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ABSTRACT

This report documents the development and progress of Marin City Families First (MCFF), a project undertaken in Marin City (California) in 1993 by the Far West Laboratory's (FWL) Center for Child and Family Studies. Its goal was to develop a model comprehensive child and family support system for low-income communities. In pursuing its objective of establishing an advocacy and case management system for Marin City residents and young children and establishing decision-making links among community agencies and networks, the intervention followed principles and collaboration strategies developed by the FWL in its previous work. FWL researchers encountered a unique mix of elements in Marin City that exerted a strong influence on the intervention. The case study communicates the MCFF researchers' experience as a community change agent in the complex Marin City environment and explores the variables that limit the impact of the intervention strategy. It recommends approaches to several key community and agency issues, including shifting funding sources, dysfunction among social service agencies, and training for staff working in a severely impoverished community with fundamental social problems. Appendix A is a chart of Families First services, and Appendix B is a lengthy table of evaluation results. (Contains 30 references.) (Author/SLD)

Far West
LABORATORY

FACILITATING COMMUNITY CHANGE

A CASE STUDY OF MARIN CITY FAMILIES FIRST

November 30, 1995

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FACILITATING COMMUNITY CHANGE

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Effective December 1, Far West Laboratory (FWL) united with Southwest Regional Laboratory (SWRL) to create WestEd, a public agency to better serve the education community in Arizona, California, Nevada and Utah

Abstract

This report documents the development and progress of Marin City Families First (MCFF), a project undertaken in Marin City, California, in 1993 by FWL's Center for Child and Family Studies. Its goal was to develop a model comprehensive child and family support system for low-income communities. In pursuing its objective of establishing an advocacy and case management system for Marin City residents and young children and establishing decision-making links among community agencies and networks, the intervention follows principles and collaboration strategies developed by FWL through its previous work in other communities, as well as those principles recommended in the intervention and collaboration literature. Although it is well established that the context of an intervention will influence how a community intervention will progress, FWL researchers encountered a unique mix of elements in Marin City which exerted a strong influence on the intervention.

The Case Study communicates MCFF researchers' experience as a community change agent in the complex Marin City environment and explores the variables which limit the impact of an intervention strategy. It makes recommendations for approaching several key community, agency and facilitation issues, including shifting funding sources, dysfunction among social service agencies, and training for staff working in a severely impoverished community with fundamental social problems. Researchers' observations and recommendations are critical to the development of future early intervention models across the region and the nation.

CONTENTS

INTRODUCTION

For nearly 50 years, Marin City, a low-income, mostly African-American community located in a county with one of the highest average incomes in the nation, has sought to evolve into the community it aspires to be. Individuals, organizations and agencies from within Marin City have grappled with the social and economic issues that have buffeted their community during these almost five decades, persistently seeking to shape and control their own futures and the futures of their children. At the same time, political, economic and social service policy makers, administrators and practitioners from outside Marin City have attempted to chart the community's course into the future. While on the one hand, this insular community has demonstrated great resiliency, it has on the other, remained resistant to change.

In 1988, Far West Laboratory's Center for Child and Family Studies began its collaboration with agencies in low-income communities as part of the Bay Area Early Intervention Project (BAEIP). BAEIP organizes existing agency services and develops new ones so as to create a coordinated support system that serves families from pregnancy through early childhood.

Far West Laboratory (FWL) researchers recognized early on that the piecemeal work of multiple agencies cannot offer the comprehensive kinds of services needed by high-risk young children and their families in such communities at Marin City, and, in January 1993, undertook development of the Marin City Families First (MCFF) project. Their concern was shared by the Office of Educational Research and Improvement, and the Stuart Foundations, who provided joint support for the project. FWL's goal was to develop a model comprehensive child and family support system for low-income communities.

Studies conducted during the planning period made clear the need for a comprehensive family support program for Marin City families. Long-term plans and solutions for Marin City families were lacking. Many agencies based in and outside of Marin City reported providing services to the families there, but in reality, many needed services were lacking and others were provided in duplicative, narrow, or incompatible ways. MCFF addressed what was, and still is, seen as a very serious need for a family-focused and locally organized program for family support in Marin City. The model brings together the diverse and fragmented service community serving Marin City families, significantly altering the way family support services are provided to the citizens of Marin City.

Objectives

MCFF's overall objectives are:

1) to provide intensive, comprehensive, integrated and continuous support services to the families of low income children from the third trimester of pregnancy to third grade of elementary school that will enhance the children's intellectual, social, emotional and physical development;

2) to revise the ways needed support services to parents and to other household members are delivered, so that these services fit into a long-range service plan for each family.

The programmatic goals are:

1. to demonstrate how conceptual, programmatic, organizational and practical assistance can be provided to a low-income community so it can develop a comprehensive, coordinated child and family service system through new alignments of existing social service agencies, schools and other institutions;
2. to document the unique conceptual, programmatic and organizational structures developed within the model, as well as the facilitative process used to create the service system; and
3. to share this model, along with information about other models intended to develop child and family service systems through interagency cooperation, throughout the Western Region and the nation.

The Importance of Intervention in the Early Years

During the first year of operation, a study of early intervention approaches and outcomes was conducted. The late 1960s and early 1970s saw a number of early intervention projects with minority families characterized at that time as "disadvantaged." (Lazar & Darlington, 1982; Provence & Naylor, 1983; Lally, Mangione, & Honig, 1988; Schwinhart & Weikart, 1980). Longitudinal findings from these studies showed that positive long-term outcomes are possible with early intervention. For example, program children exhibited fewer signs of failure in school than their controls. Moreover, attention to parent/child and caregiver/child relationships resulted in the children having more of a prosocial orientation in later years. In addition, program children experienced fewer and less severe encounters with the criminal justice systems than their controls. Equally important, early investigators were able to determine which particular intervention components and strategies were essential to their successes.

After an extensive study of the early intervention literature, and interviews with many of the directors of successful early intervention programs, Schorr (1988) concluded:

> The programs that work best for children and families in high risk environments typically offer comprehensive and intensive services. Whether

> they are part of the health, mental health, social service, or educational systems, they are able to respond flexibly to a wide variety of needs. In their wakes they often pull in other kinds of services, unrelated in narrowly bureaucratic terms but inseparable in the broad framework of human misery. These programs approach children not with bureaucratic or professional blinders, but open-eyed to their needs in a family and community context. Interventions that are successful with high-risk populations all seem to have staffs with the time and skill to establish relationships based on mutual respect and trust (p. xxii)

After studying early programs, Bronfenbrenner (Pence, 1988) uncovered three critical features of successful intervention programs:

1. The empowerment of those who are the intended beneficiaries of policy and practice, as they become the principal agents of change;
2. The importance of discovering and responding to the different characteristics, needs and initiatives of program recipients, with the program itself behaving as a social organism accommodating the families it serves; and
3. A recognition of the impact of perceptions, beliefs and meanings, as well as of objectively identified conditions, events and processes.

Bronfenbrenner also emphasized the importance of attention to developmental transitions. Existing theory and research point to the importance for the child's development of the nature and strength of connections existing between the family and the various other settings that a young person enters during the first two decades of life. Of particular interest in this regard are the successive transitions into (and within) daycare, peer group, school and work.

Lally and Mangione (1989) reported findings similar to Schorr's, adding the overwhelming need of program families for high-quality child care. At the 10-year follow-up, when parents were asked what was best about the Syracuse University Family Development Research Program, 79 % said high-quality child care.

The problem of poor quality of care provided to the vast number of children under age three who are cared for outside the home and the detrimental effect of this care on the development of the child has almost completely been ignored. Willer et al. (1991) found that 23% of babies under age one, 33% of one-year-olds, 38% of two-year-olds and 50% of three-year-olds are cared for outside the home. In two recently released studies, (Cost, Quality and Child Outcomes in Care Centers Study, 1995; and Galinsky, et al., 1994) it was found that high quality of care produced children who scored higher on measures of social, emotional and intellectual development.

It was also found that for children up to age five, that most care is mediocre in quality. Children are not intellectually challenged, activities are not developmentally appropriate, and one-half to two-thirds of the children do not exhibit trusting behavior toward their

caregivers. It was also reported that infants and toddlers are worse off than other age groups with more than 50% judged as being in care that is harmful to them. This finding bridged socio-economic groups. Yet one troubling finding was that mothers with a higher level of education and the tendency to provide quality care at home would also be the mothers who found higher quality care out of the home. This means that some children during these important formative years receive inadequate care both at home and out of home.

These findings coupled with the recent discoveries by neuroscientists that the number of brain cell connections developing in infants can increase or decrease 25% or more depending on whether the child grows up in an enriched or impoverished learning environment make attention to the early years critical (Kolb, 1989, and Ramey, 1992). So do the findings in the area of emotional development. Scientists have confirmed that infants and toddlers can suffer from depression, anxiety and traumatic stress disorders (Drell et al., 1993). These emotional conditions are most often triggered by early caregiving relationships of low quality. If not identified and corrected early they can lead to a life of emotional problems. It has been demonstrated at Boston's Children's Hospital that babies work hard to communicate with caregivers and if their efforts go unheeded, they will eventually give up and become despondent (Zuckerman, 1995). This happens frequently when parents are neglectful or abusive of their children because of preoccupation with their own problems or because alternative caregivers are untrained, unmotivated or burdened with the care of too many children.

Problems are compounded for children growing up in poor communities. Much has been documented about the negative impact on young children brought about by the following environmental conditions: community violence, family and community drug use and trafficing, inadequate nutrition and health care, parental abuse and neglect, and limited early education and social opportunities, including low quality child care and poor early education (Danziger & Danziger, 1993; Patterson, 1986; Werner & Smith, 1982).

Recent studies have shown that the psychological and social climate in a community also can negatively affect children's chances for success in school. In interviews conducted with children from depressed and dangerous communities, it was found that many lost hope for positive outcomes in their adult life and lost motivation for participation in school. It has been shown that before school starts, children can fall behind in the development of language, learning strategies, and self esteem (Drell, 1993; Marshall, 1991; Osofsky et al., 1992). It has also been shown that early years spent in stressful and abusive environments can lead children to antisocial, violent and criminal behavior (George & Main, 1979; Taylor, Zuckerman, Hanrik & Groves, in press).

Every major city in our region has neighborhoods that reflect the problems just cited. School personnel, superintendents and school boards continually report a desperate need to find workable strategies to deal with the problems that students from these communities face and sometimes cause. In a meeting with urban superintendents from the Western Region at Far West Laboratory in 1993 it was suggested that problems grounded in home

and community were the ones for which the schools needed greatest assistance. Many of the superintendents reported that they needed help to find ways to deal effectively with school readiness and family development. Specifically, they wanted assistance with: 1) early identification and prevention; and 2) developing new types of collaborative relationships with agencies and organizations within communities so that they could effectively accomplish their educational mission without the schools having to exclusively shoulder the burden of providing all necessary early childhood services.

The study of the early intervention field and the sharing of information about theory and practice with the Marin City community led to the development of working assumptions and a philosophy of intervention upon which the Marin City Families First intervention was based. These are discussed in detail in Chapter II, Marin City Families First: A Two Pronged Approach to Intervention.

The Power of Context in an Intervention

The MCFF intervention was built upon the recognition that young children and their families are dramatically affected by conditions and events that take place not only within the home, but also within the broader contexts in which family life is imbedded, i.e., the community. From the outset, FWL researchers, based on prior experiences and experience working in the Marin City community since 1988, understood that the problems faced by families and agencies were deeply woven into the fabric of daily life. No one agency working alone, it was realized, could make lasting change, nor could multiple institutions working in isolation from each other.

MCFF was founded on the belief that individual change must be accompanied by *contextual change* if the changes are to be more than temporary, that if an intervention approach focuses on only the home or on only the larger context in which the home is situated, the intervention will be incomplete. Thus MCFF was developed as a two-pronged intervention strategy to address support for both families and community services systems.

FWL assumed the role of community systems change agent, using an approach based on 20 years of implementing and studying early intervention projects. In the course of the project, FWL operated on two fronts. On the family front, researchers documented the development and implementation of the augmented family support system used in the program (*Augmented Family Support Systems: A Description of an Early Intervention Model for Family Support Services in Low-Income Communities* (Lally, 1990); the development of an early intervention program (*Community Involvement in Early Intervention: A Report on the Planning and Development of Families First*" (Lally, 1991); and recommendations for case management and family support services (*Case Management and Family Support Handbook: Lessons Learned from the Development and Implementation of Marin City Families First, An Early Intervention Program* (Lally, Quiett, Coelho & Bailey, 1993).

On the community systems front, researchers most recently documented the issues confronting the community services program directors of agencies working in Marin City, in particular the significant barriers to agency collaboration that impede successful service delivery within that community. (*Barriers to Implementing Common Principles of Interagency Collaboration: Lessons Learned from the Marin City Families First Program* (Scott, Lally & Quiett, 1994).

Throughout this case study are woven observations on the context of the intervention and the power of context on any facilitation by a change agent within a community. Clearly, no two community interventions will progress in exactly the same way, even those based on the same model. Any intervention is strongly influenced by community's social , economic and political climate, the availability of resources, and the leadership of individuals -- all of which are dynamic variables, continuously changing over time. In the instance of MCFF, as this report illustrates, a unique mix of elements at work in this small community has had a stronger influence on the intervention than researchers had anticipated.

In order to serve as a model for future interventions, it is important that researchers involved in the MCFF intervention communicate their experiences with the power of context. We believe that because of this intervention's integrated and multifaceted approach to family services, together with the need for in-depth answers to critical knowledge gaps, the study of one representative community will in fact yield -- and has already yielded -- knowledge other service providers badly need.

Our development and implementation process to date has uncovered key community, agency and facilitation issues that must be studied and described before intervention strategies are implemented widely. Given the complexity of these factors, including the unique configurations and interactions of family, support agencies, funding and larger community issues that affect early interventions in severely impoverished communities, the possibility of direct replication of any intervention model appears limited. *Generalization will depend, rather, on developing in-depth understanding of several critical context and process issues and developing successful approaches to solving the challenges they pose.*

These context and process issues include:

1. A more complete understanding of pattern of drug use and response to treatment during pregnancy and the first year of life of program children. We are finding, for example, that pregnant women go off drugs close to delivery, an indicator of intervention success, but then often return to drug use soon after delivery;
2. The impact of the level of dysfunction of local social service agencies, the frequent disruption of services, and the complete cessation of services on families and the facilitation's success;
3. The shift in both levels and types of services available to the community because of the strong influence of funding sources.

We believe that our focus on our target community will help answer these and related questions, and that the answers will be a valuable addition to the early intervention knowledge base. We see the goal of our next few years of work as achieving a better understanding of the variables that limit the impact of the intervention strategy being implemented and sharing that information with the field. We will also be able to understand, even with such limits, the benefits of the intervention.

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To provide an understanding of the importance of context in which this intervention has operated for the last three years, this report begins with a portrait of Marin City: its history, demographics and life climate, its residents, and its plans for the future, including perspectives from Marin City leaders and observers.

In successive chapters, this case study explains the MCFF intervention model approach, its philosophical underpinnings and its two-pronged structure. It reviews the enormous problems faced by children and families in Marin City. It examines the historical context in which Marin City agencies determinedly continue to provide services to these families, and it provides insight to the impact that the perceptions of agency staff have had on collaboration in Marin City.

In Chapter V the progress of the intervention towards achieving its child, family, community and agency goals within the Marin City community is reported, and, finally, in Chapter VI, this case study discusses the lessons learned from Marin City Families First and makes recommendations for approaching several key community, agency and facilitation issues that are critical to implementing similar interventions.

CHAPTER I: A PORTRAIT of MARIN CITY

Marin City is an isolated low-income African-American community located in mostly affluent Marin County, just minutes from San Francisco. It has been called variously "a black ghetto," "an island of blacks in an ocean of white," and, in reference to its economic difficulties, "a pocket of poverty." In a county with one of the highest average household incomes in the nation, 36% of households in Marin City languish below the poverty line. It is estimated that 40% of adults are unemployed and that as many as half of all adults have not completed high school. As many as 50% of adults may be functionally illiterate; one study indicated that about 41% of all residents lack the basic skills necessary for entry-level jobs.

Approximately 75% of residents are African-American, and almost two-thirds of this group reside in public housing. Eighty-nine percent of families are headed by a single mother. Marin City has high rates of unemployment, particularly among young males; crime, much of which is drug-related; and teenage pregnancy.

The geographical layout of Marin City serves to weaken an already fragile community. Marin City was built by the U.S. government during World War II to house 1500 shipyard workers as they labored at the massive Marinship shipyard in nearby Sausalito. Many of the workers were African-Americans recruited from southern states. After the war, the commercial center of Marin City crumbled as the ship building industry withered. Whites moved out to find new opportunities, while discrimination blocked African-Americans from housing elsewhere in the county, spawning a 40-year legacy of unemployment and racial isolation. In the late 1950s, Marin City's commercial district was destroyed as part of a "redevelopment project" which never materialized. Like the Bay Area communities of Oakland, Richmond and Hunter's Point, Marin City deteriorated to a status from which it has yet to recover.

As a result of the same redevelopment action, a 32-acre piece of barren land separates the public housing in a valley called "The Bowl" from the hill where the ownership portion of the community is located. Where once stood a full complement of businesses -- grocery store, barber shop, restaurant, post office -- to serve residents, there has been only a single liquor/convenience store for the last 30 years. Residents must travel several miles to nearby Sausalito or Mill Valley to purchase groceries, clothes or gasoline, to go to the post office, or find medical services. County government offices are located 15 miles north -- a 20 minute ride by car, 45 minutes or longer by bus. Its most prominent landmarks are its six churches, its child care and Head Start facilities, a recreation center, ball field, fire station and, until recently, a weekend flea market.

Housing consists of public housing and a few moderate income homes. More recently, higher priced homes have been built at the outer perimeter of the community, bringing many white residents into Marin City but with little or no contact with the rest of the community. Approximately 65% of the population lives in the The Bowl in housing consisting of public family housing, limited equity cooperative housing, and single family

housing. Half of The Bowl population resides in public housing. Almost 500 families are on the waiting list for public housing. The average household income in the public housing units is $8,000, and the monthly rent per unit is approximately $200/month.

Although substance abuse has been present in this community for many years, the introduction of crack in the 1980s has taken drug dependency to an unprecedented level of danger and despair, reaching into all aspects of families' lives. Gulley (1995) noted:

> It has been suggested that this is symptomatic of more fundamental community problems, namely, high unemployment, ineffective law enforcement, inadequate social services, and miseducation or no education about the effects of drug and alcohol use. There is much evidence that a major consequence of drug and alcohol abuse is family disruption and child neglect. As household resources are diverted for drugs and alcohol, often the basic needs of the family/children are sacrificed (p. 4).

Yet despite this grim portrait, individuals familiar with both Marin City and similar minority communities advance more positive outlooks. Omowale Satterwhite, Ph.D., president of the Community Development Institute in East Palo Alto, observed: "Marin city has the socio-demographic character of an inner-city neighborhood. It also has the vitality and promise of many other Black communities seeking to realize the benefits of mainstream America" (Gulley, 1995).

Clinging to the Past

The Marin City is frequently described as "small and close-knit. Many of the residents are among the original residents, who came to Sausalito from the South in the 1940s seeking lucrative jobs in the booming Marinship shipyards, and remained in the following years. Others are the children and grandchildren of the original residents.

The resulting community of just under 1,000 households is in many ways like a small town: people know one another and their extended families, tight social networks link residents' lives. Connections go back many years; memories of the past remain strong. While some young people leave Marin City, seeking jobs or education elsewhere, ties to their families and community are so strong that they frequently return to live. In some instances, they return with skills and education that benefit the community.

These traits, frequently likened to the positive attributes of a friendly small town, on closer inspection also have a negative side. In this geographically contained and socially defined community, the small social networks, rather than being networks of support, are frequently negative forces, their power magnified by the smallness of the community.

Mel Miles, an inner city community organizer familiar with Marin City, noted:

> In an isolated community like Marin City, personal social networks have considerably more influence on individuals than in a community with more outside influences. Family, friends, and other individuals that residents see regularly heavily influence their actions and decision-making. Rather than being support networks, the personal social network serves as a barrier to individuals overcoming their social and economic problems (M. Miles, pers. comm. 1995).

Miles also observed that this dynamic, frequently seen small ethnic communities, creates a downward, negative pull on individuals who might otherwise improve their socioeconomic status. Community organizers like himself have observed it so frequently that they have developed a saying that applies to individuals, as well as agencies: "Like crabs in a bucket, when one gets to the top, the others try to pull it back down." It is, he said, "an analogy for the family -- or agency -- trying to reverse the forces of poverty."

Similarly, Dr. Satterwhite, another long-time observer of Marin City's sociology, noted that the strength of family and friendships in Marin City often creates a "co-dependency," in which family and friends cover up for the individual rather than assisting him or her in seeking help (O. Satterwhite, pers. comm. 1995).

Psychologist Elberta Erickson, Ph.D., Family Services Agency, noted at the Marin City Project Planning Conference in July 1994:

> This is a third generation client population. Each succeeding generation is born without strong family support that was the norm in the past, a part of a generation of 'unattached children.' There is a lack of community to build trust, bonding or continuity (Berke, 1995).

The geographical isolation of Marin City has served to reinforce the power of the small social networks in the community, working against the resolution of social and economic problems of residents. Miles observes that residents of the Western Addition, an African-American community in San Francisco, have been able to move into employment opportunities elsewhere in the City because of easier access. In contrast, East Palo Alto, another geographically defined community, separated from the more affluent bedroom community of Palo Alto by a freeway, but distant from relatively job-rich San Francisco or San Jose, suffers many of the same social and economic problems as Marin City: low income; high crime; and high rates of teen pregnancy, serious drug and alcohol problems and abusive relationships.

It is easy to see why residents and the rest of the county have such a strong sense of the negative past: very little that is positive has happened in the last 50 years. Headlines in newspapers in 1995 ("Verge of Rebirth," San Francisco Examiner, July 30, 1995), can

easily be mistaken for those of the 1980s ("Marin City - A Birthday and A Dream," (Independent Journal, October 1, 1982), when the community was on the verge of an earlier development project -- which never materialized.

Referring to the strong cohesiveness of the community and its sense of the past, Satterwhite commented, "Every strength has inherent problems. It can be built on, but at the same time, you need to recognize that people may be wedded to tradition in such a way that it may impede progress."

Yet despite the negative influences at work upon them, and a historical lack of success in improving their social and economic outlook, many individuals in Marin City are committed to a vision of a successful community. Miles commented, "More people than we can imagine have a sincere belief that Marin City can be turned around into a positive living environment for them and their families." It is, he said, "a tenacious community with vision."

Looking to the Future

Indeed, a vision for Marin City will begin to materialize this fall. Residents will see not only the steel and concrete of a shopping center, but also, they are promised, affordable houses and apartments, employment training and jobs.

At the time this report is written, the groundbreaking for the construction of Marin City USA, Marin City's new development, is scheduled for mid-November of this year. Despite detractors both within and outside the community, most residents believe it signals a rebirth for the community and have pinned their hopes for their own and their community's future to the development's success.

In 1982, the economic and community development plan which this year will bring 45 acres of housing, retail and community services to the Marin City community was proposed. The land is owned by the nonprofit Community Development Corporation (CDC), which purchased part of the site with a grant from the Marin Community Foundation, and purchased the balance with a bank loan.

The retail complex at the core of the development will include a discount supermarket, home improvement center and a host of other stores that will allow residents to shop in town for the first time in more than 40 years. The CDC has provided retail and construction job training, as well as classes in entrepreneurial training to prepare residents for the estimated 375 temporary construction jobs and approximately 600 permanent retail job openings the complex is expected to provide. Marin City residents, and next, former Marin City residents will be given hiring preference.

The development also will provide housing. Forty percent of the 85 townhouses and 255 apartments are required to be rented or sold as low-cost housing (affordable to low and moderate income families) in perpetuity, rather than reverting back to market rates.

Detractors insist that even at "low" rents and/or mortgage payments, Marin City residents will not be able to afford to live there. The CDC counters that Marin City residents who are employed will be able to afford the new housing; they must first take advantage of the job training programs and the job opportunities provided as part of the development.

Social and community programs also are slated to be beneficiaries of the development. Public services, including the sheriff/fire station will be upgraded. Outdoor recreation facilities will be rebuilt, renovated and upgraded. The community center will be upgraded. A library will be located in the shopping center. New roads, lighting, landscaping will provide a facelift. A new child care facility will be constructed. Developers have pledged to return $200,000 a year to community programs.

Not all community residents support this new vision. Ever since the development was proposed, a minority of "nay sayers" has been vocal in its opposition to the changes now unfolding for the community. Al Fleming, executive director of the CDC, which is overseeing the project, noted that a recalcitrant 20 % of the community opposes the development on the grounds that it will make Marin City no longer affordable for them, changing the nature of the community.(A. Fleming, pers., comm. 1995).

Fleming said he believes that the opponents of the project are "afraid of change. They will no longer be able to say 'there are no jobs here,' 'there is no affordable housing.'" He responds, "We have provided the pieces -- the training, the jobs, the housing -- but we can't do the impossible."

Media reports, believes Fleming, have contributed to the emotionalism and sensationalism accompanying the development, playing on Marin City residents' fear of change by reinforcing the stereotype that development is always bad, that people are always pushed aside by progress. He cites such headlines as "Will Success Ruin Marin City?"(San Francisco Chronicle, October 8, 1995), noting that they widen the rift between supporters and detractors of the project.

He noted that the demise of Hayden's Market has been romanticized by media as the loss of a long-time general store and meeting place, while in fact, most residents view it as a high-priced convenience store that serves as a place for drug dealing. In addition, he said, media have given undue attention to the few individuals who are outspoken in their opposition, while ignoring or giving little coverage to the "real stories" of the community, such as the job development programs.

Within the community, supporters have organized a group called Citizens for Progress to counter the negativity. In the first of a series of informational fliers about Marin City USA's benefits published in 1995, they also offered their own perspective: "The development is the best hope we have to make our home a better place to live and work. . . It's about opportunity. It's about personal responsibility. It's about hope."

CHAPTER II: MARIN CITY FAMILIES FIRST: A TWO-PRONGED APPROACH TO INTERVENTION

A Philosophy of Responsive Facilitation

For the past 20 years, FWL has been involved in assisting local communities in the planning and development of social and educational programs to better serve young children. Over the years a philosophy of assistance has been delineated which we have come to call the Responsive Facilitation Process. This facilitation has been used to implement community intervention models throughout the country. The key operational words in this philosophy are "assist" and "enable."

At the heart of the approach is the recognition of the need for children and families to experience a continuity of care across educational and social service settings and domains. There are two overarching goals of the Responsive Facilitation Process. The first is to encourage service providers to accurately understand the needs of families. This is done by assisting and enabling administrators, teachers, service providers and caregivers to see the day-to-day life experience of community families and children from the point of view of the children and families. The second goal is to assist and enable these different groups to develop program plans based on this new "family vision," plans that address actual short-term needs and plans that provide, in the long-term, for the alteration, orchestration and continuity of currently provided services.

Three basic tenets of the FWL facilitation philosophy are:

1. *Local norms, names, customs and traditions should not only be respected but capitalized on to make the program meaningful for the community.* The role of the facilitator using the Responsive model is to customize, adapt and link intervention strategies.
2. *Local programs, community action groups and other key actors should be enlisted in support of the program from its inception.*
3. *Decision-makers are those who make decisions and act on them.* They are found at all levels of a community system. Therefore, it is important to enlist participation of all participants in a community -- administrators, teachers, parents and other key community efforts.

Ten specific principles for successful facilitation of an intervention also have been developed:

1. *Introduce new ideas.* The facilitator provides information from other communities and programs that have been successful in providing services to families and children or show promise in doing so.
2. *Assist with the development of priorities.* The facilitator helps the community define priorities and participates in the periodic assessment and reshaping of priorities.

3. *Provide options.* The facilitator offers suggestions from which the community members (educators, other service providers and parents) may choose.
4. *Provide training and technical assistance.* The facilitator provides technical support that is requested by the community.
5. *Stimulate dialogue.* The facilitator creates a non-threatening environment that allows for dialogue among the various actors on site.
6. *Be flexible.* The facilitator takes a flexible approach to change while maintaining a consistent facilitation philosophy and sensitivity to the strengths and characteristics of the local community.
7. *Keep low visibility.* The facilitator shares ownership for ideas and encourages key groups to assume leadership in creating the program.
8. *Provide insight about the big picture.* The facilitator should be able to take a stance outside the day-to-day activities for the purpose of analyzing the community's efforts to attain long-range goals and helping the community identify potential barriers.
9. *Give moral support.* The facilitator affirms community members' efforts so they can carry out their work with the confidence that they are moving in the right direction.
10. *Share research and evaluation findings and strategies from similar efforts.* The facilitator identifies models and strategies that will assist the community in its documentation of 1) program implementation and 2) program outcomes.

Based on its experience in other communities, FWL chose to apply this approach to guide the development of the intervention in Marin City.

Early Facilitation Activities

In addition to drawing on FWL's own experience in the area of early intervention, FWL gathered data about current conditions in the Marin City community and provided training and technical assistance in areas that seemed to need immediate attention.

Early activities included training and technical assistance in childcare, family support, childcare environments, and early child care transitions. FWL staff and expert consultants were brought into the community to provide assistance in making the above mentioned program components stronger, trainings were held, child care environments were changed, operating revenues were uncovered and strategies for more efficient family support activities were proposed.

Information about national models for early intervention and drug treatment programs was shared with community agencies. A conference on Drug Free Pregnancy was held, with FWL providing information to local practitioners about appropriate caregiving techniques and family support activities. New educational and treatment strategies were developed and included in an instructional training manual.

Working groups to plan community/school linkages were developed to address how to better ease the transition of children from Marin City homes and preschools into the Sausalito school system. Three groups were identified: Administrator/Program Director

Leadership Team Preschool/Early Primary Teachers, and Parent, established objectives, and met regularly.

Nationally known consultants were made available to local agencies, and clinical consultation and training was conducted for staff caring for emotionally disturbed children.

Finally, as part of its Responsive Facilitation Process, FWL proposed Marin City Families First, an early intervention model developed jointly with local community members.

Fostering Ownership

A key to the success of a community intervention by an external change agent is fostering ownership among community agencies involved in an intervention, so that the community initiates its own strategies rather than merely replicating model programs and activities. Even though FWL was invited into the Marin City community because of experience of running the Syracuse University Research Project and that it was the results of our work on the Syracuse Project that gained us credibility in the program communities, a replication effort was not seen as appropriate either by the community or FWL staff. Planning activities, information gathering and information sharing all stimulated agencies to begin initiation of their own strategies.

The planning effort drew together child and family support agencies and organizations within Marin City, agencies and organizations outside Marin City that provide services to the community and FWL. The planning group determined that of primary importance was the inclusion of reported family needs and an assessment of current agency functioning. It expressed the need for the coordination of any newly planned family support activity with other community development work, local economic development efforts and the interests of private and public funding agencies.

Studies conducted during the planning period for the MCFF project made clear the need for a comprehensive family support program for Marin City families. While there were many agencies based in and outside Marin City that reported providing services to the families of Marin City, in reality, many services were lacking and others were provided in duplicative narrow or incompatible ways.

The MCFF program plan was written to deal with what was perceived as a very serious need for a family focused and locally organized program for family support in Marin City. It was anticipated that the model proposed would bring together the diverse and fragmented service community serving Marin City families and that a more efficient and rewarding system of service would result.

After deliberation with local agencies in Marin City, a philosophy of intervention was developed that was thought would best serve all concerned. The following philosophical foundations for the work, developed and agreed upon by FWL and representatives from Marin City agencies at the outset, have guided the project.

General Assumptions

1. An early intervention program should be designed not as an inoculation but as a first step in a continuing and comprehensive system of supports.
2. Early intervention efforts should take place with and through already existing agencies in the community served, rather than stand alone; and in addition to individuals and families, service systems should be the focus of the intervention.
3. Partnerships with schools that will eventually service program children should be established well before children reach the school door.
4. To maximize educational and social benefits, intervention should be started early with particular attention paid to the development of the fetus in a drug free and healthy womb and to the quality of childcare services provided.
5. Effective early intervention calls for establishing a personal relationship between a member(s) of the early enrichment team and the families served, particularly the principal caregivers of the program children. A case manager, home-based service system is well-suited for ensuring the establishment of a personal relationship.
6. A non-judgmental analysis of family strengths and practical needs (i.e., nutrition, childcare, housing, finance) should form the basis of individualized intervention strategies for families. This intervention must include needed therapeutic services.
7. High quality childcare services must be made available to families served.
8. Special attention has to be paid to "life cycle transitions" the family goes through as a child matures.

Intervention Design: The Model

The two-pronged intervention strategy was developed to address the shortcomings of an intervention which addressed only individual change, or a focus on only the conditions and events outside the home. FWL researchers believed that without a dual focus on both the community in which the family life is embedded and the home, change can only be temporary, and the intervention is incomplete. The intention of the two-pronged intervention was to develop service strategies with the families recruited in the two years of operation which would, in the long run, change the way service agencies respond to all Marin City families. In effect, service to the target families was to become the vehicle through which broader based change in the delivery of services to all families in the community takes place.

The MCFF model (see Appendix A) provides for direct intervention with families, support to those providers who provide the intervention, and direct intervention with agencies. It draws together child and family support agencies and organizations within Marin City, agencies and organizations outside Marin City that provide services to Marin City, and FWL.

The first prong, The Augmented Family Support System, is designed to deal directly with program families using a case management system to identify and meet individual child

and family needs. This aspect of the intervention attends to the particular needs of the family: parent/child relations, other family relations, and to family relationships with the various informal neighborhood and community networks and service agencies they need to deal with to function effectively.

The second prong, the Community Services Support System, deals directly with those informal networks and service agencies. It is designed to develop long-term changes in the quality of family life in communities served. Agencies that serve program families are brought into collaborative working agreements with MCFF and participate in the design and implementation of the long-term service strategy for program families. Informal neighborhood and community networks are identified, enlisted, and facilitated in their support of program families. The Community Services Support System focuses on upgrading and expanding services as well as establishing and maintaining collaborative relationships among informal networks and service agencies.

The two prongs are coordinated by a project administrator, located within an established community agency. At the start of the intervention, Operation Give A Damn (OGAD) played this role. However, FWL assumed many of the responsibilities of this role in 1995, a change that proved pivotal in implementing the intervention, as will be discussed in Chapter VI.

The coordinating agency employs a Program Facilitation Group and arranges for assistance from a Special Services Consultant Pool. Both the Program Facilitation Group and the Consultant Pool provide specialized support to family advocates, who in turn have direct contact with families.

Family advocates receive support that includes expert assistance with issues such as infant health and nutrition, child development, substance abuse counseling for parents, child care, and employment raining for parents. They receive staff training and technical assistance from the Program Facilitation Group and the Consultant Pool.

Thus a key indirect link between the families and the community services is established through the coordinating agency's Program Facilitation Group and Consultant Pool. This link between services and families is a crucial feature of the intervention model because it creates an information channel that enables community agencies to adapt their direct services to the changing needs of developing families. Although both prongs of the intervention are presented below separately, they are closely related to each other.

Philosophy of the Augmented Family Support System

The unifying concepts of the Augmented Family Support System are support and coordination. Each participant in the intervention (members of the families and community, members of the program staff, and personnel in the service agencies), are looked upon as special resources to one another who can contribute to the quality of life

of the family. Communication and coordination among these resources make the intervention function effectively.

The approach contains the following key elements:

1. *The personal relationships between program staff and families.* Honest, trusting, dependable relationships with effective people who are understanding, friendly and helpful are the key to family interventions.
2. *The use of community resources and professional staff.* Family interventions that are part of the communities served have a greater chance of having a lasting impact won the community, being integrated into ongoing community services after intervention ceases and of being truly responsive to community needs.
3. *The establishment of a strong link between the family and the formal community services.* This link will enable families to fully utilize services available to them as well as help service agencies be responsive to the individual concerns and needs of each family.
4. *The establishment of a strong link between the family and networks of informal support in the community.* Efforts will be made to help the families expand their social networks so they can turn to friends, neighbors, and other families in the community for support. Child care, temporary respite, emergency services and help with unique problems are important issues for families that can be met either formally or informally, but need to be met.
5. *The establishment of high level and wide ranging professional supports.* The community-based staff will have primary responsibilities for direct contact with families; they will be backed up by specialists who will be available for consultation and when warranted, direct service to families.

To ensure that the program-family relationship is personal, three criteria were established.

First, only a small number of program staff (2) have direct, ongoing contact with a family. This will allow the family to get to know the people they deal with rather than having to keep getting to know one stranger from the program after another.

Second, the program staff who establish the relationship with the family have firsthand understanding of the life experience of the family; they will be closely connected to this or a similar community.

Third, there is a high degree of contact with the family. This is accomplished through weekly home visits by the same program staff members over the course of several years.

Philosophy of the Community Services Support System

Based on a previous literature review and earlier intervention experiences, FWL researchers developed a set of operating principles for community intervention to improve

the lives of children and families. These principles guide interaction with community agencies.

1. *Relationship-Focused Intervention.* The focus of intervention should be the development of supportive relationships and networks.
2. *Community Mental Health.* A redefinition of acceptable interpersonal behavior and community esteem needs to be developed.
3. *Social and Physically Safe Sanctuaries.* In order for parents and families to make long term gains, they need to have safe havens in which they can heal and grow.
4. *Two-Pronged Intervention Plan.* Both families and community agencies need to be the focus of the intervention.
5. *Individual Plans.* Each family must participate in developing their own programmatic goals.
6. *Program Facilitation.* Effective early intervention cannot be done in isolation.
7. *Quality Child Care.* Child care must be made available to families in need
8. *Culturally Grounded Expectations.* The program should develop from and be part of the community culture.
9. *Responsive Facilitation Process.* Change must come about with and through the efforts of the families being served and grow from community needs and effort.

Much has been made about the need for coordination of family services, social services budget deficits, service gaps and the like when it comes to really helping families develop. Also of great concern to those hoping to influence families positively is the power of informal networks to either support or weaken a family's functioning. A family either isolated from positive informal networks or participating in maladaptive networks will have trouble functioning.

The Community Service Support System deals directly with linking service agencies. It was designed to develop long-term changes in the quality of family life in communities served. Under this system, agencies that serve program families are brought into collaborative working agreements with MCFF and participate in the design and implementation of a long-term service strategy for program families. Informal neighborhood and community networks are identified and facilitated in their support of program families. The Community Services Support System focuses on upgrading and expanding services, as well as on maintaining collaborative relationships among informal networks and service agencies.

Working directly with schools, service agencies community groups and the networks, staff assist community leaders to develop strategies and plans for the implementation of a community-wide family service system. The program families served are the focus for this system redesign activity. Using the target child in the program families as a magnet for concern, redesign activities commence related to perinatal and early infancy issues and are developmental in nature.

Issues relating to the service of a specific program families are to be used as "content" and/or "jumping off" points for redesign discussions. Issues that arise are spotlighted for special concern by the community planners. The MCFF Clinical Coordinator provides the link between the families and community service agencies. Family advocates meet weekly to discuss progress, analyze actions, and develop strategies with the Clinical Coordinator and other staff. These meetings are used as the vehicle for deciding which collaborating agencies should be linked for the purpose of serving individual families.

A Plan for Collaboration

In preparation for the implementation of the second prong of the intervention, FWL researchers completed a study of family support activities in Marin City. The activities of 26 agencies both within and outside Marin City which provide services to families of the community were charted, and recommendations for orchestration of services were presented based on the report.

Nine community agencies which would provide key services signed memos of understanding which spelled out their commitments to the program. As part of their agreements, all agencies agreed to participate in community case conferences for specific families for the purpose of coordination of services.

This was a first step towards achieving their long-term goal of a collaboration to fundamentally change the way in which services are delivered to families in Marin City. A second major step was taken when, subsequently, the agencies worked closely with FWL in setting the goals for children, families, the community and agencies and the standards for measuring progress towards those goals. (Goals are discussed in Chapter IV, Family and Agency Issues and Problems. Progress towards the goals is discussed in Chapter V, A Progress Report on Marin City Families First.)

CHAPTER III: ESTABLISHING FAMILY and COMMUNITY SUPPORT SYSTEMS

In adherence with its philosophy of responsive facilitation, which encourages the enlistment of local programs in an intervention from its inception, finding a Marin City agency to serve as the "home" or "parent" for the intervention was fundamental to launching the intervention successfully. The home agency serves as both a symbolic and physical center of the intervention, drawing together the client families, the family advocates, and the other community agencies with which MCFF collaborates for the purposes of improving families' lives.

The Agency Home

Among the approximately 20 community agencies serving Marin City at the outset of the MCFF, Operation Give A Damn (OGAD) was the logical choice for the home agency, as it provided mental health services and advocacy through various existing components of its program. With its 25-year history of providing services to Marin City families and children, it had the most stability and the best relationships with other local agencies. OGAD became the home for the MCFF family advocates and the focus of the service delivery prong of the intervention in 1992.

Although it was the recipient of funding from United Way and the Marin Community Foundation, OGAD -- like all Marin City agencies -- had had difficulty maintaining funding levels for its programs, a reality that was demoralizing for both the program board and staff. Joining in a partnership with FWL to form MCFF was useful to OGAD in a number of ways. FWL brought to the collaboration its research experience and credibility with funders, while OGAD needed this type of support in order to sustain itself financially. With this alliance, services could be expanded in the Marin City community and more families could be reached. Additional funding that flowed from the collaboration allowed for a new sense of stability and higher morale because full-time family support staff could be hired. In turn, OGAD brought FWL its credibility within Marin City, which allowed FWL to enter the community more easily and do constructive work there.

However, in late 1994, funding uncertainties for OGAD became so great that the agency relinquished its relationship with the Marin Community Project -- a coalition of Marin City agencies -- and its role as the MCFF home agency. Management of MCFF was temporarily assumed by FWL and then transitioned to the Community Development Corporation (CDC) of Marin City, which spearheads the economic development of the Marin City Project and serves as fiscal agent for a number of family support projects including the Marin City Drug and Alcohol Outpatient Program. A partnership was developed with CDC, which assumed fiscal responsibility for case management of the program. Although staff and their clients experienced a temporary uncertainty regarding their futures with MCFF, a smooth transition was made, with Program Director responsibilities being assumed by the Clinical Coordinator for MCFF.

The Program Director

Together, the Program Director and the Implementation Director from FWL ensure that the program's operations are consistent with the mission and purpose of MCFF and are of sufficient quality to meet the program's objectives. As stated earlier, MCFF is guided by a two-pronged approach. The first prong emphasizes family case management and the second focuses on community services support. The role of the Program Director is to directly supervise the work of the family advocates, and ensure coordination with other agencies, while FWL, under separate funding provided training, technical assistance, programmatic assistance and documentation for the intervention.

As the supervisor of the family advocates, the key service providers, the Program Director teams with the Implementation Director of FWL to ensure that:

- Each program family has a well developed Individual Family Plan;
- Special emphasis is given in the Individual Family Plan to developing a strong teen parenting and drug treatment component of MCFF;
- Regular community case conferences are provided with the multiple service agencies impacting the MCFF project participants, to ensure collaboration and coordination of services; and
- Special emphasis is given to developing strong links between MCFF and economic development activities so that families will have access to jobs and job training activities currently being developed in Marin City.

The Family Advocate

The core of the MCFF intervention is a family-focused case management system through which all services to program families flow. The family advocate is the key staff member in MCFF; this home visitor has a multifaceted role as a partner with both the client and community agencies.

The family advocate's extended role consists of:

- Delivering parenting and child development information;
- Helping families assess needs and providing linkage with other services;
- Assisting in identifying and building relationships with community service agencies;
- Coordinating the work of community service agencies for the program families;
- Designing approaches and strategies for agency collaborations;
- Working with members of the Project Facilitation Group to meet family needs;
- Receiving supervision from the Program Director and FWL training and evaluation team;
- Meeting weekly with the Clinical Coordinator for case conference on each case, assist in data management & participate in inservice training,
- Meeting weekly with the MCFF management team;
- Participating in weekly treatment team clinical meetings;

- Developing knowledge of all collaborating social service agencies staff, goals and policies;
- Collecting information about the effective functioning of agencies in the community; and
- Making home visits at least once per week per family for at least an hour duration.

Her specific home visit tasks are to:

- Develop rapport;
- Develop family plan, using topic areas presented in training;
- Collect family data;
- Help families identify needs, questions and concerns;
- Conduct family interview;
- Assess needs of child and family which may or may not be congruent with the families own concerns;
- Link families with obviously needed social services;
- Link families with child care;
- Share parenting and child development information;
- Process data collected; and
- Work with members of the Program Facilitation Group to meet individual family needs.

Originally, the advocates recruited to the program were paraprofessionals with ties to the Marin City community, thus assuring familiarity with the community and its problems. They were prepared for their roles as family advocates through the intensive pre-service training described later in this chapter.

The Clinical Coordinator

The Clinical Coordinator is the primary resource person for the family advocates. In the MCFF program, he was selected on the basis of clinical as well as social service expertise, familiarity with and sensitivity to the community served, and understanding of case management in a community with a large number of depressed residents and service providers. In addition, an African-American male was sought to assist with the males (father, grandfathers, significant others, children) in the program families, as the majority of the program participants would be African-American. It was requisite that the Clinical Coordinator be familiar with internal and external community resources, the politics of the county, and local funding sources.

As the first person to whom family advocates turn for assistance in problem solving, the Clinical Coordinator has periodic contact with clients of MCFF, conducts and supervises inservice training for the family advocates, as well as provides linkage of MCFF work with the work of other agencies and institutions serving Marin City.

Each week the Clinical Coordinator meets with the family advocates to discuss progress, analyze actions and develop intervention strategy. These supervisory meetings also are used as the vehicle for deciding which collaborating agencies and members of the Program Facilitation Group should be linked for the purpose of serving individual families.

As part of the responsibilities related to Prong One, the Clinical Coordinator focuses on case management, including:

- In conjunction with the family advocate, conducting initial assessment of the children and each family member in the home and developing an initial intervention strategy;
- Assigning families to a specific family advocate;
- Conducting weekly reviews of all case records and contacts;
- Developing the Individual Family Service Plan with family advocate and family members;
- Holding weekly meetings with each family advocate in which assigned cases are reviewed and specific intervention steps are planned. A family assessment and individual service plans are used as guide in this process; and
- Maintaining contacts with other social service and educational agencies that are involved with the family directly or through the family advocate.

Responsibilities also include inservice supervision and training, such as:

- Providing ongoing support to family advocates;
- Organizing and facilitating weekly inservice meeting for family advocates;
- Assisting family advocates in developing monthly Community Case Conferences;
- Developing inservice training content pertinent to the needs of the families, family advocates and collaborating agencies; and
- Coordinating the work of the Program Facilitation team.

As part of the second prong, the Clinical Coordinator facilitates agency linkage, including:

- Assisting in identifying and building relationships with community agencies and other resources;
- Facilitating community case conferences for a specific family who is involved with multiple agencies for the purpose of coordination of services. These conferences have as a secondary purpose building linkages and effective working relationships with participating agencies. These community case conferences are viewed by the Clinical Coordinator as useful in providing indirect training in supportive family and child development work in each community.

Staff Development

The preservice and inservice training of the Clinical Coordinator and the family advocates reflect the three basic tenets of the FWL facilitation philosophy and the operating principles of the MCFF project. Training centers on the following topics:

- Assisting the trainees in becoming familiar with, identifying, and assessing family needs;
- Information on child development and parenting;
- How to link families with appropriate services with an emphasis on moving families from dependency to self sufficiency;
- Strategies to assist in getting the optimal use of the Program Facilitation Group; and
- Illustrations of how empathy, the authentic presentation of self, and a non-judgmental approach in working with clients are important elements in relationship building with families;

The orientation and training schedule used in the MCFF program is presented as an example for those planning trainings.

MCFF Case Management Orientation and Training Plan

1. Orientation Activities

- Overview meetings to discuss: history of MCFF; link with strategies used in Syracuse Family Development Research Program; what MCFF is and isn't; critical issues related to implementation; overview of Evaluation Plan; job descriptions; lines of authority
- Independent reading: MCFF proposal; Augmented Family Advocacy System; Evaluation Plan; Syracuse Family Development Research Program; job descriptions
- Links with collaborating agencies: desires/needs of collaborating agencies; critical issues related to implementation of collaboration; MCFF links to Marin City long-range plan; building a transdisciplinary system through use of a case conference strategy with collaborating agencies
- One-on-one orientation meetings with collaborating agencies: learn services, discuss MCFF role and collaboration; and
- Visits by the family advocate and Clinical Coordinator to collaborating agencies.

2. Training Activities

- Baseline data collection responsibilities: Family interview; use of management information system; collection of community/agency functioning data; collection and use of information from collaborating agencies; recruitment of program families and comparison families
- Training on the development and use of the Family Plan
- Training on appropriate parenting and care of infants and toddlers: use videos and curriculum guides from the Program for Infant/Toddler Caregivers; onsite work with supervision at Iniece Bailey Infant Center
- Training in social work component of home visitation
- Training in self sufficiency vs. codependency approach

Clinical Supervision and Training of Family Advocates

The goal of clinical supervision and training in the MCFF program is to provide a supportive environment in which the family advocates can feel free to experiment, to acknowledge successes and failures, to risk and become empowered to struggle with the complex task of work with the program families. The task of supervision and training is therefore a gradual empowering of the family advocates that is brought about by helping them to:

- Feel more confident in their ability to advocate and provide appropriate services to program families;
- Understand their own cultural values and family background;
- Learn about the culture of the families they work with; and
- Provide a theoretical framework within which they can view their work.

Support and encouragement is key to this process, because there is a definite relationship between the support the family advocate receives from their supervisor and the support they provide to families. The key to accomplishing this task is the establishment of positive relationships with the family advocate by using a model that depicts the role of supervisor as consultant rather than one of authority.

A problem-solving approach is used to teach the family advocate to use the process of problem assessment and solution as a "road map" for developing and implementing family plans. The supervisor facilitates this process by helping the family advocate to stay focused on problems to be solved and to identify the most important issues which need interventions.

Family Recruitment

Any woman who lived in Marin City and was pregnant but not past her sixth month of pregnancy by February 1993 was recruited into the MCFF program. A maximum of 34 families participated in MCFF; currently, 30 families are served.

The recruitment approach most effectively used in MCFF was based on the relationship approach to intervention. Initial contacts were made, when possible through already existing service providers that had already established a sense of trust with clients. This technique allowed for start-up activities to proceed at a faster rate than for the recruitment efforts that were not facilitated by someone already in relationship with the clients. In fact, after seven months of operation, the deepest program/client relationships were those established through facilitated recruitment.

The relationship with the families of MCFF began after the referrals were made. The referring service provider encouraged the client to get involved with MCFF, and explained to the client the benefits of doing so.

Building Relationships with Families

As with recruitment, preparation for the initial visit is done in conjunction with other trusted service providers. It included a review of information, such as tips about a client's attitude toward drug use and family that might influence the content and scope of the initial interview. General goals for the initial visit included establishing the provider/client relationship and exploring the client's view on his or her current life situation.

The initial visit frequently reveals specific issues requiring immediate assistance. These issues become part of the short range family plan. Services quickly rendered afford an opportunity for MCFF to produce practical and family-sensitive results as a way of demonstrating usefulness to the client. They also allow the client to test the honesty, consideration, and competence of the family advocate and the MCFF program. Part of providing initial emergency assistance is an analysis by the family advocate of how a particular client's family functions in a problem-solving mode. This information has proved essential to determining the way family plans are formulated.

Implementing the Family Plan

Effective implementation of the Family Plan is based on two important principles:

1. Effectively using the relationship that has been established with the client which is based on honesty, consideration and competency; and
2. Developing a plan that reflects the participation of the client and the family advocate.

The Family Plan is a tool that is used to identify particular issues to be worked on to strengthen the family system. Some of the strength of this tool relies on the development of the relationship between the family advocate and her client. As safety develops in the relationship the client can become more honest and frank about problems within the family and a more comprehensive and holistic family plan is possible. The Family Plan also is a means of illustrating to the client all the resources for support available to them as they work to reach their goals. Identification of such resources helps clients to realize that they are not as isolated as they might feel.

Generally there are two levels of client issues with which family advocates interact. the day-to-day issues of survival such as safety, shelter, food and finances; and the overall effects of substance abuse and how they impact children, adults and the environment in which these families live.

Agency Resources

The Program Director and the Clinical Coordinator provide linkage with community agencies in Marin City and outside the community for the provision of services to the program clients. At the program's outset, ten agencies signed memorandums of

understanding detailing their plans for collaboration, which focused on cooperative services to MCFF families.

The agencies and their services included:

1. Operation Give A Damn (OGAD): as the agency home, coordinates case management;
2. Pregnancy to Parenthood: provides comprehensive developmental assessments of children where possible; provides with Marin Treatment Center the ten-week perinatal Chemical Dependency group treatment; provides, as appropriate, case management services to MCFF participants;
3. Marin Maternity Services: provides on-site Marin City Clinic; pregnancy testing; medical assessments;
4. Marin City Drug and Alcohol Outpatient Services: provides services to the chemically dependent families of MCFF; education and training about substance abuse issues;
5. Catholic Charities: provides recruitment of Marin City families with children in child care programs for participation in intensive family improvement program; address Marin City families' systems issues through the Catholic Charities family advocate; designs research to examine changes in parental stress;
6. Family Service Agency: provides direct community outreach, counseling, case-management and community education through the Multi-Cultural Outreach Team; provides slots without fee for qualified individual and families;
7. Marin Services for Women: provides residential and day treatment services for women recovering from alcohol and/or drug dependency; provides a specialized day treatment program for pregnant substance dependent women; provides outreach in Marin City through the Perinatal Coordinator
8. Women Helping All People: provides community-based food and clothing giveaways; provide weekly self-esteem classes; provides early parent toy-making classes; provides on-site computer training classes;
9. Step II: provides after-school tutoring in Marin City; teaches practical educational coping skills; consults with parents and teachers; provides analysis of school student records and collaborates with school personnel for special service referrals; field trips for students;
10. The Iniece Bailey Infant/Toddler Center: reserves a designated number of slots for MCFF families; makes available the services of the Family Development Specialist; provides general resources to MCFF parents, i.e., classes and training.

Recruiting A Comparison Group

In 1994, FWL contracted with an independent community outreach worker from the Marin City community to recruit a comparison group against which the MCFF families could be measured for progress towards their stated goals.

Although it required extensive time to accomplish, the outreach worker was able to recruit 30 families with children from birth through 36 months of age through her existing

contacts with child care centers in Marin City, and through personal knowledge of families in the community.

Subsequently, an independent tester measured the children's progress on a standard development test (Bayley Scales of Child Development), and videotapes of mother-child interactions were made. Once all of the MCFF program children attain 36 months of age, they will receive the same testing and videotaping for comparison purposes.

Setting Goals for the Marin City Families First Program

MCFF is an effort to provide the continuous support to families that will foster children's intellectual, social, emotional and physical development, and to revise the ways needed support services are delivered. An important objective is the documentation and evaluation of this effort, to measure its effectiveness in meeting the needs of Marin City's families.

Early on, FWL researchers and the MCFF collaborating agencies, in consultation with experts in program evaluation, agreed that evaluation would focus on both changes in child and family functioning and community change. Over time, the goals for the program were developed, critiqued and revised in collaboration with Marin City community agencies.

The goals are divided into the areas of child functioning, family functioning, community functioning, and agency functioning. Within each of these areas are specific measurable goals. Progress in all of these areas is significant in helping Marin City families combat the problems and issues which they confront daily in their community.

General goals are:

1. Healthy children who demonstrate age-appropriate motivation and cognitive, language, psychomotor, and social development.

2. Cohesive families who facilitate the health and development of their children.

3. Supportive community functioning and community/ family interaction.

4. Cooperation and coordination among agencies to provide comprehensive service to children and families.

5. Accommodation of the special risks and needs of pregnant teenagers and teenage parents and other special populations.

In 1995, *Progress Report on Marin City Families First Interim Evaluation* (Lally & Piske) charted the progress to date of MCFF families and children age 36 months towards these goals (See Appendix B). Chapter V reports on this progress. A final progress report will reflect data gathered when all program children reach age 36 months.

CHAPTER IV: FAMILY and AGENCY ISSUES and PROBLEMS

Children and Families at Risk

The MCFF intervention described above was mounted in midst of a community that faces tremendous problems. Drug abuse, the lack of drug treatment facilities, relationship issues, child care needs, shelter needs, income and money management training; parenting practice, mental health counseling -- these are most severe, but not the only challenges that these struggling parents and children face.

Statistics from recent studies on Marin City -- *Marin City Project Proposal to the Marin Community Foundation* (Berke, 1995), and *Marin City Resident Management Corporation Five Year Anti-Drug Strategy* (Gulley, 1995) -- provide a hard look at the magnitude and pervasiveness of some of the difficulties of this community; the stories of MCFF clients provides a closer view.

- Marin City's unemployment rate is 40%, compared to the surrounding county rate of 3%.
- Half of Marin City's families live on incomes below federal poverty levels, with more than 40 percent on public assistance.
- Per capita annual income for African-Americans in Marin City is $8,889; in 1990 36% of Marin City households had annual incomes below $15,000, compared to a county-wide figure of $44,000.
- Over 20% of children in Marin City are born to teenage, unwed mothers, and more than 70% of Marin City households are led by single female parents.
- Marin City accounted for over 22% of all alcohol and drug exposed births in Marin County.
- The overall rate of crime in Marin City public housing was 2.6 times the rate for the entire county.
- Marin City comprises less than 10% of Marin County's population, but accounts for nearly 33% of the county's entire annual foster home placements.
- African American students from the Marin City community have the lowest school achievement in the county. 1990 CAP scores for third graders rank in the 38th percentile of students in the San Francisco Bay Area. The 1990 CAP scores for sixth graders indicates that they rank well below the state average in reading and writing. Disparities between white students and black students are dramatized by the test scores: black students scored 157 in reading as compared to 303 for white students.
- Nearly 51% of the Marin City population have not completed high school.
- Females head 98% of the households.
- Only 67% of Marin City male are employed, while 60% of females are employed.
- 100% of Marin City residents believe drug use and abuse is the number one problem in their community, with crack ranking number one, alcohol ranking second, and cocaine third.
- 67% of residents have seen drug selling in their area, 58% have seen drug using in their area, and 65% are aware of drug houses in their area.

Three Marin City Families

Alpha

Alpha began using cocaine again just a few months before Baby T.'s birth. As a result, Baby T. tested positive for cocaine birth and was placed in foster care in Novato. His mother, Alpha, then entered a drug treatment program in San Francisco which accepts mothers and babies. Although it is a long-term program (12 to 18 months), Alpha left early when she threatened violence to staff and residents. Alpha entered a new drug treatment program, this time in Oakland where she found a support system and learned that she liked being clean and sober. She did not want to stay in the program's transitional housing because she wanted to be able to visit Baby T. over in Marin County. Child Protective Services (CPS) wanted her to enter a new treatment program, but others involved with Alpha believed that would be a step backwards and believed she would do well in a Transitional Housing Program. Transitional Housing requires a mother have full-time custody of her child; CPS wouldn't allow it, but did agree to longer visitation times until Alpha would have Baby T. full-time. Unfortunately, the meeting to arrange the transition had to be postponed, and CPS subsequently convinced Transitional Housing that Alpha shouldn't go there until she had Baby T.

In the meantime, Alpha had began using drugs again, this time using prostitution to purchase drugs. Though her sister would not allow her to return to her home in Marin City to live, her MCFF advocate arranged for her to stay in a shelter. She was not allowed to stay at the Transitional Housing unless she entered another drug treatment program. She was very depressed about the situation but her advocate encouraged to pick up the pieces and try again. She entered St. Anthony's Farm in Sonoma County, where, again, she is doing well.

Beta and Delta

Beta, age 26, entered MCFF in her second trimester of pregnancy. A crack addict, she had no place of her own to live, and moved from one friend or relative -- including her cousin, her mother, her father and the Baby T.'s father, Delta -- to another. She tried to enter a drug program, but the confrontational style of the program resulted in her leaving after just five days. Delta, who is about 20 years older then Beta, self-employed and very stable, has supported Beta's efforts to not use drugs and encouraged her to go to school. However, he is adamant that Beta not live there while she is on drugs. He has reported Beta to CPS to say that her AFDC money is being spent on drugs and has asked for child custody. He has had Beta arrested for breaking and entering his house.

At this point, Delta became a MCFF client and the MCFF advocate tried to negotiate rules that would support both Beta and Delta. The advocate continued to support Beta in trying to enter a drug treatment program. Originally, she would only apply to programs that accept parent and child; but her situation became desperate, and she became willing to attend any program. Delta is very happy caring for Baby T. Beta is only allowed to stay at

Delta's or help with the baby when she is not using drugs. Delta's advocate has been encouraged to find time for himself by entering Baby T. in a child care program.

Gamma

Gamma is 24, married, with three of her own children and an adopted son from her husband's previous relationship. When she entered MCFF she was using drugs; her husband, O., a recovered addict, reported her to CPS and their two children were removed from her custody and placed with him. She entered a drug treatment program, but because she was directed to have bed rest during pregnancy, left the program and subsequently began using again. Baby R., who tested positive for drug toxicity at birth, was removed from Gamma's custody, but returned when she re-entered the drug treatment program. As Gamma began mending her relationship with O., it became known that O. was not the biological father of the baby. Together they decided this dilemma is a result of their drug addict lifestyle and they would bear that responsibility.

Gamma did well in the residential drug treatment program and continues in an after-care program. She continues to value her relationship with O., but is struggling with a relationship with another man. Paternity for Baby R. still has not been established. Gamma has moved forward with her education in a dental assistant program. She has Baby R. in child care, and once she settled past debts with the Marin Housing Authority, had a secure place to live. She sees a therapist and needs ongoing support from the family advocate to continue her clean and sober lifestyle.

Agencies at Risk

With unemployment, crime, drug use and teenage pregnancy among the daily facts of family life in Marin City, the plight of Marin City children and families has become more critical over the years. The Marin City Community is overwhelmed by drug-related problems; the impact of drug abuse on both pregnancy and family functioning is high. Marin City children today face circumstances that children of other times have not had to confront. Indeed, there has always been substance abuse, but the introduction of crack has taken drug dependence to an unprecedented level of danger and despair. Children must struggle with the reality surrounding them, while they are increasingly expected to fend for themselves in a fast-moving society which decreasingly values the extended family.

It is in this day-to-day environment -- one that has only intensified in recent years -- that the staff of community agencies of Marin City operate. Theirs is an overwhelming task made more so by the unique interactions of local social networks, funding agencies and larger community issues of Marin City.

A History of Dysfunction

At the start of the MCFF intervention, the need for coordination of social services to Marin City's residents was well established; it was clear that the historical lack of collaboration among these agencies jeopardized their success.

As early as 1961, collaboration among agencies in Marin City was perceived as problematic. A report that year from the Marin Council of Community Services on a proposed Marin City Program, which was to include housing, employment and economic development, stated:

> Because of their restricted living situation, which was temporary, uncertain and psychologically isolated, and prevailing community attitudes, residents of Marin City have not participated in the life of the total county community. As a consequence, attitudes of resentment and distrust have developed. Thus, a climate existed which made it hard to make known needs and interests. In this atmosphere communication was exceedingly difficult. The social service and health agencies had been unable to adequately interpret services, develop programs, determine indigenous leadership or develop new leadership.

In 1968, the Independent Journal, the county's newspaper, editorialized:

> Ever since the Marin City Housing Authority and Redevelopment Agency were created under federal auspices to take over the temporary buildings thrown up hurriedly to house Marinship workers during World War II, the potentially beautiful community has been handicapped by the very agencies created to help it. . . The people of Marin City are entitled to direct their own future. . . to make their own mistakes.

Services were at that time and still are provided to Marin City in one of three ways:

- County agencies provide services to the entire county. This service provision includes Marin City, but Marin City is only one small part of the county agencies' overall effort;
- Non-profit community-based organizations serve the entire county, including Marin City, but the governance of these agencies does not tend to involve Marin City residents; and
- Local community-based organizations within Marin City serve Marin City residents exclusively and are governed by Marin City residents.

At the outset of the project, research confirmed that agencies in Marin City tended to operate independently and not consider the impact of their services in relation to other services clients may be receiving from different agencies. In 1991, FWL conducted a survey of all Marin County agencies purporting to serve Marin City to determine what level of service Marin County agencies provide to the community and how services might

be better coordinated. The 25-page report charted a confusing network of 26 service agencies with gaps, inconsistencies in approach and duplication.

The intention of Prong Two of the intervention is to integrate the education community with other social service agencies, private organizations, community groups and family members to plan and provide comprehensive services or at-risk families. Notable progress towards achieving this goal was achieved (See Chapter V, A Progress Report on Marin City Families First). But the complex factors within the context of the intervention -- the unique interactions of history, family, support agencies, funding and the rapid change taking place within the community -- has had a major impact on the agencies' efforts to collaborate in this community.

Barriers to Agency Collaboration

Throughout the two-pronged MCFF intervention, FWL has assessed the adequacy of services and the barriers to adequate service provision. In 1994, researchers approached the issue from the perspective of agency directors and line-workers representing community agencies to determine their perceptions of the problems surrounding Marin City service delivery and how they impede collaboration among Marin City agencies. Interviews in 1995 with agency directors and community organizers both within and outside the community provided further insight into barriers to agency collaboration.

These assessments reveal that the perceptions of agency staff regarding networks and relationships within the community, on both an individual and agency level, have had a significant impact on the MCFF intervention. Similarly, issues related to funding in Marin City have interfered with effective collaboration for providing quality services to families. Finally, the way in which development of Marin City, e.g., the Marin City Project, is being approached, has exacerbated already difficult agency relationships.

Presented here are some of these key perceptions as they relate to three key guiding principles of the intervention (Principles 1, 3 and 9), discussion of how those perceptions have presented obstacles to collaboration, and suggestions for overcoming these obstacles. (Although agency staff voiced additional concerns relating to other guiding principles, these are judged to be present the greatest obstacles.)

Principle #1: Relationship Focused Intervention: The focus of intervention should be the development of supportive relationships and networks.

To be truly effective community interventions must be planned so they can become part of an orchestrated and ongoing social support system that is part of the daily fabric of community life. Effective interventions should emphasize connection -- to both isolated families and overwhelmed service providers and agencies. MCFF models and supports the development of helping relationships and community connections through facilitating the development of personal links among family members, MCFF staff and families, families

and other community members, families and social service agencies, and among service agencies at the staff and program level.

Agency Case Workers Need to Place More Value on Case Review Meetings

One important way in which agencies can collaborate with one another to create change for families is through case review meetings. Case workers and program directors of relevant agencies from around Marin City meet together around individual family cases to develop a plan for more comprehensive, coordinated service delivery. According to several agency directors interviewed, however, coordinating case review meetings among agency workers is an ongoing problem.

Although case reviews are now a more frequent occurrence in Marin City, the lives of the case workers' clients are in such crisis that problems continually surface which make it seemingly impossible for the case manager to make her regularly scheduled case review meetings. The tension is ultimately between prevention and crisis modes of working in a crisis-driven environment. Line workers find it difficult to abandon a family in crisis while they try to work on long-term, preventive solutions to another family's problems.

Nevertheless, if a truly comprehensive approach is to be effective, case managers must be able to balance their attention to immediate, acute family crises with developing long-term strategies for their clients. It is incumbent upon program directors to send the message to their case workers that the case management meetings are of critical importance to their overall scope of work.

Planning and coordination of this effort are also important. One program director complained of receiving five different phone calls from people of one collaborative group requesting her presence at the next case review meeting. Too often, agency workers reported that case review meetings are planned at the last minute and are too long, or too vague in their approach to be of real value. If agency workers do not view the meetings as useful for improving the lives of their clients, they are not likely to attend regularly, reducing further the opportunities for collaboration.

Client-Case Manager Relationships May Jeopardize Client Progress

Professionals from Marin City who go back to the community to work after their education become powerful gatekeepers to the clients they serve. Because they are a part of this community, their biases play out in both positive and negative ways. Although staff from Marin City have credibility within this community and a keen understanding of the problems that plague Marin City, they can also participate in keeping residents from creating real change for themselves. Their own familiarity with the clients can predispose them to maintain biases about their clients' ability to make progress.

Historically, agencies in Marin City have tried to hire community residents to provide services to Marin City families because they felt the knowledge of the community was

critical for appropriate service delivery. However, line workers from the area may not be able to work as effectively with these families because of their own biases and inability to maintain confidentiality in such a small community. One program director has seen four or five drug abusers who went through treatment outside of Marin City tell her they were afraid to go back to Marin City afterwards because of the biases among the professionals who knew them, as well as among their peers. They felt they would be trapped back into the same roles again.

Non-professional familiarity between staff and clients is perhaps peculiar to geographically isolated Marin City, but it may apply to relationships in rural communities as well. Although it may take longer, case managers with some distance from such tightly-knit communities can provide some opportunities and confidentiality that local residents cannot.

Concern for Survival Can Overshadow Collaboration

Streamlined coordination at the line worker level usually requires a reduction in the duplication of services to clients. When line workers began to work collaboratively in Marin City, they found that many of them were providing similar services to the same clients. For example, MCFF case managers and Marin Maternity Services case managers provide similar services to pregnant women, although MCFF is able to continue case management for the family after a child is born, while Marin Maternity Services is not funded to do this.

To deal with this problem one program director suggested putting all line workers' tasks on the table and reorganizing them according to different people's focus, skills and levels of expertise. However, many interviewed explained that changing people's professional duties can be extremely difficult because agencies are so territorial about their roles in the community. Turf issues have never been resolved in Marin City, according to several program directors, and this threatens to undermine community networking because agencies feel particularly vulnerable to loss of program funding. For example, administrative staff of three different child care centers housed in the same building refuse to acknowledge their services are similar to the others in the building. They argue that their services differ in their philosophy of care, the ages of the children they serve and the economic status of the children's parents.

Because program directors have high concern for survival, they may believe that it is in their best interest to differentiate their programs from one another in order to demonstrate community need for their particular program. Otherwise, they may face budget cuts or program closures in the future in the name of "streamlining." Although one can argue that a closer collaboration among these programs could markedly improve their services and viability, changes in program direction, philosophy and management are perceived as threats by directors of small, independent programs.

Keeping Communication Lines Open is Essential to Collaboration

Members of the non-profit community in Marin know one another and attend many of the same meetings. But Marin City program directors are reportedly often outside the information loop, so they become excluded from making certain decisions that affect their community.

According to some agency staff, community representatives who feel alienated from the decision-making process confront a dilemma: they must choose between joining the collaborative effort even though some decisions already have been made, or participating only when they are involved from the beginning. Often, they choose to remain uninvolved as a form of protest, but then services to Marin City continue to be delivered without community input. Many harbor anger at this inattention to community representation, however unintentional it might be.

Many in Marin City participate in collaborative efforts, even when the invitation seems perfunctory or overdue, to ward off further alienation. Sometimes participation serves as an opportunity to confront other collaborators about what went wrong with the process. Some collaborators, consequently, feel very uncomfortable; others believe it is a legitimate attempt at keeping lines of communication open.

Outside Agencies Need to Seek Out Local Representation in Planning Service Delivery to Their Community

Funders often identify populations with particular characteristics who need to be served by the programs that they fund. However, program directors interviewed reported that agencies outside of Marin City often do not bring in representation from within Marin City when developing proposals for funding that will ultimately be used to provide services to this community. They claim that it is very unusual for outside agencies to include Marin City agencies in collaborative planning for service delivery. Historically, most outside providers tend to tell Marin City agency directors what plans they are going to implement in the community and, at best, ask them if they want to be a part of it.

Because Marin City agency directors so often complain of being excluded from planning and decision-making by the larger community, many are now insisting that they be involved with outside agencies during proposal development or they will not be involved later. They believe that if outside providers do not work with Marin City agencies to determine the best way to provide services and potentially involve the Marin City agencies in that service delivery, outsiders should not be providing service in the community at all.

According to many interviewed, outside providers tend to assume that Marin City residents will want their services, regardless of what those services are or how they are delivered. When developing proposals for funding, agencies outside of Marin City cite the high poverty and drug abuse in this community, only to become frustrated in their attempts to provide outreach to the community once they are funded because their

recruitment efforts to provide services to these residents systematically fail. Recruiting clients for services often fails, according to agency workers, because outside agencies do not know how to reach the community effectively, are providing services not wanted by the community, or are providing services in a way that discourages participation.

For example, one county agency arranged to have their staff provide medical assistance to Marin City residents for sexually transmitted diseases. The agency executives decided to deliver this service from a mobile van that would visit the community on a regular basis. Because residents in Marin City knew what services the van staff provided, very few were willing to take advantage of their services. They feared the stigma from others in the community if they were seen. Many directors of programs in Marin City argue that if the county programs talked with people in the community about how best to provide such services, they might be able to reach more people effectively.

It is clear that agencies should try to work through existing organizations in the communities in which they plan to provide services in order to provide adequate services to families there. Without working through existing community liaisons, it is likely that recruitment efforts will fail to draw the numbers of people expected and many residents will complain of inadequate service provision.

Local Agencies Must Pursue Links with County Agencies

Some believe that, because Marin City programs were funded well in the past, the sense of program self-sufficiency that arose from this funding hindered collaboration between Marin City community-based organizations and outside agencies. Prior to the 1990s, Marin City agencies provided many direct services to residents of their community, so that in lieu of county-provided services, Marin City community residents were not deprived of necessary services. But as funding of Marin City programs diminished, Marin City residents began receiving significantly fewer services over the years. Many program directors realized that if Marin City agencies are not funded to provide needed services in the community, they must reach out to the larger community to ensure first, that services are delivered to Marin City, and second, that they are delivered in appropriate ways.

Marin City staff have begun making contacts with other agencies in a pro-active way. For example, MCFF case managers took the initiative to present some details of the MCFF project to CPS staff and offered their assistance. Their relationship with CPS has been improving ever since.

As county agencies become more comfortable with people from Marin City agencies, it is hoped that they will be more comfortable taking the initiative to include Marin City agencies in the future. But in addition, it seems apparent that Marin City needs to have agency workers and politically active residents able to work both within and outside of Marin City in order to promote greater inclusion in decision-making. It is not likely that community representatives can remain isolated from the rest of the county and still be invited onto county-wide boards and councils. A pro-active approach on the part of Marin

City may not only improve communication between agencies in the short-run, but may also help to reduce fear of the unknown agency or staff, which can promote greater collaborative opportunities in the future.

Principle #3: Socially and Physically Safe Sanctuaries: In order for parents and families to make long term gains, they need to have safe havens in which they can heal and grow.

If we wish to prepare children and families to act in more caring and less violent ways in the fearful realities they now face, we must provide them with sanctuaries to explore new ways of behaving. Everyone needs a secure place to rest and repair. David Hamburg, the President of Carnegie Corporation, has made the point that, particularly for very young children, this safe haven is necessary. Without, as he calls it, a chance for a prolonged immaturity (protected early years spent with caring adults), children are forced to develop premature rules for the attainment of their safety, security and survival. When developed early, these rules are almost always rigid, limiting and based on fear.

Unfortunately, many families living in Marin City are "in crisis" to such an extent that these safe havens are severely jeopardized. According to one case worker, a tremendous amount of work is required just to help her clients begin to have dreams about a better life, and even then, their dreams are extremely limited. The best many can hope for is to get Section 8 housing or find a way to leave Marin City. Case workers report having difficulty working on preventive strategies like teaching living skills or budgeting, which help families prevent crises in the future, because their families are so often in immediate crisis situations. Of one MCFF family advocate's 13 families, she considers only two families to be "not in crisis."

MCFF works with community members to establish familial resource centers and high quality child care settings in which trusting relationships can be established so that families and children can have safe and secure places to grow. What is now realized, however, is that not only are the families in crisis, but the agencies which house the case workers are also in crisis as a result of inadequate or misunderstood funding policies.

An array of services is needed in any community to meet the needs of low-income families in a comprehensive way. In Marin City, the under-funding of existing agencies creates an especially difficult environment for creating change because the families served by the agencies are so often in a crisis; a vicious cycle of working through crises is never-ending for both families and the agencies. Until a family can be provided with enough comprehensive services to break this cycle, the crises will continue. But breaking the cycle also requires sufficient program funding to stabilize the agencies providing the services to these families.

What follows is a discussion of some of the ways in which agency funding problems continue to impede collaboration in Marin City.

Community Agencies Need Assistance in Making Transitions

The Marin Community Foundation (MCF), the major funder of Marin City programs, has been the cause of much consternation among Marin City agencies in the last few years. A stated goal of MCF has been to reduce duplication of services, and, toward this end, it severely reduced agency funding to Marin City in 1994.

Marin City agency directors originally believed MCF would approve a planning grant for one year, during which time, the agencies could determine how they could best work together to reduce duplication of services. However, the agency directors' perceptions of this strategy were negative. They believed that only program proposals were funded, not planning proposals, and that if all their resources were spent on a program without prior planning, they would fail and their failure would then be used to justify pulling all existing program funds in the future. Agencies believed that collaboration was being forced upon them prematurely, with no opportunity for transition.

Because of the dramatic decrease in funding in 1994, many agency directors in Marin felt forced to close their doors or reduce their services to the community. OGAD, the MCFF agency home, was among those that closed temporarily. Because Marin City agencies have relied heavily on Marin Community Foundation for their support, they found themselves with nowhere else to turn for additional funding in this current crisis. According to one case worker, reduced funding decreased the number and quality of services to families in the community and resulted in an erosion of trust that families had in the agencies' stability. Without stability, she claimed, neither families nor agencies are likely to create positive change for themselves.

However, some Marin City agency directors argued that agencies had known for years that this centralization of efforts was imminent. They said that although Marin Community Foundation may not have provided an easy transition for the agencies, efforts to work more collaboratively should been developed earlier in order to offset potential disruption in services.

From either perspective, such frustrations highlight the need for funders to clearly state pending changes for agencies in advance and help develop a transition plan with them whenever possible. This form of assistance might ease the transition for agencies and their clients and thus sustain service delivery through difficult economic times rather than halt many needed services altogether.

Agencies Need Adequate Funding to be Effective

The impact of funding cuts -- from any source -- is that Marin City agencies are cutting back on their services, increasing their caseloads per worker, or shutting their doors altogether. Some interviewed agency directors acknowledged that a few agencies were no longer providing quality services. However, a dramatic reduction of needed services can

create large gaps in service delivery, which then affect the daily lives of individual families. Some believe that the gaps in service delivery to Marin City have become too wide to cover with existing services and that families are suffering as a consequence.

Funding reductions to Marin Services for Women (MSW), which provides intensive treatment for female substance abusers, provides one example of the impact sudden cuts may have. Because of funding cuts at MSW, a staff member with whom the MCFF family advocates had a primary relationship left the program. This meant that MCFF staff had to find time to make new connections with the agency's staff; time these case workers claimed they did not have. In addition, funding was also reduced for a transitional program with which MSW collaborated. When clients are going through drug abuse recovery, line workers claim that it is important to have a transitional program after their intensive in-patient treatment to ease them back into independence. But because of the reduction in funding, this program had to reduce its slots to only four women at a time and only for one year. Thus, the program's availability is so limited that the chances of providing this transition to a recovering client are minimal. Case workers argue that the lack of a transitional program decreases a client's chances of a successful recovery.

Programs Must Stop Fragmenting Their Services to Meet Funding Criteria

Some agency directors interviewed said that, in retrospect, they believed the funding cuts to Marin City agencies may have a positive long-term impact. They believe that some of the agencies had lost their vision and/or their energy over the many years they had been in existence. In addition, some in the community believe that when agencies have co-existed together for many years, destructive competition can result.

At a recent Marin City service providers' meeting, a speaker emphasized that agencies need to be service-driven rather than funding-driven; administrators need to develop a long-term, tailored approach to service delivery. He claimed that this approach will ultimately result in more financial support to agencies because they will be focused on providing a needed service well, rather than fragmenting their vision by continually adapting their program to meet criteria set by new funding sources. With this strategy, agencies can then seek out funders who fund programs more closely aligned to their visions.

Programs Must Diversify Their Funding Sources to Build Stability

Clearly, MCFF's recent approach to funding has had both negative and positive effects within Marin City. While its impact on agencies has fostered distrust, disarray and in many cases, dysfunction, that has negatively affected agency clients, it has forced Marin City's agencies to act collaboratively and to begin thinking about diversifying their funding sources.

Unfortunately, many program directors have found that funders outside of Marin County believe Marin-based agencies should not need additional resources in such a wealthy

county. In addition, Marin City agencies have found that because it is such a small community -- just under 1,000 households -- federal funds are frequently unavailable; funding agencies are reticent to fund such a small population base.

One agency head said that in the near future, the Marin City Project and the agencies that are collaborating within that project must find a source of funding other than grants. The process of application, the changing funding guidelines, the uncertainties inherent in not knowing whether or not funding will be granted -- all of these detract from the agencies' ability to coalesce a common vision. The importance of accountability to a funding source is not in question. However, it is often difficult to distinguish between being accountable and being funding-focused. For sustained effectiveness, the agencies should be focused beyond short-term service delivery towards large-scale comprehensive service delivery at the system level.

Principle #9: Responsive Facilitation Process - Change must come about with and through the efforts of the families being served and grow from community needs and effort.

The Responsive Facilitation Process described in Chapter II has been used to implement community interventions throughout the country. It has two goals: 1) to help service providers to accurately understand the needs of families; and 2) to assist and enable these different providers to develop program plans based on the new "family vision" -- plans that address not only short-term needs of families, but plans that involve alteration, orchestration, and continuity of currently provided services. As noted earlier, the key words are "assist" and "enable."

Community development efforts can be an important vehicle for creating significant change in communities and can serve to encourage collaboration among service agencies. However, discussions with agency directors and staff indicate problems with the ways in which community development -- and their role in assisting and enabling that development -- is currently taking place in Marin City. These relate to two issues in particular:

- Technical assistance to programs doesn't match needs
- Lack of community's voice in decision-making

Below, we discuss these issues in greater detail.

Technical Assistance Should be Tailored to Meet Program Needs

MCF is trying to build capacity in Marin City by providing them with technical assistance support. However, some program directors do not view this effort is effective because they believe agencies are not consulted regarding their critical needs, and there is a lack of follow-up afterwards.

In addition, many agency directors feel their programs are being "micro-managed" by the foundation. Others believe that Marin Community Foundation only wants the agencies to be successful and so they are very concerned about how the agencies should be run.

What is clear is that agencies need to be involved in determining what kind of technical assistance they need and how it is provided. The ideal approach, according to one program director, is in the form of a true partnership. Funders would aid programs in getting additional funding by connecting them to other resources. Funders would spend time with programs so that they could critique the program and make constructive suggestions for improvement. They would also provide information about similar programs elsewhere in order to provide new direction and operations strategies.

Communities Need a Legitimate Voice in Determining Their Needs

MCF's approach to the Marin City Project, which emhasizes economic development and employment, has met resistance from the program directors of Marin City's social services agencies who believe that critical social needs are being ignored. They argue that in order for job readiness programs to work as MCF intends, individual and family issues, including substance abuse and self-esteem, must be addressed first, or at the minimum, simultaneously.

The impact of programs which focus on economic development for families, as proposed in Marin City, rather than on the well-being of at risk children and their families, has been extensively researched.

Programs for welfare dependent families have traditionally focused on either adult employment needs or on parents and child development. However, as noted in a report by the Foundation for Child Development (Smith, Blank & Collins, 1992), a two-generation intervention that integrates services to address *both* these sets of needs is necessary. As the report indicates, programs which successfully implement a dual focus are now underway in many cities throughout the country.

> (Dual focus programs) provide immediate support for children's development such as high quality child care and preventive health services, while also enhancing key family resources -- parental education, employability and income -- that can sustain children's early gains. In this way, two-generation programs place both children and parents on a path to self-sufficiency. (p. 3)

There is valid concern that welfare-to-work programs might create new problems for children by adding strains to family life or by exposing children to poor substitute care arrangements. At the same time, there is agreement that under the right circumstances, these programs could be powerful catalysts for enhancing the well-being of children and improving their health and educational outcomes.

It is a significant challenge to maintain a focus on children's needs during the development and expansion of economic development programs, especially in an era of budget constraints that make it difficult to provide even basic education, training and support services for adult participants. Nevertheless, accumulated knowledge about the prerequisites of healthy child development argues for vigorous attention to children's need for nurturing parental support, a stimulating home environment that afford opportunities to learn, access to preventive health care and high quality child care. This knowledge strongly suggests that if children's basic needs are neglected in welfare to work programs, the investment in parents' self-sufficiency will be squandered. Neither society nor individual families will be better off if parents are helped to move from welfare to employment, but children fail to attain the competencies they need to become productive adults.

Currently, a Marin City Project proposal under the development by collaborating Marin City agencies is being tailored to meet the MCF funding guidelines emphasizing economic development. However, community agencies, including the CDC, believe that the Foundation's total investment of $3.8 million over three years, with a matching requirement of 1:2 beginning in the second year, is unrealistic, given the objectives and obstacles to achieving those objectives. Of special concern to the Marin City agencies and FWL is the Family Development and Enhancement program, budgeted at $540,000 for the three years.

How the agencies within Marin City will manage with both the approach and budget remains to be seen. Some agency directors are extremely pessimistic about their futures. Others, looking at the histories of their resilient community and organizations, philosophize that they will manage, just as they have for the last 50 years. Still others are confident that the Marin City Project now underway will, in fact, bring about the social and economic change that has been so long in coming to their community.

CHAPTER V: A PROGRESS REPORT on MARIN CITY FAMILIES FIRST

Since 1990, MCFF has worked to both implement the two-pronged intervention model, to documenting its progress and thus providing a detailed blueprint that others may use in implementing a similar intervention in another community. These efforts include:

- Documenting the development of the Augmented Family Support Systems model (1990);
- Documenting community involvement in planning and development of MCFF (1991);
- Developing a handbook for planning and practice of a Comprehensive Family Service System (1992);
- Developing a case management and family support handbook (1993); and
- Identifying barriers to implementing common principles of interagency collaboration (1994).

In 1994-95, FWL researchers conducted research on outcomes of the two-pronged intervention -- the impact of the intervention to date, in terms of child, parent, family and agency functioning. The resulting document, *Progress Report on Marin City Families First* (Lally & Piske, 1995), addresses how the MCFF program families and the involved agencies are progressing with regard to achieving program goals outlined in *Evaluation Plan for Families First* (Lally & Mangione, 1993). (The complete *Progress Report* is included in Appendix B).

The report contains information about progress toward meeting the five general goals specified:

1. Healthy children who demonstrate age-appropriate motivation and cognitive, language, psychomotor, and social development.

2. Cohesive families who facilitate the health and development of their children.

3. Supportive community functioning and community/ family interaction.

4. Cooperation and coordination among agencies to provide comprehensive service to children and families.

5. Accommodation of the special risks and needs of pregnant teenagers and teenage parents and other special populations.

These general goals have remained constant throughout the history of the program. Some specific goals have been altered. The report lists general and specific goals, the method by which the goals were measured, and the outcome data for each measure. Some comparison data is included when possible. Several of the analyses focusing on program children's functioning cannot be completed until the focus children reach 36 months of age. Data on 36-month-old comparison children have, however, already been collected.

The data for this report have been collected from the Marin City Families First Management Information System (MIS), and from interviews completed with each of the family advocates and the Clinical Coordinator of the project. Family advocates have been entering data on the program families in the MIS over the past year and continue to enter data on a biweekly basis. The forms which are referred to in the report are automated forms in the MIS.

Comparison data sources include family and agency interviews, developmental testing, and videotaped interactions completed in 1994, and a study completed by the Center for Child and Family Studies, titled *African-American Births in Marin City, California* (Lally, 1992).

Prong I Highlights: Progress of Program Families Toward Program Goals

- Over 90% of focus children were born full-term, receive regular medical screening, have current immunizations, and have not had a serious accident or illness.
- All 100% of families have completed bi-annual needs assessments and have been monitored as working with their family advocate toward program goals.
- More than 50% of families have been documented as participating in learning and development experiences of their infant.
- More than 80% of families are maintaining drug free homes.
- More that 75% of families have had 10 or more prenatal clinic visits.
- All families indicate better access to and utilization of local and county agency services.
- 100% of teenage mothers had 10 or more prenatal visits, and 92% had full-term pregnancies.
- 50% of the program's teenage mothers continued to attend school after becoming pregnant, and of these, 100% graduated with a high school diploma.

Discussion of Key Findings

Children's health is a priority for families involved in MCFF.

The findings indicate that the program mothers are aware of the child's safety, health and nutritional needs, and are making concerted efforts to meet those needs. According to medical records, 91% of program mothers had full-term pregnancies with the focus child and just 11% of the focus children were considered low birth weight (below the weight of 5.5 pounds), both risk factors for developmental difficulties. A full 95% of children have been medically screened regularly and maintain growth records with a pediatrician. Just 7% of focus children have been hospitalized for either a serious illness or injury.

Program families' parenting skills are improving.

MCFF believes that families which are informed on a variety of child-rearing practices and families with an intense relationship with the child foster the child's cognitive, social and motivational ability. Compared to last year, significant progress has been made toward specific program goals, including: 53% of program families demonstrate behaviors that meet their child's daily needs, compared to advocates' estimates of just 33 % having made progress on this goal last year. Forty-seven percent of program parents have either completed or are attending parenting classes.

In contrast, last year at this time, advocates rated 33% of program families as having made progress in promoting positive and frequent interactions among all family members, while this year, they rate 63% of families as having made progress in this area.

Teenage mothers and their babies benefit from the MCFF program.

Data on teenage mothers in the MCFF study were compared to data on teenage parents from a study completed by the Center for Child and Family Studies in 1992, *African-American Births in Marin City, California* (Lally, 1992). This 1992 study was completed just before the start of MCFF. In all of the areas of the report comparing the MCFF teenage mothers to the teenage mothers in the 1992 study, the MCFF teens show more positive outcomes.

A full 100% of the teenage mothers in the program have had 10 or more prenatal visits, compared with just 45% of mothers in the 1992 group. Full-term pregnancies were achieved by 92% of the teenage mothers in the program. None of the focus children were born at low birth weights, compared to 12% of the 1992 group.

Educational outcomes were also better for teen mothers in the MCFF program. In 1992, none of the teen mothers study continued to attend high school after giving birth, and 40% continued with home teaching. Just 11% of those teens completed 12 years of education. In contrast, 50% of the MCFF teen mothers continued to attend school after becoming pregnant, and all of those graduated with a high school diploma.

Program families are learning to focus attention on their own self-development and to identify areas for improvement.

All of the program parents maintain both short-term and long-term goals which are monitored monthly by family advocates and evaluated and rewritten biannually, and 97% of program families have documented progress toward these goals. Families also are learning to develop effective strategies for working with agencies to either resolve their problems or have their families' needs met. Last year at this time, advocates rated just 42% of families as having made significant progress on this goal, while this year they noted that 91% have made progress towards this goal.

The most prominent and difficult problem for parents to deal with is drug use.

Contradictory findings have resulted. Advocate ratings of the percentage of mothers who used during pregnancy is estimated at 67%. Yet only 24% of the program mothers and 10% of the focus children tested positive for drugs in their systems at the time of the focus child's birth. Substance abuse was identified as a problem with which they need help by 59% of program mothers. According to family advocates some mothers temporarily quit abusing substances during pregnancy, which may account for the low number of positive drug toxicity tests for mothers and focus children at birth. Drug toxicity tests will often only detect recent use, meaning that use early on in the pregnancy would not be detected. Family advocates claim that many mothers begin to use drugs again after the birth of their children. Although family advocates estimated that 67% of the program mothers have substance abuse problems, they were confident that the majority of focus children (81%) are not exposed to drugs in their homes.

According to the advocates, of the 67% of mothers who have substance abuse problems, 22% are in treatment, another 23% have completed treatment and are presently sober. Therefore, almost half of the mothers with substance abuse problems are not presently using drugs. The other half who are not in treatment at this time continue to abuse substances, but this group is only 37% of the total number of program mothers. Some of these substance abusing mothers in need of treatment (37%) are included in the 19% of parents who do not keep safe, drug-free homes. The family advocates, who make consistent home visits, have observed that the remaining 18% of substance abusing mother *do* maintain safe, drug-free homes. Advocates believe that substance abusing parents leave their children with relatives in the home and engage in use of drugs outside the home.

The discrepancy between parents requesting help with substance abuse and family advocates' ratings of families needing help is more obvious since many families with substance abuse problems will not admit to the problems. Many families deny their use is a problem. Just 30% have obtaining sobriety as an immediate goal, and even fewer -- 27% -- include maintaining sobriety among their long-term goals for personal development.

Despite the varying percentages concerning substance abuse, it is clear that this issue directly affects families' levels of success in all other areas. A substance abusing mother must obtain sobriety before she can even begin any sort of successful educational pursuit or job training. If a mother cannot begin educational training or job training, she often cannot obtain child care locally because many low-fee child care services require the mother to be enrolled in one of these programs.

Employment and child care remain problematic for MCFF families.

Enrollment of a child in a child care center is an indication that the child is receiving quality child care with a consistent program philosophy throughout the first five years of life, and that parents are afforded the opportunity to complete their education and participate in employment training. In addition, child care utilization provides a natural

mutual support network with other parents, as well as supportive relationships with child care staff.

However, although 48% of parents stated that finding child care was an immediate goal, just 30% of program children are cared for in child care centers. Enrolling in either job training or educational classes is a requirement of many child care services; parents are put on the waiting lists while they begin the process of enrolling in training or classes. Fifty-three percent of parents cited continuing their education as a long-term goal, and 30% cited obtaining employment as long-term goal. These seemingly contradictory results are a reflection of both the shortage of child care openings in the community and access to job training.

Prong II Highlights: Progress of Program In Strengthening and Coordinating Service Agencies Serving Marin City Residents

- 100% of program families are more able to access and utilize various services.
- 55% of families have successfully worked with CPS to have their cases closed while in the program; just 7% have open cases with CPS.
- 100% of the families needing services for a developmentally disabled child receive services to address and aid them with the disability.
- 80% of agencies involved with MCFF families coordinated regularly with other agencies, while only 38% of Marin City agencies consistently coordinate their efforts with agencies that provide similar services.

Discussion of Key Findings

In 1994, the Center for Child and Family Studies completed agency interviews with service providers from several agencies, some based within the Marin City community and some based in other parts of Marin County. Analysis of the interviews show that many of the agencies interviewed throughout the county do coordinate with other agencies at a board level, but many do not at the direct service level.

Only 38% of the providers interviewed consistently coordinate their agencies' efforts with those of agencies that provide similar services. Of the interviewed agencies, 40% worked directly with the MCFF families. However, of those agencies that *were* involved with MCFF families, fully 80% had regular contact with other agencies involved to better coordinate their services and provide a clearer understanding of their roles and responsibilities.

This last figure -- 80% -- is a clear indicator of the success of the Community Services Support System's efforts in linking agencies in the community in support of family and child functioning.

However, the agencies' efforts to coordinate with other agencies that provide similar services are problematic, as indicated by the 38% figure noted above. The barriers to

interagency collaboration within the Marin City community, as discussed previously in Chapter IV, are multiple. Many of these problems arise from the particular context in which MCFF is being implemented, including its unique social, economic and funding issues and the pervasiveness of drug use within the community.

The Future

As a result of the implementation of the Marin City Project over the next few years, many economic and social changes will unfold which will have major impacts on the individual agencies now providing services to clients in the Marin City community, and on the individual families and children of Marin City. The type and extent of community services that will be provided by community agencies has not yet been finalized; but there is no doubt that the final shape will be different than it is today as a result of the Project's focus on jobs and economic development.

In recognition of the major upcoming change in the delivery of agency services to Marin City, MCFF has continued to focus on the expansion of the Community Services Support System. In recent months the MCFF Program Director has worked intensively with other agency representatives in order to influence the amount and tenor of services which will be provided of Marin City children and families as part of the Marin City Project.

As a direct result of these efforts, the Augmented Family Support Services approach to case management is being used as the model for health and family support services in the Marin City Project.

The Project's final form also is heavily shaped by MCFF insights into alcohol and drug use in Marin City. Qualitative and quantitative information that has been gathered has provided critical information for the development of a Marin City Project proposal for a Community Recovery Center which would provide alcohol and drug recovery services to Marin City residents, including the 85% of MCFF families who deal with drug abuse problems.

Similarly, MCFF input to the Marin City Project's Child Care Task Force is shaping the kind of services and number of services which will be provided for both MCFF families and families of the community at large with similar needs.

A final report on the progress of Marin City children, families, agencies and the community as measured against the MCFF goals will be forthcoming when all program children reach age 36 months.

CHAPTER VI: LESSONS LEARNED from MARIN CITY FAMILIES FIRST

Lesson 1: Defining the Role of Change Agent in an Intervention

It has become apparent that great strides have been made in the last year of MCFF toward the goals of providing intensive, integrated support services to families and revising the delivery of support services that fit into long-range service plan for each family.

A recent pivotal change in the management of MCFF, described by the current Program Director as "a tightrope balance between leading and facilitating," has proved instrumental in reaching these outcomes. The roots of this change go back to the beginning of the intervention.

When MCFF began, FWL and Marin City's community agencies agreed that a philosophy of Responsive Facilitation, as explained in Chapter II, would guide the intervention. This philosophy embraced the concepts of enabling; assisting with development of priorities; providing options, training, and technical assistance; and stimulating dialogue. It is a "gentle" approach requiring "low visibility" for FWL as the change agent, and one that was deemed appropriate in this community which had a history of outside agencies and foundations taking what were perceived as forceful and arrogant approaches in the past.

A well-respected and well-connected local agency, Operation Give A Damn (OGAD), was selected to serve as the agency home, and its director served as the MCFF Program Director. OGAD's history within the community served MCFF, in retrospect, as both a positive and negative force. On one hand it was recognized in the Marin City community and facilitated FWL's entry. On the other hand, OGAD's history was so intertwined with the community and that of the other agencies and their staffs that it was difficult for OGAD staff to maintain objectivity and to keep the longer-term goals in focus.

FWL researchers continue to support the strategy of having a "host" agency from within the community introduce the change agent to the community -- as OGAD did. However, FWL has adapted its role as a change agent to one of a more involved, hands-on participant in the intervention in order to successfully achieve the intervention's goals. Perhaps the most important change is that FWL now supervises the critical case management function.

The over-shadowing concern for OGAD and its staff, like the other agencies and staff in Marin City, was economic survival. While, understandably, it is difficult for any agency to make its own goals secondary to those of a collaboration, in a true collaboration, agencies realize that their individual interests cannot be allowed to derail the collaboration's goals. Because of the shrinking funding base in Marin City, OGAD and the community's agenies found themselves in a competitive environment which obstructed their focus on the larger, longer-term goal of developing linkages within the community.

Because of funding difficulties, OGAD relinquished the roles of home agency and Program Director. The Community Development Corporation (CDC), which embraced the case management approach advocated by MCFF, became the home agency, and the Clinical Coordinator for MCFF assumed the role of Program Director.

Although the new Program Director had been involved in the Marin City community for many years and knows many of the agency directors and staff personally, he is able to maintain a professional perspective in his new role by virtue of his relationship with FWL, rather than as a director of a local agency.

The role of Program Director requires doing "community therapy" on three levels. First, on the general community level: the Program Director must understand how the context for the intervention affects both agencies and clients. Second, on the agency level: the Program Director must be able to envision and help to design a system that transcends individual agencies for the ultimate benefit of the community. And third, on the individual agency directors' and staff level: the Program Director must provide individual support for agency staff on a professional and personal basis.

In their description of the elements of successful collaboration, Melaville & Blank (1991) note that neutral leaders, independent of the internal complexities and demands of participating agencies, are in a better position to ensure that the ultimate purposes of collaboration -- more effective services and better outcomes for larger numbers of individuals -- remain the guide and measure of success rather than the advancement of any single institution's agenda.

The FWL Program Director found that, unburdened by the funding pressures that local agency directors must carry, he is able to both assist agency directors in Marin City in their day-to-day work, and facilitate the process of collaboration. Without a financial, vested interest in any one program, he is able to credibly advise on development of collaborative, long-term projects. A direct result of the increased assistance from the FWL Program Director, as discussed in Chapter V, is that MCFF has had considerable influence on the shape of the Marin City Project proposal.

The key to gauging how much involvement is required on behalf of the community change agent in an intervention may lie in a better understanding from the beginning of the extent to which agencies are able to -- and committed to -- collaborating for long-term system change.

This agreement is essential to any long-term systems change. When partnering agencies agree to work together, they must determine at what level or to what degree. Essentially, if the intent is to change fundamentally the way services are designed and delivered throughout the system, the goal of Prong Two of the MCFF program, a higher degree of commitment to a long-range vision is required than if the partners desire to simply coordinate existing services.

In retrospect, FWL researchers believe that a lack of communication regarding the extent and nature of problems within the community impeded collaboration among the agencies and that with better information about the inherent problems of the agencies, a different set of expectations might have been formulated.

FWL researchers now believe their expectations regarding how quickly collaboration could be achieved by the Marin Citiy were unrealistic given the information that they now have, and that their estimate of the extent to which FWL should be involved in the day-to-day management of MCFF, too low. As a consequence, they recommend that more emphasis be placed by the change agent at the outset of an intervention on two key areas:

- Understanding client, community and agency problems, with the goal of reaching consensus on the nature and extent of those problems; and
- Communication among community agencies around their motivation and commitments to collaborating.

In summary, FWL researchers believe that the principles upon which the MCFF intervention were based continue to remain relevant and serve as important guides for staff and agencies within a community. However, they now believe that the communication process needs additional emphasis and monitoring, and that the change agent must assume a stronger, more active role in facilitating an intervention.

Lesson 2: Seeing Agencies as Clients

As described above, honest and open communication about the nature and extent of community, client and agency problems is essential to beginning an intervention based on collaboration.

A major factor in determining the role of the change agent in guiding the intervention is knowing the extent of healthy functioning or dysfunction that exists among the community's agencies. FWL researchers believe that with a true understanding of Marin City agencies' problems from the outset of the intervention, FWL would have taken a stronger leadership role in its interactions with agencies.

Like many of their clients, Marin City agencies are struggling for economic survival. And, like their clients, their vision and perspective has, as a consequence, become clouded. In recent months, it has become apparent that the difficulties experienced by agencies serving Marin City have taken a toll on the staff, cutting across levels, from caseworker to management.

Descriptions of the effects that have been observed include "dysfunction," "burnout," and "depression." These effects did not appear overnight; they are the result of a long-time cutback in agency support, constant crisis, indecision, and politics dating back many years.

Those who have observed the dysfunction which has arisen among agency management and staff because of the economic insecurity of their situations and its associated frustrations have likened it to the low morale and lack of productivity which result among workers when a company is in financial difficulty. resources and support are cut, staff is cut, the ability to stay focused is impeded. How can they focus on their clients, when their own job survival is in question?

Both agency staff and management may look for a scapegoat to blame for the problem. Visible symbols are sometimes attacked, especially if they are successful. One long-time community observer noted that in Marin City, agencies that are financially secure and successful are accused of having "sold out" to other interests.

Unfortunately, the "fallout" from agency and staff crisis does not stop there. Agencies whose funding is insecure cannot provide security for their staff. Staff who are insecure cannot provide security for their clients. And parents who are insecure cannot provide a safe environment for their children.

Marin City's agencies are among the community's social networks which, as discussed earlier, have both positive and negative aspects. Many directors and staff have known one another for ten or more years -- a familiarity that would be advantageous if they were able to collaborate. But this familiarity has its flip side in the competitive, fearful environment in which Marin City agencies operate: they are hesitant to be assertive for fear it may be interpreted as intruding on another agency's "turf," with the consequence that someone might tread on theirs in turn. Thus they limit their own spheres of influence and effectiveness.

Perceived as ineffective by the agency that funds them, by many other agencies in Marin County, and often, by one another, they have developed a defeatist attitude that has resulted in a downward spiral. Although they struggle to improve, outside funders continue to bring in their own strategists for recommendations, yet fail to provide the technical assistance to help the agencies do better. The result: further frustration on agencies' behalf, an unwillingness to participate in further endeavors and a continued perception of lack of cooperation.

The atmosphere of anger, frustration, manipulation, defeatism and constant crisis has created a network of agencies that operate in much the same manner as a dysfunctional family. The agencies have been likened to abused clients, and they manifest many of the same characteristics as battered clients in their interactions with one another. Typical reactions are denial of problems and defensiveness, especially to agencies outside of Marin City, when confronted with their inadequacies. Co-dependency -- agency staff and directors defending one another's programs, rather than acknowledging weaknesses -- is another commonly observed symptom of their dysfunction. This inabilitiy of agencies to communicate frankly about the efficacy of the services being provided serves not only as a disservice to one another, but ultimately, as problems fail to be corrected, as a disservice to their clients.

The recognition of the extent of Marin City agencies' dysfunction in the last year has caused FWL researchers to explore a new concept: helping agencies to function at a higher level, in the same way in which case managers help families, in effect providing "agency therapy."

Although the MCFF model introduced by FWL researchers included an agency support process consisting of training and technical assistance in efficient agency functioning, the crisis mode in which agencies have operated have all but precluded agency leadership and staff participation in such training, with the result that agency functioning remains less than optimal.

As described earlier, the context in which the MCFF intervention was launched was complex and difficult: competition and lack of communication among agencies precluded true collaboration. Intensive staff workshops focusing on a process of self-discovery, led by an impartial staff facilitator, are essential groundwork for building the trust among agencies.

Strong leadership is critical to both the individual agencies' survival, as well as to the collaboration. Unfortunately, many community observers interviewed have noted that leadership at the board level of many of the Marin City agencies is weak, and without a strong, clear vision of what it can accomplish.

The crisis atmosphere of the agencies caused by concern for short-term survival has contributed greatly to distracting agencies' board leadership from pursuing its focus on the community at large, its potential allies, and its long-term vision. Consequently, without strong leadership at the board level, agency directors have been forced to assume inappropriate responsibilities normally carried by board members. The domino effect of lack of leadership at the top lands ultimately with staff, who have been forced into inappropriate decision-making roles and responsibilities they have not been trained to carry out.

New perspectives are required at all levels of leadership within the Marin City agencies. The observation that "sometime you need to go somewhere else to be appreciated" has great applicability within this community. The present leaders are not without ability, but they have been involved for so long they are unable to regard their own situation with impartiality and professional perspective; they may be more effective elsewhere. In the same vein, new agency and board leadership which brings new perspectives and has achieved recognition in other communities needs to be recruited to Marin City's agencies.

In retrospect, FWL researchers now recommend a stronger emphasis on agency leadership and management development, with support for community agencies such as those in Marin City through ongoing intensive training and facilitation in three areas:

- Assistance with self-evaluation; helping agencies to honestly recognize their strengths and weaknesses, and learn strategies for efficient functioning;
- Leadership recruitment and leadership training for agency directors and agency boards; and
- Modeling of optimal personal and agency interactions.

Exposure to new, successful models for agency and personal behaviors is critical to breaking the repetitive, destructive cycle of Marin City's community agencies. Just as family support and intervention is necessary to get families back on track, so too is an agency support process critical to setting the stage for fully functioning, competent agencies.

Lesson 3: Formal, Professional Staff Training is an Essential Element of Success

Cultural sensitivity has been a key concern for the MCFF intervention since its inception. The intervention's philosophy emphasized providing services that are developed from and are part of the community culture.

In keeping with that philosophy, a decision was made at the intervention's outset to employ family advocates who are familiar with the Marin City community, or with similar communities, and could in effect, provide clients with peer support, rather than to require family advocates to have formal training in social work. It was believed that with orientation to the MCFF philosophy and intensive training activities, paraprofessional family advocates could provide the links with and support to program families that are at the core of the intervention.

FWL researchers now realize that the seriousness of clients' problems in Marin City requires a different level of staff training. Staff must have formal, rather than informal, training in social issues, the experience to interject professional perspective into client and agency relationships, and the ability to deal with models for client and agency relationships.

Experience has shown that staff without formal social services training have been unprepared for helping clients cope with the complex problems they face. The MCFF Program Director points out that frequently the problems faced by clients were the same as those being experienced by family advocate. The family advocate then begins to question her abilitiy to help her clients becasue of her own inability to help herself.

In addition, the seriousness of problems experienced by MCFF families, especially the pervasiveness of drug abuse, and the complicated pattern of drug use and response to treatment, has resulted in a crisis-orientation among MCFF family advocates which made it difficult to focus on longer-range family supports and goals. Family advocates so frequently had to participate in crisis resolution, that they never tapped the resources of the Program Facilitation Team, which provided staff development in the specialty areas of

infant/toddler development, family development and education, community resources, career development/job training, substance abuse, medical and health service delivery, child care programming and community education.

Since last year, professionally trained case workers with Master's level education in social services have been recruited to fill vacant family advocate positions. Their backgrounds include clinical understanding of clients, case work and experience in other communities through internships. In addition, they have an understanding of theoretical models and systems change, which enables them to see beyond the isolated family to the larger picture: a comprehensive, coordinated child and family service system.

Based on their increased understanding of the skills required by family advocates, FWL researchers recommend:

- Family advocates in an intervention be required to have formal training in social services;
- Regular professional development activities be required for all family advocates; and
- Family advocates have available to them an opportunity to process their experiences working in a community such as Marin City , given the difficulty and severity of their clients' problems. In effect, the change agent should provide family advocates with therapy that enables them to continue to function at an optimal level in these circumstances.

In retrospect, as a result of their experience with family advocates in Marin City, FWL researchers have gained considerable insight to both the requisite professional qualifications of staff and the personal toll that an intevention can have on its staff members.

Conclusion

The lessons discussed above raise several critical context and process issues that go beyond the MCFF intervention and the Marin City community. The experience of FWL as a community change agent in this complex environment, with its unique configurations and interactions of family, support agencies, funding and the community project now unfolding there, has yielded knowledge that affects the development of future early intervention models in severely impoverished communities with fundamental community problems across the region and the nation.

Within this intervention model, clear cut progress has been made with regard to providing comprehensive, integrated services to families and children, and, despite the barriers to collaboration which have arisen from the context in which the model was implemented, the ways support services are delivered in the Marin City community are on the threshold of change.

We hope that this reflection on the experience of Far West Laboratory working in Marin City will encourage others involved in collaborative efforts to share assessments of their progress, their strategies for overcoming barriers, and the lessons they learn. Through reflection on the gaps in our collective knowledge, we can develop successful approaches to solving the challenges they pose to successful service delivery for our families and children.

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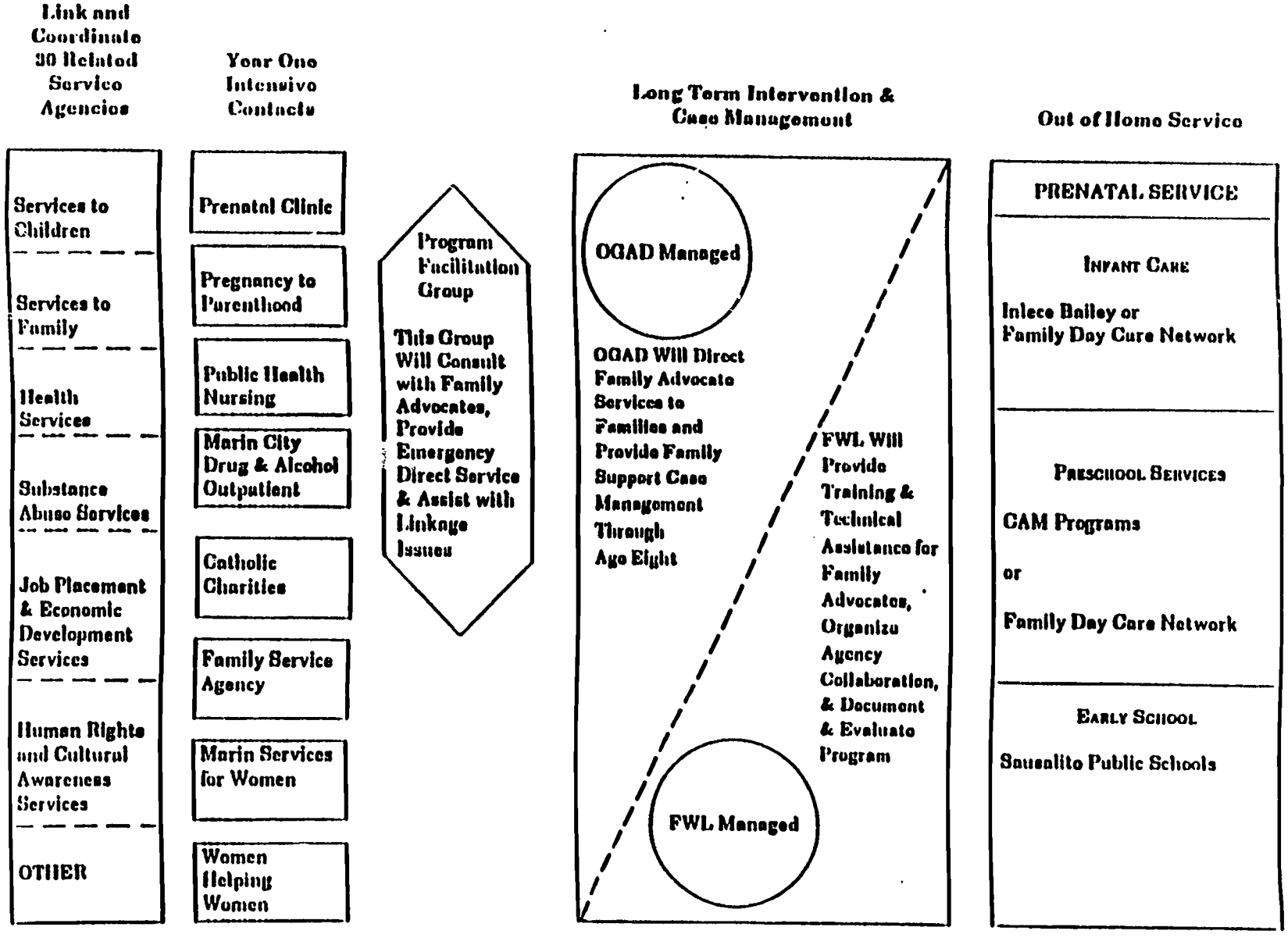
Appendix A

Families First: Long Term Family Support



Appendix B

Marin City Families First Evaluation - 1995

I. Healthy children who demonstrate age appropriate motivation and cognitive, language, psychomotor, and social functioning.

IA. Child Health: The goals for children are based on child health status together with age appropriate functioning. These goals also indirectly address family and service agency attention to children's health.

Goal	Measure	Data / Data Source
1. Program mothers have healthy, full-term pregnancies resulting in average to above average birth weight for focus children	1. Percentage of women having full-term pregnancies (37 weeks or more) as indicated in medical records. 2. Percentage of focus children born at low birth weight (<5.5 pounds).	1. 91% of program mothers had full-term pregnancies with the focus child. 2. 11% of the focus children were born below the weight of 5.5 pounds.
2. Children receive regular medical screenings including well care visits.	Percentage of focus children medically screened and maintaining ongoing growth record with pediatrician.	95% of the focus children have been medically screened regularly and maintain growth records.
3. Children maintain current immunizations	Percentage of focus children with current necessary immunization as indicated on their immunization records.	95% of the focus children have current immunizations documented in medical records.
4. Program children maintain stable overall health status with few serious illnesses or injuries.	The percentage of focus children with serious illnesses and/or injuries documented by family advocates.	7% of the focus children have been hospitalized for either a serious illness or injury.

IB. Age Appropriate Child Functioning

The data for this subgoal is to be collected on the program children when they reach thirty-six months of age. The Bayley Scales of Infant Development will be utilized to assess the focus children's functioning as well as a ten minute videotaped interaction between the focus child and his/her mother. At this time, data has been collected on the comparison children examining their level of functioning. A comparison group of 30 thirty-six month old children have been videotaped with their mothers and Bayley Scales have been completed for the group.

Goal	Measure	Data / Data Source*
Subgoal 1: Focus children demonstrate age appropriate motivation and positive personal learning styles.	Extent to which children show curiosity and an interest in their environment, pursue difficult tasks, and other behaviors indicating motivation and movement to inner controls.	Data has been collected on the comparison group of thirty children only, using the Bayley Scales of Infant Development and a videotaped interaction between the mother and the child. Data will be collected on program children when they reach thirty-six months of age. After data is collected on the program children, analyses comparing the two groups (comparison and program) will be completed.
Subgoal 2: Focus children's behaviors indicate age appropriate cognitive functioning.	At age three, children are able to understand cause and effect relationships, look through books, and understand abstract qualifier concepts such as like-unlike, quantity, and classification.	
Subgoal 3: Focus children exhibit age appropriate language functioning.	Children, at age three, are able to label and name objects, sing songs,imitate adult language, use verbal fantasy, and understand questions and directions.	
Subgoal 4: Focus children demonstrate age appropriate psychomotor functioning.	Extent to which children are capable of various large-motor and small-motor skills.	
Subgoal 5: Focus children engage in age appropriate social functioning behaviors.	Focus children's behaviors by age three include the ability to cooperate in activities with peers, respect feelings of others, experience friendships, go to adults for help and security in situations.	

* Data source is listed if data is not yet available.

II. Cohesive families who facilitate the health and development of the child.		
IIA. Family Cohesiveness: This goal addresses our belief that the most important influence on a child's development is his/ her family. Families First attempts to link program families to extended family members and to supplemental services to increase family involvement with the focus child. The goal is divided into three subgoals all focusing on increasing program families' cohesiveness.		
Goal	**Measure**	**Data / Data Source***
Subgoal 1: Development of an intense mother-child relationship. Parental behaviors are responsive to children's needs and promote the necessary infant-parent bond.	1. Family advocate ratings of parents who demonstrate the following parenting behaviors that meet their child's daily needs: • Coming to the assistance of crying infants • Holding young infants • Knowing and responding to child's cues for assistance and overall temperament. • Showing a mutual exchange of affection. • Making or acquiring objects for child (toys, clothes, books). • Engaging in vocal and verbal play with their child.	1. 53% of the program families have made significant progress toward achieving this program goal. At this time last year, advocates rated 33% of program families as having made progress on this goal.
1a. Parents who are are either requesting guidance or show little ability in developing an intense mother-child relationship are aided in learning the importance of the relationship and taught the skills to enhance the relationship.	1. An analysis of the Needs Assessments completed by program parents shows the percentage of parents requesting help with their parenting skills. 2. Case notes report the percentage of parents in parenting classes to enhance parenting skills.	1. 57% of program parents have listed parenting skills as an area of need in the Needs Assessment. 2. 47% of program parents have either completed or attending parenting classes.

Subgoal 2: Positive and frequent interactions among all family members.	Family advocate ratings of whether the focus child's immediate family promotes the development of the child by including the child in varied family activities with extended family (grandparents, aunts, uncles).	63% of the program families were rated by family advocates as having made progress in this area. At this time last year, advocates rated 33% of the program families as having made progress in this area.
Subgoal 3: Parent Development: This subgoal focuses on personal development in program parents' educational and career opportunities, their economic independence, and their ability to provide for their family members.		
Goal	**Measure**	**Data / Data Source***
3a. Parents participate in completing an assessment of family needs.	Percentage of families having completed a Needs Assessment every six months with Families First advocates.	All of the program families (100%) complete biannual Needs Assessments.
3b. Parents develop goals with the family advocates that work toward fulfilling their family needs as well as individual needs of family members.	Analyses of the Member Goals forms show the percentage of parents with goals set to address the needs outlined in their needs assessment.	All (100%) of the program parents maintain goals which are monitored monthly with family advocates. These goals are evaluated and rewritten biannually after a Needs Assessment is completed.
3c. Parents maintain goals to address both immediate problems and long-term solutions.	1. Analyses of the Member Goals form reveal the percentage of parents, at this time, with goals addressing very immediate problems, e.g. loss of custody of children, loss of housing, substance abuse. 2. Percentage of the above parents who also maintain long-term goals addressing employment, education, sobriety, etc..	1. Immediate goals and the percentage of parents with such goals: • Find suitable/ stable housing: 38% • Obtain sobriety: 30% • Regain custody of children: 7% • Find medical care for family: 27% • Find child care: 48% 2. All (100%) of the above parents also maintain long-term goals.

* Data source is listed if data is not yet available.

3d. Program parents maintain goals that focus them on their personal development in educational and career opportunities, their economic independence, and their ability to provide for their family.	Analysis of Member Goals forms completed by program parents reveal percentage of parents with long-term goals for personal development.	Long term goals and the percentage of parents with such goals: • Continue education: 53% • Obtain employment: 30% • Maintain sobriety: 27% • Complete ILS classes/ driver's training classes: 43%
3e. Family advocates and parents work together to monitor their progress toward attaining their goals.	The Member Accomplishments forms indicate the percentage of program parents making progress toward achieving documented goals.	97% of the program families have accomplishments documented indicating progress toward both long-term and short-term goals.
3f. Parents make progress toward attaining their long term goals in education and employment.	Case notes show the percentage of program parents and/or parental figures with custody of the focus child who have: 1. Enrolled in job training programs 2. Obtained either part-time or full-time employment. 3. Enrolled in either high school or GED programs 4. Completed high school or their GED 5. Attending college classes	Percentage of program parenting figures presently enrolled or engaged in the following: 1. 10% are enrolled in job training 2. 26% employed (Of this total, 25% are employed full-time and 75% part-time) 3. 17% in high school or GED programs 4. 26% completed either GED or high school. At this time last year, 21% of program mother had completed this goal. 5. 20% are attending college classes. At this time last year, 13% of the program mothers were enrolled in college classes.
3g. Parents develop effective strategies for working with agencies to either resolve their problems or get their families' needs met.	Family advocate ratings of the percentage of families who have increased their utilization of agencies available to address specific needs of their family.	91% have made significant progress toward utilizing services to address their specific needs. At this time last year, advocates rated 42% of the families as having made significant progress on this goal.

IIB. Family Facilitation of Child's Health and Development: This program goal focuses on informing families about important health practices for pregnancy and on various child-rearing practices that will result in the families increased facilitation of the development of their children. The means for achieving this goal are provided through the direct work of the family advocate in the home visitation program and the linking of families with services.

Goal	Measure	Data / Data Source*
Subgoal 1: To facilitate active family participation in the learning experiences and development of the focus child.	Family advocate ratings of the percentage of program families engaging in the following: • Daily learning experiences with the focus child. • Facilitate cognitive interactions among children and adults in family. • Attempt to increase their awareness of child development leading to an expansion in their maternal philosophy of child-rearing practices.	53% of the program families have made significant progress in this area. At this time last year, advocates rated 33% of the program families as having made significant progess on this set of goals.
Subgoal 2: Family advocates aid families in learning about nutritional, health, and safety needs of their children. Families, in turn, are able to provide a safe, healthy home environment for their children.	1. Analyses of the Needs Assessments show the percentage of parents requesting help with: • Child proofing their home • Creating space in their home specifically for their children • Buying and preparing healthy meals on a limited budget • Parenting skills focused on children's hygiene and health • Time management to organize home responsibilities (cleaning, laundry, shopping) (box continued on next page)	1. Percentage of parents listing following in needs assessments at this time: • Child proofing home: 30% of program parents • Creating space: 37% of program parents • Buying and preparing healthy meals: 37% of program parents • Parenting skills for hygiene and health: 50% of program parents • Time management: 37% of program parents (box continued on next page)

* Data source is listed if data is not yet available.

	2. The percentage of parents recorded in case notes to have taken parenting classes that included information on children's health and nutritional needs.	2. 47% of program parents are either attending or have completed parenting classes. All of the program parents or parenting figures receive counseling and guidance around their parenting and their child's development during in-home visits with family advocates.
2a. Parents create and keep a safe, drug-free home environment for child rearing.	Ratings by family advocates of the percentage of families maintaining a safe, drug-free home environment.	81% of the program families are maintaining safe drug-free homes and 19% are making progress toward having a consistently safe drug-free home, but still need work.
2b. Pregnant mothers have adequate prenatal care throughout pregnancy.	1. Medical records show the percentage of program mothers who had an adequate number of prenatal visits (10 or more) throughout pregnancy with the focus child. 2. Percentage of program mothers who rated their prenatal care provider positively on the Pregnancy Description form. 3. Family advocate case notes show the number of pregnant women presently maintaining regular prenatal visits.	1. 77% of families have had an adequate number of prenatal visits (10 or more). 2. 94% of the program mothers rated their prenatal care provider positively and felt comfortable with the provider. 3. Two program parents are pregnant, one of whom has regular prenatal visits at this time.
III. Supportive community functioning and community/ family interaction.		
IIIA. Employment and Economic Opportunities and Participation: This goal focuses on family members being able to choose and take advantage of employment opportunities within the community during the ongoing development of the community.		

* Data source is listed if data is not yet available.

Goal	Measure	Data / Data Source*
1. Families will be able to obtain employment opportunities.	Family advocate ratings of the percentage of program parents or parenting figures with custody of the focus child who are presently: 1. Enrolled in job training programs 2. Employed in either part-time or full-time employment.	Percentage of program parents or parental figures engaged in following: 1. 10% in job training 2. 26% are employed presently (Of this total, 25% are employed full-time and 75% part-time)
2. Parents continue to make progress toward fulfilling educational and/or employment goals.	1. Analysis of the Member Goals forms shows the percentage of program parents with goals relating to education and/or employment. 2. Analysis of the Accomplishments forms shows the percentage of program parents listing accomplishments relating to education and/ or employment.	1. 67% of the program parents have goals relating to education and/or employment at this time. 2. 63% have accomplishments listed related to education and/or employment.
IIIB. Quality Chid Care Opportunities and Participation: This goal addresses the need for program parents to acquire child care in order to then focus on their own personal development goals of employment and education. The families' utilization of child care would also provide developmentally appropriate cognitive and social experiences for children and help put parents in contact with other parents to provide mutual support.		
Goal	**Measure**	**Data / Data Source***
1. Quality child care opportunities will be available to families allowing them to pursue work and/ or educational goals.	As documented on the Family Information Form, the percentage of families utilizing child care outside of the home.	30% of the focus children are cared for in child care centers.

* Data source is listed if data is not yet available.

2. Family advocates work with families in need of childcare to acquire the service.	Family advocate ratings of: 1. The percentage of program families needing child care services. 2. The percentage of program families in need of child care who are listed on waiting lists for local child care centers.	 1. 48% of the program families need child care services, but must enroll in either job training or educational classes to qualify for the available services. 2. All of the families in need of childcare have been put on waiting lists while they begin the process of enrolling in job training and/ or classes.
IIIC. Reduced Incident of Illegal and other Harmful Drug Use in Program Families (more comprehensive measures under last evaluation goal.)		
Goal	**Measure**	**Data / Data Source***
Drug-free pregnancies for all program mothers.	1. Medical records showing the percentage of program mothers who had drug-free pregnancies. 2. Family advocate ratings of the percentage of program mothers who had drug-free pregnancies.	1. 24% of the program mothers had positive tox tests at the time of their focus childs' birth, meaning the other 76% had no drugs detected in their systems at the time of their focus child's birth. 2. Family advocate ratings indicate that 33% of program mothers had drug-free pregnancies with the focus child.
IIID. and IIIE. Cultural Affirmation, Identification, and Participation in Cultural Events: These program goals address the importance of recognizing, respecting, and supporting the cultural differences of the program families and of the Marin City community. The goal also points to the importance of program families involvement in the community to develop their own informal, personal support network with other families. **Note: Data for these goals has been collected on the comparison group only. Much of the data concerning cultural awareness and parental participation in the local community will be gathered from the program parents in the parent interview, which will be given to program parents when their children reach thirty-six months of age. Some examples will be included as qualitative data for these subgoals.*		

* Data source is listed if data is not yet available.

Goal	Measure	Data / Data Source*
1. Parents are able to take time to participate in cultural events which affirm and encourage the cultural strengths of the community.	Parent ratings of the extent to which the cultural strengths of the families and community are recognized and supported by local cultural events.	*Parent Interveiw to be completed when focus child reaches thirty-six months. *Example*: One event which was jointly created by the *Families First* clinical director, community child care centers, and the Sausalito school district is the "Stepping up Ceremony". Program parents are invited to attend this event to celebrate their children's entrance to school.
2. Family advocates are familiar with the history and culture of Marin City and are able to provide support for the cultural strengths of the family.	Parent ratings of the family advocates' level of support of program families cultural differences when working with them.	*Parent Interview *Example*: Family advocates engage in family planning upon enrolling a program family. These family planning sessions include educating family advocates on the culture of each family. The ongoing case conferences and supervison of family advocates also focus on maintaining cultural awareness when providing services.
IV. Cooperation and coordination among agencies to better provide comprehensive services to children and families. **Note: At the start of Families First, baseline data was collected from twenty-six family service providers representing various agencies, some of these were community based and some were county based. This agency interview examined what services are provided to Marin City residents as well as the level of coordination between various service providers. The agency interview will be given again to some of these same service providers after the completion of the project.*		
IVA. Increased Access and Utilization of all Family Services: Families First family advocates work with program families on increasing their utilization of various family services, including any medical, health and human services, as well as educational. Part of this work involves the family advocates educating families about the available services, but a large part of the work involves helping families become more comfortable with approaching service providers and agencies for necessary services.		

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* Data source is listed if data is not yet available.

Goal	Measure	Data / Data Source*
Program families are better able to utilize various family services.	Family advocate ratings of the percentage of program families who have improved in their ability to utilize family services.	All (100%) of the program families are more able to access and utilize various services (e.g. see section *VC.*, focusing on CPS Families). Last year at this time, advocates rated 42% of the families as having made progress on this goal.
IVB. Coordination Among Agencies in Goals for Services, Roles and Responsibilities, and Eligibility Criteria: This project goal applies to not only the Families First families, but to the entire Marin City community. The goal focuses on the need to increase county based agencies involvement in coordinating various services needed in the Marin City community which is very isolated from the rest of Marin County. Family advocates work with many agencies to coordinate services for program families, which may then educate county based agencies on the needs of Marin City residents and the best ways to meet these needs.		
Goal	**Measure**	**Data / Data Source***
Agencies working with residents of the Marin City community coordinate with other agencies involved in the community leading to a clear understanding of their roles and responsibilities. This coordination will help to avoid duplication of services, resulting in a smooth flow of comprehensive services to Marin City families.	Analysis of the agency interviews indicates the percentage of the agencies interviewed that coordinate with other agencies providing similiar services (e.g. Do all of the child care providers interviewed coordinate their efforts to provide child care to families in need?)	Although all of the agencies interviewed could provide concrete examples of coordination with other agencies, only 38% of the providers interviewed maintain consistent coordination efforts with agencies that provide similar services.
2. *Families First* program families have access to an overall service network which is more responsive to their needs. Agencies involved in serving program families coordinate services to avoid duplication or gaps in services provided.	1. Analysis of the agency interviews shows the percentage of agencies interviewed that work with *Families First* families. 2. Agency interviews indicate the percentage of the above agencies that coordinate regularly with each other through case conferences, regular meetings, or phone contact.	1. At the time of the interviews (early 1994), 40% of the agencies interviewed worked directly with *Families First* families. 2. 80% of the interviewed agencies which were involved with *Families First* families had regular contact with other agencies involved to coordinate services.

* Data source is listed if data is not yet available.

IVC. Competent and Effective Family Advocates and Case Workers: Families First family advocates will demonstrate competence and effectiveness in all aspects of their family support functions. Advocates will also work with agency case workers to mediate for program families who are having problems with particular agencies.		
1. Family advocates meet their weekly responsibilities with program families.	Documentation in the Contact Log indicating the percentage of families having received weekly visits (either in home, office, or job site of family member) from the family advocates.	75 % of the families have met weekly for at least an hour with family advocates over the last year. Advocates maintain some form of contact (phone, brief check-ins out in the community) weekly with all (100%) of the program families.
2. Family advocates provide program families with both support and advocacy as needed. An immense problem, which is addressed here, is the lack of transportation for families to reach service providers.	Analysis of data in the Contact Log shows the percentage of program families who 1. have weekly supportive discussions with advocates 2. receive mediation and/or advocacy from family advocates. 3. receive transportation subsidies or help with getting transportation to a provider to obtain a necessary service.	1. 73% of the program families engage in weekly supportive discussions with the family advocates. 2. Over the past year, advocates have provided advocacy for 90% of the families to receive services from various service providers. 3. 75% of the program families have been provided either transportation or transportation subsidies by advocates to reach a service provider.
3. Family advocates attend weekly case conferences and scheduled trainings to increase awareness of interventions and available services applicable to their families. 92	Both the clinical director and the family advocates were interviewed about trainings attended this year by family advocates. (box continued on next page)	1. Family advocates have attended the following trainings during the last year: • A series of six half-day trainings focused on infant/ toddler development. • A two day (16 hours) conference on substance abuse and domestic violence. • A full day conference on respite care. 93 (box continued on next page

* Data source is listed if data is not yet available.

	2. Clinical director's rating of the Program Faciliation Team involvement in trainings	2. Members of the Program Facilitation Team provide training and consultation biweekly. The Consulting and Training Team from The Children's Developmental Center of Oakland Children's Hospital is presently providing the biweekly trainings. 3. Family advocates attend regularly scheduled case conferences with the clinical coordinator and any involved agencies.

V. Accomodation of the special risks and needs of pregnant teenagers and teenage parents and other special populations.

VA. Pregnant teenagers and teenage parents receive special services which promote healthy pregnancies as well as completion of high school education.
**Note: Some points of the Families First teenage mothers' data will be compared to the Bay Area Early Intervention Program (BAEIP) study completed in 1992 titled "African-American Births in Marin City, California". The 1992 study includes information on teenage parents living in Marin City prior to the start of Marin City Families First.*

Goal	Measure	Data / Data Source*
1. Pregnant teenages in the *Families First* program receive adequate prenatal care.	1. Percentage of teenage mothers in the program. 2. Medical records of the percentage of the pregnant teens who have received adequate prenatal care (10 or more visits). 3. Data from 1992 BAEIP study	1. 26% of the program mothers are teenagers. 2. 100% of the teenage mothers in the program have had 10 or more prenatal visits. 3. Before *Families First* began, the 1992 BAEIP study showed that 45% of Marin City teenage mothers had 10 or more prenatal care visits.

* Data source is listed if data is not yet available.

2. Teenage mothers in the program have full-term pregnancies resulting in average to above average birth weights.	1. Analysis of the Pregnancy Description forms indicates the percentage of teenage mothers who had full-term pregnancies. 2. Medical records show the percentage of teenage program mothers who gave birth to children with low birth weights (>5.5 pounds). 3. Data from 1992 BAEIP study	1. 92% of the teenage mothers had full-term pregnancies. 2. None of the program teenage mothers' children were born at low birth weights. 3. 12% of the Marin City teenage mothers in the 1992 BAEIP were born below 5.5 pounds.
3. Pregnant teenagers and teenage parents receive adequate education focused on parenting skills.	1. Case notes document the percentage of teenage parents in the program who have attended parenting classes.	1. 50% of the teenage mothers have attended parenting classes while in the program. These classes were provided either through high school or while the teen was in a residential parenting program.
4. Teenage parents in the program are able to continue and complete their high school education.	1. Family advocate ratings of the percentage of teenage parents in the program who continued to attend school after becoming pregnant. 2. Data from 1992 BAEIP study 3. Percentage of teenage parents in the program who have completed their high school education. 4. Data from 1992 BAEIP study	1. 50% of the teenage mothers continued to attend school after becoming pregnant. 2. In the 1992 BAEIP, 40 % of the teenage mothers started home teaching after giving birth. None of the teenage mothers in the study continued to attend high school after giving birth. 3. The same 50% who continued school after becoming pregnant have since graduated with a high school diploma. 4. According to the 1992 BAEIP study, 11% of the teenage mothers in the study completed 12 years (high school) of education.

* Data source is listed if data is not yet available.

5. Teenage parents enrolled in the program avoid having more children while in their teenage years.	1. Percentage of teenage parents in the program who have children other than the focus child. 2. Data from 1992 BAEIP study 3. Percentage of teenage mothers in program who practice birth control.	1. 91% of the teenage mothers have no other children at this point. 2. In the BAEIP 1992 study, 85% of the teenage mothers had no other children while in their teenage years. 3. 75% of the program teenage mothers practice birth control, 16% are pregnant with a focus child, and 9% do not practice any method of birth control at this time.

VB. Substance abusing parents receive substance abuse treatment. This goal addresses both the family advocates' work with the families as well as agency work with the families in need of substance abuse treatment. Family advocates provide support and advocacy for families who are attempting to enter substance abuse treatment. Advocates also work with family members who deny they're having substance abuse to help them admit their need for treatment.

Goal	Measure	Data / Data Source*
1. Substance abusing program parents are focused on receiving treatment.	1. Analyses of the Needs Assessments show the percentage of program mothers who have listed substance abuse as a problem they need help with at this time. 2. Family advocate ratings of the percentage of program mothers with substance abuse problems. 3. The Member Goals forms indicate the percentage of program mothers who have set goals that address substance abuse problems.	1. 59% of the program mothers have listed substance abuse as a problem. 2. Family advocates rate 67% of the program mothers as having substance abuse problems. This total will be used to refer to program mothers with substance abuse problems instead of the above in #1. 3. 47% of the program mothers have set goals up for themselves that address substance abuse problems.

* Data source is listed if data is not yet available.

2. Program families with substance abuse problems receive appropriate treatment.	1. Case notes show the percentage of program mothers with substance abuse problems who have enrolled in inpatient treatment. 2. Case notes show the percentage of substance abusing program mothers who have received outpatient services.	1. 50% of the mothers with substance abuse problems have enrolled in inpatient treatment programs. 2. 20% of the program mothers with substance abuse problems have received outpatient treatment services.
3. Substance abusing program parents are able to become sober and maintain sobriety.	1. Family advocate ratings of the percentage of program mothers with a history of substance abuse problems who have obtained sobriety. 2. Family advocate ratings of the percentage of program mothers with a history of substance abuse problems who continue to abuse substances.	1. 23% of the program mothers with substance abuse problems are fully recovered and maintaining sobriety. At this time last year, family advocates ratings revealed that none of the program mothers had obtained sobriety. 22% are in treatment presently. 2. 55% of the program mothers with substance abuse problems are in need of treatment at this time. (They are 37% of the total number of program mothers).
4. If a program parent is not able to maintain a drug-free home, his/her children are cared for by someone other than the parent until the parent can achieve sobriety.	Number of focus children who are cared for by someone other than their biological parents due to their parent having substance abuse problems.	Two focus children are cared for by relatives due to his/her parents' substance abuse problems.
5. Pregnant program mothers with substance abuse problems maintain sobriety throughout pregnancies resulting in healthy drug-free births.	1. Percentage of program mothers taken from medical records, who had positive tox tests at the time of the focus child's birth. (box continued on next page)	1. 24% of the program mothers tested positive for drugs or alcohol at the time of the focus child's birth. As noted on page 10, goal *IIIC* of this report, family advocate rating indicate that 67% of the program mothers were involved in substance abuse during their pregnancy with the focus child. (box continued on next page)

* Data source is listed if data is not yet available.

	2. Medical records show the percentage of focus children in the program who had positive tox tests at birth. 3. Birth Outcome forms show the percentage of program mothers who have had previous children (before focus child) who tested positive for drugs in their system at birth.	2. 10% of the focus children who were tested had drugs in their systems at birth. 3. 42% of program mothers who have had previous children who tested positive for drugs in their system at birth.
6. Families who continue to deal with legal problems (custody loss, probation) related to substance abuse are supported in their efforts to resolve legal problems.	1. Family Information Forms and Needs Assessments show the percentage of families with past or present legal problems related to substance abuse. 2. Percentage of the above families who have either resolved the legal problems or are working on resolving them presently with family advocates.	1. 30% of the program parents have listed legal issues related to substance abuse as a problem they need help with while in the program. 2. Half (50%) of the above families have resolved their legal problems related to substance abuse, while the other half continues to work on resolving the problems.

VC. Child Protective Services families receive services focused on helping them resolve problems resulting in closure of their cases.

Goal	**Measure**	**Data / Data Source***
1. Program families successfully work with CPS to close active cases.	Family advocate ratings of the percentage of program families who have successfully worked with CPS to close their case and end need for involvement of CPS.	55% of program families have successfully closed CPS cases while in the program.

* Data source is listed if data is not yet available.

2. Program families who have active CPS cases are able to work with CPS toward closing their cases.	1. Percentage of program families who have open CPS cases. 2. Family advocate ratings of the percentage of the families with active cases who have improved their ability to work with CPS.	1. 7% of the program families have open cases with Child Protective Services. At this time last year, 21% of the program families had open or active CPS cases. 2. All of the above program families have improved their abilities to work with CPS.
VD. Families with disabilities are able to secure appropriate services.		
Goal	**Measure**	**Data / Data Source***
1. Families with developmentally disabled focus children receive services to meets their special needs.	1. Family Information Forms indicate the percentage of program families with developmentally disabled focus children. 2. Case notes show the percentage of focus children who receive special services for their disability.	1. 3% of the program families need services for a developmentally disabled family member. 2. The 3% of families with developmentally disabled focus children all receive services to address and aid them with the disability.