children/youth–a great accomplishment.

East District Family Resource Center (EDFRC)

- East District Family Resource Center hailed as a "community spot" for families and residents

  EDFRC became "a community spot that residents would feel comfortable in, where they would have a place to go and get their service needs met," because it provided an extensive array of universal and preventive services including: parenting enrichment and support; health and exercise especially for women, infants and children; 'Men of Vision', promoting stronger male presence in East District families; educational/outreach programs such as computer classes, free child care, transportation, Summer Food program; the Welfare Department's WIC program; the Health Department's medical services, etc.

Service Issues and Challenges

- Extra funding is still being sought to help sustain MHI programs and launch new ones, such as local HMO managed care contracts, Charter and other service funding agencies to further increase and strengthen EDFF case management staff capacity aimed at better prevention services delivery.
- There appeared to be some confusion in delineating service roles of EDFF staff and EDFRC staff.

Richmond Builds on MHI Momentum For Sustainability

- "Building on the momentum of the initiative," and with additional funding of $150,000 from the Casey Foundation for the year 2000, local government funding ($86,000 in 1999), and other private agency grants and support, the East District Initiative has been able to strengthen EDFRC's universal programs and prevention oriented services for children and families and to better sustain MHI programs in the East District.
- In another recent landmark post-implementation step, the EDI introduced intensive, home-based family case management services in its four target neighborhood housing development projects (Whitcomb, Creighton, Fairfield, and Mosby in Churchill). These services were made possible by a $28,000 award from the City of Richmond with an additional federal grant to the city through its Health Department.
- Also on the list of on-going post implementation projects, was the Vernon Harris Health Clinic's new board created from left over EDFF flex funds from the Casey grant. The board has representation from Spectrum Families First; Memorial Child Guidance Clinic, a local private provider; Richmond Redevelopment and Housing Authority; Office of Juvenile Justice; Richmond Health Department and Department of Social Services.
- The East District Family Resource Center has also experienced significant growth and development in its services and programs since the end of MHI implementation. Service data reported for the month of April 1999 show a total membership of 370 residents with 26 new members; 1,296 total visits by East District residents, including 166 volunteer members and 929 program-based members; and 201 non-members, etc. These numbers increased by 100% by summer of 2000.
- Another 1999 addition to East District's post-implementation services was a United Way funded Teen Education Enrichment and Nurturance (T.E.E.N) program Center opened July 6, 1999.

APPENDICES

- **APPENDIX A: Methodology**
- **APPENDIX B: Site Logic Models**
- **APPENDIX C: Additional Service Information**
- **APPENDIX D: References**

APPENDIX A
Methodology

Evaluation of the service delivery component of the Mental Health Initiative for Urban Children was conducted at the direct frontline service level and at the macro or overall service implementation level. The Evaluation of Direct Frontline Services looked specifically at direct services that the sites were providing. The primary strategies used to evaluate the development and provision of direct services at the four sites were Focus Groups and the Family Experience Studies (FES). Supplemental information for this evaluation was gathered through Document Reviews of site and Foundation reports.

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

Evaluation of Direct Frontline Services

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

Focus groups

Focus groups were used to evaluate the universal, targeted prevention type services which sites generally provided through their Family Resource Centers. Focus groups are carefully planned discussions designed to obtain information about a defined area of interest in a permissive and non-threatening environment. An important consideration in conducting these groups is ensuring that participants exhibit certain common characteristics. The discussion is conducted using open-ended questions that allow participants to reflect on experiences or perceptions without being confined to respond using specific categorized answers as is typical of surveys.

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

The first set of focus groups were grouped into the following categories during the early implementation phase of the Initiative (1993 & 1994).

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

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

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

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

Family Experience Study

Family Experience Study (FES) was used to evaluate the intensive intervention services provided through the sites' case management models. The family experience studies (FES) studied the interface between service systems and consumers. The principal question asked through this methodology was "how is the existing system addressing meet the needs of individual children and families in the Mental Health Initiative's target neighborhoods?"

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

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

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

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

Family Centered/Focused: Services are dictated by the needs of the child and family, are based on the family's strengths, and are provided in a manner which maximizes opportunities for involvement and self-determination in planning and delivery.

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

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

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

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

Case Sampling

A total of twelve families typically participated in each round of FES. For the purpose of this study, a case was represented by an individual child receiving services from one or more service systems (e.g., mental health, juvenile justice, special education, and child welfare), his or her primary caregiver, persons who provide informal support to the child and family, and representatives of the different systems serving them, including case managers and direct service providers.

The approach included interviews with the target child, primary caregivers, service providers, case managers and other informal sources of support. This

methodology also included an extensive review of records and documents relating to the target child's care and support.

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

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

Document Review

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

Evaluation of Service Implementation at the Macro Level

The primary method used to evaluate implementation of the MHI service component at the macro level was a series of focus groups. Document reviews provided some supplemental information.

Focus Groups

These focus groups were conducted with representatives from all major stakeholder levels.

- Technical assistants and foundation staff
- Providers and Initiative staff
- Representatives from the State and local levels
- Residents from the four target communities

These groups were held towards the end of MHI implementation, and questions centered on major site accomplishments and challenges, as well as lessons that could be gleaned from implementation.

Document Review

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

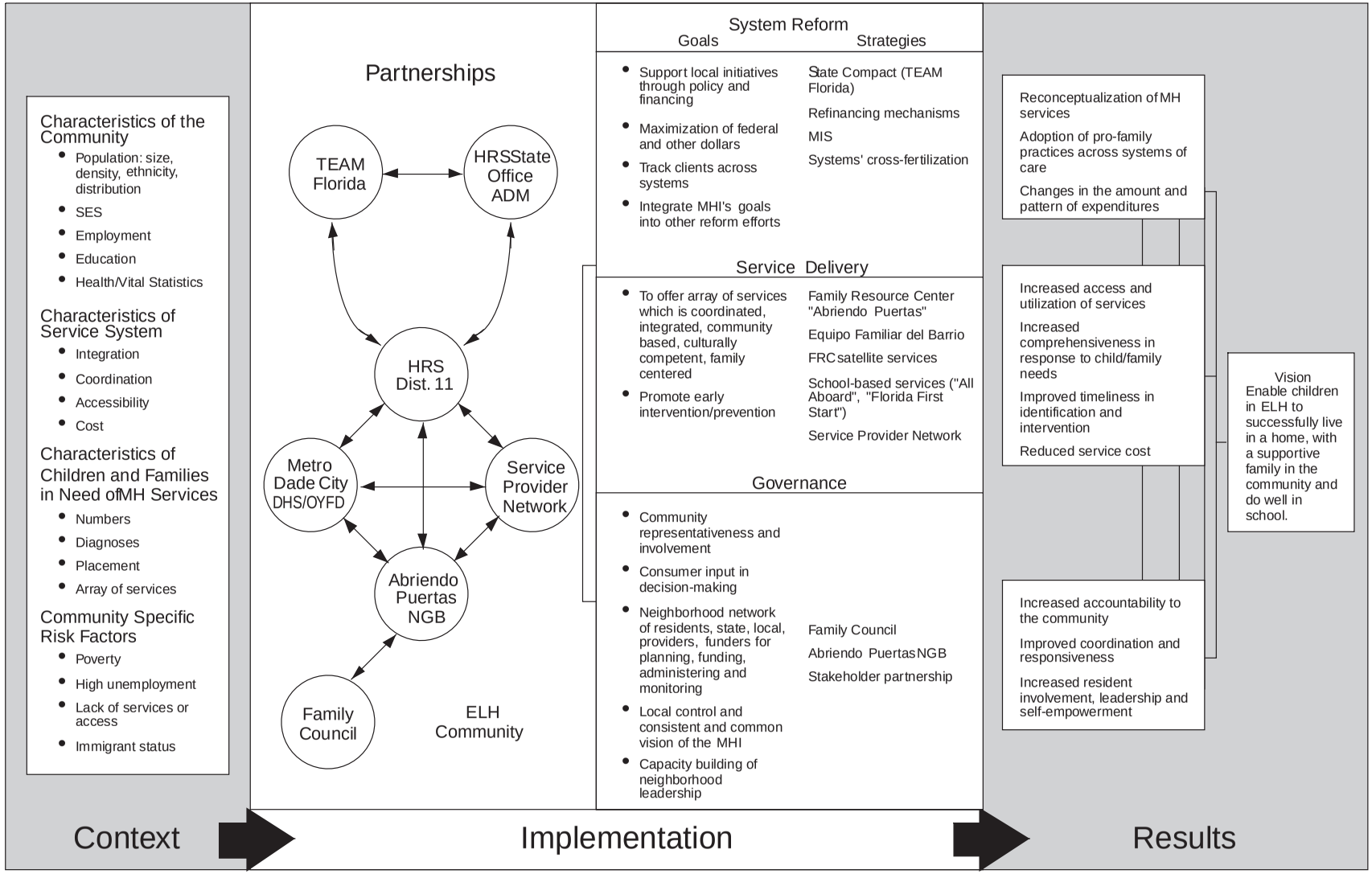
Stakeholder Interview

A limited number of phone and/or in-person interviews conducted with key stakeholders were used for clarification purposes and to provide supplemental information.

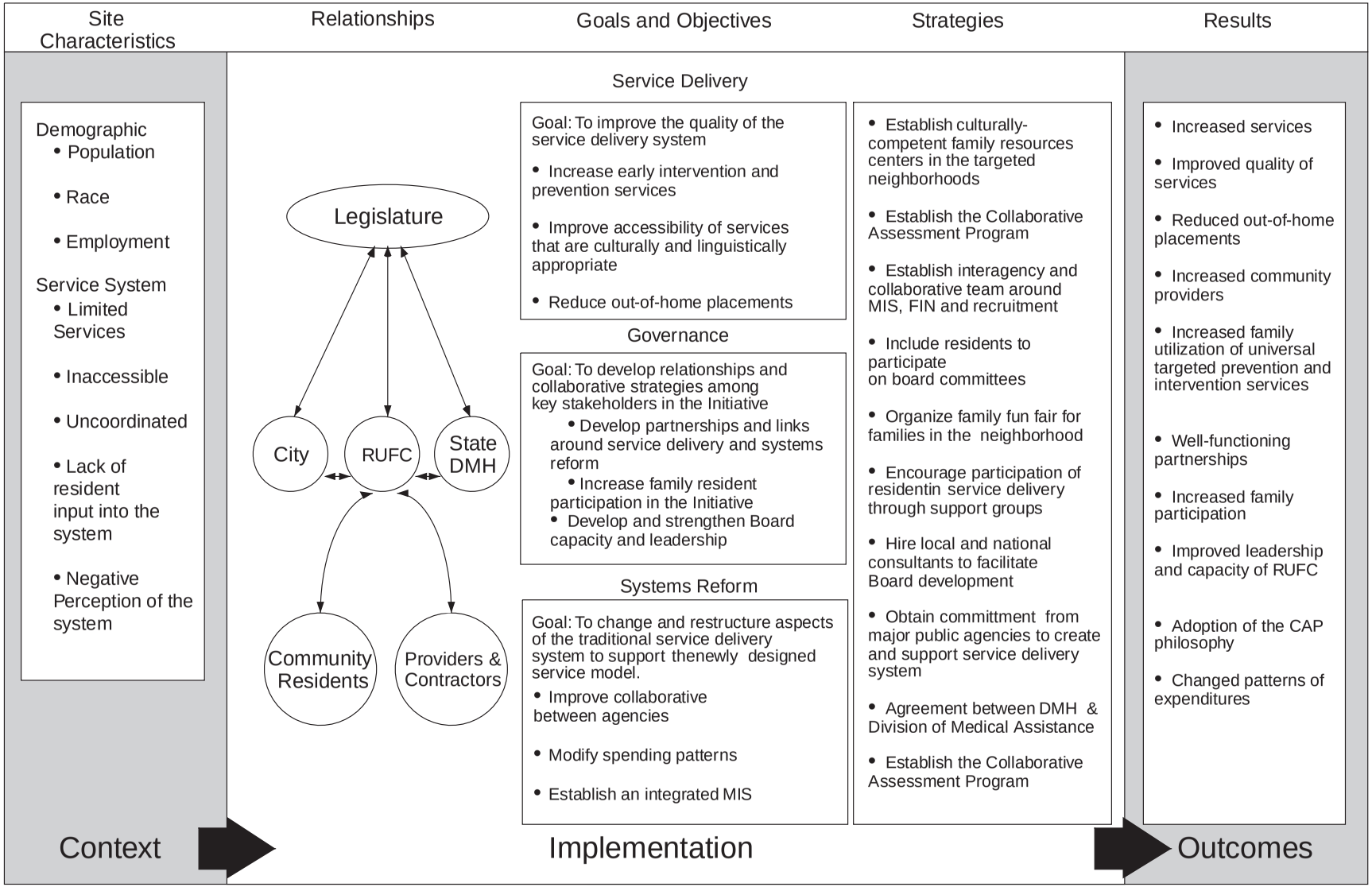
APPENDIX B
Site Logic Models

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

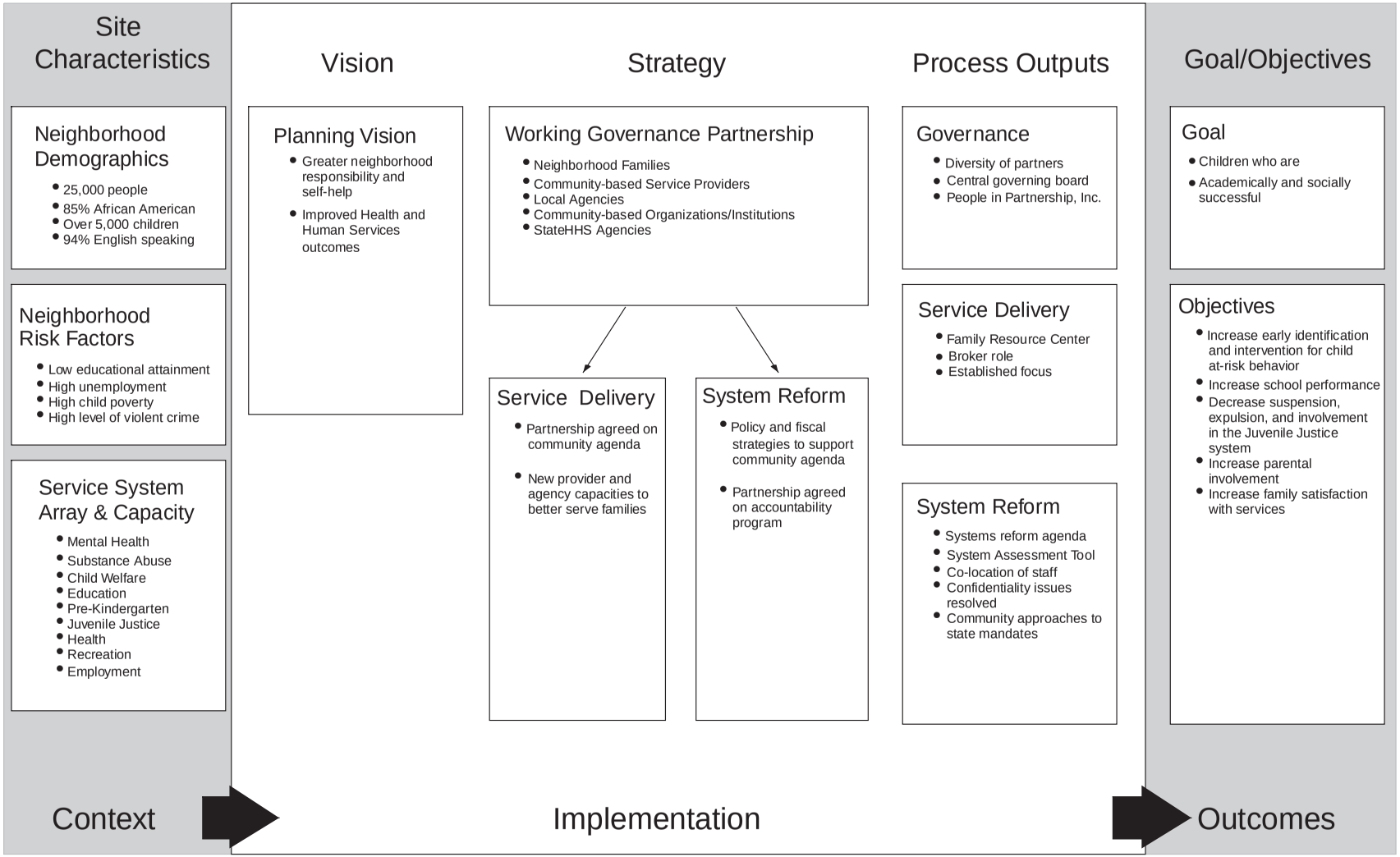
Logic Model of the Annie E. Casey Foundation's Mental Health Initiative for Urban Children in East Little Havana



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

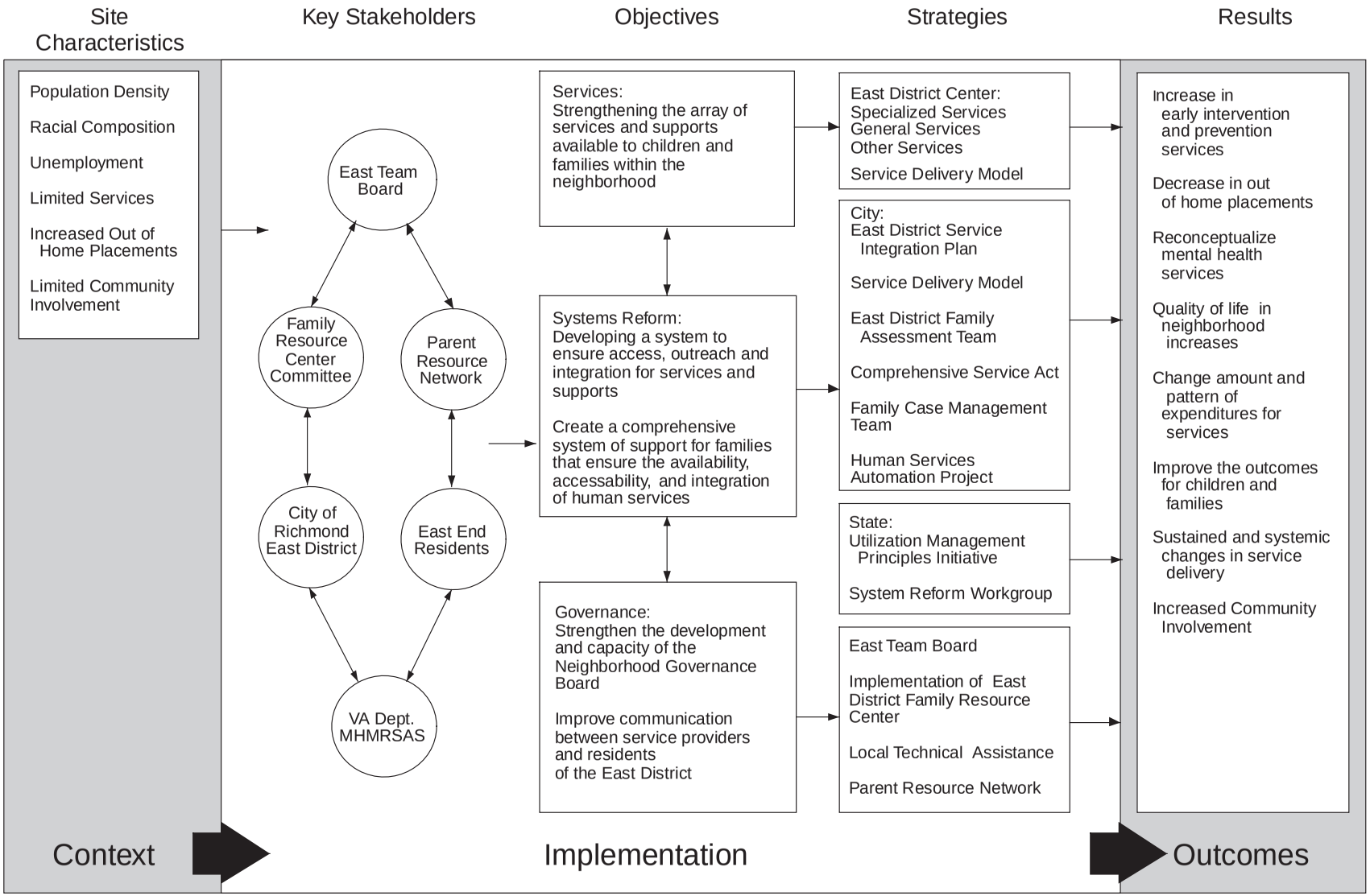


Logic Model of the Annie E. Casey Foundation's Mental Health Initiative for Urban Children in Houston



Virginia/City of Richmond Urban Mental Health Initiative

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



APPENDIX C
Additional Service Information

- **Service Activity Report, February–July 1999**
- **RUFC Network Service Codes**
- **List of Project Outcomes**
- **List of Sources for Boston**
- **List of Evaluation Reports for Boston**

Service Activity Report, February – July 1999

Category	Frequency	Category	Frequency
ExpressiveTherapy	1	Home – SupervisedVisit	1
FamilyAssessment	1	Home – ParentAide	1
FamilyCounseling	1	School – AfterSchoolProgram	58
FamilyTherapy	1	School – CrisisStabilization	1
GEDProgram	1	School – DayCare	1
GroupTherapy	1	School – EducationalAdvocacy	1
HomeVisit	1	School – EvaluationEduc/AcaD	1
IndividualCounseling	1	School – Eva[Psychological	1
IntensiveFamilyIntervention	1	School – IndividualCounseling	1
InterpeterServices	1	School – ParentSupportGroup	1
JobSkillsTraining	1	School – ParentingSupportGp	1
LivingSkillsTraining	1	School – HealthCare	1
ParentingSkillsTraining	1	School – GroupTreatment	1
ParentingSupportGroup	1	Wrap – InformationLink	90
PreserveFamilyTherapy	1	Wrap – MonitoringLink	0
PreserveGroupTherapy	1	Wrap – SupportLink	0
PsychDayTreatment	1	Wrap – FamilyLink	0
RecruitPerm.Home	1	Wrap – CommunityLink	1
ResourceDevel.Visit	1	Wrap – Consultation	0
ResourceSupportVisit	1	Camp – DayCamp	31
ReunificationAssessment	1	Camp – OutwardBound	1
SexAbuseTreatment	1	Camp – Overnight	0
SexOffenderTreatment	1	Camp – Therapeutic	1
StreetTracking	1	Camp – CrisisStabilization	0
SupervisedVisit	1	Camp – EvalEduc/Academic	0
Tutorial	1	Hosp – AdultlnptPsych	3
ViolencePrevention	1	Hosp – ChildInptPsych	0
SubstanceAbuseTx.	1	Hosp – AdultInptSurg	1
Home – Visit	54	Hosp – ChildlnptPsych	0
Home – CrisisStabilization	1	Hosp – AdultInptMedical	0
Home – FamilyAssessment	1	Hosp – ChildInptMedical	0
Home – FamilyCounseling	1	Hosp – AdultInptPartialPsyc	0
Home – FamilyTherapy	1	Hosp – ChildInptPartialPsyc	1
Home – IndividualCounseling	1	Hosp – AdultOutptPsych	0
Home – IntensiveFamilyInterv	1	Hosp – ChildOutptPsych	1
Home – InterpreterServices	1	Hospice	0
Home – LivingSkillsTraining	1	Detox	2
Home – FamilyPreservationTx	1	SupervisedVisit	0
Home – ReunificationAssessment	1		

Notes:
Data Collection begun ‘May 30
Prototype of Quartely Report

RUFC Network Service Codes

Please use the following codes to record services and activities.
Be sure to include the number of times or the amount of time in hours.

Prefixes		Suffixes	
B	Services Begin	AG	Agency
R	Receive Service	HM	Home
E	End Services	SC	School
X	Client Skipped-Excused	CT	Court
U	Client Skipped-Unexcused	RA	Residential
F	Provider Unavailable	WA	Wrap Around
		CM	Camp
		HS	Hospital
		FM	Other Family

Prefixes (use T or C)	
C	Clinical conference
T	Treatment Conference
T/C1	Prevent Out of Home
T/C2	Return form Out of Home
T/C3	Stabilize
T/C4	Growth
T/C5	Sustain
T/C6	Network
T/C7	Educate
T/C8	Respite
T/C9	Pre-Placement
T/C10	Wrap Around

Prefixes (use G or H)			
G	Status Begin	G/H8	Close/Comp
H	Status End	G/H9	Run
G/H1	Screening	G/H10	Return Run
G/H2	Intake	G/H11	Crisis
G/H3	Treatment Plan	G/H12	Emergency Call
G/H4	Ongoing	G/H13	Review
G/H5	Services	G/H14	Refuses
G/H6	Monitor	G/H15	Suspend
G/H7	Close/Lost	G/H16	End Suspend

RUFC Network Service Codes

Please use the following codes to record services and activities.
Be sure to include the number of times or the amount of time in hours.

1.	ADL Skill Training	41.	Sex Abuse Treatment
2.	Adoption Disruption Counseling	42.	Sex Offender Treatment
3.	After School Program	43.	Street Tracking
4.	Crisis Stabilization	44.	Supervised Visit
5.	Day Care	45.	Tutorial
6.	Day Treatment-non Psych	46.	Violence Prevention
7.	Domestic Violence Intervention	47.	Substance abuse
8.	Educational Advocacy	48.	Health Education
9.	Emergency Assistance	49.	Parent Aide
10.	Evaluation of Eating Disorder	50.	Agency Care Mngt.
11.	Evaluation-Psych-Social	51.	Residential Treatment
12.	Evaluation Sex Abuse	52.	Residential Treatment
13.	Evaluation-Education/Academic	53.	Aids Outreach
14.	Evaluation Medication	54.	Treatment Plan
15.	Evaluation Neurological	55.	Health Care
16.	Evaluation Neuro Psych	56.	Group Treatment
17.	Evaluation Psychiatric	57.	Grand Rounds
18.	Evaluation Psychological	58.	Treatment Plan
19.	Evaluation Sex Offender	59.	Health Care
20.	Expressive Therapy	60.	Group Treatment
21.	Family Assessment	61.	Pre School
22.	Family Counseling	62.	Supported Link
23.	Family Therapy	63.	Family Link
24.	GED Program	64.	Community Link
25.	Group Therapy	65.	Consultation
26.	Home Visit	66.	Evaluate Educ/Academic
27.	Individual Counseling	67.	Outward Bound
28.	Intensive Family Intervention	68.	Overnight Camp
29.	Interpretive Services	69.	Therapeutic Camp
30.	Job Skill Training	70.	Adult InPt Psych
31.	Living Skill Training	71.	Child InPt Psych
32.	Parenting Skills Training	72.	Adult InPt Surgical
33.	Parenting Support Group	73.	Child InPt Surgical
34.	Preserve Family Therapy	74.	Adult InPt Medical
35.	Preserve Group Therapy	75.	Child InPt Medical
36.	Psych Day Treatment	76.	Adult Partial Psych
37.	Recruit Per. Home	77.	Child Partial Psych
38.	Resource Develop Visit	78.	Child Outpt Psych
39.	Resource Support Visit	79.	Outpt Psych Clinic
40.	Reunification Assessment		

List of Projects Outcomes*

Outcomes	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
1. # of children in .5 and .6* placements returned to the community per year.	24	36	48	72	96	110
2. # of children at risk prevented from out of home placement.	72	96	120	144	168	192
3. % of families that will be satisfied with services provided.	85	90	95	95	95	95
4. % of children served that will show a clinically significant decrease in conduct disorders as measured by the CBCL **	10	10	15	20	25	30
5. % of children served that will show a clinically significant decrease in socialized aggression as measured by the CBCL**	10	10	15	20	25	30
6. % of children served that will show a clinically significant increase in overall functioning as measured by assessment tools.	10	10	15	20	25	30
7. % of children served that will show a clinically significant decrease in depression.	10	10	15	20	25	30
8. % of children served that will show a clinically significant decrease in PTSD.	0	10	15	20	25	30
9. % of IEP and ISP conducted on[1] children in out of home and at risk of out of home that* will be integrated.	0	10	15	20	25	30
10. % of children served that will decrease and maintain the IEP prototype.	50	60	65	70	75	80
11. % of families referred from DSS with previous abuse history that will demonstrate reduced abuse incidents.	90	80	70	60	50	40
12. arrest free behavior among DYS referred youth.	40	50	60	60	70	70
13. reduction in the number of crisis incidents reported prior to services among families referred by BPS, DMH, DYS, and DSS	10	8	8	6	6	4
14. % reduction in dollars spent on the Casey Service Delivery in comparison with the cost of residential care	10	15	20	25	30	30
15. Levels of psychiatric and residential recidivism among referred youth over 12 months.	10	10	8	8	6	6
16. Levels of improvement in school attendance in the families served by the family resource centers	15	20	25	30	35	40
17. % reduction in school drop-out rates based on prior history	0	10	15	20	25	30
18. reduction in the incidence of psychiatric hospitalization for community residents.	75	75	75	75	75	75
19. reduction in the length of residential stays across agencies	10	20	30	30	40	40

* This represents the list of outcomes that the Department of Mental Health mandated that Children Services of Roxbury should accomplish.

APPENDIX D
References

Miami

Contreras, R., Gomez, A. & Gutierrez-Mayka, M. (1997). *Residents' perceptions of services of the mental health initiative in East Little Havana. Tampa,* Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

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

Gutierrez-Mayka, M. (1998). *Family experience study: Baseline findings from Miami*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Boston

Joseph, R. & Gutierrez-Mayka, M. (1997). *Residents' perceptions of RUFC's Family Resource Centers in Mission Hill, Highland/Washington Park and Lower Roxbury.* Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Joseph, R., Gutierrez-Mayka, M. & Hernandez, M. (1995). *A report on parents' perceptions of life and services: A focus on Mission Hills, Washington/Highland Park and Lower Roxbury communities in Boston, Massachusetts.* Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M. & Gomez, A. (1997). *Family experience study: Baseline findings from Boston.* Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M. *(*1998). *Findings from the second round of Family Experience Study in Boston*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Houston

Joseph, R. & Uzzell, D. (1998). *Residents' perceptions about services from people in partnership in Houston's Third Ward.* Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Brown, W., Hernandez, M. & Joseph, R. (1995). *The Third Ward focus groups: A report on parents' perceptions of life and services.* Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Kay, P. A. & Joseph, R. (1997). *Family experience study: Baseline findings from Houston*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Richmond

Kay, P.A. & Joseph, R. (1997). *Richmond's urban metal health initiative assessment of parent resource network's impact*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Brown, W., Kay, P.A. & Hernandez, M. (1995). *The East End focus groups: a report on parents' perceptions of life and services*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M. & Hernandez, M. (1997). *Family experience study: baseline findings from Richmond. Tampa*, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Sengova, J. (1999). *Findings from the second round of Family Experience Study in Richmond*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

General

Joseph, R. (1997). (Array and Capacity of Services). *An evaluation of services: A descriptive analysis of services in the mental health initiative communities of Boston, Richmond, Houston, and Miami*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Kershaw, M. A., Gomez, A., Gutierrez-Mayka, M., & Hernandez, M. (1996). *Family experience study: Training guide for protocol utilization*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Friedman, R., Hernandez, M., Brown, W., Rugs, D., Unterberger, A., Joseph, R., Kay, P. A., Ford, E. & Farrar, M. A. (January 1994). *Quarterly report: service system data collection framework, the matrices*, Volume 1, Number 3. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Friedman, R., Hernandez, M., Brown, W., Rugs, D., Unterberger, A., Joseph, R., Kay, P. A., Ford, E. & Farrar, M. A. (1994). *Quarterly report: Overview social indicators ethnography*, Volume 1, Number 1. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

People In Partnership. *(*1999). *Family Development Services Report*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

People In Partnership. *(*1999). *Behavioral Care Unit Report*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

List of Evaluation Reports

Gutierrez-Mayka, M., Hernandez, M., Ford, E. J., Hodges, S., & Brown, W. (1994). *Neighborhood governance: A developmental analysis year 1 for Boston, Richmond, Houston, and Miami*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M., Joseph, R. & Hernandez, M. (1996). *Neighborhood governance in Boston: A developmental analysis year 2*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Brown, W., Kay, P. & Hernandez, M. (1996). *Neighborhood governance in Richmond: A developmental analysis year 2*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Friedman, R., Hernandez, M., Gutirrez-Mayka, M., Joseph, R., Kay, P. & Farrar, M.A. (1996). *Neighborhood governance in Houston: A developmental analysis year 2*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Kay, P. & Gomez, A. (1997). *Neighborhood governance in Richmond: A developmental analysis year 3*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Joseph, R. & Gutierrez-Mayka, M. (1997). *Neighborhood governance in Boston: A developmental analysis year 3*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Joseph, R. & Uzzell, D. (1998). Neighborhood governance in Houston: A developmental analysis year 3. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Kay, P. & Sengova, J. (1998). *Neighborhood governance in Richmond: A developmental analysis year 4*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M., Joseph, R., Sengova, J., Uzzell, J. D., Contreras, R., Hernandez, M. & Friedman, R.M. (2000). *Systems Reform in the Mental Health Initiative for Urban Children Final Evaluation Report*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Gutierrez-Mayka, M., Joseph, R., Sengova, J., Uzzell, J. D., Contreras, R., Hernandez, M. & Friedman, R.M. (2001). *Neighborhood Governance in the Mental Health Initiative for Urban Children Final Evaluation Report*. Tampa, Florida: University of South Florida, Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.