

CATALYSTS for CHANGE:

How California Nonprofits Can Deliver
Direct Services and Transform Communities

PART TWO—CASE STUDIES


The California Endowment


Building Movement Project
Inspiring Activism in the Nonprofit Community

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BACKGROUND AND INTRODUCTION

In 2009, with the support of The California Endowment, the Building Movement Project launched an initiative to explore whether California-based health and human service providers engage in activities beyond direct services and how these programs address the root causes of the problems facing their constituents. Anecdotal evidence indicates there is growing interest among groups that deliver direct services in becoming more involved in “social change” activities such as policy advocacy, grassroots organizing, and community engagement.

The findings from our inquiry are presented in *Catalysts for Change*, a two-part document. In Part One, we discuss results from a survey of more than 450 California nonprofit service providers about the ways in which they are (or are not) integrating social change activities into their work. Part Two offers five in-depth case studies of California-based health and social service providers that are engaging in non-service activities to address systemic issues—including poverty, inequality, and health disparities—as well as building the voice and power of their constituents. The case studies illustrate and highlight many of the concepts explored in Part One of this report and they give readers the opportunity to delve more deeply into the work of different organizations that are engaged in direct service delivery and other change-oriented activities.

As discussed in Part One of *Catalysts for Change*, five main themes emerged from the survey findings and the case studies: **constituent civic and leadership development**, **external action**, **internal capacity**, **strategic partnerships**, and **organizational leadership**. To read Part One—Report of Catalysts for Change, go to http://buildingmovement.org/pdf/catalysts_part_one.pdf. While the survey findings point to the role that any of these factors can play in bolstering a service provider’s ability to expand their reach beyond direct services, the case studies underscore the powerful, long-term impact that pursuing a combination of these elements can have to help groups achieve a larger vision for social change.

The organizations profiled in the case studies were selected on the basis of various criteria. They are located in different geographic areas of the state, they serve diverse constituencies, they focus on a range of health and social issues, and they are in different stages of organizational development with regard to their activities beyond direct services. For example, some groups have had a dual approach to service and social change from their inception, while others began to incorporate activities beyond direct services into their work at some point later in their development. Nonetheless, all five share a common trait: they are trying to impact the causes of the problems facing their clients by pursuing various activities in addition to direct service delivery. These practices are different for each organization and include community organizing, policy advocacy, constituent leadership development, alliance building, and civic participation, among other strategies for creating change.

The examples presented in the case studies do not represent all of the possible ways that providers of direct health and social services can be engaged in social change work. However, they do give readers the opportunity to learn from what others are doing and to stimulate our thinking when it comes to the broader issues raised by this report. In addition, we hope that the learnings that emerge from the case studies will support the four key recommendations for future action and investigation that we present at the end of Part One of *Catalysts for Change*. These recommendations, which are directed at service providers and the groups that support and influence their work, include the following:

- 1 Encourage and support nonprofit direct service providers to lift up the voices of constituents in and outside of their organizations.
- 2 Connect service providers to venues where they can take action on key issues that lead to larger, systemic change for their constituents.
- 3 Expand the role and effectiveness of intermediaries and nonprofit networks by focusing their work with service providers on targeted efforts for larger social change.
- 4 Conduct more research on the impact direct service providers can have on long-term solutions to systemic issues facing constituents and communities.

ST. JOHN'S WELL CHILD AND FAMILY CENTER: LOS ANGELES, CA

ORGANIZATIONAL PROFILE

CEO: Jim Mangia

Location: Los Angeles, CA

Service Area: South Los Angeles, CA

Founded: 1964

Number of Staff: 207

Current Budget: \$18 million

Funding: Federal 28%; County 20%; Foundations 18%; Fees for Service 15%; State 12%; Other 7%

Mission/Vision Statement:

Our mission is to eliminate health disparities and foster community well-being by providing and promoting the highest quality care in South Los Angeles.

The vision of St. John's Well Child and Family Center is to deliver high-quality primary and preventive medical, dental, and mental health services that go beyond the borders of tradition to uninsured, underserved, and economically disadvantaged persons in Los Angeles. We are devoted to instilling the value of well-being to our communities, resulting in self-advocacy, self esteem, and self-sustenance, through innovative and developmental programs and collaborative endeavors.

Program Areas:

- Comprehensive medical services, dental services, mental health and case management, and family support services that include youth development programs, parent workshops, and legal services and counseling
- Program in Social Medicine and Health Equity carries out elements of St. John's mission relating to the promotion of health equity and social justice and the reduction of health disparities

Patient Demographics: 65% Latino; 35% African American

INTRODUCTION



CEO Jim Mangia

It was 1994 and Jim Mangia was still in his first year as the new CEO of St. John's Well Child and Family Center, a community health clinic in south Los Angeles. "I still remember it vividly," says Mangia as he recalls a mother who held her 18-month-old son in her arms as she entered the clinic. "The child was limp, he couldn't speak or walk...he had no motor capacity." Clinic doctors immediately began running tests, but they could not identify the source of the boy's disturbing symptoms. Then, Jim remembered an article he had read about lead poisoning and something clicked. Most Los Angeles-area homes were built before 1978 when lead paint was outlawed in the United States, but routine lead

testing was not standard procedure. Jim and the clinicians at St. John's quickly realized that they needed to conduct a simple blood test to check for lead poisoning. The child's lead levels were off the charts.

Fortunately this story had a good ending. Based on the clinic's strong working relationship with Children's Hospital Los Angeles, where treatment for lead poisoning was available, the doctors at St. John's were able to immediately start chelation therapy¹ for the toddler before severe brain damage occurred. That boy is now a healthy teenager who started college at California State University, Los Angeles this fall. But Jim Mangia began to wonder how many other children had undetected lead poisoning. So St. John's started testing every child that came into one of its clinic sites and they made an alarming discovery: Over 50 percent of the children had elevated blood lead levels.

Jim and the doctors at St. John's suspected that the culprit was lead paint, but in order to confirm their hunch they needed to gain access to the sub-standard housing where many of these children lived. He brought this dilemma to Nancy Ibrahim, the health programs director for Esperanza Community Housing Corporation (Esperanza). At the time, Esperanza—which is located across the street from St. John's at St. Vincent's Catholic Church—was training *promotoras*² (community health outreach workers) in the same neighborhoods that the clinic was serving. Jim and Nancy decided to join forces and send some of the *promotoras* into patients' homes to find out what was causing so many children to have elevated levels of lead in their blood.

The environmental assessments conducted by the health outreach workers uncovered the depth and breadth of the low-quality housing conditions pervading the poorest neighborhoods of South Los Angeles. These conditions included chipping and peeling paint, deteriorating lead paint that causes poisoned dust, leaking pipes that cause mold and mildew, and severe cockroach and rat infestations. As this information reached St. John's, Jim remembers some of the doctors coming to him and saying, "You can't expect us in good conscience to treat these kids and send them back to the same slum housing conditions that made them sick in the first place. We have to do something about it." Those words put St. John's on a new path—one that transcends their role of a 'traditional' health clinic by not only improving patients' health, but also building community leadership and power.

You can't expect us in good conscience to treat these kids and send them back to the same slum housing conditions that made them sick in the first place. We have to do something about it.

THRIVING—DESPITE THE ODDS

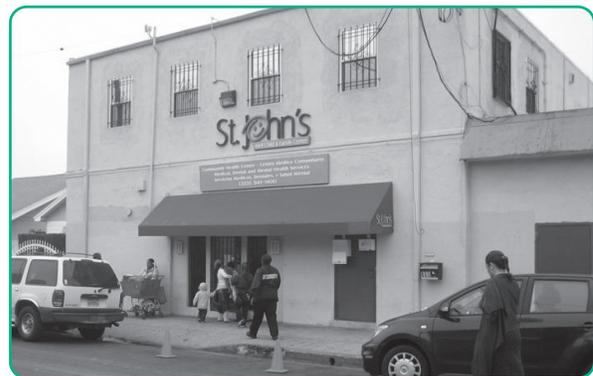
Founded in 1964 as a volunteer clinic in the back of St. John's Episcopal Church, St. John's clinic sought to address the extreme poverty and health inequities experienced by many South Los Angeles residents. As a faith community, the church had a progressive stance on social justice issues, which helped to inform the clinic's mission from the very beginning. For the first three decades of its existence, St. John's was small and mainly run by volunteers. When Jim Mangia was hired as the clinic's CEO in 1994, he was tasked with growing the organization and integrating it into the broader healthcare delivery system. Since that time, St. John's has established itself as a major force; it now consists of a network of federally qualified health centers (FQHCs)³ and school-based clinics throughout downtown, south, and northeast Los Angeles. The clinic's 11 sites provide comprehensive medical, dental, and mental health services as well as case management, health education, and other programs to support over 120,000 patient visits each year.

St. John's patients live in communities that are among the poorest in the United States. The clinic's 2009 Annual Report also notes that "the overwhelming poverty, poor living conditions and lack of access to adequate preventive and primary health care puts the health, social and economic status of the residents of this community on par or below many third world countries." For example, the poverty rate in South Los Angeles is 28.3 percent⁴, compared to 18.7 percent in Jamaica⁵. Even more alarming, the infant mortality rate is nearly double that of Cuba⁶, and the life expectancy for adult males is 68-years old, the same as North Korea⁷. However, the same report notes that St. John's patients are thriving despite these dismal statistics. The clinic has dramatically improved health outcomes for its patients by addressing the underlying social determinants of health and by giving patients the tools to serve as agents for social change in their own homes and communities.

HEALTHY HOMES, HEALTHY KIDS

St. John's approach is to continually search out the root causes of the problems facing their patients. For example, as they continued to diagnose hundreds of cases of lead poisoning among children, St. John's and Esperanza started to map the buildings where these families were living. They then joined forces with the organizing and advocacy group Strategic Actions for a Just Economy (SAJE). SAJE brought significant community and tenant organizing expertise to the table, including a recent campaign in which they succeeded in extracting major concessions from developers that were displacing hundreds of low-income residents in downtown Los Angeles.

The three organizations formed the Healthy Neighborhoods, Same Neighbors Collaborative, a targeted effort to address the negative health outcomes associated with sub-standard housing in South Los Angeles. The Collaborative exemplifies how strategic partnerships between service providers, organizers, and advocates can affect larger social change. St. John's and Esperanza identified the root cause of the housing-related health problems experienced by the clinic's patients, while SAJE added a new dimension by holding tenants clinics to inform residents of their rights and support their efforts to organize for better living conditions. Some landlords retaliated against tenants who were speaking up, threatening to evict them or to call the immigration authorities, so the collaboration widened to include the public law community to provide legal support when needed. "St. John's is a better organization because of the collaborations that Jim and others have enabled with our community partners," says the clinic's Chief Operations Officer, Nomsa Khalfani. "We are better at doing what we do because of those partnerships."



And the Collaborative's work developed as additional funding became available. For example, St. John's updated their computer system to be able to extrapolate data on blood lead levels for tens of thousands of children, and they hired a nutritionist to inform patients about foods with natural chelating (lead-removing) properties; the *promotoras* started teaching tenants about low-tech barriers to in-home environmental hazards and informing willing landlords about available resources to help ameliorate hazardous conditions; and SAJE led large-scale tenant organizing efforts against intransigent landlords [see Facing Down L.A.'s "Worst Landlord" below].

St. John's has been successful in pursuing a broader vision for social justice, at least in part, because it plays to its own strengths and those of its organizational partners. In addition, Jim stresses that "the issues that you focus on have to be organic to the community that you serve." Over 35,000 patients come through the clinic's doors each year from neighborhoods across South Los Angeles. "We have a captive audience," he says, "and there is something to be said about partnering with community [groups] that can help organize these folks." And St. John's partnerships—like the Healthy Neighborhoods Same Neighbors Collaborative—have developed deliberately over the course of many years. "You have to respect the time that it takes to build something. It's a relational and iterative process," says Mangia.

The Healthy Neighborhoods Same Neighbors Collaborative has been able show impressive results. For example, in housing where landlords made improvements, St. John's has data to show that tenants' health improved too, including a 95 percent reduction in blood lead levels and a 100 percent reduction in hospitalizations for asthma. Meanwhile, a shift began taking place within the walls of St. John's clinic. "Each step of the way you become more politicized. . . you, your doctors, your patients," Jim says. This process of 'politicization' has gradually infused a social change approach to delivering health care at all levels of the organization.

FACING DOWN L.A.'S "WORST LANDLORD"

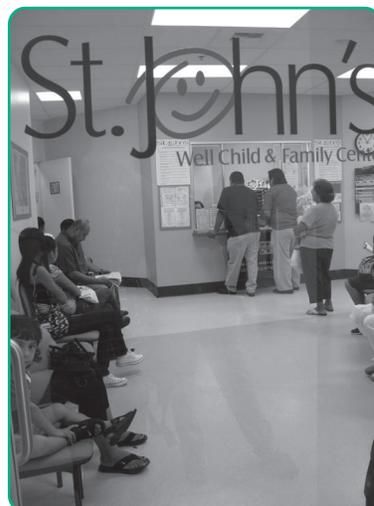
As St. John's clinicians documented numerous cases of lead poisoning and asthma among children in South Los Angeles's poorest neighborhoods, they began to notice a trend. Many of these children lived in buildings owned by 85-year-old Frank McHugh, a notorious landlord who owns more than 150 buildings in South Los Angeles that house over 8,000 residents—most of whom are children. In April 2009, the *Los Angeles Times* reported that "[m]any of his buildings have fallen prey to rats, cockroaches and mold, and are plagued by inoperative plumbing and rotting ceilings that cave in with regularity." (In January 2010, one of his buildings collapsed in Los Angeles's Koreatown, injuring four people who were inside at the time.) The article notes that despite numerous investigations and fines, officials had previously failed to end his pattern of flagrant violations. At one point, McHugh even showed up at St. John's with bodyguards to interrogate Jim Mangia and his staff about why they were visiting his buildings and meeting with tenants.

In addition to the evidence that was being systematically collected by St. John's about the health of tenants in McHugh's buildings, SAJE launched a campaign against the landlord in 2006, which led to the Los Angeles City Attorney's Office getting involved in the case. In October 2007, the city attorney filed 57 charges against McHugh based on numerous violations found by health and fire inspectors. McHugh agreed to sell all of his rental properties as part of a plea agreement that would allow him to avoid jail time. In May 2010, when McHugh failed to comply with the terms of this agreement, the court ordered that the landlord had to divest all of his properties or he would be sentenced to jail.

A DEVELOPING, EVOLVING SOCIAL JUSTICE MISSION

St. John’s clinic has always operated within a social justice framework, but according to one senior staff member, the work was elevated to “a whole new level” when Jim Mangia assumed the role of CEO. “You see his passion, his drive, his commitment. This is not just a job, this is his life’s work.” Tim Neiman, who joined the clinic’s board of directors in 2007, observes that Jim has pushed for a new way of thinking about St. John’s role in the community. “Jim is always looking for the biggest possible impact and is constantly broadening the definition of what health care really is,” he says.

There is little doubt that Mangia’s dynamic leadership has been a driving force behind St. John’s dramatic growth over the past 16 years; the clinic became an FQHC in 2004, the number of staff and programs have grown ten-fold, and the budget has increased by 75 percent. And while St. John’s work in the community was developing in an organic way to respond flexibly to patients’ emerging needs, changes within the organization were unfolding in a more intentional way. Specifically, Jim and other members of the clinic’s senior leadership have made strategic investments to ensure that St. John’s mission and vision are widely shared across the organization. These four key lessons are described below.



1. Make staffing decisions that support engagement in both service and social change.

In the course of becoming more “politicized,” St. John’s clinic has experienced some attrition among staff who were not aligned with the new direction, but it has also attracted new staff members who are interested in work that blends the delivery of direct services with social justice activities. “In some ways it was helpful to weed out folks that weren’t interested in this developing, evolving social justice mission,” says Jim Mangia. St. John’s has been successful in bringing on staff who share the organization’s mission and vision, in part because it has adjusted its recruitment strategy.

The clinic’s job descriptions now state that positions are “biosocial” and not “biomedical,” a shift in language that recognizes inequalities based on social class, race, ethnicity, and gender contribute to access to care and inequalities in health conditions.⁸ For example, Anne Farrell, Director of Environmental Health for the clinic’s Program in Social Medicine and Health Equity, said that the Healthy Homes, Healthy Kids program spoke to her passion for social justice and her interest in merging public health programming with clinical care. Before she was hired at St. John’s, Anne attended the opening of one of the clinic’s new buildings and she remembers thinking to herself, “these folks have made that shift...they have integrated these pieces in a way where it’s a holistic model.”

2. Break down internal ‘silos’ between direct service activities and advocacy work.

There has also been a conscious effort to bring the entire organization into the conversation about St. John’s commitment to service and social change. “This kind of work cannot be done only at the top,” stresses Nomsa Khalfani, “it needs to be a larger body at all different levels.” She emphasizes that this is particularly important when some staff members are engaged in advocacy efforts, community organizing, or other external public activities

that go beyond the scope of delivering primary medical services. By involving the entire staff in larger vision for your work, “everybody understands the purpose [of a particular activity], why we are doing it, and how it impacts everything across the board, both internally and externally,” says Nomsa. She is also overseeing the integration of support services into clinical practice at St. John’s, adopting a more holistic approach to medical care. “Integration of support services has to do with where we are going and the impact we want to make, not only with the people who walk through our doors, but the communities that we serve,” reflects Nomsa.

In a bold expression of its commitment to promote health equity and social justice to reduce health disparities, St. John’s established a program in Social Medicine and Health Equity in the fall of 2008. This program, headed by Rishi Manchanda, MD MPH, strives to break down internal ‘silos’ between the direct services that the clinic provides and its broader social change activities. Dr. Manchanda explains, “We used our vision statement to gather input from staff and other stakeholders. We asked them what they thought, and what they thought was possible.”

One of the Social Medicine program’s goals is to integrate a biosocial model into the direct practices of the clinic. An example of this concept is a Medical Evidence Form used by doctors at the clinic, a simple tool that helps providers screen for housing-related health problems. According to Dr. Manchanda, this screening “transforms each provider-patient encounter in a way that elevates housing conditions in the minds of both persons.” Dr. Manchanda adds, “It shifts the needle in terms of what [the doctors] think about what is ‘appropriate medical care’ and it brings the providers into this team approach.” The program also focuses on community-engaged research and education such as insuring that partnerships with academic research institutions are aligned with patients’ interests as well as building research literacy among staff, providers, and patients. Recently, Dr. Manchanda organized a community-provider ‘House Call’ for all 18 of the clinic’s doctors. The goal of the outing was to “get us out of the walls of the clinic and understand the context of our patients’ needs,” says Manchanda [see sidebar].

MAKING A ‘HOUSE CALL’ TO THE COMMUNITY

In May 2010, Dr. Rishi Manchanda, Director of St. John’s Program in Social Medicine and Health Equity, organized a community-provider ‘House Call.’ The purpose of the event, according to Dr. Manchanda, was to “get us out of the walls of the clinic and understand the context of our patients’ needs.” All 18 of St. John’s clinicians participated in the House Call, which brought them to two patients’ homes in South Los Angeles to walk in the shoes of the community health outreach workers or *promotoras* who normally make these kinds of visits.

Accompanying the group was Dennis Hsieh, an attorney with Neighborhood Legal Services who helps St. John’s patients address the legal problems affecting their health. The providers were pre-tested about their knowledge of the law and then Hsieh briefed them about what is required of landlords under California’s Habitability Code during the van ride to the patients’ homes. Once there, they used the same visual assessment tools that the *promotoras* use to check for mold, chipping paint, lack of running water, and other conditions that can contribute to adverse health effects. “We asked them to use a checklist so that they wouldn’t just look at the patient in a medical way out of habit.”

The providers were deeply impacted by their visits, with many describing the experience as “humbling” and “eye-opening.” St. John’s will likely continue—and even expand—this program in the future to support cross-fertilization between its direct service providers and those who are engaged with patients in other ways, including community organizing, advocacy, and leadership development.

3. Assemble a board that shares your vision for social change.

From the beginning, St. John’s clinic has had a board that supports its larger social justice mission and, according to board member Tim Neiman, “whenever there is an opportunity to do more within the umbrella of the services that St. John’s provides...the board is always behind it.” Former board chair Lynne Gillies was recently honored for 30 years of service to St. John’s; she presided over the clinic’s transition to a FQHC and fully embraced patients’ participation on the board.⁹ Lynne added a standing agenda item for patients to share their views on things that are happening in the clinic and in the community. For example, the board conducts its meetings in Spanish twice a year—using interpreters for non-Spanish speaking members. Tim Neiman recalls attending his first board meeting in Spanish and thinking that St. John’s was “really serious” about involving patients in a meaningful way.

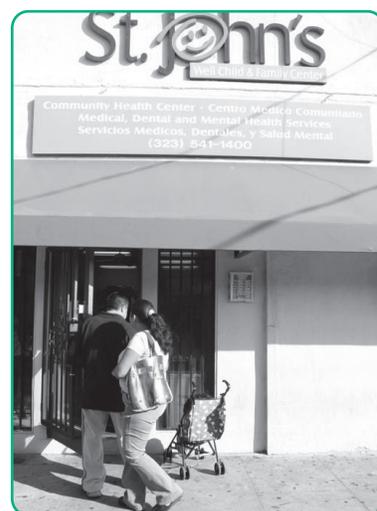
Neiman says that the patients on the board “report to us from the ground level about what their lives are like, [which] keeps me in touch in a very central, very real, and very ‘every meeting’ kind of way.” He adds that the patient board members do not just serve as a rubber stamp; they provide a constant reminder of the importance of the clinic’s work and “they give us a sense of the difficulty of people’s lives, how much they need us, and how we constantly need to do better for them.” Jim has never had to ‘sell’ the clinic’s board members on the value and importance of engaging in social change activities. The role of the board is to provide “leadership not just around health care services, but the elimination of health care inequity, which would result in broader inequities being addressed,” says Neiman. “That’s our mission.”

4. Partner with funders that support policy change as well as delivery of direct services.

In addition to the internal shifts described above, St. John’s has also diversified its funding base in order to support an integrated strategy of providing direct services and engaging in social change activities. Unlike most nonprofit organizations, FQHCs have a certain amount of medical revenue that is attached to each insured patient it serves.¹⁰ However, Mangia notes that while St. John’s may have more financial capacity than its smaller nonprofit partners, the clinic lacks the unique perspective and expertise that these groups bring to the table. The kind of inter-agency collaboration that is occurring through the Healthy Homes, Healthy Kids project would not be possible without the support of foundation funding. “Having funders support policy change is so important,” says Mangia. For example, in 2009, St. John’s received a \$1 million grant from the Everychild Foundation to expand the Healthy Homes, Healthy Kids project to 4,000 additional children throughout South Los Angeles. The grant supports both direct medical and case management services and allows St. John’s to channel compelling health data into advocacy to help children across Los Angeles.

A PLACE TO GET INVOLVED AND BE HEARD

There is little doubt that St. John’s has helped to transform some of the poorest neighborhoods in South Los Angeles – not only by improving patients’ health, but also by supporting residents to serve as agents of social change in their own communities. With Jim’s leadership, St. John’s staff, board, and patients continue to be motivated to view the clinic as a provider of primary medical services and a vehicle for achieving broader social justice goals. “I still get frustrated in meetings when people only see clinics in one way and they struggle with the possibility that they can be so much more than a place where you come in to get a physical,” says Nomsa Khalfani. She says that patients see St. John’s as a place “where they can go for resources, get involved, and be heard.”



In the spring of 2010, the Healthy Neighborhoods, Same Neighbors Collaborative¹¹ released its second report, *Shame of the City – The Sequel, Slum Housing: L.A.'s Hidden Health Crisis*, which documents the findings and outcomes from the Collaborative's two-year Slumlord Criminalization and Health Impact Project. In addition to improved individual health outcomes and environmental health conditions in targeted buildings, the project also achieved improvements in housing and health practices and government alignment. And perhaps the most profound change that has occurred is the increased power of tenants to change policy and practices. The report describes how the Collaborative has "transformed patients into active change makers, expanded the role of tenant leaders and community health promoters into human rights defenders, broken down barriers between traditional housing and health work, and have built the foundations for a broad base of residents working together in solidarity across race, geography and issue area."

Hundreds of community members, stakeholders, and public health and housing professionals gathered in South Los Angeles on April 20, 2010 in an effort to find solutions to substandard housing. The event marked the release of *Shame of the City – The Sequel*, but it was also an opportunity to present the report's overwhelming evidence to city and county elected officials and press them on how they were going to respond. When the Collaborative released its first report three years earlier, it was difficult to get the attention of those in power; this time, they were there in person to listen to what the community had to say—and their voices were heard.



First Annual South Los Angeles Health and Human Rights Conference

FUTURE DIRECTIONS: A HEALTH AND HUMAN RIGHTS FRAME

In November 2006, Dr. Paul Farmer, renowned physician and anthropologist, delivered the keynote address at the American Public Health Association's 134th Annual Meeting. In his speech, titled "Challenging Orthodoxies in Health and Human Rights," Farmer stated that "[t]hose of us in public health will have to learn to move beyond crude notions of cost-effectiveness and sustainability and to return to the concept of social justice, which once inspired public health." He went on to say that despite the challenges facing the

field—both in the United States and globally—that "[h]uman rights and social justice, once staples of public health, are slowly being revived on a grand scale." Farmer's speech had a huge impact on Mangia, who had been leading the charge to connect health outcomes with social disparities in South Los Angeles for nearly a decade. Jim thought to himself, "Where is this movement in the United States?" This question continues to spur St. John's clinic on as it moves forward in new directions.

Despite the fact that the field of human rights is widely embraced by many in the international arena, the framework has largely been ignored in the United States. "What better place to raise the issue of health and human rights than South Los Angeles," says Jim, "with its vast and deeply entrenched disparities, the health status of the population, and all of the social determinants right in front of your face." This realization catapulted the clinic's social justice work into a new phase, one in which longstanding injustices and inequalities facing the poorest residents in South Los Angeles would be viewed through the prism of human rights. *Shame of the City – The Sequel* notes that the lack of a human rights approach in the United States "has had dramatic repercussions for poor and underserved communities struggling against a myriad of social and economic conditions which have severely and negatively affected their health status." The human rights framework provides a practical, effective tool for addressing a wide range of cross-cutting issues.

In June 2009, St. John’s and its collaborative partners convened the First Annual South Los Angeles Health and Human Rights Conference. The event drew over 740 south Los Angeles-based residents, services providers, and advocates as well as colleagues from across the nation who “explore[d] transnational partnerships, and demonstrate[d] the effectiveness of community-led, place-based, and results-oriented approaches to healthier communities and human rights.”¹² A series of community events followed the conference to produce the South Los Angeles Declaration of Health and Human Rights¹³. Hundreds of patients were involved in the process of drafting the Declaration, which was released on International Human Rights Day, December 10, 2009, when more than 200 community members gathered around Los Angeles’ City Hall to call on the Mayor and the City Council to prioritize healthy and affordable housing as an inalienable right for all Angelenos.

The momentum of the First Annual¹⁴ South Los Angeles Health and Human Rights Conference has led to a number of other exciting developments. Anand Grover, United Nations Special Rapporteur on the Right to Health, recently accepted an invitation from St. John’s to visit South Los Angeles and learn more about the health disparities impacting its residents. On May 18, 2010, St. John’s held a Town Hall Meeting with the UN Special Rapporteur, elected officials, and community leaders to highlight the health and human rights crisis in the community. Also, since the conference, patients have continued to call the clinic to ask when the next human rights-related event would be take place. This led to the idea of starting community-led human rights committees, which—according to Dr. Rishi Manchanda—will help “build a constituency of folks who are aware of their rights and can articulate the need for realization of their rights.” In other words, they would be using the concept of the right to health as a way to mobilize patients for community change.

Although the idea of developing human rights committees through St. John’s and its community partners is still in its nascent stages, Jim Mangia recently heard from his staff that hundreds of patients were already signing up to participate. “Clearly, we have to harness this social motion,” says Mangia.

TO LEARN MORE ABOUT ST. JOHN’S WELL CHILD AND FAMILY CENTER AND ITS WORK, VISIT:
[HTTP://WWW.WELLCHILD.ORG](http://www.wellchild.org)

CENTRO BINACIONAL PARA EL DESARROLLO INDÍGENA OAXAQUEÑO

(Binational Center for the Development of Oaxacan Indigenous Communities, CBDIO):

FRESNO, CA

ORGANIZATIONAL PROFILE

Executive Director: Rufino Domínguez Santos

Location: Fresno (main office), Santa Maria, Greenfield, Hollister, Los Angeles, and Pajaro, CA

Service Area: Madera, Fresno, Tulare, San Benito, Monterey, Santa Cruz, Santa Barbara, Los Angeles, and San Diego Counties

Founded: 1993

Number of Staff: 12 FTE

Current Budget: \$667,114

Funding Sources: 57.5% Foundations; 22.5% County; 18.7% Other; 1.8% Individuals

Mission/Vision Statement:

Vision: Achieve the well-being, equity and self-determination of the indigenous communities.

Mission: Implement programs that drive the civic participation, economic development, social and cultural development of the indigenous communities.

Program Areas:

- Indigenous language interpretation
- Health education, interpretation, and individual assistance navigating health and social service systems; adoption of healthy lifestyle behaviors to prevent and reduce the incidence of childhood obesity
- Child development training and education for parents
- Leadership training to improve cultural competency and language access within selected health care systems
- Education and information about the health effects of pesticide exposure

Patient Demographics: 50% Mixtecos; 25% Triquis; 20% Zapotecs; 3% Chatinos; 2% Chinantecos

ONE WOMAN'S JOURNEY

“When I met Fidelina,” remarks Rufino Domínguez Santos, Executive Director of the Centro Binacional para el Desarrollo Indígena Oaxaqueño (The Binational Center for the Development of Oaxacan Indigenous Communities, CBDIO), “she didn’t want to talk at all. Her Spanish was very limited and she wouldn’t even raise her eyes when I spoke to her. She wasn’t sociable and she never laughed.” Fidelina Espinoza, who only completed two or three years of schooling in Mexico, migrated to Madera, California in 1997 to work in the fields. In 2001, she accepted an invitation to take part in one of CBDIO’s civic participation workshops. “In the beginning,” says Fidelina, “I was even scared to give my name.” In an effort to help Fidelina overcome her extreme shyness, Rufino and the other staff at CBDIO looked for opportunities that would allow Fidelina to slowly gain confidence to speak in public. She progressed from speaking up in small groups to moderating meetings at CBDIO and, eventually, serving as the Master of Ceremonies for La Guelaguetza, an annual festival celebrated by the indigenous community.



Fidelina Espinoza

Today, Fidelina, who has since become a CBDIO staff member, coordinates a nutrition education project for the Mixteco population in Madera County. She is friendly and extremely personable—even quick to laugh—and she is comfortable being interviewed in Spanish (versus Mixteco) about her experiences with CBDIO. “Now I can help other people,” Fidelina says. “I have received training in leadership, child development, advocacy, how to fill out medical insurance forms, and more.” She has even become a vocal advocate for the kinds of leadership development opportunities that CBDIO provides to the community. “I get frustrated sometimes because I want people to be independent, to have more knowledge. When people come to me for help, including my own family members, I tell them that their [civic] participation is very important.”

Fidelina provides an example of the transformation that many community members have undergone as a result of CBDIO’s commitment to culturally sensitive leadership development. “We have many examples of folks like Fidelina who were [initially] afraid to speak in public,” says Rufino. “It’s not easy. We always look for spaces and opportunities for participants to speak.” He continues, “We can give these workshops and talk at people, but if we don’t let them practice they are never going to speak.” CBDIO has developed a unique approach to its service delivery model; it not only provides the essential direct services that the indigenous Oaxacans need, but it also encourages them to develop the skills and confidence to become more engaged in the civic and political life of their communities in the United States. By linking civic participation to traditional indigenous cultural values and practices, CBDIO is shifting the way its constituents conceive of their role as agents for social change.

BACKGROUND

There are approximately 200,000 indigenous people from Mexico who currently reside in the United States. Of those, it is estimated that over half live in California. There are more than 60 different indigenous communities that exist in Mexico today and the following have large concentrations in California: Zapotecs; Mixtecs from the Mexican states of Oaxaca and Guerrero Triquis, Chatinos, Chinantecos, Mixes, and P’uhrépechas from the state of Michoacan.¹⁵ Each of these communities has its own unique language and culture which distinguish it from all others, and yet many face the same struggles as indigenous people worldwide: poverty, lack of access to health and social services, and linguistic and cultural barriers, among others. Indigenous people are also united by a struggle for self-determination as well as a grounding in traditional cultural values that “help us to defend ourselves and help others,” according to Rufino.

In order to address the significant challenges faced by indigenous Oaxacan migrants in the United States, community leaders—including Rufino, who is Mixtec—formed a social network in 1991 that would eventually become the Frente Indígena de Organizaciones Binacionales (Binational Front of Indigenous Organizations, FIOB). FIOB is a community-based organization and coalition of indigenous organizations, communities, and individuals settled in the Mexican states of Oaxaca and Baja California, and in the U.S. state of California.¹⁶ While FIOB’s work initially focused on organizing the community to draw attention to the needs of the Oaxacan people, it always had a view toward providing direct services support to the community through specific projects. In 1993, FIOB’s leaders registered CBDIO as a 501(c)(3) nonprofit organization in the United States so they could receive foundation funding to implement cross-border projects related to education, economic development, and training.



Executive Director Rufino Domínguez

CBDIO’s broader vision is to achieve the well-being, equality, and self-determination of indigenous communities by implementing programs that drive their civic participation, as well as their economic, social, and cultural development. Today, Fresno-based CBDIO has five satellite offices in Santa Maria, Greenfield, Hollister, Los Angeles, and Pajaro, communities where migrant workers are employed in large numbers. Many indigenous migrants continue to maintain strong ties with their hometowns even when they are in the United States, which allows CBDIO to stay connected to local communities on both sides of the border. “Like many migrants, indigenous peoples maintain strong ties to their home communities once they move abroad. These linkages serve many purposes, including the production of cultural resources to strengthen indigenous cultures, membership, and maintenance of customs.”¹⁷

Indigenous migrants often face language barriers¹⁸ that affect their everyday activities ranging from the mundane, like going shopping or riding public transportation, to those that have much more serious consequences, such as communicating with law enforcement officials or accessing medical services and treatment. Rufino says that many indigenous Oaxacans experience discrimination not just by Caucasians, but also by Latinos. “Some Latinos don’t even know who indigenous people are and how we are different. For example, they don’t even know that we don’t speak Spanish and they are surprised when we say that we need an interpreter.”

For several years after it was founded, CBDIO relied solely upon small donations to support its program work. However, in 1996, the organization received its first substantial grant from California Rural Legal Assistance (CRLA) to start an Indigenous Interpreter Project, which continues nearly 15 years later. This project has helped to fill a critical gap in services for monolingual indigenous migrants in California as well as other parts of the country¹⁹ and—at the same time—it is symbolic of CBDIO’s role as a ‘bridge’ between the indigenous population and other residents in the communities where migrants have settled.

PROVIDING SERVICES AND CREATING CHANGE

CBDIO takes a long view in its approach to providing direct services and supporting community members to become more civically engaged. “We’re never going to stop providing direct services because there will always be new immigrants who need our help,” says Rufino. “However, I think that it’s better to invest in developing leadership, civic participation, and advocacy because this creates change.” He points out that, in many cases, the provision of direct services alone does not affect the root causes of wider issues or problems facing the community. “Somebody comes in to get help filling out forms [for example]. They go away and then they have to come back the next time they need help. This does not cause changes for more than one person. It doesn’t serve the community.”



Naa Xini Graduates

Each of CBDIO's programs has a different emphasis, but they all share a common trait: they interweave direct services with opportunities for leadership development and civic participation to strengthen the voice and power of indigenous Oaxacans. CBDIO is focused on meeting the basic needs of its constituents through the provision of direct services. However, by simultaneously developing the advocacy capacity of the people it serves, CBDIO is helping to insure that constituents will be able to seek out and access additional services beyond those it provides and that they will also be able to affect larger changes that benefit their families and communities. In this way, CBDIO serves as a kind of intermediary for indigenous Oaxacans.

CBDIO keeps this balance through its different programs. Listed below, each program exemplifies the organization's dual approach to service and social change:

- ▷ The **Proyecto de Salud Indígena** (Indigenous Health Project, PSI) focuses on improving access to health and social services for indigenous migrants in the Central Valley. Through this program, CBDIO provides health education, interpretation, and individual assistance navigating health and social service systems. It also provides cross-cultural training for health and social service providers regarding Oaxacan indigenous culture. CBDIO trains promotores²⁰ on various aspects of health and healthcare to assist in improving community health. These individuals are selected based on their established record of community participation and they are provided with additional education and training to support their continued civic engagement.
- ▷ Through its **Civic Engagement Project**, CBDIO provides a series of workshops for indigenous community members on themes such as the organization and operation of schools, local government, collaboration with other community-based organizations, and the importance of (and obstacles to) civic participation. The stated goal of the project is to create awareness about our human responsibilities to carry out political, social, cultural, and educational actions for the community, and through collective action, to facilitate a positive social change that will benefit everyone. Project graduates are using their training in various ways. Some have gone on to work for other nonprofits, such as CRLA and Headstart, or founded their own organizations. Others have started community gardens or are focused on preserving aspects of indigenous culture, including traditional medicine and folkloric dance.
- ▷ The **Naa Xini** (Community Health and Civic Participation of Indigenous Immigrants) program—which blends the Civic Engagement Project and Proyecto de Salud Indígena—aims to develop a culturally based health policy advocacy model for the indigenous populations in Fresno and Madera counties. Using this model, CBDIO is training leaders in these two regions to engage in advocacy activities to improve cultural competency and language access within selected health care systems. (Specific outcomes from the *Naa Xini* program are discussed below.)
- ▷ The **Xi'na Navali/Nacoa Snia** and **Jasno Isnai** ("Children First" in Mixteco and Triqui) programs help indigenous parents in Monterey and San Benito Counties increase their understanding of their children's development and the role they play as the children's first teachers. They seek to promote the effective engagement of indigenous families in decision-

making forums in the city of Greenfield (Monterey County) to promote changes that improve the education and well-being of their children.

- ▷ With the objective of achieving an accurate count of the indigenous people who work and live in the United States, CBDIO launched a comprehensive **2010 Census Campaign**. Following the 2000 Census, CBDIO, FIOB, CRLA, and other indigenous rights groups successfully advocated for the 2010 Census form to include an extra space where indigenous people could fill in their specific ethnicity (e.g., Mixtec, Triqui, Zapotec, etc.). Through its 2010 Census Campaign, CBDIO provided constituents with education and information about the importance of census participation using written materials, workshops, public forums, presentations, community events, and ethnic media.

The organization and its founders have had a clear sense of its role as a force for community change from its inception. Indeed, CBDIO’s mission statement compels it to “implement programs that drive the civic participation, economic, social, and cultural development of the indigenous communities.” Nayamín Martínez, CBDIO’s Advocacy and Development Coordinator, notes that they decided to expand the range of direct services that the organization provides in 2002 as a result of the organization’s commitment to civic engagement. “We were trying to organize folks [around broader issues], but we realized that people had to be able to put food on the table first,” she says. For the staff at CBDIO, there is an important symbiosis between direct services and advocacy, and they never miss an opportunity to fulfill their organizational mandate to “drive civic participation.”

CBDIO is always “bringing new people through the door,” says Nayamín, by providing essential services and it views each encounter with a client—even if it is just a brief exchange—as a chance to engage that person on a deeper level. “People come here because they have a need,” says Nayamín, “and maybe they didn’t have anything in their minds about getting more involved, but when they leave they have that opportunity.” Nayamín gives the example of a client who might come in to inquire about her child’s eligibility for California’s Healthy Families²¹ program. “Even if she just wants to know how to enroll, we take that opportunity to say, you know, the state is proposing cuts to that program that may affect your child. Would you like to sign a petition or send in a postcard [expressing concern about those cuts]?” She adds that if that client continues to show interest in being civically engaged, they might invite her to a workshop about the state budget or to take part in a demonstration. The fact that CBDIO’s constituents are participating in these kinds of activities in larger and larger numbers is significant, particularly given the linguistic and cultural barriers that they must overcome in order to do so.

WORKING WITH ONE ANOTHER FOR THE GREATER GOOD

When CBDIO staff members conduct trainings on civic participation for indigenous community members, they will often start by asking participants, “What experience do you have with civic participation in Oaxaca?” “Usually,” says Rufino, “there isn’t a single hand that goes up in the room.” But when they ask how many have participated in *tequio* (working together for the community’s well-being), nearly everyone raises their hand. Rufino says, “We tell them that *tequio* is civic participation. When we work together to build a church, a school, or a road, we are getting together to make a change.”

In addition to *tequio*, there are a number of other cultural values and practices [see sidebar on page 16] that inform CBDIO’s civic participation work with indigenous community members as well as the orientation of the organization as a whole. By placing the concept of civic participation in an appropriate cultural context, CBDIO has helped community members to find their ‘voice’ as advocates—even if they are initially reticent about engaging in activities that may initially seem incongruous with their cultural norms.

The National Community Development Institute (NCDI)—a group that provides technical assistance for grassroots organizations in low-income communities of color—worked with CBDIO to develop a culturally-based, collaborative advocacy/policy training curriculum for the *Naa Xini* program which addresses community health through civic engagement. In an assessment prepared for CBDIO by NCDI, the authors write that “[w]hile there are some cultural inhibitions that the advocacy training must face, the community also brings a wealth of strong traditions which—if tapped into—can greatly enhance the success of the *Naa Xini* project. The indigenous culture has a long and honored practice of meeting community obligations and working with one another for the greater good.”

This approach has proven to be successful with many of CBDIO’s programs. For example, CBDIO has provided a series of workshops to cohorts of 20 community members²² in Madera and Fresno Counties as part of *Naa Xini*. The program is geared toward helping participants understand how they can “join together in a collective manner—utilizing the concept of *tequio*—and try and change something that affects them locally [related to community health],” says Leoncio Vásquez. One of the workshop sessions deals with how to identify problems facing the community and participants are encouraged to consult with their neighbors, family members, and others to help focus the group’s advocacy agenda. Some of the issues that have surfaced as part of this information-gathering process²³ are a lack of qualified indigenous interpreters at the Department of Social Services and health clinics in both counties, racial profiling by law enforcement officials, and poor quality food being served in elementary schools in the Madera Unified School District.

Each cohort develops an advocacy plan on the topic(s) they have chosen to focus on and participants receive training on media and advocacy strategies from partner organizations and consultants, which helps shape the work as it unfolds. Among the activities that community members have planned and participated in as part of the *Naa Xini* program are: 1) meeting with county supervisors and other elected officials to seek support for desired changes; 2) holding press conferences and vigils; 3) collecting testimonies of community members’ personal experiences; 4) conducting public service announcements and television and radio interviews; and 5) writing letters to the local civil rights office as well as other forms of administrative advocacy. And their efforts are producing results.

INDIGENOUS CULTURAL VALUES AND PRACTICES: GUIDING CIVIC PARTICIPATION

Tequio – A tradition that emphasizes working together for the community’s well-being or the communal good. An example of tequio is the construction of a road or another community-based labor project that benefits all residents.

Cargos – It is customary in indigenous culture (mainly for males) to serve in some leadership capacity in their community of origin. Cargos are unpaid positions that lead to greater and greater authority throughout an individual’s life.

La Guelaguetza – An annual festival that celebrates the commitment to sharing and the practice of contributing for the betterment of the community. Guelaguetza is Zapotec for “offerings or gifts” which is realized by participants that perform music, dance, and songs from their respective regions.

Storytelling – Stories are an important aspect of communicating traditions, issues, and encouragement. Storytelling is also an excellent way for community residents to gain collective understanding of issues and their impact on the community as a whole.

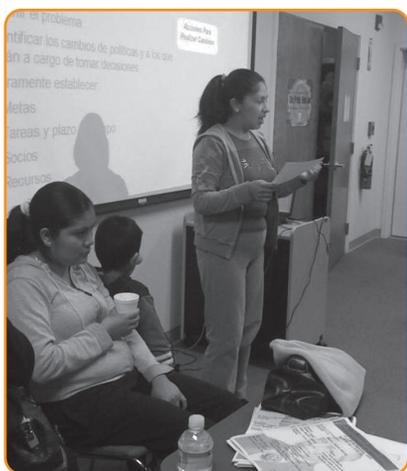
Collectivity – A custom of collectively making decisions by coming to a consensus about what is best for the community.

Trust – Indigenous people rely greatly on trusted individuals within their community. It is a common practice to go to a trusted individual to ask for information.

Respect – The indigenous community is very respectful towards all. Respect is shown by maintaining physical space between individuals, lowering one’s eyes when listening to a person in authority, and not questioning authority figures.

—Excerpted and adapted from “Participatory Organizational Capacity Assessment: Capacity to Implement a Culturally-based Health Advocacy Model”, prepared for CBDIO by the National Community Development Institute, pgs. 9-11.

In Madera County, the Department of Social Services has responded to advocacy by *Naa Xini* participants and CBDIO’s organizational partners by providing awareness training to their staff about indigenous Oaxacan culture. They also created a position for a Mixteco worker and institutionalized bi-monthly meetings with the indigenous community where administrators can address complaints directly. The Fresno County Department of Social Services has translated and recorded a whole packet of “Rights and Responsibilities” materials onto a CD that workers can play for Mixteco clients, and they developed tools to help staff communicate better with indigenous clients (e.g., “I speak...” cards written in Mixteco and English). In addition, the Fresno County Board of Supervisors approved a resolution increasing the income guidelines for the Medically Indigent Services Program (MISP)²⁴, another pressing issue that had been identified by *Naa Xini* participants for advocacy.



CBDIO Advocacy Training

OVERCOMING BARRIERS TO PARTICIPATION

CBDIO has always set ambitious goals for engaging indigenous community members in advocacy, leadership development, and civic participation activities. “We want people to be motivated to make a change for themselves,” says Rufino Domínguez. This has been a challenging process, according to Leoncio Vásquez. “People have always been scared to speak up because of [their immigration status], a lack of education, and language problems. With time, we have overcome some of these barriers.” Leoncio describes the process that many constituents must go through in order to feel comfortable speaking in public, which often begins by them taking a more active role during meetings and workshops at CBDIO – like Fidelina Espinoza.

One of the most profound ways in which CBDIO is influencing civic engagement among the indigenous Oaxacans it serves is by encouraging the participation and leadership of women. Traditional indigenous Oaxacan culture dictates strict gender roles and, in general, the participation of women in public spheres is not accepted. The slow and gradual process of developing indigenous women’s leadership began in earnest with FIOB, which appointed Teresa Ramos as the group’s first Women’s Coordinator in 1994. Although there was some initial discomfort among participants who were not used to having both men and women interacting in a public setting—much less one in which women were being asked to speak up and give their opinions—most have come to accept and even embrace the shift. Today, women make up the majority of CBDIO’s staff as well as those who attend CBDIO’s and FIOB’s meetings and events. “There is now a culture of participation,” says Rufino, “there has been a change.”

Rufino observes that CBDIO—like FIOB—has “broken with tradition by having women and young people participate actively in our meetings, workshops, and forums. We all have a voice and a vote.” CBDIO’s efforts to shift the needle in terms of women’s leadership are reverberating back in Oaxaca too, where women have actually assumed positions of authority in some villages. In part, this is a product of the emigration of men who leave in search of work (mostly in the United States), but it also reflects a bigger change that is taking place.

When indigenous migrants arrive in the United States, they are at once supported, bound, and challenged by traditional values and cultural norms. In many ways, CBDIO’s role is to facilitate a process whereby constituents can honor the values they brought with them from Oaxaca—values which help inform and guide their civic participation in the United States (e.g., *tequio*)—and, at the same time, examine those that may hinder them from realizing the full potential of all members of their community (e.g., gender discrimination). Because CBDIO’s staff and leadership represent the communities that the organization serves, they approach this aspect of their work as cultural insiders and from a place of profound respect.

STAYING TRUE TO OUR VALUES



CBDIO Staff

Since CBDIO's inception, its founders have been clear about the impact that they want to have in the community, including the ways in which they hope to affect broader social change. However, CBDIO's infrastructure has developed more gradually. For example, although CBDIO was founded in 1993, the executive director position was only created in 2001; prior to that time, Rufino supervised three staff members as a volunteer. In 2002, CBDIO held a retreat to develop its first strategic plan and to draft the organization's mission and vision statements. This gathering included staff, board members, and representatives from the community.

CBDIO has always sought to hire bi- or trilingual indigenous staff members, and the members of its Board of Directors also reflect a direct connection with those whom the organization serves.

Indeed, there has always been a fairly porous boundary between CBDIO staff and community members. CBDIO and its 'parent' organization, FIOB, were founded by community members, so there is a sense of ownership and shared responsibility that flow in both directions. There is little doubt that CBDIO's effectiveness in fulfilling its mission and vision is directly related to the high level of trust they have established with the indigenous community.

Internally, CBDIO operates in much the same way that it does in the community—everyone has a voice and a vote. Each new funding opportunity is discussed during a team meeting, which allows all staff to weigh in about the needs of constituents, the capacity of the organization, and the potential impact of the grant. In addition, CBDIO frequently involves community members in the design and evaluation of their projects and programs; this type of inclusiveness helps it to assess its effectiveness at the ground level. "CBDIO has a very horizontal structure," says Nayamín Martínez, and when decisions are made, everyone is at the table—including constituents. She goes on to say that this is one of the organization's greatest strengths in that it gives CBDIO a very "open and fresh perspective of the community and the problems that it faces."

CBDIO advances its work—and its vision for social change—in collaboration with diverse organizational partners that include local healthcare coalitions and statewide groups like CRLA, as well as Líderes Campesinas, an organization that works to develop the leadership of women farmworkers so that they can serve as agents of political, social, and economic change. CBDIO has also established key allies in the immigrants' rights movement to support their advocacy and organizing work in this important arena, and it has a fruitful partnership with Radio Bilingüe, a nonprofit public radio network that serves the Latino community and helps CBDIO provide information to an audience of thousands. These partnerships are strategic in the sense that they build on each group's strengths, including—in the case of CBDIO—the ability to activate a large base of constituents who have been trained in advocacy and leadership development and who are committed to pursuing civic engagement for the betterment of their communities. Inherent in these partnerships is recognition that social change is a collective process that is fueled by leveraging the assets, expertise, and involvement of groups whose visions are closely aligned – even if their programmatic goals and activities are different.

And CBDIO continues to fulfill its mission on both sides of the border. In addition to its work in California, in 2002, CBDIO launched the Education and Training Project on Human Rights, Organizing, and Advocacy²⁵ in the Mexican states of Oaxaca and Baja California. Through its work, CBDIO acknowledges the strong ties that most indigenous migrants maintain with their hometowns. For example, last year Leoncio Vásquez took a leave of absence from his position at CBDIO to return to his hometown in Oaxaca to serve as the *Secretario Municipal* (Municipal Clerk).

Although many indigenous migrants are unable²⁶ to go back to Mexico to fulfill their obligations to their communities in the same way as Leoncio, their traditional cultural values and practices are helping to inform their civic participation in the United States.

As CBDIO continues to grow, both in terms of the numbers of individuals it serves as well as its ability to provide training and capacity building to constituents, it will have a larger and larger impact on important issues in the United States and in Mexico. By developing a culturally relevant model for encouraging civic participation among indigenous Oaxacan migrants, CBDIO has succeeded in creating a ‘multiplier effect’ in which community members become agents for ongoing social change. “I would like the whole community to know how to make changes in their children’s schools,” says Rufino. “What can we do if there are gangs? What do we do if there aren’t benches or parks in our community?” Rufino says that by equipping constituents with the tools to answer these questions for themselves, CBDIO will fulfill its vision of achieving the well-being, equality, and self-determination of indigenous communities.

TO LEARN MORE ABOUT CBDIO, VISIT: [HTTP://WWW.CENTROBINACIONAL.ORG](http://www.centrobinacional.org)

HILL COUNTRY HEALTH AND WELLNESS CENTER: ROUND MOUNTAIN, CA

ORGANIZATIONAL PROFILE

CEO: Lynn Dorroh

Location: Round Mountain, CA

Service Area: Shasta County

Founded: 1982

Number of Staff: 72 (55 FTEs)

Current Budget: \$4.5 million

Funding: Patient Fees 62%; Federal 15%; Foundations 12%;
County 7%; State 4%

Mission/Vision Statement:

Mission: With kindness, Hill Country Health and Wellness Center works in partnership with our patients and community, providing to everyone the health care services, education and support needed to live whole, healthy and satisfying lives.

Vision: Hill Country Health and Wellness Center inspires health and wellness in all areas of life so that we may learn to heal ourselves and our communities through the choices that we make every day.

Program Areas:

- Comprehensive medical, dental, and mental health services, including: preventative care; well child care; women's health; men's health; senior care; family planning; accidents; acute illness; dental care; and mental health counseling for individuals, couples, groups, families, children, and adolescents
- Acupuncture, massage, nutrition, exercise, and other holistic care
- DEPTH Teen Outreach Program and Student Internship Program
- School-based Mental Health Program
- Circle of Friends: Mental Health Wellness and Recovery
- KKRN, 88.5 FM, a locally-owned, not-for-profit radio station

Patient Demographics: 90% White; 5% Latino; 5% Native American

INTRODUCTION



Richard Hardie, Lynn Dorroh, and former Executive Director Ray Hamby

Round Mountain (official population 122) is a rural area of Shasta County, California, on the southern edge of the Cascade Range. In Shasta County, most businesses and services are clustered around the Interstate 5 corridor, but once you head east on Highway 299 from Redding—the largest California city north of Sacramento—the terrain quickly becomes more rural. The region’s natural beauty is juxtaposed against the significant challenges its residents face: there is very limited public transportation, affordable, well-constructed housing is scarce, there is widespread substance abuse, and many people live below the poverty line. According to census figures, the median income in Round Mountain was \$18,500 in 2000.

Most area residents are politically conservative and tend to favor self-reliance, but there is also a strong sense of mutual support and shared responsibility. “It’s a very independent community, that’s why people live out here,” says Hill Country Health and Wellness Center staff member Patrick Moriarty, “and yet they have to depend on each other because it’s so rural.”

In 2004, Hill Country Health and Wellness Center was designated as a Federally Qualified Health Center (FQHC)²⁷ meeting the federal definition of a Frontier Clinic due to its location in a sparsely populated rural area with a population density of six or fewer people per square mile. “People have come to Round Mountain before and asked me what is this clinic doing out in the middle of ‘nowhere,’” says Hill Country Chief Executive Officer Lynn Dorroh, “and I tell them that it’s not actually nowhere.” Today, Hill Country is the largest employer along a 50-mile stretch of Highway 299 and the clinic serves over 3,000 patients from all over Shasta County each year.

Over the years, Hill Country’s leadership has found itself in the position of challenging assumptions that policy makers, funders, and others make about communities like Round Mountain. For example, some have the notion that it is less expensive to provide services in a rural area simply because there are fewer people. “There are very different issues in small rural clinics,” notes Deputy Director and Chief Financial Officer Richard Hardie, “and that doesn’t always get recognized.” However, the bigger story is how Hill Country, which was founded by four self-described “hippies,” has been able to help local residents develop a sense of ownership of the clinic, become advocates for health care, and foster a sense of community—despite their ideological differences. To understand this process, it is important to return to Hill Country’s roots.

HAVING GOOD, MEANINGFUL WORK

In 1982, four young and idealistic friends were looking for a way to make a difference in their community. One of the four, Joe Stenger, had just finished his medical residency, which sparked the idea of starting a health clinic. According to founder Lynn Dorroh, “the initial impulse was more about working together and having good, meaningful work.” The group also included Chief Financial Officer Richard Hardie. “We all came out of the Sixties and our intention from the very beginning was about social change,” says Hardie. “There has been a great deal of intentionality from the very beginning about what this place would be.” The fourth member of the group was Joe’s wife and Richard’s sister, Kathleen Hardie.

With seed money from the Irvine Foundation, the group purchased the shell of a modular building for \$30,000 and raised additional funds to finish the structure by making and selling homemade raviolis and bartering with local

merchants. What was then known as Hill Country Community Clinic opened its doors in 1985 and, for the first month, no one received a paycheck. After that, everyone made five dollars an hour, including the clinic’s doctor, Joe Stenger, who supplemented his income by doing surgical assists in Redding. This spirit of community and collective action for the greater good has informed the clinic’s efforts over the past 25 years, even as the organization has experienced significant growth.

HELPING EACH OTHER AND OURSELVES

In Round Mountain, folks lend significant weight to the notion that those who live in the community understand its needs best. Hill Country’s founders were all living in rural Shasta County when the idea for the clinic was first hatched. “We are our patients,” says Lynn Dorroh, “I was on Medi-Cal²⁸ when my son was born.” She adds that “it’s not that we are ‘helping poor people,’ we are all helping each other and ourselves.”

Despite the fact that they were already members of the community, the founders faced a significant challenge in terms of establishing trust with other local residents. Not only were their politics different, but the language that Lynn, Richard, Joe, and Kathleen used to describe their broader social change goals did not necessarily have the same resonance with people in Round Mountain—people like Dorothy Buffington, a local retiree. Today Dorothy is one of the clinic’s biggest supporters, but that wasn’t always the case.

For a long time, Dorothy resisted going to Hill Country for health services because the doctor had long hair and it was “run by hippies.” Although Dorothy’s conservative politics haven’t changed, her view of the clinic has. This is a direct result of the long-term personal relationships that she has developed with clinic staff, patients, and other community residents through her involvement with Hill Country. “We’re all coming together,” she says on the clinic’s promotional video, “we’re all here for the same reasons. We all have our political beliefs, but we all get along.” Dorothy is very involved in the local Lions Club. She recruits new members at Hill Country, and the clinic is a collection site for used eyeglasses. Dorothy recently traveled to rural Mexico on a mission with the Lions, distributing these glasses to people who do not have access to vision care. Dorothy has served as a spokesperson for Hill Country many times over the years, eloquently expressing the importance of local health care and community development.

“We say ‘health equity,’ we say there are ‘too many people living in poverty.’ We don’t have any consistent jargon that we use—we just use clear simple language.”

CEO Lynn Dorroh

In large part, Dorothy’s story is emblematic of Hill Country’s approach to its work and to its role in the community. According to Lynn Dorroh, their philosophy is simple: See people where they are, meet them where they are, and invite patients to make it their health center. Lynn and Richard—the two remaining founders who are still working at the clinic—haven’t abandoned the ambitious social justice goals that led them to start the clinic in the first place. In fact, one might argue that they have become even more ambitious over the past 25 years as the clinic has developed a stronger and stronger foothold in Shasta County. However, they are intentional about describing their efforts in a way that is not politically charged. “We say ‘health equity,’ or we say that there are ‘too many people living in poverty,’” says Lynn. “We don’t have any consistent jargon that we use—we just use clear, simple language.” Hill Country board member Larry Russell remarks that “they built this clinic in the bastion of conservatism. . . they keep the peace, keep their heads down, and keep doing things for the people.”

Hill Country has been described by various stakeholders as a “hub” of local activity, Round Mountain’s “de facto town hall,” a “community center,” and a “nexus for community activities.” While these are not phrases typically used to describe most health clinics, they are quite relevant in the context of the local environment. It has taken more than two

decades of slow, steady, and deliberate work for Hill Country to become what it is today—a thriving health clinic that is a center for wellness and community life in Round Mountain. Lynn, Richard, and their peers have earned the trust of local residents not only by providing essential health services, but also by being a place that is truly a ‘home’ for everyone in Shasta County.



Hill Country's new LEED-certified clinic facility.

THE FOUNTAIN FIRE: A TURNING POINT

In 1992, the Fountain Fire blazed in central Shasta County for eight days, ultimately destroying 300 homes and turning 64,000 acres of dense forest and brush into what has been described as a ‘moonscape.’ The Hill Country Community Clinic burned to the ground and everything the group of friends had built over the course of seven years was lost—except for patients’ medical records, which were loaded into the trunks of staff members’ cars with just moments to spare. By that time, Hill Country had established itself as an indispensable part of the community. Registered nurse

Bobbi Tryon recalls that losing the clinic represented “an injury to the soul of this community.” However, they were determined to rebuild.

Despite its devastation, Lynn Dorroh says that, ironically, the fire actually provided a ‘boost’ to the clinic. The generosity and flexibility of people in the community, along with local organizations and state agencies, helped Hill Country get back up and running within six months. Some of the institutions that had lent them money forgave their debts, which helped launch the clinic with a stronger financial base. The fire also provided an unanticipated opportunity for reflection and renewal—a chance to assess the role of the clinic in the community going forward.

Hill Country conducted a comprehensive community survey to ask what local residents wanted the clinic to do next, and the results pointed to a number of pressing needs, most of which were beyond the scope of the direct health care services being delivered by the clinic. They included: activities for youth, adult education, affordable housing, and access to afterschool activities. At the time, Hill Country did not want to stray too far from its core services, so in 1998, Lynn and her husband founded Acorn Community Enterprises, a family resource center, to respond directly to these identified community needs. Acorn is still in operation today and maintains a strong connection with Hill Country.

In 2003, Lynn came back to Hill Country as a part-time employee²⁹ to run a behavioral health program, and she quickly realized that there were a lot of patients showing up regularly on the clinic roster because it was their only contact with the outside world. “At Acorn, it was so hard to reach the people who you really wanted to help,” Lynn remembers, “but it became clear to me that [a health clinic] is the best place in a rural community to do prevention and community organizing. People are more vulnerable when they come to see the doctor.” So, when the clinic’s former executive director, Ray Hamby, announced that he would be retiring in 2004, Lynn decided, at the request of the Board of Directors, to dedicate herself fully to transforming the local community through her work at Hill Country.

CAPTAINS OF THEIR OWN HEALTH CARE

Bridging actual or perceived ideological differences between the clinic and the community has been an incremental and deliberate process—not the product of a single event. In large part, Hill Country has had staying power because its founders have too; Lynn and Richard, along with original employees Terri Orwig, a licensed vocational nurse, and Bobbi Tryon have been a part of the local community for the past 25 years, a reality which has greatly informed their approach to their work. Put more simply, the issues that affect their patients affect them too.

Hill Country has strived not just to meet, but to raise the expectations of local residents when it comes to the quality and standard of health care to which they feel they are entitled. Over the years, the clinic has grown substantially in order to address the needs of patients and the community alike. It was Hill Country's strong relationship with the community that helped the clinic complete a massive 12,500 square foot expansion project in 2009. The new facility, which anticipates a LEED Gold certification³⁰, includes three new dental operatories, an expanded mental health suite, medical exam rooms for specialty providers, and a large multipurpose room with a commercial kitchen that is used for exercise and health promotion activities. The clinic also boasts a library where patients can log on to the Internet or pick up a book, a kitchen that serves healthy food and provides nutrition information and education to the community, and an open, light-filled waiting area with children's toys and original artwork.



Circle of Friends participants and supporters at a health care rally in Sacramento, CA.

In fact, since the expansion, Hill Country has started serving more privately insured patients who no longer see it just as a clinic for poor people, but a place that's known for "letting people be the captains of their own health care," according to Lynn. "At the most fundamental level," she says, "it's about patient empowerment and getting people to believe that they can lead the lives they want to live." In 2009, the organization changed its name to Hill Country Health and Wellness Center. In the clinic's promotional video, Lynn says that the name change was "a reflection of our commitment to this being really more than just clinical care, but a place where all kinds of activities are happening to help people keep their health, regain their health, and live happier, healthier, and more contributive lives."

In many ways, Hill Country is always striving to create broader social change through its programs. For example, the clinic receives funding from Shasta County through the Mental Health Services Act (MHSA) to serve the chronically mentally ill. Through the clinic's growing work with this population, they have discovered that many residents have been struggling with untreated mental illness (15 percent of their current patient population has a serious mental illness). The vision and philosophy of Hill Country's Circle of Friends: Mental Health Wellness and Recovery Program are deeply rooted in wellness, recovery, and resiliency. Program participants gain, regain, or maintain their ability to live, work, learn, and participate fully in the community.

The MHSA includes several advocacy components, such as facilitating peer-to-peer support and giving people living with mental illness the opportunity to speak on their own behalf. This is an approach that is embraced by the Circle of Friends Program, which has provided participants with basic advocacy training as well as opportunities to travel to Sacramento to protest cuts to Medi-Cal benefits and meet with elected officials about pressing health care issues. "Getting people involved in the public arena is not easy to do when people's self-confidence isn't that high," says program director Patrick Moriarty. He goes on to say that when people don't feel like they count, it can create a victim mentality. The challenge is to get people to become part of their own healing process. "Is the person engaged in the process?" he asks, "and if not, are we really helping?" By supporting those with mental illnesses to be able to advocate on their own behalf, the clinic is building a bridge to a community that has been largely 'invisible.'

DEVELOPING A DREAM: HILL COUNTRY'S WORK WITH YOUTH

Many people connected with Hill Country feel that their work with local teens is breaking new ground in terms of its long-term impact on the community. "Our youth work is the most significant way in which we are trying to address the underlying determinants of health," says Lynn. In 2005, Hill Country established a youth-led, youth-run advisory board to determine whether they should include a teen center in the plans for the new building. The Board of Directors and

the clinic leadership were committed to establishing a permanent, dedicated place for young people at the clinic, but they wanted the decision to come from the teens themselves. Not only did the youth decide that they wanted a teen center, they also helped to design it and they raised \$5,000 to help complete and furnish it. Behavioral Health Director Tammy Allan, LCSW, has supported the Youth Advisory Board since its inception, providing guidance to the group about how to govern themselves.



Radio production training for teens at Hill Country

Over the past five years, the Youth Advisory Board has continued to meet on a monthly basis and Hill Country's teen center and youth-focused programs have transformed the lives of dozens of young people in a place where it can be really tough to be a teenager. For example, kids go to elementary school in Round Mountain, but when they reach middle school they must travel to Redding or Burney to continue their education. The income disparity between Round Mountain and these communities is significant: students from Round Mountain are always the poorest students and are often on the outside. "You have to be a motivated kid to ride a bus an hour and a half each way to

school each day and not participate in afterschool activities," says Richard Hardie.³¹

A challenge for rural teens here, and in other places, is that there is not a lot for them to do. As a result, some get into trouble or fall into drugs. "They get trapped here and they don't have a picture of themselves in the world," Richard continues. Hill Country is trying to provide area teens with that picture and combat the isolation that many rural youth experience.

The Youth Advisory Board organizes numerous activities during the course of a month—from river rafting to camping and dances to community service projects. Ashley Sherbundy, a 16-year-old high school junior from Montgomery Creek, is a Youth Advisory Board member and works as a teen program assistant at the clinic two days a week—her first formal paid job. "I call teens in my area and tell them about what we will be doing and encourage them to join us," Ashley says. She estimates that 80 to 90 percent of area teens now participate in teen center activities. "The clinic has changed a lot of teens' lives and it has given us employment opportunities," Sherbundy says, adding that she'll be the first in her family to get a bachelor's degree. "I'm interested in working with teens because of my work here."

Hill Country's Discovery, Exploration, Purpose, Training, and Hope (DEPTH) Program provides tutoring, mentoring, and assistance with educational loans, grants, and financial aid. On the surface, DEPTH looks like a traditional youth-focused direct service program, but it manages to accomplish a larger goal: helping older teens develop a dream and achieve it. Most teens in Round Mountain have never even been to San Francisco (less than five hours away), but through the DEPTH Program, Hill Country has taken them to visit colleges and trade schools, opening them up to a world of new opportunities. Hill Country also operates a student internship program that provides jobs at the clinic so that students can gain experience in the health care field. For the past four years, Hill Country has paid young people to fill entry-level jobs that need to be done, but "it's been completely clear to everyone that the teen employees are the lives that have been most transformed," says Lynn. [See sidebar on page 7: A Young Leader Makes a Difference.]

As a result of Hill Country's work, young people in Shasta County are more involved in the life of their communities than ever before—and they see that they have a part to play in the future of the region. Richard Hardie believes that many more youth have the sense that they can not only go off to college, but that they can come back to live and work in the area too—leaving is not the only option. Part of Hill Country's unique approach is helping young people view themselves as stakeholders who have a vested interest in the issues impacting the region. Ashley Sherbundy notes that the teen center "has given the community a chance to see us [teens] as contributors."

A YOUNG LEADER MAKES A DIFFERENCE

The first person to complete Hill Country's student internship program was Maggie Barragan, a 16-year-old Native American student who worked 10 hours per week in the clinic's café helping older patients learn how to use the computer. At the time, the clinic needed to develop a database for a First Five California oral health outreach project, but no one on staff knew how to use the required computer program. Maggie enrolled in an online course to learn the program and developed the database in a relatively short amount of time. She later had the opportunity to present her tool at a statewide First Five California conference. This all took place against the backdrop of a very difficult home life: She was living alone in a travel trailer without access to electricity or running water, her mom was in jail, and her younger brothers—whom she had been caring for—had recently been taken into custody by Child Protective Services.

Hill Country's internship program gave Maggie the opportunity to discover and develop her strengths in a community with very limited options for teens. It also gave her the support and motivation that she needed to continue her studies. In May 2010, Maggie graduated from dental hygiene school and she plans to move back to Round Mountain. "She's an extraordinary person," says Hill Country CEO Lynn Dorroh, "and she will be a huge asset to this community."

A SHARED UNDERSTANDING OF MISSION AND VISION

Being able to sustain a long-term commitment to meeting community needs requires a strong set of shared organizational values and principles. Diverse stakeholders acknowledge that Hill Country would not be what it is today without the creativity of its founders and the farsighted leadership of Lynn, Richard, and the Board of Directors. Ray Hamby, who served as the clinic's Executive Director until his retirement in 2004, guided the rebuilding effort after the Fountain Fire and left the new clinic leadership with an organization that was fiscally sound and was known for its high-quality work. There are a number of other senior staff members who have worked with the clinic for many years and who share the mission and vision of the organization in the same deeply held way as its original founders. They, along with Lynn and Richard, have shaped the clinic's work for the past 25 years, and their vision is directly infused in day-to-day operations.

"There is no substitute for talking about the mission, why we envision it that way, and what we want this place to be," says Richard. "As long as Lynn and I are here," he continues, "we're not going to become something different than we are." But the reality is that Lynn and Richard are not going to work at Hill Country forever. Although they do intend to remain in the community and stay involved with the clinic after they retire, Lynn and Richard have already begun the process of succession planning with Hill Country's board of directors.

While there has been significant emphasis placed on the clinic's 'visionary leadership,' there is an acknowledgement that the clinic's mission and vision must have shared meaning for all staff, not just for those at the top of the organizational chart. This has always been a priority for Lynn, Richard, and others, but it has taken on new meaning as part of the succession planning process. There are four key ways in which Hill Country's leadership team has developed a shared mission and vision of their work:

1. Inspire staff to embrace your mission.

Every month, the leadership team convenes a full staff meeting with all 72 Hill Country employees. Lynn views these meetings as an opportunity to reinforce the clinic’s mission, to update staff on programs that don’t involve the delivery of health services (e.g., the teen program, Circle of Friends, etc.), and to discuss patient engagement and employee health. Lynn also views this as an “inspirational” time to talk about why they work there, what makes Hill Country different, and why their patients love coming to the clinic. They regularly discuss issues that are the root cause of patients’ ill health, including poverty, substance abuse, and lack of transportation. Occasionally, she and other staff incorporate the use of media as a platform for these discussions. For example, the entire staff viewed the PBS series “Unnatural Causes: Is Inequality Making us Sick?” which explores the role of the social determinants of health in creating health inequities in the United States.

Lynn acknowledges that “people have things in their job description that they might not have if we weren’t trying to achieve the mission that we are trying to achieve.” This clear sense of direction and purpose has drawn new employees to the clinic, it has informed management’s hiring decisions, and it has transformed the way in which long-time staff members approach their work. “Overall, there is buy-in to the vision that we’re not just about providing services, but that we’re about community building,” says Patrick Moriarty, “and there is an element of that in nearly all of our meetings.”

2. Involve the community in decision making.

Since its inception, Hill Country has been intentional and serious about involving the wider community in the clinic’s decision-making processes. Indeed, in a place like Round Mountain, it is difficult to separate the ‘internal’ from the ‘external’ and the local residents have to be part of the equation in order for the clinic to be relevant to people’s lives. Hill Country conducts periodic community surveys in order to assess the needs of local residents and follows up to find out how those needs are evolving over time. In addition, the clinic has an outreach coordinator who works closely with area community and civic groups, including the Lion’s Club, the Grange, and others in order to share information, ideas, and concerns. And while Hill Country does not convene formal stakeholder meetings, community members’ input was integral to the organization’s recent strategic planning process.

3. Assemble a board that fully supports your mission and vision.

Lynn and Richard view the support of their 11-person Board of Directors as crucial to the clinic’s success. Nine of the board members are patients at the clinic³² and—in many ways—they serve as Hill Country’s fingers into the community. For example, a board member recently approached Lynn over lunch at the clinic’s café to express concern about the fact that the local hospital is about to go bankrupt (its ambulance service covers 1,000 miles of Shasta County’s intermountain area). In anticipation of the hospital’s closure, she wondered if Hill Country could start teaching first aid classes in the community. “We’ve been judicious in choosing board members who philosophically share our vision, and that has served us really well,” says Richard Hardie. Hill Country board members have been known to corner county officials and members of the board of supervisors to press them about issues affecting the clinic and its patients. When asked about why clinic’s board members are committed to the Hill Country’s involvement in activities beyond primary health services, local journalist Loretta Carrico-Russell notes that “it’s their home too.”

4. Partner with other groups to use resources strategically.

Hill Country leverages its limited resources by partnering with a wide range of other organizations in order to spend their money “wisely and well,” according to Lynn. This approach has helped to ensure that they have resources available for programs and activities beyond primary health services, even during tough economic times. The clinic

has always had a symbiotic relationship with Acorn Community Enterprises, for example, which provides staffing for the teen center, and Mountain Valley Health Center, which serves as a collaborative regional partner for the DEPTH Program. As part of Hill Country’s contract with Shasta County to provide services to the seriously mentally ill, it has a dedicated partnership with the Tri-County Community Network in Burney to provide complementary employment and housing support.

BUILDING COMMUNITY VOICE AND POWER

Despite their political differences, clinic patients are joining forces to exercise their collective voice and power. For example, a caravan of local residents recently traveled to Sacramento with clinic staff to protest health care cuts to the state budget. A group of protesters, including some Hill Country patients, even stormed a local state representative’s office who opposed health care reform. Loretta Carrico-Russell, who was with the group says, “a lot of the patients were scared, but they agreed to go because they believed in the cause.” She adds, “the longer they were [in the representative’s office], the more vocal they became. These are people who are used to being ignored or seeing indifference.” Not only does the clinic do some formal advocacy training with patients (through Circle of Friends), it plays an important role in educating patients about issues and policies that directly impact their lives—and providing them with opportunities to make their voices heard on those issues.

And there are other signs that a bigger shift has occurred. In the spring of 2009, the Transmission Agency of Northern California (TANC) proposed adding a new 600-mile high-voltage transmission line through Northern California. Under the proposed project, the line would have run directly behind Hill Country and the clinic’s new LEED-certified facility would have been directly in the shadow of a new 200-foot tall transmission tower. There was immediate and strong opposition to the TANC project from all sectors of Round Mountain and a vigorous local organizing effort was launched.



Hill Country patients at a health reform march in Redding, CA.

Although Hill Country was instrumental in supporting the effort to oppose the transmission line, including providing an educational display about the proposed project in the lobby of the clinic, the campaign was staffed and managed by a group of community volunteers. Hundreds of residents packed informational meetings in many of the towns that are served by the clinic and opponents organized rallies, held marches, and met with local legislators to voice their concerns about the project. Ultimately, TANC’s opponents were successful and the project was dissolved. “There is no way to prove this,” says Lynn, “but I think that the remarkable TANC effort was a result of a lot of the work that we’ve done over the past 20 years.”

The grassroots movement to stop the power line project came from local residents and it united people from all walks of life and from across the political spectrum. One staff member observed that when you can get people together on an issue like TANC, it’s easier to get together on other issues—a fact which certainly bodes well for the future of Round Mountain and Hill Country Health and Wellness Center.

TO LEARN MORE ABOUT HILL COUNTRY HEALTH AND WELLNESS CENTER AND THEIR WORK, VISIT: [HTTP://WWW.HILLCOUNTRYCLINIC.ORG](http://www.hillcountryclinic.org)

SHIELDS FOR FAMILIES: LOS ANGELES, CA



ORGANIZATIONAL PROFILE

Executive Director: Kathy Icenhower

Location: Los Angeles, CA

Service Area: South Central Los Angeles, inclusive of the Watts/Willowbrook and Compton communities

Founded: 1991

Number of Staff: 320 FTE

Current Budget: \$21 million

Funding Sources: 61% County; 30% Federal; 2% State; 2% Foundations; 2% Fees for Service; 2% Other; 1% Individual Donations

Mission/Vision Statement:

Mission: To develop, deliver, and evaluate culturally sensitive, comprehensive service models that empower and advocate for high-risk families.

Vision: We believe in our families, that they can overcome whatever challenges they are facing...that they can build a foundation of hope and acquire the skills and support needed to accomplish their goals...and they can become productive members of the community, nurturing parents, and achieve all of their dreams.

Programs:

- A full continuum of services for families impacted by the child welfare system—from child abuse prevention to adoption
- Comprehensive services for children and youth including a Healthy Start program aimed at reducing infant mortality and morbidity, Child Development Centers for children ages 0–5, and after-school programs for children ages 6–18
- Comprehensive mental health services (in English and Spanish) for children, youth, and families
- Substance abuse prevention, treatment, and recovery services for men, women and their families, and adolescents with co-occurring disorders
- Supportive services that meet clients' needs for housing, transportation, and food as well as vocational and educational services

Client Demographics: 50% Latino; 45% African American; 3% White; and 2% Other

BACKGROUND

“Our idea was to help them get better right where they got worse and be stronger for it when they go back out.”

—SHIELDS Co-Founder
Norma Mtume

In 1987, physicians at Martin Luther King Jr./Drew Medical Center delivered 1,200 infants prenatally exposed to drugs, an all-time annual high in Los Angeles and in U.S. history. At the time, Dr. Xylina Bean was the head of the neonatology unit at Martin Luther King Hospital, while Kathy Icenhower and Norma Mtume were working at the Los Angeles County Drug Abuse Office. All three women were witnessing the same disturbing trend—and they were determined to do something about it.

In response to this unprecedented situation, Los Angeles Congresswoman Diane Watson sponsored legislation that designated funding for four Los Angeles County hospitals, including Martin Luther King, to serve the growing number of mothers and children affected by substance abuse. In 1990, Kathy, Norma, and Xylina developed a program in partnership with Martin Luther King Hospital, which was launched as the Genesis Family Treatment Program in 1990. Genesis was a flagship program for substance abusing mothers with children under the age of five. As part of the program, mothers went to treatment six hours a day six days a week while they continued to live with their children, who received specialized child development services. This was a radical departure from traditional residential treatment programs where the person struggling with addiction is removed from her home environment. “In a way, treatment is a false atmosphere because you have to live in the world when you come out of there,” Norma says. “Our idea was to help them get better right where they got worse and be stronger for it when they go back out.”

Genesis, which still exists as a day treatment substance abuse program at SHIELDS for Families (SHIELDS), evolved and grew as its founders attempted to meet the complex and interrelated needs of the clients that it served. Initially geared toward moms with children under five, the program quickly expanded to include older siblings who needed the same child development services. Kathy, Norma, and Xylina also discovered that many of the women they were serving were homeless. In response, they were able to leverage available funding to purchase an 86-unit apartment complex where families could live while receiving treatment. The SHIELDS Exodus program, which houses up to 45 families in active treatment, continues to be the only program in the country that allows entire families to stay intact while receiving supportive services on site. Families can remain in their housing for up to a year after they complete treatment “allowing for adequate time to develop vocational, educational and/or supportive systems necessary for ongoing recovery and family maintenance.”³³



Kathy Icenhower



Norma Mtume

BELIEVING, BUILDING, BECOMING

What started as a small program run out of a trailer that served as a makeshift office for three staff members, SHIELDS has grown to become an organization that is recognized across the United States and around the world. With an annual budget of \$21 million, the group employs more than 320 full-time staff and serves over 5,000 families from south central Los Angeles per year. Today, SHIELDS operates 30 programs at 16 different sites that encompass child welfare, children and youth, mental health, substance abuse, and vocational and educational services. SHIELDS has an impressive track record in the service delivery arena including, for example, developing a family-centered

model for substance abuse treatment that has success rate of over 80 percent, nearly four times the national average. Kathy Icenhower serves as the group’s Executive Director, Norma Mtume is the Associate Director and Chief Financial Officer, and Xylina Bean is the current President of the Board of Directors.

SHIELDS is unique in that it not only provides direct social services on a large scale, but it is also deeply engaged in a range of other activities aimed at building voice and power for the clients and communities it serves, which are among the most challenged in Los Angeles County, not to mention the country as a whole. According to current population estimates, the geographic area served by SHIELDS has the largest percentage of minorities as well as the highest rates of unemployment and overcrowded housing units in Los Angeles County. To compound these challenges, 95 percent of SHIELDS’s clients live below the federal poverty level. The group’s founders, who are still involved in its day-to-day operations nearly 20 years later, have never viewed the organization’s social change work as an ‘add-on’ to the direct services that it provides, but as an integral part of its mission, vision, and mandate. At a fundamental level, they believe that in order for clients’ lives to be transformed, the community must be similarly transformed.

Kathy doesn’t use complicated terminology to describe SHIELDS’s approach to social change. “‘Creating change’ is the phrase that I use the most,” says Kathy. She and the other staff also refer to the agency’s motto—“Believing, Building, Becoming”—to describe the impact that they hope to achieve through their work. “You have to decide that this [dual commitment to service and social change] is part of your mission and your vision,” says Kathy. “In social services, we tend to put a Band-Aid on something and let the person go.” However, that approach is not likely to lead to the kind of long-term, systemic change that SHIELDS wants to affect.

Kathy points out that, because our health care and social service systems are so “siloeed,” many organizations view clients’ problems in isolation and not as part of a larger system. “I’m going to treat you for your schizophrenia, but don’t tell me that you are homeless and that your kids were taken from you, because then I might have to take responsibility for that.” She goes on to say that “you don’t anticipate that your life is going to be filled with these problems. . . [but] until we are able to address why they happen, or why they shouldn’t happen, then we’re not going to make any difference.” This unequivocal approach to addressing the root causes of the issues affecting the group’s clients is widely shared among staff at all levels of the organization—and it informs all aspects of their work.

A BROADER FORCE FOR CHANGE

SHIELDS is transforming lives and fighting for broader social change by developing the leadership, advocacy, and vocational skills of clients so they can serve as active change agents in their families, community, and society as a whole. In addition, SHIELDS takes an inclusive approach to its work with its organizational partners; it pursues collaborations that help develop the local economy and build the capacity of smaller, less established community groups.

There are four key areas in which SHIELDS is realizing its dual mission of providing direct services and affecting social change. These areas, which are described in detail below, include: 1) developing staff and client leadership, 2) building advocacy capacity, 3) pursuing strategic partnerships, and 4) deeply embedding mission and vision throughout the organization.

1. Tapping into the leadership potential of clients and staff to promote community engagement and civic participation.

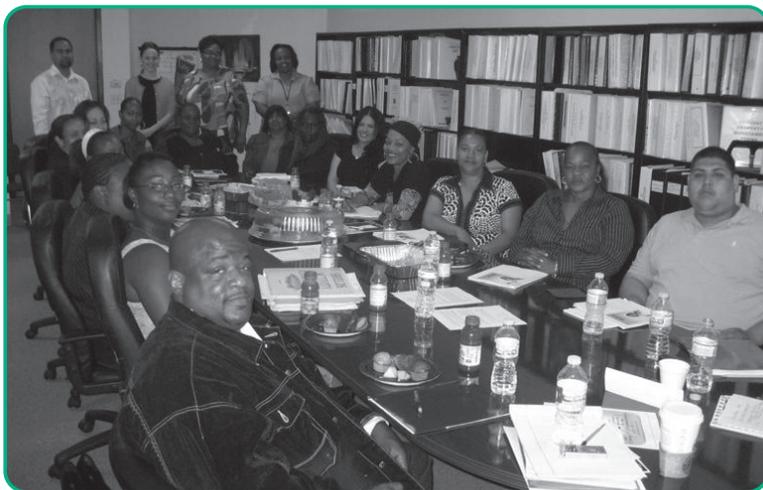
Perhaps the most profound and lasting way in which SHIELDS is developing clients’ leadership potential—and impacting the community as a whole—is through internal structures that allow clients to assist with policy development and shape agency-wide programs and activities. Although SHIELDS has a legal Board of Directors that governs the organization, Kathy, Norma, and their managers lend considerable weight—and deference—to

the perspectives of the families whom they serve through their programs. There are two main bodies through which clients are able to exercise their leadership at SHIELDS: Client Councils and the Community Advisory Board.

Each one of SHIELDS’s substance abuse treatment programs³⁴ operates a Client Council, a leadership board that represents a segment of clients and meets regularly to plan activities, raise funds (mainly for outings and social events), and address concerns that arise within each program. “The Client Council helps to build, shape, and formulate some of the program policies as they relate to daily client procedures, rules, and cultural sensitivity and responsiveness of the project,” writes Kathy in an article published in the *International Journal of Therapeutic Communities*. “The major purpose of the collective body is to promote ownership and to enhance accountability of client participation in the program.”

Each Client Council elects an Executive Board and appoints representatives to an agency-wide Community Advisory Board, which meets with the executive director on a monthly basis to present updates from each of their programs, including upcoming activities, information on clients’ progress, and any emergent concerns or barriers to clients’ progress. Many individuals who participate in the group’s substance abuse treatment programs live with their families on site at SHIELDS for up to two years, so the Community Advisory Board has to provide “a different kind of engagement process,” says Kathy. “This is their program and these are their services, so they have a responsibility for investing in them, for helping to improve them, and for getting out of them everything that they need.”

During a recent Community Advisory Board meeting, the level of importance that Kathy and her colleagues attach to the input provided by this group was clearly evident. The Community Advisory Board actively shapes the way in which SHIELDS operates. At this particular meeting, each member of the Community Advisory Board provided a report about his or her program and presented any issues or concerns that had arisen over the past month. In turn, Kathy updated the group on a range of substantive issues that related to the organization’s operations as well as wider issues affecting the community. These included giving members a preview of SHIELDS’s new website, an advance copy of their 2009-2010 annual report, and an update on the status of federal health care reform efforts.



SHIELDS Community Advisory Board Meeting

It is a moving experience to watch SHIELDS’s Community Advisory Board in action and to witness the sense of empowerment that its members derive from exercising organizational leadership at such a high level. This client-centered, community-focused approach has been a core part of the organization’s service delivery model from its inception; it tips the balance of power toward those who—for a variety of reasons—have often felt powerless. “Low self-esteem is an issue for folks who are using [drugs and alcohol],” says Kathy, “so it’s transformative for them to learn that they can make change happen.”

SHIELDS’s clients are developing a newfound sense of confidence as well as an ability to advocate effectively for their families and in their communities. Kathy says that this experience signifies that “you are important, you matter, and you have a say. You have a right to speak up for what is yours.”

In addition to the Client Councils and Community Advisory Board, there are other important ways in which SHIELDS

is developing community leadership. It should be noted that it is often difficult to separate the ‘internal’ ways in which SHIELDS approaches leadership development (staff, interns) from the ‘external’ targets for these activities (clients, community members) since there is a fairly porous boundary between the two. “We are the statistics in the community,” says Norma Mtume, “a lot of the people we hire are from here.” In fact, nearly 20 percent of the group’s staff members are also program alumni, many of whom have pursued further education and training as clients and/or as employees of the organization. For example, six alumni have become licensed therapists and they are all currently employed by SHIELDS or other local agencies. SHIELDS has also invited young nonprofit leaders from the community to take part in a Young Executives Mentoring and Coaching Institute, developed by Norma with the support of a Durfee Foundation Stanton Fellowship.



Recently, SHIELDS instituted an innovative new program with California State University, Dominguez Hills, to offer an accelerated on-site Masters in Social Work (MSW) program for its staff as well as employees at SHIELDS’s partner agencies. “A lot of our staff want to go back to school,” says Kathy, “but can’t afford to decrease their time at work or take the time to go back. This allows us to really build the capacity of our community.” The first cohort of MSW students graduated in May 2010 and they are already putting their new degrees into practice. In addition, SHIELDS brings on approximately 50 student interns at a time, focusing on ‘root cause’ issues as part of their training. Kathy hopes that

some of the students will return as SHIELDS employees, but even if they don’t, “we’re training them to look at issues in a different way.” For example, she says they want them to complete their internships with the understanding that “people aren’t poor because they want to be.”

2. Building client and staff capacity to advocate for necessary changes.

In 2009, Kathy received the James Irvine Foundation Leadership Award, which highlights and supports the work of individuals who are advancing innovative and effective solutions to significant state issues. Kathy elected to use part of her award from the Irvine Foundation to provide 80 hours of formal advocacy training for the staff at SHIELDS. She viewed this as an important opportunity to invest not only in their leadership skills while they are employees of SHIELDS, but also in their role as future directors and leaders at other community agencies. After the training, Kathy encouraged her staff to begin building their own relationships with local and state policymakers. “It can’t just be me [engaging policymakers],” Kathy says, particularly given the fact that policy advocacy is one of the primary ways in which SHIELDS seeks to create change in the communities it serves.

In their ongoing commitment to keeping root cause issues front and center in the organization’s day-to-day work as well as its efforts to impact broader policy changes, Kathy and Norma also brought all of the managers at SHIELDS to a two and a half day Undoing Racism Workshop offered by the People’s Institute for Survival and Beyond. The training provides human service practitioners and educators with an opportunity to move beyond the symptoms of racism to an understanding of what racism is, where it comes from, how it functions, why it persists, and how it can be undone.³⁵ Kathy hopes to be able to provide the same training to all SHIELDS staff members in the near future. “I want them to see the larger picture,” she says.

In addition to its staff, SHIELDS involves clients meaningfully in public policy efforts by providing them with the skills and training to become effective advocates. “It’s not a requirement of substance abuse treatment that you teach your families advocacy and leadership development, but we’re going to do it anyway,” says Kathy. “My goal

is to build individual skills and empower people in the community to actively speak up for themselves,” she adds. A number of the organization’s clients have participated in “Crossing the River,” a leadership and advocacy training offered by the Rebecca Project for Human Rights. “Crossing the River” provides an opportunity for low-income people—particularly those struggling with addiction—to “claim their space, come into voice, and emerge as community leaders and advocates.”³⁶ Participants are encouraged to join the project’s Sacred Authority chapters, a leadership network that focuses on bridging the divide between the public, policymakers, and vulnerable families with substance abuse issues through advocacy.³⁷

SHIELDS’s clients, including a number of Community Advisory Board members, have testified at legislative hearings in Sacramento, California, and Washington, D.C. “All our clients know how to write letters to policymakers,” says Kathy. Through the group’s advocacy training, clients are able to analyze not only how specific legislation may impact their families and communities, but they are also able to develop a greater understanding of how it affects SHIELDS’s ability to deliver programs and services. Staff member Audrey Tousant points out that this is particularly important in the event that SHIELDS has to make the difficult decision to cut or scale back a specific program in response to a policy change or, for example, the current state budget crisis. “That way the community doesn’t feel like we are abandoning them,” says Tousant.

SHIELDS provides other opportunities for clients that are leading to greater civic participation. For example, SHIELDS clients have served as poll workers during elections, which—for many—was their first experience with electoral politics. “It’s important for our clients to know the history of gaining the right to vote. We have folks who died for that right,” says Norma Mtume, “and we have to continue to stand on their shoulders.” More recently, SHIELDS has been engaged in 2010 Census activities. The organization brought in 250 residents to complete testing for census employment and it was the training site for those who were hired as census workers. It also served as place where community members could complete their census forms if they did not fill them out at home. The group’s clients also served as part of a “Street Team” that went door-to-door educating residents about

ASK, SEEK, KNOCK (ASK)

In 2008, SHIELDS implemented Ask, Seek, Knock (ASK), a collaborative effort to help prevent child abuse and neglect before it occurs, in partnership with the Los Angeles County Department of Children and Family Services and eight partner organizations.

The program operates at four locations in south Los Angeles known as ASK Centers. Families can drop by an ASK Center or be referred by another organization and get help from bilingual (English-Spanish) “navigators” with housing, food, legal services, counseling, education, or employment needs. “The ASK Centers were designed to present an alternative to case management so that clients are able to have a say in what they need and what services would have the most impact on their families. ASK Center staff become partners with families in achieving outcomes and they follow up with them to see if they have encountered any barriers or need additional resources.” (Prevention Initiative Demonstration Project [PIDP] Year One Evaluation Summary Report, 2009)

At the ASK Centers, parents can join support groups, receive vocational training, and participate in other activities that target social isolation such as community resource fairs, book clubs, parenting workshops, scrapbooking, stress management programs, women’s empowerment groups, and many others. The program, which has served over 5,822 families in south Los Angeles since 2008, is having a profound impact on the lives of parents and children at risk for child abuse and neglect.

“I feel like we are making a difference because I get to see it on the ground level with clients,” says ASK Program Manager, Audrey Tousant. “I’ve had families that come in the door ‘broken.’ They don’t even know that there are resources [to help them] and that they are in the community. They just need education so they can empower themselves to make a better situation for their families.”

the role and the importance of participating in the census, particularly in terms of how state and federal resources are allocated at the local level.

As in other aspects of its work, SHIELDS frequently collaborates with partner organizations when engaging in policy advocacy on issues that range from economic development and TANF³⁸ reauthorization, to health care and child welfare. Many of its organizational partners offer specific public policy expertise, such as the Community Coalition of South Los Angeles, a frequent collaborator with SHIELDS. In turn, SHIELDS is able to activate its large base of clients, program alumni, and community members to lend support to such efforts by writing letters, attending rallies, meeting with policymakers, and generally bringing their ‘real life’ experience to bear in public forums.

3. Building organizational capacity—and that of your partners—through strategic collaborations.

SHIELDS has been particularly effective in increasing the impact of its work and achieving broader social change goals through collaboration and partnership. “We collaborate with everybody under the sun,” says Kathy. “I’m a firm believer [in partnering with other groups],” she adds. “I’m not going to pay for something that somebody already does; I’m not doing to waste resources like that.” And SHIELDS is strategic about the types of engagements that it pursues with other groups, which Kathy describes as ‘authentic partnerships.’ For example, SHIELDS works closely with the Institute for Maximum Human Potential (IMHP), which is also located in south central Los Angeles, among many other organizational partners at the local, state, and national level.

IMHP is a human service agency that seeks to enhance the well-being of individuals, families, and neighborhoods by addressing human rights issues in the community. “Our visions are aligned and we try to move collectively to try and have some kind of systemic change for communities,” says Delores Brown, IMHP’s Executive Director. Recently, IMHP, SHIELDS, and several other partner agencies have been working together to analyze the financial benefits of owning their own buildings. They determined that, by tapping into special financing for nonprofits, SHIELDS could save \$100,000 annually by owning their own administrative office. SHIELDS eventually purchased a 23,000 square foot building on 1.8 acres of land, an asset not only provides financial security for the organization, but also serves as an investment in the community’s economic growth and development.

SHIELDS also continues to reach out to less established groups in order to further the broader interests of the community. As described previously, they have opened up training and leadership development opportunities—including their on-site MSW program—to staff from other community organizations. “Because we have been lucky enough to start an organization and sustain it at a certain level,” says Norma, “we have reached out to younger, smaller organizations in an attempt to help strengthen them and to help with their capacity building so they can stabilize and continue to grow. We know that we can’t do it all.”

4. Embedding your mission and vision at all levels of the organization.

Since the inception of SHIELDS, its founders have always had a clear vision of the role that the organization could play in delivering direct services while pursuing broader social change goals. SHIELDS staff and clients are afforded frequent opportunities to build and strengthen their leadership and advocacy skills, but always with an eye to ameliorating the root causes of the issues affecting the community. As Kathy is quick to point out, “no one chooses to be poor or an addict,” and the group’s approach to service delivery takes this reality into account. Kathy also stresses that, as the executive director of the organization, all of the decisions that she makes have to be tied into the SHIELDS mission and vision, including “what funding you go after, what kind of programming [you pursue], how you approach your programming.”



ASK Program Manager Audrey Tousant (left), Executive Director Kathy Icenhower, and a graduate of SHIELDS' fiber optics training course (right).

SHIELDS's mission has not changed since it was founded, but its capacity has expanded dramatically. "My thinking has always remained the same," says Kathy. "I'm a social worker and I believe you have to work at all levels of the system. I can do that more effectively now because of our size and our capacity." The challenge, Kathy admits, is staying true to your mission and vision the larger you get. However, SHIELDS has been successful in doing just that; it has maintained its commitment to providing direct services while advocating for larger systemic changes. Kathy, Norma, and other members of the organization's leadership are continually reinforcing the organization's mission and vision during staff meetings, retreats, and trainings by connecting every aspect of their work back to the broader goals the group wants to achieve.

Perhaps the most direct way in which Kathy, Norma and other senior management ensure that SHIELDS's mission and vision are shared in the same way throughout the organization is through the staffing decisions that they make. "I have a set of managers that think like I do," says Kathy. "We believe in the same things." In fact, all five SHIELDS program directors have been with the organization for 18 years or more, each carrying with them a significant amount of institutional memory. According to Norma, they pay close attention to not just the skill set, but the philosophical background of candidates for staff positions by asking, "Is there a good match with the organization's mission and vision?" For example, Audrey Tousant, a masters level social worker who directs the Ask, Seek, Knock program [see sidebar on page 37], was drawn to SHIELDS because of their reputation for empowering clients through their programs and services. Tousant, who is from the local community, says "I feel the mission of SHIELDS every day when I am doing the work."

THE ROAD AHEAD

There is clear evidence that SHIELDS is having a positive impact on clients' lives through the direct services that it provides. Clients are conquering substance abuse and finding a second chance in new careers, their families are staying intact, and their children are experiencing less abuse and more success in school. Specifically, since 1996, more than 450 SHIELDS participants have received high school diplomas, over 800 were provided with computer classes, and over 700 individuals have found employment in jobs paying above minimum wage. In the past year, more than 93 percent of children who participated in SHIELDS's Therapeutic Nursery³⁹ have been able to transition to regular school settings, and in the last five years, more than 83 percent of participants completed all phases of its family-centered substance abuse treatment program, nearly four times the national average. Taken at face value, these statistics are noteworthy, but they are also a reflection of SHIELDS's commitment to pursuing systemic change at the community level in conjunction with support for individual transformation.

"Having people who complete their treatment programs stay in the community is also making an investment," says Kathy. SHIELDS alumni are using their newly acquired skills and training to gain stable employment and serve as role models for their children. "They are buying homes here and working here. Their children are with them and going on to college because of what they have learned about the value of education." And there are other benefits to having more residents who are civically engaged. For example, it used to take six months to get an Individualized Education Plan (IEP) for students with special needs in the Compton Unified School District. With sustained advocacy from a cohort of parents, including a cadre of SHIELDS clients and alumni, that timeframe has been reduced to two months. Kathy says that every client who participates in one of SHIELDS's programs develops a greater understanding of their own rights as well as their children's—and they are speaking up for those rights in greater numbers.

There are still more signs that bigger changes in the community have occurred as a result of the group's efforts. "Our purchasing of housing [for clients to live in while in treatment] is a conscious part of our social change effort," says Kathy. "At Keith Village, which is our largest facility, if you'd have seen it in 1993 before we purchased it—there were drugs everywhere, no businesses. And to see it now where the businesses are all the way around the place, things have really dramatically changed." Purchasing their own building to house their administrative offices has also galvanized the organization's leadership. "We want to do more economic development in the community. That's how I see the future," says Kathy.

SHIELDS has tapped into a number of different entry points for creating social change, but for many of their clients, the process of claiming their 'voice' as advocates begins as Client Council and the Community Advisory Board members—a totally new experience for most participants. In fact, among the 24 current Community Advisory Board members, only three have ever been part of a similar governing or decision making body before. The goal, says Norma Mtume, is to "help to build folks up as much as you can and help them to be able to maneuver out there in the world to help further social change."

The goal of building clients' confidence and skills is evident here. During a recent Community Advisory Board meeting, participants eagerly answered questions about what the experience means to them.

Reflections by SHIELDS Community Advisory Board Members

"When I walk into this room I feel very special. . . to me it's very exciting and I feel like I'm doing something or making a difference."

"It makes me feel like I am somebody, like I have a certain level of importance that I haven't had before."

"I'm a part of something. Back then, I was never a part of something. I know I made a big change and I know I'm doing something right when I got here. It makes me feel very proud of myself."

"[Being part of Client Council and the Community Advisory Board] teaches me a lot of patience. It's a positive thing for me to see [people] change and grow as we are growing with them by them knowing that we do have a certain amount of power. . . we're not just some people off the street. They do believe in us. For me being here, it is a test of patience, and I appreciate that."

"It gives me a responsibility. . . it keeps me humble and it keeps me doing something besides treatment. . . when things don't get resolved in Client Council we know we can take it back to the board and bring it to Ms. Icenhower. It's a good experience for me."

"It's a chance for all of our voices to be heard. It's something to take back to Client Council—everything that we said here is being heard there and things are going to happen."

Although she has been steeped in this work every day for the past twenty years, Kathy was visibly moved by these responses. "It's not often that I stop and ask those kinds of questions," she says. Indeed, Kathy, Norma, and their colleagues are steadfast in their efforts to help clients become change agents not only at SHIELDS, but also in their families, communities, and society as a whole. It is this authentic commitment to combining direct services and social change activities that keeps them focused on the road ahead.

TO LEARN MORE ABOUT SHIELDS FOR FAMILIES AND THEIR WORK, VISIT:

[HTTP://WWW.SHIELDSFORFAMILIES.ORG](http://www.shieldsforfamilies.org)

THE FRIENDLY CENTER: ORANGE, CA

ORGANIZATIONAL PROFILE

Executive Director: Cathy Seelig

Location: Orange (main office) and Placentia, CA

Service Area: Orange Unified and Placentia-Yorba Linda Unified School District boundaries (includes the cities of Orange, Placentia, Villa Park, Yorba Linda, and parts of Santa Ana, Anaheim, Anaheim Hills, Garden Grove, Fullerton, and Brea)

Founded: 1924 (incorporated as a nonprofit in 1967)

Number of Staff: 22 (14 full time, 8 part time)

Current Budget: \$500,000 (an additional \$500,000 is in-kind)

Funding: 43% Individual Donations/Events; 30% Government (federal, state, and county); and 27% Foundations

Mission/Vision Statement:

Friendly Center is a comprehensive family and community resource center dedicated to improving the lives of children, adults, and seniors by helping them move toward self-sufficiency through immediate aid and a variety of educational and life skill programs.

Program Areas:

- Afterschool academic tutoring and enrichment for children and youth
- Parenting classes and support groups
- Adult English as a Second Language (ESL) classes
- Emergency services including rent and utility assistance, clothing, and seven food programs
- Family advocacy, counseling, and case management
- Domestic violence intervention
- Low-income housing for Section 8-eligible families

Patient Demographics: 78% Latino; 13% White; 3% African American; 2% Asian; 4% Other

BACKGROUND

If you walk through Killefer Park on most weekday mornings you will see a cluster of up to 50 people outside the Friendly Center's main site picking up a bag of food donated by local grocery stores. Traditionally, most of the people making use of the Center's services have been Latino or Vietnamese, but the current economic crisis is reflected in the growing race and class diversity among those waiting in line. Passersby might think that the Friendly Center is merely another emergency food program helping to meet the needs of local residents. And it is. But what they might not know is that behind the Center's unassuming adobe façade is a bustling hub for two dozen other programs that assist 5,000 individuals annually, free of charge.

Founded in 1924 by a group of men in an interdenominational Bible class, the Friendly Center has a long history of serving low-income residents in the City of Orange. The Center's founders were concerned about the welfare of migrant workers and their families who were living in a barrio near the local citrus packing house. In response, they built a community center where church members and volunteers provided assistance with food, as well as family and legal problems. The Orange school district offered citizenship and English language classes, and a public health nurse provided health clinics and classes. According to Executive Director Cathy Seelig, the Friendly Center is the oldest continuously running community resource center in Orange County. In 2007, the Friendly Center was named by the California Family Resource Association as one of four family resource centers (FRCs) and family-strengthening organizations in the state with a model community mental health program.

Like other FRCs [see sidebar], the Friendly Center traces its roots to the Settlement Houses of the late 1800s, which provided support to immigrants "in the form of acculturation, skill building, and social advocacy as part of assisting them to understand and adapt to American culture."⁴⁰ Settlement House workers, like those who founded the Friendly Center, lived in the communities that they served and were actively involved in larger social reform efforts aimed at improving the working and living conditions for families in newly developing urban communities.⁴¹

Housed in an enclosed picnic shelter at Killefer Park since 1985, the Friendly Center is tucked amongst a public school, a busy playground, and a baseball diamond; in fact, if you weren't looking for it, you might not know that it was there. The Friendly Center strives to be highly accessible in all of its locations, which also include a church, a community center,



Executive Director Cathy Seelig

and even an outdoor picnic area at another park where they provide afterschool tutoring. In addition, the Center has several mobile family advocates who travel by van to other low-income neighborhoods, bringing its services directly to those who need them. "The model of planting Family Resource Centers

WHAT IS A FAMILY RESOURCE CENTER?

Family resource centers (FRCs) are a key prevention strategy for addressing many of the challenges that face families, whether they live in rural, suburban, or urban areas. The goal of FRCs is healthy families in healthy communities. To improve outcomes for both families and communities, an FRC brings together services and activities that educate, develop skills, and promote moving in new directions for families. This increases the capacity of families to be healthy, involved members of dynamic communities. This unique approach of involving families in problem solving while at the same time developing skills, abilities, and talents, works to create healthy and functioning families and communities.

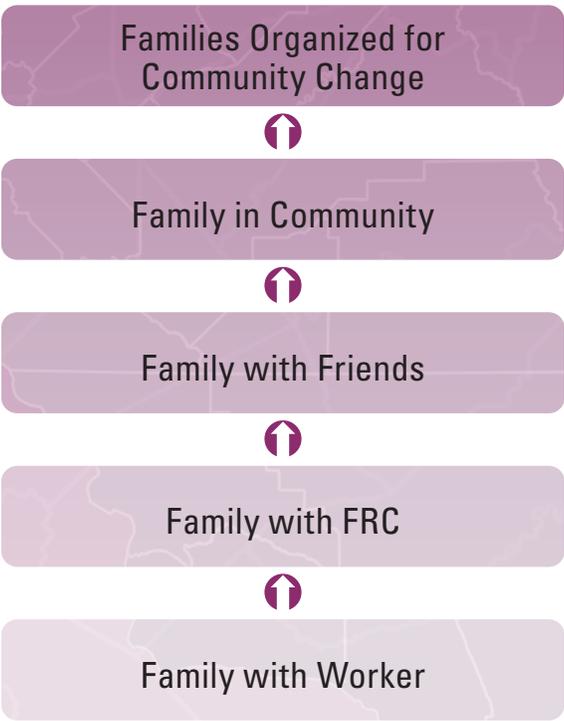
—From *Family Resource Centers: Vehicles for Change*, The California Family Resource Center Learning Circle, April 2000

in the middle of low-income neighborhoods works,” says Cathy Seelig. She continues by saying that the key is to “make yourself accessible and maintain an open-door policy.”

REVIVING KILLEFER PARK: A COMMUNITY-LED EFFORT

Through the services and support provided by the Friendly Center, individuals gain the confidence to test their newfound skills in other arenas—looking for a job, becoming involved in their children’s school, or pursuing advanced education or training. There is also evidence that the Center’s clients are exercising greater leadership in the community and within the organization itself. This individual-to-community transition has been documented by Strategies, an alliance of training and technical assistance centers that supports Family Resource Centers throughout the state. The FRC Relationship Continuum (Figure A) documents the process of helping families become engaged as change-agents in their communities using their own unique strengths and perspectives.

FIGURE A: FRC RELATIONSHIP CONTINUUM



New model moves the focus from the individual to the community

In a document that reflects on the 10-year impact of FRCs’ family strengthening approach, Strategies found that “strengthened family members often assume leadership roles relative to local issues, and subsequently utilize what they have learned to strengthen their community.”⁴² The report goes on to say that there is “evidence. . . that FRCs are acting as incubators for talent and leadership in local communities.”⁴³ While FRCs engage constituents in a range of activities that are oriented to social change, serving as an ‘incubator’ for community leadership is a key way in which they are having an impact on the various problems and challenges facing the families that they serve. The Friendly Center provides several examples that help illustrate this concept, including a participant-led effort to bring a new playground to Killefer Park.

In 2004, a group of Friendly Center clients approached the organization’s leadership about improving Killefer Park, where the Center is located. The park is a popular gathering place for neighborhood families, but prior to the clean-up effort it lacked proper lighting, public restrooms, and had run-down play equipment. Friendly Center staff helped the group of monolingual Spanish speakers to prepare their testimony to the City of Orange Park Commission. After the first meeting with the commission, the park’s lights were fixed and residents

noticed that the playground sand was being cleaned and raked on a more regular basis.

The group of women returned to thank the park commissioners for their initial efforts and to follow up on their request for a public restroom and updated playground equipment. Despite voicing concerns about the potential for vandalism, the commissioners reluctantly installed a portable toilet in the park, but they informed the group that it would be at least 10 years before the playground equipment would be replaced given the city’s renovations waitlist. Undeterred, the women decided to start raising funds for new equipment on their own by holding pancake breakfasts and other events. Eventually, KaBOOM!—a national nonprofit that seeks to create play spaces through the participation and leadership of communities—heard about the group’s efforts and decided to step in and provide assistance through a collaborative



partnership with the City of Orange, Orange Unified School District, the Friendly Center, and AMC Mortgage.

Fifty community residents attended a bilingual meeting with KaBOOM! to provide input about the project and share their vision about the type of playground that they wanted for the park. On the day that the equipment was installed, 200 volunteers arrived to help, including a large cadre of Friendly Center clients, community members, area youth, and others. Six years later, the playground remains the pride of Killefer Park, a bustling center of activity for the community and a safe place for children to play and families to gather. Crime and vandalism in the park have been significantly reduced, the result of greater policing activity and informal community monitoring efforts.

The women who led this successful initiative exemplify the leadership “incubation” phenomenon described previously; most had participated in the Center’s programs for a long period of time, which provided them with the confidence to assume a leadership role in the community. While they may have started at the beginning of the FRC Relationship Continuum (Figure A)—in

relationship with their case worker at the Friendly Center—the women progressed to the point where they were able to organize with other families for community change.

The Killefer Park playground project is the most visible external example of Friendly Center participants organizing for community change—in large part because the playground is regularly used and enjoyed by local residents—but it has led to other efforts. For example, a group of Friendly Center clients recently organized themselves in order to obtain an adult English as a Second Language (ESL) class at Friendly Center-North, and they requested support to deal with a sudden increase in neighborhood gang activity. On the latter issue, the Friendly Center brought together area residents and representatives from the local police department, and they provided dinner and child care so working parents could attend. The police used bilingual interpreters to hear residents’ concerns and to provide information about community policing.

During the meeting, community members decided to form a neighborhood watch group, which has contributed to a subsequent decrease in crime and gang activity in the area surrounding Friendly Center-North. For example, the church where the Center’s office is located has reported a significant reduction in broken windows, vandalism, and graffiti. Formal community policing has helped, but Friendly Center clients



Killefer Park today

have also played a role in confronting crime and vandalism in informal ways, such as involving offending youth in clean-up activities. These efforts have combined to improve neighborhood safety, which is an important factor in the quality of life for all residents—not just Friendly Center clients.

A CULTURE OF RECIPROCITY

The Friendly Center has readily added new programs and services to the extent that they are needed, and it has provided families with the space to make the Center their own by promoting a culture of reciprocity; clients can receive the services that they need, but they are also encouraged to contribute their own talents and skills. Examining and influencing public policies that might affect a large number of clients, such as immigration status, food justice, health care, and others, is not part of the Friendly Center’s mission or mandate. Yet the Center is highly responsive to input from clients.

This responsiveness helps to create a sense of trust between those who use the Center and its staff members, and clients feel motivated to serve as volunteers and to start new programs. For example, some of the same women who went before the Park Commission organized a “Day of the Child” celebration at the Center, which emphasized the importance of education, and they approached the program director about offering a traditional needlework class for their daughters. Another example of how client, staff, and community roles converge involves a small group of dedicated volunteers who help to run the Center’s food program, an integral part of the emergency services it provides to over 4,600 people annually. The group is comprised of mostly Latina women whose families have all benefitted from the Center’s programs and services at some point in time. The volunteers, who also include a Vietnamese-speaking person, have not only organized and streamlined the food distribution system over the years, but they also serve as frequent spokespersons for the Center, encouraging community members to access available programs and services. “People come to the Friendly Center because we speak Spanish, we give out all the food that we have, and we distribute it fairly,” one volunteer shares.

The community helps to inform the delivery of the Center’s services in other ways. Namely, a few staff positions have been assumed by former clients, who have received training and support to develop professionally. In addition, the Center connects community members (of all ages) with a younger generation by relying heavily on interns and work study students to meet the demand for its services. The Center also has a fruitful partnership with Providence Community Services to employ at-risk transition-age youth without prior work experience who join the organization for six-month internships. “We have found out that this is our role,” says Program Director Cynthia Drury, “we are a training ground.” The young staff members that the Center helps to develop not only benefit the community of Orange, but the nonprofit sector generally as most elect to continue their careers in that field.



Friendly Center food program volunteers

SHIFTING TO SELF-SUFFICIENCY

According to census data, the median household income in the City of Orange was just above \$75,000 in 2008, but this statistic obscures the fact that there is a substantial divide between the city’s wealthier residents and those who are struggling just to put food on the table. “People in Orange don’t want to know that people are poor, that they lack food, and that there are gangs,” says Cathy, who frequently addresses local service groups and civic organizations. Under her leadership, the Friendly Center has expanded its programs and services dramatically in order to help clients achieve economic self-sufficiency, a significant challenge given the cost of living in Orange and the surrounding area. However, the Center is meeting this challenge. In 2008-2009, 70 percent of its Family Advocacy program participants completed their case plan and no longer needed the Center’s services in order to be self-sufficient.

Community members may initially come in to the Friendly Center for emergency food aid, but after meeting with a family advocate, they can be referred to any number of the 25 multilingual programs the Center has to offer, including parenting classes, financial literacy, domestic violence intervention, counseling, job training, ESL, computer classes, and academic tutoring. “What do they need to move forward?” is a question that Center staff members are constantly asking of those whom they serve, according to Program Director Cynthia Drury. “How can you take a person with a second grade education and put them into a job that will pay them a living wage and lift them out of poverty in one generation?” asks Drury. Indeed, helping families move toward self-sufficiency is often a long-term and multi-generational process.

Three years ago, the Friendly Center revised its mission statement to reflect the organization’s commitment to helping program participants achieve self-sufficiency. “We don’t want to be considered a hand-out organization,” says Cathy Seelig, “we are about making a change in the clients’ lives.” That change occurs mainly through the support of the Center’s advocates, who work closely with family members to assess individual strengths, needs, and goals. However, the reality—according to Seelig—is that a number of families continue to depend on the Center’s safety net of services over the course of many years, returning for support when they are met with an unanticipated challenge such as the loss of a job, an illness, or an eviction.

In many ways, the Friendly Center fits the mold of a traditional service delivery organization, but its holistic approach to helping families become healthy, involved members of dynamic communities is deeply rooted in the FRC model. In order to achieve this goal, the Center has two important tools in its toolkit—one is the Family Development Matrix (see Figure B). Modeled on a strengths-based approach, the Matrix helps case managers in FRCs to assess and build on family strengths, identify family needs, and support their progress toward identified goals. As part of a six-year pilot project, the Institute for Community Collaborative Studies at California State University Monterey Bay, Strategies, and the California Department of Social Services Office of Child Abuse Prevention, created public/private partnerships with 88 family support agencies in 16 California counties to use the Family Development Matrix as a model for providing services to at-risk families. Each agency, including the Friendly Center, is tracking core measurement outcomes associated with each of the 20 indicators in the Matrix with the goal of strengthening and empowering families that will, in turn, help strengthen their communities.

“We take families right where they are and we give them the tools and the ownership for them to make a difference in their own lives. Families that are self-sufficient are confident, empowered, and able to move around society with assuredness.”

—Executive Director Cathy Seelig

FIGURE B: FAMILY DEVELOPMENT MATRIX/PATHWAY, GOALS AND INDICATORS⁴⁴

Goal One: Children and youth are nurtured, safe, and engaged	Goal Two: Families are strong and connected	Goal Three: Identified families access services and supports	Goal Four: Families are free from substance abuse and mental illness	Goal Five: Communities are caring and responsible
<ul style="list-style-type: none"> ▷ Child Safety ▷ Child care ▷ Supervision ▷ Risk of emotional and sexual abuse ▷ Children’s physical and mental health ▷ Nutrition ▷ Appropriate development 	<ul style="list-style-type: none"> ▷ Parent/child relationship ▷ Nurturing ▷ Parenting skills ▷ Family communication ▷ Family communication skills 	<ul style="list-style-type: none"> ▷ Basic needs ▷ Budgeting ▷ Clothing ▷ Employment ▷ Shelter ▷ Stability of home or shelter ▷ Home environment ▷ Access to services ▷ Health services ▷ Community resources knowledge ▷ Child health insurance ▷ Transportation 	<ul style="list-style-type: none"> ▷ Substance abuse ▷ Presence of abuse ▷ Life value ▷ Emotional well-being/sense of life value 	<ul style="list-style-type: none"> ▷ Community engagement

The other tool in the Friendly Center’s toolkit is the Self-Sufficiency Calculator, an online resource that the Friendly Center helped to pilot for Orange County’s United Way. The Self-Sufficiency Calculator allows case managers to calculate the wages required for low-income families to meet their basic needs based on the size and makeup of their family. It also informs clients of their eligibility for certain benefits and where those benefits can be accessed. The Calculator is designed to be used in conjunction with job training, education, and other family support services that help families exit poverty.⁴⁵ “We take families right where they are,” says Seelig, “and we give them the tools and the ownership for them to make a difference in their own lives. Families that are self-sufficient are confident, empowered, and able to move around in society with assuredness.”

CREATING A SPACE FOR DREAMS TO BE REALIZED

The Friendly Center’s social change efforts are largely focused at the individual, family, and local community level, which makes its programs and services highly relevant to those whom it serves. The organization does not have an advocacy agenda, nor does it operate a formal community engagement program beyond the direct services it provides. However, it maintains an open and flexible organizational structure that allows clients to easily bring community needs forward to the Center’s leadership.

The Friendly Center has managed to create the conditions that facilitate clients and community members coming together to find solutions to the collective challenges that they face—whether it is to address gang violence or to build a new playground for their children. In this way, the Center is not just fulfilling the role of an ‘incubator’ for talent and leadership in local communities, it also creating a space for people to address their day-to-day realities. Moreover, there is clear evidence that the Friendly Center is engaging families in such a way that they are progressing along the FRC Relationship Continuum in the direction of organizing for community change. As one Friendly Center client and food program volunteer notes, “They teach us here that if we don’t speak up, we won’t be heard.”

TO LEARN MORE ABOUT THE FRIENDLY CENTER, VISIT: [HTTP://WWW.FRIENDLYCENTER.ORG](http://www.friendlycenter.org)

ENDNOTES

- 1** Chelation therapy is a treatment for lead poisoning that involves taking medication that binds with the lead so that it is excreted in the urine.
- 2** *Promotoras/es* (outreach workers) provide outreach and education to members of their community. Often their training is on the job, not formal, and in many cases they are volunteers. *Promotoras/as* are an integral part in linking underserved populations to existing resources and services.
See: <http://hia.berkeley.edu/promotoras.shtml>
- 3** The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.
See: <https://www2.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>
- 4** Los Angeles County Department of Public Health, Key Indicators of Health, June 2009.
- 5** United Nations World Population Prospects Report, 2009.
- 6** Ibid.
- 7** Ibid.
- 8** See: <http://ghsm.hms.harvard.edu/about/premises/>
- 9** By law, all FQHCs must be governed by a board of directors that includes a majority (at least 51 percent) of active, registered clients of the health center who are representative of the populations served by the center.
- 10** Amid the California State budget crisis, healthcare cuts have devastated many traditional clinic programs which reimbursed community clinics for healthcare services. If cuts to the Medi-Cal program remain part of the Governor’s plan for balancing the state budget, patient revenue for community clinics will be significantly impacted.
- 11** The Collaborative now includes SAJE, St. John’s, Esperanza Community Housing Corporation, and the Los Angeles Community Action Network.
- 12** See: <http://www.southlahealthandhumanrights.org/>
- 13** See: <http://www.southlahealthandhumanrights.org/declaration.html>
- 14** The Second Annual Conference is scheduled to take place on International Human Rights Day, December 10, 2010.
- 15** See: <http://centrobinacional.org>
- 16** See: <http://www.fiob.org>
- 17** See: <http://www.migrationinformation.org/USfocus/display.cfm?id=776>
- 18** In Mexico, there are 62 indigenous languages and 16 are spoken in Oaxaca alone. Each of these languages may have two or more variants or dialects.
- 19** CBDIO has trained interpreters from other states and, when necessary, interpreters from California can travel to other parts of the country to assist in specific cases.
- 20** Community health outreach workers.
- 21** California’s Healthy Families is a low-cost insurance program for children and teens who do not have insurance and do not qualify for Medi-Cal, the state’s Medicaid program.
- 22** Since the inception of the *Naa Ximi* program in 2007, a total of 80 community members have been trained by CBDIO.
- 23** Short oral interviews are conducted with community members to accommodate those who are not literate in their native language.
- 24** The MISP income threshold had not been adjusted since 1996, which made Fresno the county with the lowest eligibility income in the state.
- 25** Proyecto Educación y Capacitación sobre Derechos Humanos, Trabajo Organizativo y Abogacía.

- 26** This is either because their immigration status will not allow them to leave the country and reenter with lawful status, or because it would be financially prohibitive, or both.
- 27** The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. See: <http://www2.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>
- 28** The State of California’s Medicaid program.
- 29** Both Lynn and Richard have held a variety of roles with the clinic over the past 25 years, including serving as board members (Lynn was the founding board chair) and grant writers as well as helping to establish new programs.
- 30** The Leadership in Environment Engineering and Design (LEED) rating system is designed to improve profitability while reducing negative environmental impacts and improving occupant health.
- 31** The ‘activities’ bus that allowed students to participate in sports, music, and other extracurricular activities was eliminated 18 years ago.
- 32** By law, all FQHCs must be governed by a board of directors that includes a majority (at least 51 percent) of active, registered clients of the health center who are representative of the populations served by the center.
- 33** Icenhower, K. *Family-Centered Therapeutic Community Treatment: The SHIELDS for Families Exodus Program*. Therapeutic communities, 29, 1, spring 2008.
- 34** Although the members of the Client Councils and Community Advisory Board are participating in SHIELDS’s substance abuse treatment programs, they and their families are also receiving a wide range of other services from the organization (e.g., mental health, child development, vocational, and educational services). Thus, they are providing input about and helping to shape a wider range of programming in addition to that which is related to the treatment of substance abuse.
- 35** See: http://www.naswnyc.org/new_copy2003/Currents03/UndoingRacismWorkshop.htm
- 36** See: http://www.rebeccaproject.org/images/stories/files/crossing_the_river_description_curriculum.pdf
- 37** Ibid.
- 38** Temporary Assistance for Needy Families (TANF) replaced various welfare programs, such as Aid to Families with Dependent Children (AFDC), under the 1996 welfare reform legislation.
- 39** SHIELDS’s Therapeutic Nursery serves 30 children ages 3 to 5 who are unable to attend preschool due to severe emotional and behavioral problems.
- 40** *Family Resource Centers: Vehicles for Change*, The California Family Resource Center Learning Circle, April 2000.
- 41** Ibid.
- 42** *An Appreciative Inquiry: Reflections from Family Resource Centers in California*, Strategies, 2008.
- 43** Ibid.
- 44** This is also decision driven by budgetary constraints; the Center runs a lean operation with more than 90 cents of every funding dollar used to provide direct services, and a \$1 million budget that is 50 percent in-kind.
- 45** See: <http://hhspp.csUMB.edu/community/matrix/pathways.php>
- 46** Ibid.
- 47** See: <http://www.unitedwayoc.org/ourcommunity/orangecountydatalink.asp?id=1>

ADDITIONAL INFORMATION

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ABOUT THE BUILDING MOVEMENT PROJECT

The goal of the Building Movement Project is to build a strong social justice ethos into the nonprofit sector, strengthen the role of nonprofit organizations in the United States as sites of democratic practice, and promote nonprofit groups as partners in building a movement for progressive social change.

Many individuals in the nonprofit sector are strongly motivated by the desire to address injustice and promote fairness, equality, and sustainability. The Building Movement Project supports nonprofit organizations in working toward social change by integrating movement-building strategies into their daily work.

To learn more about the Building Movement Project and our work, please visit:

<http://www.buildingmovement.org>

ABOUT THE AUTHORS

Felecia Bartow is a nonprofit consultant who served as the California-based project coordinator for this initiative of the Building Movement Project and The California Endowment. Felecia conducted all of the interviews and served as the primary author for the five case studies included in Part Two of this report. In addition to her work as a consultant, Felecia has been involved in the field of immigrant and refugee rights since 1993. She has held positions with various immigrant rights organizations including the National Immigrant Justice Center in Chicago, Illinois, and the American Friends Service Committee in Philadelphia, Pennsylvania.

Frances Kunreuther directs the Building Movement Project, which works to strengthen U.S. nonprofits as sites of civic engagement and social change. She is co-author of *From the Ground Up: Grassroots Organizations Making Social Change* (Cornell, 2006) and *Working Across Generations: Defining the Future of Nonprofit Leadership* (Jossey Bass, 2008). Frances is also a senior fellow at the Research Center for Leadership and Action at New York University and spent five years at the Hauser Center for Nonprofit Organizations at Harvard University. She headed the Hetrick-Martin Institute for LGBT youth, and was awarded a year-long Annie E. Casey Foundation fellowship in 1997 for this and her previous work. Over the years, Frances has worked with homeless youth and families, undocumented immigrants, crime victims, battered women, and substance users. She is a writer and presenter on variety issues related to nonprofits, leadership, and social change.

ADDITIONAL TOOLS AND RESOURCES

We also encourage you to consult the following Building Movement Project resources and publications for additional frameworks for approaching social change work:

Social Service and Social Change: A Process Guide (2006)

This guidebook was developed for staff and board members of nonprofit service organizations who are interested in learning how to incorporate progressive social change values and practices into their work. It introduces a step-by-step process for nonprofit organizations that can be used to identify how groups can address systemic problems through social change work within the context of their usual services and activities. The process proposed in this guide can help organizations decide which strategies and actions will work best for them.

Making Social Change: Case Studies of Nonprofit Service Providers (2009)

The Building Movement Project developed this set of case studies as a response to numerous requests from groups looking for real-life examples of the often challenging process of incorporating social change models into social service work. The organizations highlighted were selected not to lay out a set of best practices for all organizations, but to serve as practical illustrations of how groups decide to extend their work to promote client/community voices and the challenges posed by that decision. The case studies—geared toward practitioners, board members, and funders interested in this work—include organizational profiles, a reflection guide, and a list of additional web resources.

Evidence of Change: Exploring Civic Engagement Evaluation (2010)

In many cases, not knowing how to demonstrate results of civic engagement and social change work has hindered service providers from adopting these activities and prevented them from receiving funding for this work. The Building Movement Project, the Alliance, and the Ms. Foundation, came together to draw on their collective experience with their networks and respond to this call for methods and tools for measuring the impact of social change work. This report examines how organizations currently view their relationship with impact measurement, presents a brief summary of the key findings that came out of the Civic Engagement Evaluation Summit convened by the partner organizations, and ends with a set of recommendations for how to increase the nonprofit sector's capacity to respond to the increasing need for tools to measure the impact of civic engagement and social change work.

Tools for Social Change (Fall 2010)

This online resource provides dynamic exercises and engagement models for organizations ready to take the process of incorporating social change models into traditional service work to the next level. The toolkit is targeted to service providers but written to be useful to all groups interested in this area.

Opportunities for learning, reflection, and evaluation are consistent throughout this online resource, along with tools and models that focus on culturally relevant models of engagement. To access Tools for Social Change, visit: <http://buildingmovement.org/news/entry/140>.

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