BUILDING PARTNERSHIPS

Models OF Family Support AND Education Programs

Child Welfare Reform Initiative, North Dakota
Decategorization Project, Iowa
Full Service Schools, Florida
Early Education Services, Vermont
Medical-Legal Services, Massachusetts

HARVARD FAMILY RESEARCH PROJECT
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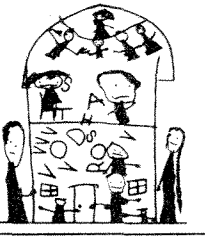

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The Harvard Family Research Project

Heather B. Weiss, Director

The Harvard Family Research Project, established in 1983 as an affiliate of the Harvard Graduate School of Education, conducts research relevant to current U.S. public policy debates about the effectiveness of support and education programs for families with young children. Its mission is to examine and assist in the development of policies and programs designed to strengthen and empower families and communities as contexts of human development. Its activities are guided by the belief that to educate the whole child, public schools must expand their role to include partnerships with parents and other community agencies supporting child development from infancy through adolescence.

The Project collects, analyzes, and disseminates information about family support and education programs. It reaches an audience composed of practitioners, policy makers and evaluators. Current projects include case studies of comprehensive child and family services through the auspices of education, social services, health, and child welfare; technical assistance on the development of school-affiliated family support, education, and involvement programs; the evaluation of teacher training courses which aim to foster partnerships with parents and other community agencies; and the assessment of parenting and child development materials.

This booklet is part of a series of profiles on family support and education programs across the United States. The first two booklets, **Pioneering States: Innovative Family Support and Education Programs** and **Innovative States: Emerging Family Support and Education Programs** focused on state-sponsored policies. The current booklet follows the development of the family support movement as it seeks to create a continuous, comprehensive system of community services for children and families both at state and local levels. Additional publications of the Harvard Family Research Project can be found on page 51.

Overview and Lessons

Our society is advocating a new commitment to children. Rising child poverty rates, transformed family structures and living arrangements, and a lack of coordinated institutional supports for families stimulated a broadening of policy directions. New initiatives have led to a shift from individual and remedial services to family-oriented programs focused on prevention and early intervention. They call for a commitment to support the caregiving role of families and advocate a comprehensive approach to address family issues. The broadening of views and practices in family and child policy has far reaching implications for redesigning public service systems: their implementation requires recasting the current fragmentation of health, education, and social services into an integrated and comprehensive system.

The thrust toward early, family-focused, and linked interventions occurs at a time of greater need but fewer resources to support children and families. The decade of the nineties has opened with an economic recession, increasing numbers of those seeking public assistance, and more families with multiple stresses. At the same time, services responding to children's needs have been reduced. Organizations noted for innovative programming have shifted priorities. Instead of offering badly-needed new services, they are using available funds to maintain core services. Providing comprehensive services becomes an increasing challenge as public and private entities have found their service capacity diminished.

This booklet contains profiles of five diverse programs working out a better future for children through family-focused and comprehensive service delivery. The programs are: North Dakota's Child Welfare Reform Initiative (CWRI), Iowa's Decategorization Project, Florida's Full Service Schools, Brattleboro's (Vermont) Early Education Services (EES), and Boston's (Massachusetts) Medical-Legal Services Project. Each profile includes a history of the initiative, a description of the program, and reflections on the past and future by the state- or local-level director. Our goal is to provide policy makers, advocates, and administrators with concise information on policy development and the program characteristics of these five varied approaches to attaining comprehensive services.

The Programs

The five programs represent efforts to transform public service systems that deal with children, families, and communities, exemplifying the characteristics of the evolving comprehensive approach of the 1990s. The programs combine services to meet the multifaceted goals and needs of families. They encourage cooperation and collaboration among agencies and attempt to institutionalize mechanisms for initiating and sustaining this collaboration. These programs involve participants on advisory boards, serving as resources for one another, and they evolve to meet participant concerns through individual or community-based assessment. They also strive to be sensitive to the cultural characteristics of the communities they serve. Local empowerment is part of this new way of doing business and it operates at every level: for the individual, the family, the staff, and the community.

While they share a common, family support philosophy, the five programs' patterns of service delivery and strategies of advancing systemic change differ. Different agencies—education, health and social services—take the lead role in mobilizing the resources to transform the service delivery system. This reflects the range of possible entry points for collaboration and approaches to making service systems more responsive to community conditions. Because the interest in collaboration spans many levels of the public service system, the programs also illustrate both state and local initiatives.

The North Dakota CWRI represents a foundation-inspired effort to transform a state's entire social service delivery system. The initiative involves statewide planning and coordination with local management. Originally administered by state-level officials, the program has struggled over the years to negotiate local ownership. As one of the earliest efforts in collaboration, the North Dakota experience demonstrates the importance of maintaining flexibility as blueprints become operating realities and develop over time. At the service delivery level, the case-management approach is being developed and refined in two pilot counties.

Iowa's Decategorization Project has literally removed categorical restrictions from funding streams within county social service budgets, thereby allowing counties to reorganize funding and programs in a way that better suits the needs of their participants. The program was conceptualized by state-level commissioners and

opened to counties by a bidding process. Counties then created departmental and community advisory and planning groups to create new systems of service creation and delivery. The decategorization theoretically provides a mechanism for constantly readjusting and recreating a service system to meet the evolving needs of children and families.

While North Dakota and Iowa have channeled their efforts through the state departments of social services, Florida and Brattleboro, Vermont have looked to the public schools as the locus of service innovation. Florida's Full Service Schools and Brattleboro's Early Education Services are examples of the new directions schools are taking to promote the full development of children by supporting their families. The concept of full service schools in Florida involves a collaborative effort to make the school a venue of health and social services. It is supported by two parallel state initiatives, one in education and the other in health. Here the state has responded to local social problems and supported and encouraged community-based planning for change. Local school districts design comprehensive services for students and families with state resources. These services also provide the supports teachers need to do their jobs effectively in the classroom.

Early Education Services, also a school-based program, offers a model of grassroots expansion to provide continuous and comprehensive services. Beginning with a parenting and early education program, this unit of the school system has built a network of referrals, shared resources, and community planning to coordinate services for children and families. In a rural community with diverse resources, the program has attempted to fill gaps in service delivery and to avoid duplication.

In the context of scarce resources to support children and families, it is important for programs to develop mechanisms that encourage the needy to take advantage of their entitlements. The Medical-Legal Services Project in Boston does just that by using hospitals as an entry point for client access to a full array of social services. It highlights the importance of integrating different expertise and resources to ensure that individuals and families are able to resolve issues that cut across traditional professional and program lines. The project staff inform patients of the benefits they are entitled to receive, advocate on their behalf, and obtain legal advice from project-affiliated lawyers on interpreting regulations of government

programs. Without such advocacy a high proportion of the poor and sick simply are not receiving all the benefits to which they are entitled. Additionally, the project educates physicians and other hospital staff about the broader roles they can assume in fulfilling their practice.

Factors Facilitating Effective Collaboration

The experience of the five programs suggests certain key factors in developing collaboration to support young children and their families.

Communities with a history of agencies working together are particularly well positioned for the resurgent interest in collaboration. Personal networks built over time facilitate goal setting, resource sharing, and flexibility in interpreting bureaucratic rules in order to create family-focused services. These communities use new collaborative incentives from foundations, federal or state sources to expand geographically and substantively their successes and to transform previous failures into learning experiences for future programming. If communities do not have a past history to guide them, they must create their own history of collaboration.

Collaboration thrives under a leadership that combines vision, astuteness and entrepreneurship. Emerging leaders recognize the value of team work and co-ownership. They bring people together to affirm a common mission and to craft the mutual responsibility and resource sharing that underlie joint enterprises. These leaders know how to enlist broad support and minimize opposition. In a context of scarcity they are able to fit their goals with existing resources and garner the funds to piece together a comprehensive, family support program. As part of their long-range vision they seek to build programs that remain viable even with a leadership turnover.

The commitment and dedication of staff are essential to successful collaboration. Staff that put children and families first are interested in combining caring attitudes with efficient services. They are motivated to develop working relationships with other community resources to secure needed services. Although trained as specialists they recognize the need to expand boundaries and make team work the foundation for improved services for children and families.

Comprehensive family support and education programs must involve communities in developing programs to serve their own members. New initiatives reflect a commitment to community involvement in all phases of program development. State leaders are now recognizing the importance of incorporating local knowledge in planning and program development and sustaining that input so that programs evolve to meet the changing needs of the community. Such long-term cooperation and commitment allows communities to benefit from the technical assistance the state offers in designing local programs and allows the state to design better programs. These mutually beneficial relationships indicate a new paradigm in social policy: communities are not social laboratories for outside experts but resourceful and innovative networks that can support and empower families.[1]

Challenges to Effective Collaboration

The experiences of the five programs also raise challenges to sustaining and supporting collaboration in child and family services.

Funding is crucial to initiating and sustaining effective collaboration and poses a particular challenge in an uncertain economy. Although policy makers view collaboration as cost-effective, in part by reducing the duplication of services, setting up the system to facilitate collaboration involves an investment of resources. In today's economic recession, state-assisted programs are at risk of becoming victims of budget cuts. Collaboration is harder when resources are diminished. It takes people to make a collaboration work and staffing cuts diminish the viability of coordination and the availability of services.

Furthermore, stable sources of funding are needed to maintain collaboration. Programs supported by "soft money" and research and demonstration grants cannot expect to rely on these sources indefinitely. The decategorization of funds at state and federal levels offers one strategy for redesigning systems with no or minimum infusion of new resources. Existing health, education and social security legislation can also be interpreted anew for

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[1]Peter Berger (1992). "Neighborhood and Enterprise." *Agenda* 2(1):10-15.

provisions that allow collaborative, family-oriented services using available resources. Furthermore, public education can go a long way to build local commitment and strengthen national advocacy for the well-being of children.

The goal of collaboration is effective service delivery. Collaboration cannot be understood as an end in itself. The coordination of service development and delivery and the participation of various groups in planning are steps towards a more humane and responsive system. Collaborative programming must ultimately be evaluated not by the extent or smoothness of coordination but by the quality and effectiveness of the services themselves.

While the delivery of services may be improved by creating a supportive environment and incentives for cooperation, the collaborative process involves more than just sharing resources and opening communication among service deliverers. Concrete steps must be taken to overcome the fragmentation and gaps in the service system. Indeed, interagency referrals and linked service systems will not improve the lives of children and families if the system cannot provide the necessary levels of quality and support for the services themselves.

Collaboration requires sustained time and effort. As collaboration is a continuous process, community representation needs consistent nurturing. Clarifying the roles of agencies in a cooperative enterprise and working out the details that encumber operations takes time and a major commitment on the part of administrators and staff. The continued involvement of schools, public service agencies, and other community groups in decisions affecting implementation is a prerequisite to reforms that advance the capacity of public service agencies to serve families in a holistic manner.

Collaboration may open new agendas for child and family services. Collaboration may serve not only to identify areas of service duplication and inefficiency but gaps in service provision as well. Collaboration thus may result in more than just a cost-effective streamlining of existing services; it may also call into question the ability of certain services to meet client needs, perhaps necessitating the expansion of current services or the development of new services. These outcomes underscore the notion that collaboration is neither a "quick fix" nor a "cheap and easy solution" for the

problems of the current system of family and child services.

Finally, policies and programs designed to foster collaboration have yet to be instituted on a large scale. Resources are currently concentrated in a limited number of model programs. It is heartening to note that quality programs are flourishing in many parts of the country and that small-scale efforts have been disseminated by expanding program sites. However, it is also painfully clear that we have not found the means or resources to make these collaborations integral to the core functioning of service systems, nor have demonstration projects been sustained over time.[2] This sobering reality suggests that policy makers and children's advocates need to continue to plan incremental and do-able objectives, accepting that system-wide change is a long-term commitment and one that we are still learning about.

Diversity is a crucial ingredient in advancing the agenda of collaborative service delivery. The process of institutionalizing collaboration requires supporting initiatives at all levels of government and in all parts of the social service system. Yet as collaboration is being encouraged in overlapping policy circles, there is also a need to link and complement local, state, and federal initiatives, both within and between these levels. Communication flows have to be designed to ensure that stakeholders are appraised of what is going on within their scope of operations. Otherwise the problems of fragmented service systems may be replaced with those of duplicate collaborations. At the same time, different levels of the service system should connect in ways that ensure policy is responsive to the changing needs of children and families.

The impetus toward comprehensive, family-oriented services is still at a formative stage. The five initiatives in this booklet are not completed programs but works in progress. They represent "new beginnings" in service delivery and the systems on which they are grounded. The profiles are meant to provoke ideas on what can be accomplished, what strategies work in their specific contexts, and the diversity of networks and resources that can be tapped. They suggest thinking about the service system as a dynamic entity that

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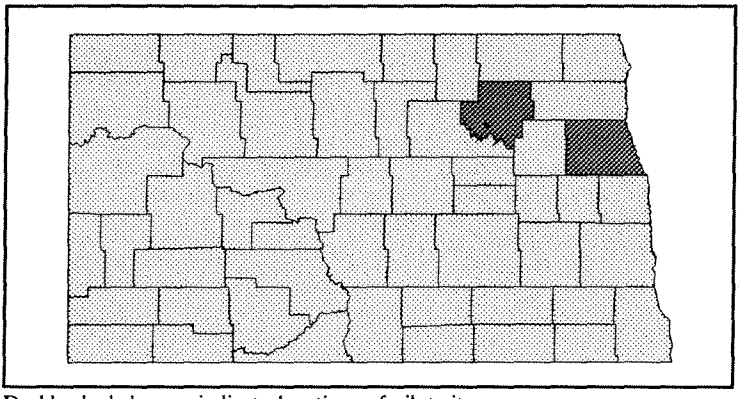
[2] Department of Health and Human Services. *Services Integration: A Twenty-Year Retrospective.* Washington, D.C.: Office of the Inspector General, (January 1991).

evolves with the values and organization of the larger society in which it is embedded. As such we are reminded that family support and education programs are necessary but not sufficient to promote the success of children in school and in later life. Family and child policy will work best when implemented in conjunction with policies that ensure more equitable access to quality education, employment, housing, and health care.

M. Elena Lopez
Jacqueline Kraemer
Heather B. Weiss
June 1992

NORTH DAKOTA

Child Welfare Reform Initiative (CWRI)



Darkly shaded areas indicate locations of pilot sites

North Dakota's Child Welfare Reform Initiative (CWRI) aims to reduce the number of children in the state's foster care system by improving services for families. Under the guidance of the Annie E. Casey Foundation, the project invests in case management and family support systems, both new approaches for the state of North Dakota. This strategy aims to limit the foster care caseload. Savings from reduced caseload are redirected into the family services system. This emphasis on family services is also an attempt to overcome intergenerational welfare dependency and mend the fragmentation of family and child services. North Dakota's effort is supported by a five-year grant from the Casey Foundation and matching funds from various participating state agencies. The two pilot sites have just received their fourth year of funding from the Casey Foundation and have served approximately 600 families.

Program Development

Origins

CWRI was developed by the Children's Services Coordinating Committee (CSCC) in 1987 at the suggestion of the Casey Foundation. North Dakota was one of three states that received grants to reform their system of children's services. The foundation

provided CSCC with a $100,000 grant to develop a proposal. The CSCC itself was created by the state legislature in response to the recommendations of a study of the delivery of services to children which was conducted by the Governor's Children and Adolescents at Risk Committee. CSCC was charged with clarifying the roles of different agencies, identifying risk factors, describing available services for children and families, and developing a plan to improve these services. The resulting CWRI was funded in 1988 at $3.75 million over five years contingent upon the fiscal support of a coalition of state agencies. CWRI is notable for securing the cooperation of the Indian Affairs Commission; its pilot site at Devil's Lake serves primarily Native American populations. There are no plans to expand beyond the two pilot sites at Devil's Lake and Grand Forks.

Key Events

1988 CWRI is funded by the Annie E. Casey Foundation

1989 CWRI begins operation at two pilot sites.

The Robert Wood Johnson Foundation grants North Dakota $100,000 to develop a four-year, $2.4 million program for emotionally disturbed children to be based at CWRI sites.

The state legislature establishes CSCC as a permanent oversight and funding agency for CWRI.

1991 Authority is transferred from CSCC to local Families First boards.

Program Description

Organization The CSCC, chaired by the Lieutenant Governor's Office and drawing membership from eleven state agencies, initially acted as the administrative and funding agency for CWRI. Two regional organizations, called Families First Boards, were created to carry out the initiative at each of the two

pilot sites. The authority of the Families First Boards, composed of local agency directors and school administrators, had been limited to hiring staff and choosing services to deliver. In 1991, however, management authority was transferred from CSCC to the Families First Boards and CSCC was left with only fiscal and program monitoring responsibilities. The Children's Welfare Research Bureau at the University of North Dakota has also assisted with program planning and coordination.

Agency Collaboration

CWRI is an interagency effort. CSCC includes representatives from the Department of Human Services, the Division of Juvenile Services, the Department of Health, Job Services, the North Dakota Supreme Court, the Office of the Attorney General, the Office of Management and Budget, the Indian Affairs Commission, and the Department of Public Instruction. The members of Families First Boards were chosen by the local planning committees which included representatives from county and tribal social service agencies, juvenile and family courts, tribal councils, public schools, special education departments, mental health agencies, medical and public health providers, community residents and parents.

Goals

CWRI is intended to preserve and strengthen families by coordinating services effectively and efficiently for the entire family unit. It aims to eliminate time consuming and frustrating multiple assessments and fragmented service delivery by adopting a community-based approach. Long-term goals include reducing out-of-home child placements, decreasing the number of children entering foster care annually, lessening the length of foster care, and minimizing the number of repeat and sibling entries into state custody. Although families at risk of foster care placement are CWRI's first priority, the initiative aims to

develop an integrated, community-based system of comprehensive support services for all families. When Families First Boards assumed responsibility for program activities, they added the goal of testing new models of service delivery to their mission.

Funding

The Annie E. Casey Foundation provided a five-year, $3.75 million grant for CWRI in 1988. State matching funds are required and have come in the form of reallocated funds, staff, and contracts for early intervention and prevention programs. The tribal governments and local housing authorities have also contributed program space and housing for families in crisis, and local special education districts have contributed to case managers' salaries. The amount of local funding and in-kind contributions are different at each site. Both the CSCC and the Families First Boards are planning now for continued funding after the Casey Foundation grant ends.

FY	Annie E. Casey Foundation	State Agencies
87-88	$40,000	
88-89	$466,292	$447,000
89-90	$746,419	$1,240,955
90-91	$800,400	$806,836
91-92	$748,906	*

*figures not yet available

source: Children's Services Coordinating Committee, Office of the Governor

Participants

Three populations have been selected for CWRI: families with children in out-of-home placement; families whose children are at imminent risk of

placement; and families with children who are at-risk for abuse and neglect. Participation is voluntary and parents may be self-referred or referred by school or agency staff. The majority of participants receive public assistance.

Staff

Case management staff have been drawn from the staff of existing agencies and from the community. The state does not specify qualifications for case managers and, as North Dakota lacks a large pool of professionals, regional Boards look to life experience and demonstrated skill as much as formal education. The Boards also attempt to hire trusted and respected members from within the community. All staff participate in initial and ongoing training provided by the Children and Family Services Training Center at the University of North Dakota. Each site has a regional manager and a staff of approximately ten caseworkers and program administrators who report to the Families First Boards.

Services

CWRI is premised on case management systems and community-based family services. In the two regions, referrals come from schools, county social services, juvenile courts, and other local service agencies, and case managers create individualized service plans. Most plans last from six to twelve months. Two group support centers have been built since the initiation of CWRI, and services are provided both at the centers and in traditional service centers. CWRI has also sponsored new school-aged parents programs, drug and alcohol prevention initiatives, and a "neighbors" program matching volunteers with parents identified as at risk. These services are available to families even if they do not take part in the case management system. The schools and juvenile courts play an important role in developing new services and service plans.

Parents' Role Parents served on planning committees at both sites and are represented on Families First Boards. They also play a crucial role in designing service plans with case managers.

Evaluation The Casey Foundation is funding an independent evaluation of all three states that have received grants. The Research Triangle Institute was selected to complete the evaluation. North Dakota is also soliciting bids for an independent evaluation of its two projects. The local programs have developed streamlined data collection methods and tracking systems to facilitate internal and external assessments.

Program Reflections

Chuck Sanderson, Program Manager, Families First, Devil's Lake

"Although I have been involved in human services for 21 years, Families First has re-taught me about the struggles families have in meeting their basic needs. I have been overwhelmed by the number of agencies serving at-risk families, and I can easily understand families' confusion with the very systems that are designed to assist them. The duplication that occurs in the paperwork and tasks performed is amazing. Planning in agency isolation still continues, and many providers are not aware of new or existing services. This results in a lack of accountability between systems and between systems and families.

"Flexibility, consistency, continuity, empowerment, and engagement of families are the most critical components in reform of the system. These qualities must be present in a treatment team if we expect families to benefit from their involvement with the system. Families function as well as the treatment team that is formed to help them. Reforming the system along these lines however, is not easy; change is a very slow process. Patience is necessary, and we must recognize that failure is as great a teacher as is success.

"Families First is attempting to reform this system by using flexible

funding for families, emphasizing greater emphasis on collaboration and planning, mixing services to better meet the family's needs, improving evaluation mechanisms, and increasing local governance."

Carol Meshefski, Program Manager, Families First, Grand Forks

"During my two-and-a-half years of work in the CWRI, it has become apparent that change in systems, agencies, and services happens very slowly. It is also apparent that "line workers" more clearly see the changes needed to serve families better. Line workers are eager to help families and are hopeful that administrators and policy makers will make changes at the federal and state level to facilitate the development of services more responsive to the needs of the family rather than to the bureaucratic system.

"Both the formation of the local boards and the clarification of the roles, authority, and responsibility have been critical steps in CWRI's development. Over time the members of our governing board are gaining trust in each other and improving communication. They are planning services and programs together and combining funding to support comprehensive programming. A Regional Community Plan is currently being shaped to meet the needs of at-risk families. These developments indicate that the process, while time-consuming, is effective."

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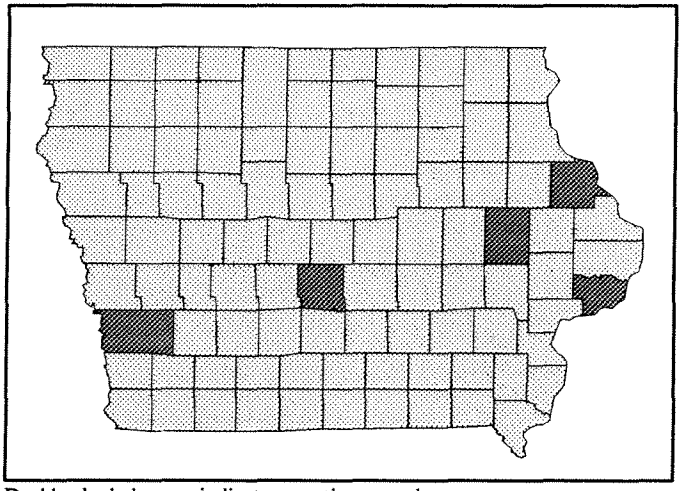
IOWA

Decategorization of Child Welfare Services



Darkly shaded areas indicate counties served

Currently operating in five counties representing close to 25 percent of Iowa's population, Iowa's Decategorization of Child Welfare Services is predicated on a concept of restructuring child welfare services rather than on providing additional funding. It allows counties to combine various state and federal child welfare funding streams into a single fund. Counties are required to create a joint governance structure including the Department of Human Services, the juvenile courts and the County Board of Supervisors. The initiative is intended to encourage the development of innovative and flexible funding arrangements for children, youth and family services and to focus the system on community-based, family-centered, placement prevention programming. Counties are given the authority to reinvest savings from foster care and other more costly and structured services in community-based preventive services. State legislation was adopted in 1991 to allow any county in the state to apply for decategorization waivers.

Program Development

Origins

The decategorization initiative was a response to the alarming increase in foster care placements in the early 1980s and the sense of fragmentation within the human services system. State officials felt that Iowa counties were placing too many children out of their homes rather than using home-based preventive services. This situation arose because foster care placements could draw on entitlement funds while family-based services drew upon harder-to-access and less-reliable funding. The fact that many of the placements were outside the state added to the escalating cost of the entire system.

Following a mandate to implement family preservation programs, the Iowa General Assembly passed a law to decategorize services in 1987 and to reduce the added financial burden of out-of-state placements. Two pilot counties—Polk and Scott—were chosen by a state advisory committee the following year and began planning for a July 1989 implementation date. Two additional counties—Dubuque and Pottawattamie—began activities in July 1990. Linn County is scheduled to begin planning in 1992.

Key Events

1987 Iowa Legislature passes a bill directing the Department of Human Services to decategorize child welfare services in two demonstration counties.

1988 Polk and Scott Counties are chosen and planning for the initiative begins.

1990 Dubuque and Pottawattamie Counties are selected.

1991 New legislation allows any county or group of counties to apply for decategorization.

Linn County applies and is accepted.

Program Description

Organization A statewide decategorization advisory committee composed of representatives from various state agencies as well as the legislature, the juvenile courts, the child welfare provider community, and county government was initially established to create procedures for selecting pilot counties. It is now a permanent feature and provides statewide coordination. Each county develops its own decategorization plan and management structure. All sites have a designated coordinator and have organized departmental and interdepartmental committees. Polk County, for example, has an executive committee, a case facilitation committee, an operations committee, an advisory committee, and a providers advisory committee.

Agency Collaboration As the initiative is based on the notion of collaboration, the pilot counties also have interagency planning committees, which meet to set goals and program guidelines, and monitor progress. Local school districts, provider agencies, child welfare and juvenile court personnel, and United Way are involved in these committees.

The state legislation provides a nine-month planning period for pilot counties. Both Polk and Scott Counties created interagency planning committees. In Scott County this group has met weekly since September 1988. After three months of meetings, the county convened four task forces composed of a diverse group of representatives to identify and propose reforms in services for four developmental stages from prenatal to adolescent. This structure was intended to encourage thinking about a range of services available to particular families. The recommendations were integrated into a list of specific programmatic changes including the development of in-state treatment centers for specific populations, the redefinition of

levels of foster care service, and a flexible family assistance fund for special needs.

After Polk County's small executive committee and larger planning group formulated some decategorization concepts, the planning group moved on to assess the current system. Reform efforts centered on developing appropriate services for multiple-problem, hard-to-treat youth, and expanding family preservation services. The committee established new service categories and allowed line workers to provide "wrap around" or special services on a case-by-case basis. A case facilitation committee was established to review complex cases and monitor provision of decategorized services. Polk County paid particular attention to building links between public schools and the juvenile justice system.

Goals

The Decategorization Project is a direct effort to decrease the number of foster care placements both in and out of state. It also reflects a more general concern that the child welfare system should respond to children's needs, emphasize community-based services, stress early intervention and preventive services to avoid out-of-home placements, and focus on greater system integration.

Funding

Based on a "revenue-neutral" notion, the Decategorization Project legally cannot spend more than would have been spent in the categorical funding system. While funding neutrality is maintained, the goal of the project is to develop services that best meet children's needs rather than save money.

Foundation funds were secured, however, to fund county coordinators. These funds were then expanded to include a state coordinator. In addition, the pilot counties have received outside

funding directly. Polk County, for example, has received several foundation grants, including one from the Danforth Foundation to support collaboration between the county and the DesMoines School District.

Participants The Decategorization Project is currently open to any county in Iowa. It serves children and families in need of child welfare services. The counties have targeted underserved populations and identified service gaps such as group care for adolescents.

Staff In addition to county coordinators, the project relies on existing staff to deliver services. Each county has developed its own staffing strategies. As staff salaries are considered decategorized funds, the counties have considerable flexibility. Counties are also responsible for organizing their own staff training although the state has periodically provided state-wide training. Scott County, for example, secured foundation grants to train its staff as it moved towards a county-wide case management model of service delivery.

Services The goal of the Decategorization Project is to reform the system rather than provide particular services. However, all the counties have developed new services due to the project's redefinition of service categories. In Scott County, examples of new services include a residential treatment center and day treatment for adolescents, day-care services for foster children, a discretionary Family Assistance Fund for basic living expenses, a crisis nursery, a family support network, a neighborhood youth council, and expanded substance abuse treatment programs. Polk County has developed new family preservation programs, a needs-based foster care system, and a case-management system to create more individualized treatment plans.

Parents' Role Foster and adoptive parents have served planning roles in most counties. The new emphasis on case-management provides for increased involvement in the creation and implementation of case plans.

Evaluation The counties provide annual progress reports to the state committee. The pilot counties have already reported significant cost savings in foster care budgets which allow the transfer of these resources to other services. The state reports enthusiasm for the continuation of the project's efforts to bring about increased flexibility and placement prevention in the child welfare system. The Decategorization Project has been the subject of studies at the Child and Family Policy Center, an independent research organization. Scott County also received foundation funding to implement a new data collection system appropriate for the new services.

Program Reflections

Barry Bennett, State Decategorization Coordinator

"Decategorization has proven a significant planning and funding strategy for providing more comprehensive services to children and families. This project has demonstrated that to serve families in a more individualized, comprehensive manner, service systems must be flexible and locally designed, within an overall philosophical framework of placement prevention and family-based services. Collaboration at the local level between various service systems, premised on the value of placement prevention and family support, is also an indispensable element. Finally, we have learned that allowing flexibility in modifying and merging child welfare funding streams is critical in improving service focus and effectiveness.

"At the local level, decategorization should result in the evolution of a child welfare service system that is more effective and responsive to local needs and rooted in a solid foundation of family-based, in-home interventions. In addition, the community collaboration

inherent in the project should result in expanded pooling of resources between systems to develop more comprehensive family support services. At the state level, the project should encourage flexibility in service system development and reduce rigidity in child welfare funding streams. Serving as a model of the cooperative planning and funding that will become a catalyst for collaborative projects between DHS and other state agencies such as education and health, Iowa's Decategorization Project will encourage expanded federal support of similar innovative service coordinating projects and result in reduced rigidity between the numerous, federal-service, funding streams."

Dennis Timmerman, Scott County Decategorization Coordinator

"The Decategorization Project in Scott County has illustrated that integrated funding does indeed cut down on fragmentation and duplication of services and facilitate comprehensive community planning. Initiating a community planning process provides the opportunity to develop services based on the specific needs of the community. The process has also resulted in more cooperation and understanding among public and private agencies. The budget-neutral concept of the Decategorization Project has enabled us to assist families with more appropriate services and not just save the state money. We have seen that this focus on prevention and intermediary services can decrease the need for out-of-home and out-of-community placements. More appropriate services mean that families will become empowered and spend less time in the system."

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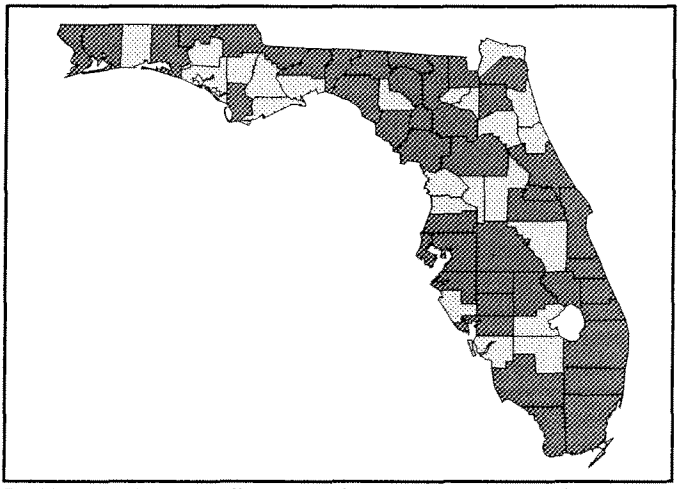
FLORIDA
Full Service Schools



Darkly shaded areas indicate counties served by Full Service Schools, Supplemental School Health Services, or both

Full Service Schools is a joint initiative of the Department of Education (DOE) and the Department of Health and Rehabilitative Services (HRS). The concept is based on the recognition that children bring more than education needs to the classroom and that a service delivery system operating on discrete categorical boundaries fails to meet children's needs. To address these issues, the Full Service Schools initiative integrates education, health, social, and human services for children and youth, their families, and the surrounding community on school grounds or in nearby locations. Florida's initiative is supported by two major resources at the state level: the Supplemental School Health Services, funded through the health budget; and the Full Service Schools, funded through the education budget. The Supplemental School Health Services was funded at approximately $9 million in FY 1991-1992 to support 49 projects affecting 192 schools across the state. During the same year, with a budget of $6.2 million, 32 school districts and one university-affiliated developmental research school were awarded grants from DOE to implement the Full Service Schools program. Twenty-four counties receive funding from both programs.

Program Development

Origins

The Full Service Schools concept evolved from parallel initiatives of the Florida legislature in 1990. The Full Service Schools legislation (Florida Statute 402.3026) requires HRS and DOE to jointly establish full service schools to offer high-risk students and their families prevention, treatment, and support services through collaborative arrangements among state, local, private, and public entities. While there was no specific appropriation for the legislation, it required that the program be fully implemented by the 1995-96 school year. The Supplemental School Health Services (Florida Statute 402.321) provides primary health care to children and youth in public schools, with an emphasis on improving child health and reducing teen pregnancy.

Key Events

1990	Florida Legislature passes laws establishing Supplemental School Health Services and Full Service Schools. No appropriation made for Full Service Schools. $2.6 million appropriated for Supplemental School Health Services.
1990-91	Supplemental School Health Services makes funds available to county public health units in collaboration with schools. Twenty-eight projects serving 113 schools are begun.
1991-92	$6.2 million appropriated to the Education Department for Full Service Schools program and operations begin in 71 school sites. Additional funding also provided for Supplemental School Health Services bringing the 1991-1992 appropriation to $9 million.

Program Description

Organization Full Service Schools and Supplemental School Health Services are administered by the education and health departments respectively. Full Service Schools operates out of the DOE's Office of Interagency Affairs. Supplemental School Health Services is supervised by the HRS Office of Family Health Services.

Each local program designs its own service strategy when applying for either one or both of the above grants. Each Full Service School is expected to establish a program oversight council to monitor the project and implement policy changes. In most cases, the interagency planning team drafting the grant proposal evolves into the oversight committee. This oversight council may include school, HRS, community, and business representatives.

Agency Collaboration The Interagency Work Group on Full Service Schools offers support to local development efforts. The Work Group is comprised of representatives from DOE, HRS, the Department of Labor, the Governor's Office, and the two branches of the legislature.

Supplemental School Health Services requires that the design of the proposal involve joint planning by county public health units and school districts, and community and parental support of the program. Some Full Service Schools projects are bringing a variety of service agencies, including HRS, to the school site or to alternative locations to serve children and their families. Systems for interagency service planning with families are also being developed.

Goals The Full Service Schools initiative seeks to provide children, youth, and families with the non-

educational support services necessary to ensure the school success of students. Programs created by the initiative emphasize service integration and interagency coordination in meeting the needs of participants.

Funding

Funds from state health and education budgets are available to school districts. However, many collaborative efforts are occurring without either of these grants, as schools and social service agencies bring together whatever is available in terms of human and financial resources.

In 1991-1992, Supplemental School Health Services grants to HRS public county health units averaged $183,861. Full Service Schools grants to schools districts ranged from $150,000 to $250,000, with a ceiling set at $400,000. Some local programs seek other sources of state and federal funds to enhance their service capacity. Many of the Full Service Schools fund the health component of their programs through Supplemental School Health Services grants.

Participants

Programs are located in schools with high rates of at-risk students needing health and social services. Supplemental School Health Services projects operate in districts with a high incidence of medically underserved high-risk children, low-birth-weight babies, infant mortality, and teenage pregnancy. Full Service Schools are established in schools characterized by one or more of the following at-risk factors: a high rate of students eligible for free or reduced lunches, high incidence of teen pregnancies, and student needs for public-supported health, social services, and other types of assistance. Local programs serve all children and families affiliated with the school, but some program components—such as AFDC, Food Stamps, and Medicaid—have particular eligibility criteria which must be met.

Staff

Each project develops staffing to meet the needs of children and families. A composite of the project staff might include the following: professional nurses, health aides, social workers, and counselors or psychologists.

Staff are hired by the county public health unit, the school board, or by other participating agencies and co-located in the school. Job descriptions are often developed jointly by the principal, a local coordinator who administers the project and HRS, the county public health unit, or other relevant agency personnel consistent with project goals and objectives. Training for staff is handled locally to meet each school's needs. Statewide conferences, workshops, and technical assistance are also provided.

Services

The Full Service School concept is not intended to duplicate services that are already offered at school sites. It is designed to bring more resources into the schools to complement and strengthen teachers' efforts in the classroom. Programs and services already provided by many schools include adult education, parenting skills, early childhood education, and before- and after-school programs. Health, nutrition and medical services, individual and family counseling, and income eligibility services are provided through the two new grants. Because each school assesses its needs and designs its own program, programs differ from school to school.

Parents' Role

Parents are represented in advisory councils or community work groups attached to the programs. They offer their perspective on what programs and services should be offered at the school site and on the effectiveness of operating programs. Some sites also recruit parents as volunteers and as paraprofessionals to work in the programs.

Evaluation The Supplemental School Health Services legislation specifies an evaluation of the program to be submitted to the legislature by January 1, 1993. An independent evaluation has been contracted to the Florida State University Learning Systems, Inc. and started in 1992. The Department of Education is working with the University of South Florida (USF) in conjunction with Full Service Schools project staff to design a reporting system. USF will then compile the individual reports to produce a single state report in August 1992, documenting the accomplishments of the first phase of the Full Service School development.

Program Reflections

Lynn Groves, Director, Office of Interagency Affairs, DOE

"The measure of whether or not services are comprehensive, integrated, coherent, sufficiently intense, timely, and effective is in whether or not they make a positive difference for the family targeted. If we can't claim success at the individual case level, then we are not successful.

"The long-term impact of Full Service Schools is really a shift in how we work in Florida. What is referred to as the 'new way of doing business' will become the way we do business as a matter of course. Health, education, and human services agencies all serve the same families. None of us can do it independently. Our focus on children and families as the measure of our success will be our legacy."

Diana Lincoln, Education Coordinator, Office of Program Policy Development, HRS

"A familiar phrase is being used as a unifying force in many local Full Service School planning groups—'it takes a whole village to raise a child.' Successful Full Service Schools are locally planned and designed to meet the holistic needs of children and families. Community leadership, private industry, public and private social

service agencies, and a representative cross section of families and students must be integrally involved in planning, developing, implementing, and operating a Full Service School.

"In Florida, Full Service Schools are considered an evolving process. It is unrealistic to expect Full Service Schools to deliver a comprehensive range of services overnight. By not requiring a core of services in every project, we have encouraged local decision-making and fostered development of services to meet identified needs of a particular school's students and families. Those needs may then be met by any willing and appropriate local partner. Any successful school-linked collaborative service may prove to be the seed from which a broader range of services is eventually developed."

Annette Townsend, Program Administrator, Family Health Services, HRS

"School Health Services are essential to meeting the complex needs of all school children. These school-based services address the important issues of access, cost, and compliance in the health care system. It is clear that schools can only accomplish their education mission if they attend to students' emotional, social, and physical problems. Every school should have a health room staffed by health care professionals. This is a small price to pay to provide the chance for our children to lead healthy, successful lives. All children need to be at their maximum health potential in order to be ready to learn, not only at school entry but throughout their lives."

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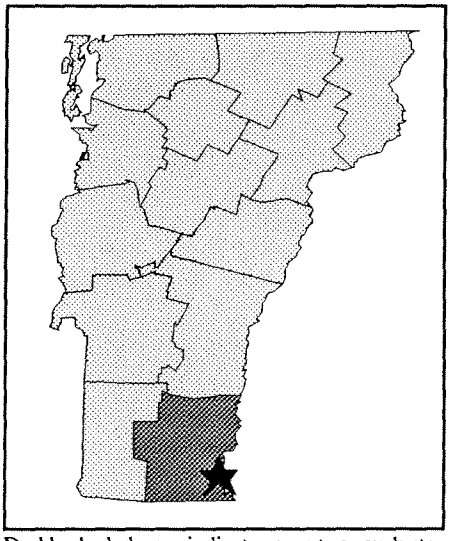
BRATTLEBORO, VERMONT

Early Education Services (EES)



Darkly shaded area indicates county served; star indicates Brattleboro

Early Education Services (EES) is an umbrella organization that develops, implements, and houses primary prevention and early intervention for families in Windham County, Vermont. These collaborative programs include a Comprehensive Child Development Program (CCDP) called the Windham County Family Support Program, Even Start, Parents as Teachers (PAT), Early Education Initiative, and Follow Through. EES provides a model of the growth of a grass roots family support program through the involvement and commitment of human service providers, the school district, and community members. Begun in 1987 as a modest, town-based initiative focusing on parenting education and early childhood development, EES now offers a more comprehensive program of social, educational, health, child care, and employment services supported by local, state, federal, and private foundation funding. In 1991 EES served 170 families and 232 children throughout Windham County. The total budget in FY 1991-1992 amounted to $1,112,957.

Program Development

Origins

In 1987 the Town of Brattleboro and the school department established a parent education program in response to an alarming increase in the number of children who were not ready for school. The school district researched various school-based early

intervention models and chose to implement a modification of Yakima, Washington's PAT program. With seed capital from town monies and a foundation, the school district began the program. This initial investment provided a basis for the program to secure grants to expand outreach and services.

Key Events

1987 Brattleboro Town School District establishes PAT program whose services include home visits, parent-child support groups, and developmental workshops.

1988 Vermont DOE's Early Education Initiative funds PAT preschool program for at-risk children ages three to five.

1989 Even Start of Windham County—a four-year, federally funded, parent-child, literacy program—is administered by the Windham Southeast Supervisory Union and implemented by EES. The Union is the school district for five towns, of which Brattleboro is one.

A federal CCDP grant is awarded to the Brattleboro Town School District for the Windham County Family Support program. The grant funds PAT expansion and provision of comprehensive and intensive services to 60 at-risk families with young children.

Early Education Services is organized to house the addition of services to the core PAT program.

A main office is located in Brattleboro and satellite centers established in two other towns.

1990 The Vermont Agency of Human Services provides a grant for a Parent-Child Center to expand PAT to cover the entire county.

1991 The Brattleboro Town School District and the National Child Day Care Association are awarded federal funds for Follow Through. The program provides a single source of comprehensive service continuity to participants of Head

Start and the early intervention programs run by EES. It is being implemented in eight classrooms at the K-3 level.

Program Description

Organization EES is the early education unit of the Brattleboro town school district. It develops and secures funding for program initiatives and coordinates with other service providers to plan, implement, and house them. The Brattleboro Town School District and the Windham County Southeast Supervisory Union function as fiscal agents of these programs.

Agency Collaboration In 1987 the PAT program invited staff from other agencies to attend weekly team meetings and developed a community policy advisory committee. Over the years EES has developed close working relationships with health, education, and human services providers in Brattleboro. EES makes and receives frequent referrals with these agencies, attends interagency case conferences, and participates in joint service planning and coordination.

Through the CCDP grant, EES trains daycare providers and helps communities identify and plan services most needed to support families. EES also sponsors conferences and workshops open to human service providers in the community.

Goals The programs run by EES strive to promote the healthy development of young children; prepare them to succeed in school; enhance the social, economic, and personal well-being of the whole family; and empower families to use existing community services more effectively.

Funding In 1987 the Town of Brattleboro funded PAT with $45,000 from the local levy. The Turrell Foundation

contributed an additional $25,000. The program continues to be funded by the town. This local commitment has been key to securing additional private and public funds.

EES services are county-wide and are funded by state and federal grants. The Agency of Human Services, which funds the Parent-Child Center, allocated $25,000 in FY 1991-1992. Federal programs are funded yearly as follows: Even Start, $239,000; CCDP, $672,000; and Follow Through, $179,000. The federal programs require local matching funds and may increase funding in the coming years. The National Day Care Association also provides $200,000 for staff development for Follow Through.

EES is currently planning a long-range funding effort to continue to provide comprehensive and continuous services when federal grants end.

FY	Total Budget	Town Contribution
87-88	$70,000	$45,000
88-89	$100,000	$50,000
89-90	$729,000	$50,000
90-91	$911,000	$50,000
91-92	$1,112,957	$50,000

source: Early Education Services

Participants

The PAT program serves any parent with children from birth to age four and pregnant women, regardless of income and education. The federal programs are targeted and have more specific eligibility criteria.

Staff

The staff for the different programs may include a combination of the following: home visitor, home tutor, nurse, early childhood educator, and social worker. Home visitor positions are paraprofessional and do not require a degree. All staff undergo regular, thorough, and extensive in-service training. Staff also participate in workshops and conferences and attend professional development courses.

Services

The combined programs offer a wide array of services including home-based parent education; family literacy and adult education counseling; parent support groups; information resource and referral; health education, assessments and support services; preschool; play groups; and child care information. Participants in the CCDP program receive more intensive and comprehensive services, including case management.

Parents' Role

Parents are represented in advisory councils attached to the programs. As advisory board members they participate in program development and fund raising, make budget and program recommendations, volunteer to help with program events, and provide community support for the program at town meetings.

Evaluation

The Town of Brattleboro requires monitoring of the developmental progress of children in the PAT programs. Parents fill out a family satisfaction assessment form provided by the Department of Education. Preschool children are administered the McCarthy IQ tests and the Minnesota Child Development Profile.

The federally-funded programs—the CCDP and Even Start—are being evaluated by independent evaluators with the help of program consultants.

Program Reflections

Judie Jerald, Director, Windham County Family Support Program

"What continues to be confirmed and reaffirmed for us at EES is the importance of a well-trained and caring staff, the need for positive and collaborative communication with community agencies, and the recognition that everything builds from the staff, especially home visitors' relationships with the families.

"Those relationships are the building blocks to successful growth and development of the families. As a rural community, it was clear that we needed to do most of our intervention in the homes. (I suspect that this is not specific to our community.) I think it is easier to develop an individual relationship first. A very special, ongoing relationship with a home visitor can encourage a young person to join a parent group or bring a child to a play group, perhaps even then become part of a community group or become an advocate for something.

"Another characteristic of the people we serve is that they are not accustomed to receiving benefits and they don't know what is available. One of the things we try to do is educate people about what is available and how to ask for it. It is important that we are part of the school system: there is no stigma attached to school services. If you go to a mental health agency or a social service agency there is an implication that there is "something wrong with you." If we offer a service as part of the school system, it's something we can offer everyone. It sets a different tone.

"As a family support and education program, we have not tried to recreate services that are already in the community. Instead we broker existing services and create services to fill gaps. A program such as ours creates a mindset in the community that values and appreciates early education and intervention and raises awareness of the needs of children and families. For this reason, we have become a model in our state; state and community leaders look to us as they begin to initiate early intervention initiatives."

Laurie Emel, Director, Parents As Teachers

"It is possible to do quite a lot with very little resources. Our PAT program in Brattleboro is known for running programs on a shoe string. I think it is possible to start small and grow bigger. I want to encourage a community to do a careful job of analyzing its own needs and let a program grow, in an organic way, to fit the community and its needs. No one should be discouraged by starting small. Start with something you believe in and make it a really good program. Then it will build on its success."

Diane Coleman, Former Director, Even Start

"For community agencies to feel some ownership of a new program, they have to be involved from the start. Yet even when programs involve community people at the planning stages, once programs are operating it becomes hard to sustain that involvement. Continuing to keep community agencies involved and updated in decision making is important.

"Agencies appreciate having programs that they can refer people to. Referral, however, is not an automatic process. It depends on the time invested in it. Establishing an effective referral system involves reminding, encouraging and thanking agency contacts. It also creates an extra burden on staff contacts because there are many programs in the community that would like these agencies to do the same thing for them."

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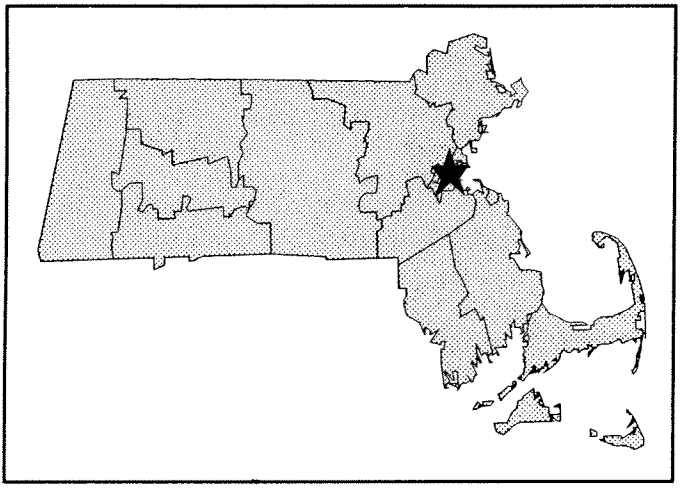
BOSTON, MASSACHUSETTS

Medical-Legal Services Project



Program serves metropolitan Boston

The Medical-Legal Services Project, initiated in 1988 as a joint project of the Brigham and Women's Hospital in Boston and the Harvard Law School-affiliated Legal Services Center, is designed to improve the access of the medically needy and elderly to the full array of social welfare services to which they are entitled. Selected patients are interviewed to determine eligibility for health, financial and social services. The project advocates on their behalf to secure any services to which they are entitled but not receiving. If advocates fail to secure these services, patients are referred for assistance to the Legal Services Center. In addition to direct advocacy, the project also educates hospital staff about helping patients learn about and apply for benefits beyond direct medical services. Supported by several foundation grants, the project received approximately $320,000 over the past three years and has interviewed nearly 300 medically needy individuals.

Program Development

Origins

The Medical-Legal Services Project was conceived in the mid-1980s by a group of physicians and lawyers who realized that low-income patients often do not receive the benefits to which they are entitled. The project was designed not only to help patients secure benefits but as a research project as well. The research agenda aims to determine how often patients in an urban teaching hospital do not receive benefits and other assistance to which they are entitled; how often these patients' problems can be solved; the exact nature of the interventions required; the effects of intervention on health status; and whether advocacy is effective in getting patients social welfare benefits which they have not received previously.

Key Events

1988	The Medical-Legal Services Project obtains funding and begins development.
1989	The project begins to interview and advocate for patients at Brigham and Women's Hospital.
1990	Families at Children's Hospital and patients at Roxbury Community Comprehensive Health Center are interviewed.
1991	The project approaches the Department of Public Welfare about a private-public partnership to improve access to Welfare Department programs.

Program Description

Organization The program is based at Brigham and Women's Hospital in Boston. The project staff collaborate closely with lawyers from the Harvard Law School-affiliated Legal Services Center. There is a satellite program at the Roxbury Community Comprehensive Health Center. Children's

Hospital, which had a satellite program, is seeking funding to support full project operations.

Agency Collaboration A key premise of the program is that close coordination between the hospital and the legal services center is effective in obtaining services for patients. In addition, project staff have developed working relationships with individual staff in a variety of social service agencies to resolve problems of specific patients. The project has approached the Department of Public Welfare about an explicit partnership that would result in greater efficiency in processing applications for programs.

Goals The primary goal of the project is to facilitate the access of the medically needy and elderly to the full array of social welfare services to which they and their families are entitled. It is also hoped that the medical care and health status of patients will be improved. A secondary goal is to educate health professionals about helping patients apply for and receive social-welfare benefits, including those related to health care coverage.

Funding The annual project budget is approximately $200,000. It is funded by the Charles Stewart Mott Foundation, the Public Welfare Foundation, and the Monell Foundation.

Participants Participants are identified by project staff or referred by hospital staff. Project staff select patients for interviews who are without medical or government insurance and/or are 65 years or older. Hospital staff are also free to refer patients they suspect may be lacking services. Participants are primarily residents of areas surrounding the hospital. These areas of Boston are diverse but have predominantly lower-income and minority residents, and include several housing projects. Approximately 25 percent of the participants are

Spanish-speaking and a smaller percentage are Haitian. Approximately 40 percent are single women with children.

Staff

The project is directed by a physician. It also supports two advocates: one is a law school graduate and the other a former school teacher. Patients are interviewed either by project staff or, in the satellite site, by a physician or clinic staff. Advocacy is generally done by project staff.

Project staff meet every other week with attorneys from the Legal Services Center to review cases. The lawyers provide advice on interpreting the program rules and pursuing an issue. The lawyers also represent patients in formal legal actions if the project staff are not successful in obtaining benefits.

Services

Project staff conduct a structured interview with each participant to determine potential eligibility for a broad range of federal, state, and local programs including the various Social Security programs, Medicare, Medicaid, AFDC, and Food Stamps. From each interview, the staff develop a list of "solvable" problems, and, if the participant chooses, advocate to obtain additional benefits. Staff pursue the case until it is resolved or refer the patient to the Legal Services Center for formal legal action. All participants are contacted a year after their initial interview to determine what services they have actually received and whether they are continuing to receive them.

Project staff also educate hospital staff about services available for patients who cannot afford health care and the processes hospital staff need to go through to help patients obtain those services. Hospital staff are encouraged to cross traditional professional boundaries and formal job descriptions to assist patients.

Parents' Role The project concentrates on working with individual families and encourages patients to work with the advocates to secure benefits.

Evaluation As the project combines research and service delivery, research components are built into the project operations rather than being conducted by a separate organization. The major sources of data include: the structured interviews conducted with each participant; logs of actions taken for each participant; records of the one-year follow-up done on all participants; changes in health status and health care utilization of each participant as measured at entry to the project and at the one-year follow-up.

Program Reflections

JudyAnn Bigby, M.D., Project Director, Medical-Legal Services Project

"The results of our project interviews are sobering: we found that 90 percent of the patients interviewed were eligible for at least one benefit which they were not receiving at all or which they were receiving at an inappropriate level. This happened despite the fact that all of the patients had primary care physicians and access to social workers. Our experience confirms other work that shows major gaps in social welfare entitlement in our country. Not only do these gaps have serious implications for the social circumstances in which people are living but, also important from our hospital perspective, they have serious health implications. For example, some of our patients took prescribed medications for chronic medical problems only sporadically because they did not know that the cost of the medication would be paid by a program for which they were eligible. Others were distressed by unpaid doctor, clinic, or hospital bills and did not know they were eligible for medical coverage that would have eliminated their out-of-pocket expenses. Many families with children were living on less income than necessary and not availing themselves of nutritional support programs.

"At the same time, the results of our limited interventions are energizing. By asking the right questions, we can identify the services that people need and the programs for which they are eligible. We have been successful in helping people obtain additional benefits in a significant number of cases in which a problem was identified. One of our biggest surprises has been how successful the project staff have been in negotiating favorable outcomes for patients. When we began, we envisioned a major role for the Legal Services Center lawyers in appealing denials of benefits. But, in fact, we have formally referred only 40 cases to them. The lawyers' more important role has been to advise project staff early in their advocacy process. This experience indicates that the resolution of problems for medically disadvantaged patients does not have to be adversarial.

"The Medical-Legal Services Project continues to evolve as we learn more about our patients and our processes. We are working now to address several concerns. We want to learn more about who succeeds in getting benefits after project assistance and who doesn't. Among participants who pursued their issues on their own, less than 20 percent have been successful in obtaining additional benefits. Among those for whom project staff advocated, roughly half have received some additional benefits. But we are concerned about findings from our follow-up contact showing that some people whom the project staff had helped get benefits actually only received them for a short time because the patients did not go through the recertification process required to maintain benefits. We are trying to figure out which patients (and families) do not continue benefits on their own and how they differ from those who use their experience with the project to maintain the benefits. The key issue is how to help people while at the same time empowering them so they do not become reliant on an advocate.

"Overall, we are encouraged by the success of our model of having advocates work with people to resolve an array of problems across traditional professional and programmatic lines. The model is relevant not only in a health care setting but could be used anywhere, with schools, community centers or churches serving as the project's organizational home. Attempts to address the problems resulting from a fragmented social welfare system are important across settings."

MASSACHUSETTS

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