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MANAGEMENT NOTES

Building a Coalition of Non-Profit Agencies to Collaborate with a County Health and Human Services Agency: The Napa County Behavioral Health Committee of the Napa Coalition of Non-Profits

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ABSTRACT. It is rare that a group of community-based non-profit social service providers can successfully develop a coalition that includes not only a range of providers, but the County Health and Human Service Agency as well. This is a case study of a coalition of non-profit agencies that has come together in an attempt to plan and implement a comprehensive service delivery system to address the human service needs of residents in Napa County, California. With the goal of developing a

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comprehensive and seamless system of care for all residents of Napa, this non-profit coalition has begun to transform: (a) the way that services are designed and delivered, (b) the way that non-profits work together, and (c) the role of the county health and human services agency. The case study includes a set of obstacles encountered and lessons learned. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]

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It is rare that a group of community-based non-profit social service providers can successfully develop a coalition that includes not only a range of providers, but the County Health and Human Service Agency as well. It is more common for non-profit service providers to compete with each other for clients, status and reputation within the community, and scarce resources. Additionally, their relationships with the county agency are typically characterized by tension and even mistrust, and often resemble a funder-fundee relationship, rather than a partnership. This is a case study of a coalition of non-profit agencies in Napa County that has come together in an attempt to plan and implement a comprehensive service delivery system to address the needs of Napa residents. The case study is based on the coalition's first five years, and the first three years of its behavioral health committee.

The Napa non-profit coalition came together to address a multitude of issues and dilemmas that presented barriers to the delivery of high quality and effective services to residents, for example (1) fragmentation of services in non-profits, (2) competitive relationships between non-profits, (3) dependence upon the county health and human service agency for funds, (4) lack of collaboration among non-profits and between non-profits and county, (5) no sense of shared destiny, and (6) little understanding about shared client populations.

A BRIEF HISTORY

In 1980, the first incarnation of the non-profit coalition of Napa was formed by a small group of agency directors interested in forming a co-

alition in order to increase their potential for sharing resources and skills, and leveraging funds. The directors asked the county to support them in a revenue-sharing program. The County Health and Human Services Director encouraged the directors to organize themselves and to be as inclusive of other agencies as possible. With this support from the county, the directors expanded the group of non-profit agency directors from three to six, and began to discuss the benefits of working together. Once organized, the county asked the six members to assist with the county decision-making process as advisors in ranking the importance of a group of capital expenditure projects totaling \$500,000. These projects related to funding non-profits through revenue-sharing. This experiment in shared decision-making was deemed a political failure by some and was short-lived. The group folded after a year and a half.

In 1995, another group of agency directors began to discuss the need to work more cooperatively and to nurture younger directors as many of the current directors were nearing retirement. The group included the Executive Director of Napa County Council for Economic Opportunity, the Director of Napa County Health and Human Services, and the Executive Director of The Napa Volunteer Center. It met monthly for several months to determine how best to address their goals, which were to (1) find ways to empower agencies and clients, (2) explore ways to share resources among agencies, (3) identify ways to consolidate efforts to serve the needs of Napa clients, and (4) search for joint grant writing opportunities. Despite the past failures, they decided to try and build a coalition. As one director put it, "It was clear that the world was changing at this time. We could see welfare reform, health care reform, managed care, realignment and capitated costs coming. The trend was moving toward block granting, consolidating, and local control. We were looking to empower the community agencies as a political, economic, and social force for change." Their vision was to develop a seamless system of health and human services in Napa County managed and delivered collaboratively by community-based non-profit agencies and the county health and human service agency. This rebalancing of responsibility for health and human services between the county agency and the non-profit sector is the central theme of this case. With the "behind the scenes" support of the county health and human services director, these non-profit agency directors began to actively discuss and plan for the future direction, scope, and design of the county service delivery system.

It is important to note that, in addition to the vision of the agency directors and the coalition leader, there was another factor that contributed to the development of a coalition of non-profits focused on systematically changing service delivery. It was the decision by Napa County Health and Human Services to shut down two critical programs due to changes in state funding; the twenty-four hour walk-in crisis clinic in 1992 and the residential detoxification program for alcohol and drugs in 1995. Those changes had caused concern about whether the county health and human services agency was equipped to fulfill its obligation to provide these services. Both losses had a major impact on the landscape of health and human services in Napa County and increased the burden on Napa's non-profits without any increase in funds or resources. It was the loss of these programs that motivated the behavioral health committee of the fledgling non-profit coalition to develop a plan for a 24 hour system of care that ranged from education and prevention to outpatient services to crisis hotlines to residential care.

The group of agency directors felt that a coalition of non-profits was necessary to shift from a reactive to a proactive posture in order to bring about changes in the local service delivery system. In 1995, they invited other non-profit health and human service agency directors to participate and 15 directors showed up for the meeting. Many were meeting each other for the first time, despite their long-term involvement in their particular agency and in the community. Clearly, establishing trust and moving beyond turf issues would be a challenge for this new coalition, as it began its ambitious attempt to radically transform the way that services are designed and delivered in Napa County. After competing with each other in the community for funds and for status, these agency directors found themselves struggling to move beyond the "business as usual" approach in order to construct together a whole new way of "doing business" in the form of a seamless service delivery system. However, it is important to place the developments within a larger context and the experiences of others around the country.

BRIEF LITERATURE REVIEW

While much of the recent literature about behavioral health services integration and agency collaboration focuses on examples of managed care organizations, this brief literature review highlights the challenges and benefits of service integration and coalition-building in the non-profit context. This review focuses on the benefits of service inte-

gration and collaboration to clients, related to service accessibility, early intervention, and increased resource allocation.

The behavioral health care delivery system tends to be fragmented and difficult to navigate (Jensen, Hoagwood, & Petti, 1996). Negotiating the various types of providers and their specialized services and eligibility not only challenges, but also discourages some clients from pursuing the services they or their family member truly needs. Awareness of this problem has caused a shift in resource allocation in recent years from funding public mental health providers to funding community-based services. The rationale behind this shift in values is the belief that community-based care is best for delivering services to those populations that face barriers to accessing services, for example, low income clients, homeless clients (McGrew, Wright, Pescosolido & McDonel, 1999).

Despite the support for community-based approaches, the effectiveness of community-based services has been called into question. Research suggests that community-based delivery systems can be hampered by the ideological differences of diverse community-based agencies, and that these differences have created a splintered and de-centralized system at the grassroots, level with range of client and treatment philosophies (Rosenheck, 2000).

Research indicates that not only community-based, but also integrated service delivery systems are more effective for children and families than fragmented service delivery systems. For example, the most successful mental health interventions for youth appear to involve not only youth, but their parents, as well. These integrated systems and interventions that treat the whole family not only reduce negative behaviors and improve school outcomes for youth but also can improve the functioning of the whole family. Additionally, integrated services are preventative in nature. For example, integrated youth interventions have been shown to reduce the likelihood of out-of-home placements in families at-risk for involvement with the child welfare system (Jensen, Hoagwood, & Petti, 1996).

While a community-based integrated system of care provides an alternative, it also presents challenges. Developing a coalition comprised of agencies that have traditionally competed for funds with staff members distrustful of inter-agency collaboration is a tremendous challenge for any community leader (Schmieg & Climko, 1998).

There is growing interest in integrated community-based mental health service delivery models that rely on community coalitions or advocacy groups, but little research to document those few attempts that

have been made; even fewer have systematically collected data or followed theoretical models (Nelson, 1994). While there are models available for communities to follow, it may prove difficult to apply a single coalition-building framework to a range of communities with diverse stakeholders and community contexts. The challenge of developing coalitions may overwhelm leaders, causing them to experiment with what might appease members rather than emulating other successful models (Nelson, 1994).

Jenkins (1983) found that the success of a coalition is related to two key factors: organizational bases of support (resource allocation and policy developments) and the political climate (the politics of decision-making and who is involved). To relate this framework to community mental health coalitions, success could be defined as client and community-based provider participation in shared decision-making linked to securing adequate resources and relevant policies to support community-based mental health efforts.

For example, Nelson (1994) described a coalition of mental health reformers in Vermont that was successful, in part, due to Vermont's progressive government, a well-developed community support system, relative consensus among stakeholders regarding their values and philosophy, and the access to resources needed to shift them to community-based programs.

In Maryland, major stakeholders were recruited toward the goal of shifting resources into community mental health. A diverse group of agencies came together to form a statewide coalition. The prior informal relationships of these key players was instrumental to the development of the coalition and its success in obtaining increased resources for community mental health services and other policies (Nelson, 1994).

Timing and personalities can be critical, as well. A group of community-based care advocates in Connecticut were not as successful in their fight for a regionalized community mental health system. While they did make some progress, the implementation of their plan was thwarted by the state's mental health commissioner and bureaucrats. When this commissioner retired, he was replaced by an individual that supported the group; soon after they were able to redirect funds to community care (Nelson, 1994).

Based on these case examples, it is clear that the support of local officials is critical to the success of community coalition-building. Success is also related to a favorable political climate, as well as the importance of public awareness and familiarity with the issues. Finally, these cases demonstrate the importance of relationship building in coalitions, both

within the coalition and outside. It is clear that a coalition can achieve its goals and change the service delivery landscape of mental health services if it is able to build relationships and public awareness of the issues.

COALITION LEADERSHIP AND GROWTH

A recently retired health care professional (the retired county health and human services director) was recruited by some agency directors to provide the leadership and the facilitation necessary to begin the process of coalition-building. In 1995, the group of 15 adopted the name Napa Coalition of Non-profit Agencies. It opted not to formally incorporate, in order to allow the collaboration to evolve and not constrain it with formal policies and procedures. Their monthly meetings soon became the “meeting not to miss” in the non-profit community. As the size of the group grew from 15 to 30 by 1996, it became clear that some formalized policies and procedures needed to be in place, especially to share responsibilities for agenda development and policy formation.

The membership of the coalition grew quickly and by November 1996 they decided to re-evaluate their purpose in order to formalize their group process. One of the newest members was the newly appointed Director of Napa County Health and Human Services. The coalition had invited her to be an associate member of the coalition, which meant she could attend meetings, but not vote; only directors of non-profit organizations could vote as members of the coalition. The coalition sought to extend this welcome to the Health and Human Service Director to keep her informed of their plans, include her in the process, gain access to county resources, and to develop and maintain a relationship with the county.

In February 1997, the coalition appointed a committee to clarify the coalition governance, mission, goals and objectives. Out of that effort a new name “Napa Valley Coalition of Non-Profit Agencies” and a mission statement: “working together to strengthen and support non-profit service providers and their health and human service mission in the Napa Valley.” At a planning retreat in early 1997, the coalition refined its purpose, which was “to develop a partnership between the public and private non-profit sectors that would lead toward the development of a single system of health and human service in the Napa community.” By 1998, the coalition was operating with a formal process and had policies and an evaluation process in place.

The Coalition's Mental Health Committee

During the first few years of the non-profit coalition (1995-1997) most meetings were characterized by a degree of informal group process, which included discussion and debate among the agency directors about the types of services and delivery system that would work best. The dialogue featured discussions about the effectiveness and relevance of current services and which were deserving of increased funding or whether consolidation was an option to be explored. The coalition leader and facilitator was critical in keeping the coalition members involved and focused on the mission of strengthening and supporting non-profit service providers.

While these discussions were taking place, two members of the coalition, the Executive Director of the Volunteer Center of Napa and the Executive Director of Lutheran Services, volunteered to submit a proposal for a three year service planning grant from Blue Cross. The grant proposal addressed the gaps in mental health services created by the closure of the county's 24 hour crisis center and the long-term vision of a seamless system of mental health services available to all Napa residents, regardless of ability to pay.

In 1996, when a \$400,000 three-year grant was awarded, the coalition members, as well as other non-profits in the community took notice. This successful fund development effort proved to the coalition members that their vision of a single system of care might actually have a chance of being implemented.

The two directors that wrote the grant sought to bring together a group of mental health care providers to participate in the grant-funded planning process. The agencies selected were primary mental health service providers. It was difficult to select this group of agencies, as many agencies that provided mental health services, in addition to other services, were interested in participating. Many agencies wanted to become committee members, those that had been involved with the coalition, but not the mental health committee, as well as agencies that had not been involved with the coalition. Whether they were attracted by the grant funds, by the opportunity to be involved in an important project, or the fear of being left behind, more and more agency directors became interested in joining the committee. It had become clear that if a social service agency sought to stay relevant in Napa, it needed to become part of a coalition that was leveraging new funding and building a single system of care.

While there was a degree of political “fall-out” in terms of how the agencies were selected and which agencies were “left out,” the process of pulling together a group of agencies to begin to fill service gaps marked a significant turning point in the long process of developing a seamless system of care, primary outpatient and crisis agencies (Aldea, Family Service of the North Bay, Community Counseling, The Napa Walk-in Center, Child or Family Emergency (COPE), and the Volunteer Center) began the planning process in early 1996, and became known as the mental health committee of the non-profit coalition. The mental health committee coalesced around the process of implementing the first year of service planning which was part of the three-year planning grant from the Blue Cross Foundation.

Overall, the purpose of the planning grant was to begin the process of building the capacity of each agency member to contribute to a full continuum of care to meet the mental health needs of Napa County residents, with an emphasis on outpatient care. The group of primary mental health care providers comprising the mental health committee identified the array of existing mental health services provided by each participant in the community, the level of client demand, and the steps needed to begin the process of redesigning the system. Several gaps in services were identified (including the [under-served populations] of low-income families, children, and the Latino population) along with increased capacity needed to fill those gaps.

These conversations were not always easy, as committee members had difficulty moving beyond turf issues to address the needs of clients for comprehensive and integrated services. The diverse group of mental health agencies reflected an array of values and services, each with deeply held beliefs about the effectiveness of their services. Another factor that complicated the discussions was the fear that service integration might lead to the consolidation of existing programs and/or agencies. Throughout these discussions, committee members attempted to stay focused on a client-centered and services system-centered vision. Ultimately, the focus on the mental health needs of Napa County residents helped committee members to move beyond their own agency’s funding needs or their personal investment in a particular program.

While the planning grant signaled the official inauguration of the coalition, members had serious concerns about the ambitious plan to integrate non-profit community services. For example, some agencies might receive reduced reimbursements for their services or none at all, others feared that delayed reimbursement could jeopardize their limited cash flow, resulting in the need for different levels of staffing (more low-cost

staff). However, the group was determined to “weather” the challenging process for the benefit of the clients who deserved and needed integrated services.

While the grant term was three years, the Blue Cross Foundation that awarded the grant stopped its grant-making activities after fulfilling one year of the grant term, leaving the mental health committee without the prospect of funds to assist with streamlining mental health services. Due to their success in their first year of planning, the committee was able to secure additional resources through the efforts of coalition members, the coalition leader, and the county health and human service agency director. The Queen of the Valley Hospital’s Health Care for the Poor Fund awarded the committee a \$200,000 grant in 1997 for the continuation of planning and implementation, and encouraged them to incorporate behavioral health service agencies into the process by requiring their participation as a condition of the grant funds. This presented a challenge to the committee, as they had undergone an assessment of existing services and had identified gaps, had built trust and developed relationships between six agency directors. Including a new group of agencies meant they had to begin building once again. The mental health committee became the behavioral health committee and brought in behavioral health and substance abuse providers to round out the array of services for the new grant. In addition to the original six, the additional group of five included:

1. Our Family (outpatient services)
2. Head Start (early childhood services)
3. Jammin Company (youth job readiness)
4. Los Ninos early childhood services
5. Nuestra Esperanza outpatient services

The purpose of this local grant was to continue the process begun by the Blue Cross Foundation grant. While the committee underwent the challenge of rebuilding trust, its vision, and reframing its purpose, it simultaneously attempted to continue working toward the establishment of the following: (1) service protocols, (2) a referral system, (3) quality assurance system, (4) utilization review process, (5) and an evaluation of the planning and implementation. In addition, the purpose of the new grant was to provide subsidies for the provision of professional mental health services for poor and uninsured individuals. In addition to the funded agencies, many directors of agencies not receiving funds were invited to participate in the planning and design of the system of care.

They understood that the vision of the committee was based on addressing the service needs of clients, not the funding needs of agencies and programs. One director who worked closely with the committee and never received any funds at all, explained it this way. “The clients they serve are also my clients. Whatever we can do to improve those services helps my client and makes my job easier. It’s really not about the funds. This is a client-centered vision.” While this feeling was echoed by other members, all agreed that it took time to get there.

Components of the New System of Care

The purpose of the planning has always been to provide a continuum of care that is accessible to the poor and uninsured residents of Napa. All services are designed to be available at no or low cost to residents. The committee also sought to emphasize services for children, as they viewed this as a way to intervene early in an individual’s life, in order to prevent more serious problems later. The committee also emphasized the need for supportive crisis services, due to the absence of adequate crisis services in the community. Interventions like crisis hotlines and weekend and evening access were viewed as ways to address problems early and prevent escalation of issues. Not only would this provide residents with needed services and assist them in avoiding major family or individual crisis, but it could also reduce the number of hospitalizations and law enforcement emergency calls. By 1997, the behavioral health committee had coordinated the provision of the following:

- Subsidized outpatient psychotherapy (limited to 15 sessions, with possibility of extension)
- Para-professional lay counseling and crisis counseling
- Suicide prevention crisis line
- In-home support services
- Group counseling

Building capacity was another priority. In the initial planning process, the committee found that there were not enough services to meet the needs of seniors, children, and bilingual and bicultural populations. Agencies used their own funds to fill some of these gaps by hiring counselors that specialized in senior services as well as bilingual/bicultural counselors. By the end of 1997, due to the committee’s focus on capacity-building and support from local funders, the system of care grew to include:

- Psychological assessments and evaluations
- CORE Training program for volunteers and non-profit staff
- Increased availability of subsidized outpatient psychotherapy sessions
- Internship committee and subsidy for stipends and supervision
- Increased services to Latino community, including co-locating therapists at Nuestra Esperanza facility
- Implementation contract with Napa County health and human services agency for EPSTD billing of Medical clients
- Potential co-location of two mental health service provider agencies
- Contracted counseling and consulting services to other non-profit agencies
- Plans to consolidate crisis hotlines

How the New System of Care Works

The Volunteer Center is the fiscal agent for the new service system. As fiscal agent, the Center reviews all requests from participating agencies for reimbursement for services provided. Agencies are reimbursed by the Volunteer Center with grant funds on a monthly basis. In order to ensure that the reimbursement will be approved by the fiscal agent, all agencies thoroughly review client eligibility to ensure that there are no other avenues for reimbursement or service provision, such as Medi-Cal or school-based services. In other words, the participating agencies screen carefully and only request approval to utilize grant subsidies as a last resort.

Napa's new system of care operates in the following way with respect to assessment, referrals, treatment, and utilization review:

Step One: Assessment

When a client contacts one of the agencies, a therapist does an assessment of the client's needs. After assessing the client, the therapist fills out an intake form, which includes basic client information and a DSM code. Therapists first review all other avenues of payment before and requesting authorization for subsidies from the Volunteer Center as a last resort.

Step Two: Referral, if Necessary

If the therapist recognizes that another agency could better serve that client's needs, a referral is made. If the client could benefit from family

or children services, the therapist informs the client about those options and makes the appropriate referrals. For example, a low income recently divorced mother with two children can get counseling for her depression, a children of divorce group for her children, and referrals for school-based support or tutoring for her children.

Step Three: Treatment

When the approval is received from the Volunteer Center (that same day), the authorization for service from the appropriate agency is made. Each client receives 15 sessions of free therapy through the new service delivery system without any delays or waiting lists. Clients copay from \$2 to \$5 per visit or pay nothing if they cannot afford to pay. The types of treatment include:

- Subsidized outpatient psychotherapy (limited to 15 sessions, with possibility of extension)
- Para-professional lay counseling and crisis counseling
- Suicide prevention crisis line
- In-home support services
- Group counseling
- Family and play therapy
- Youth development services
- School-based supportive services

Step Four: Utilization Review

After 12 sessions of therapy, a therapist can request an extension for the client. The utilization review committee reviews requests for extensions and can grant another 15 sessions of therapy.

This system is remarkable for two main reasons: (1) convenience for the client with no waiting after the assessment and referrals for a range of high quality services that lead to treatment for the whole family in one stop, (2) services at no cost or low cost depending on the client's ability to pay. This means that services are accessible and available to all residents and that no one is left to "fall between the cracks." Prior to this program, many of these clients went unserved, due to service barriers such as language, financial, and waiting lines. Additionally, there were barriers around scheduling, as appointments were not available after hours for working parents. To date, participating agencies have been

so conscientious about their assessments and funding considerations that the lead fiscal agency has never turned down a request for services.

The “Front Porch” Program

More recently, in December 1999, the behavioral health committee, in partnership with the county health and human service agency, was awarded a \$2 million planning and implementation grant from the California Endowment for its “Front Porch” program, which will reestablish Napa’s 24 hour walk-in crisis center. The “Front Porch” will be a “24 hour integrated system of care and a full continuum of client-centered services promoting the mental health and behavioral well-being of the people of Napa County through public and private interagency collaboration” (California Endowment Grant Proposal, 1999) The “Front Porch” will accomplish this in four main ways:

- (1) Napa’s crisis hotlines, which include the suicide prevention, stress, and phone friend support lines, are consolidated and housed at the “Front Porch.” The lines are staffed by student interns and trained volunteers from the participating non-profit agencies. Licensed supervisory staff are provided by both the county health and human service agency and a non-profit agency. This consolidation helps to improve the quality and coordination of crisis support services.
- (2) The “Front Porch” offers a range of behavioral health, mental health, prevention, and substance abuse services, which include:
 - Information
 - Drop-in services
 - Peer counseling
 - Brief mental health counseling
 - Drug and alcohol intervention
 - Groups (self-help, support and therapy)
 - Walk-in crisis response
 - Psychiatric evaluations
 - Emergency psychiatric services

In addition to these services delivered on site, there is outreach to people in crisis and eventually crisis prevention and response services will be delivered to “hard-to-reach” communities.

- (3) Respite care is provided to prevent escalation and reduce the need for crisis intervention.
- (4) The “Front Porch” also provides a range of other critical services, including adult protective services, child protective services, sexual assault response, and emergency aid, such as food vouchers, baby formula and other essential items.

In addition to offering clients an integrated truly one-stop mental health, social, and substance abuse service delivery system, the “Front Porch” program expands the after hours access for Napa residents. Its services are available after hours five days a week in order to address the needs of residents who would not otherwise be able to access services. The goal is to eventually expand the hours further in order to become a 24 hour integrated system of care. The implementation of the “Front Porch” program brings Napa closer to achieving its ultimate goal: a sustainable 24 hour integrated human service delivery system for Napa residents.

Successful Components

System of Care

- The committee has successfully implemented a system of care that includes high quality outpatient services ranging from information to group therapy to psychiatric assessment for all residents of Napa regardless of ability to pay.
- The system of care has treated an average of 300 clients per month through the subsidies, individuals and families who, otherwise, would not have access to counseling services.
- The behavioral health committee’s ultimate goal of developing a 24 hour system of care has become a reality with a \$2 million California Endowment grant to plan and implement, in partnership with the county health and human service agency, the “Front Porch” program.
- The committee, in partnership with the county, has been able to leverage increased resources for other important projects related to behavioral health such as a large-scale family home visiting program and a program for school-based counseling in partnership with the state MediCal Program.

Coalition-Building Process

- Agencies have put funds back on the table for other agencies to use; this level of sharing and trust between participants and com-

mitment to the project reflects a willingness to first consider client service needs and coalition support, rather than agency turf and ego.

- The leadership of agency directors proved to be a critical part of the committee's work. Many on the committee have worked in Napa for years and know their organization's strengths and histories well enough to understand how they could link with other agencies. Each one had also been around to witness the failure of the prior attempt to develop a coalition. They were determined to make this attempt successful. Agency directors demonstrated a high level of commitment to staying at the table through extremely difficult discussions and debates.
- The insistence that directors are able to make decisions at the table without conferring with their boards of directors has been another key to success. The boards placed final authority over decision-making related to the single system of care in the hands of the directors so that decisions could be made quickly. This also demonstrates the level of board commitment to the new service system.
- Leadership of the committee facilitator was also essential when it came to procuring resources, bringing in new participants and keeping everyone focused on the goal/vision. Some participants felt that the role of the outside facilitator, someone who was not an agency director, was helpful, while others perceived his connections to his former employer (the county health and human service agency) as a sign that he was not a totally independent facilitator.

The coalition has been able to influence long term and systemic changes in Napa through its involvement in local decision-making, for example:

- The county director asked the coalition for input for Napa's Welfare Reform Plan submitted to the state of California.
- The coalition was asked to recommend one of its members to sit on the advisory board of the Partnership Healthplan of California.
- The coalition radically transformed the City of Napa's Community Development Block Grant (CDBG) decision-making process to include non-profit agencies as recipients of funds, resulting in \$700,000 for Napa non-profits.
- The coalition provided leadership in successful community establishment and adoption of an inclusionary zoning ordinance for the City of Napa.

- The coalition provided direction in the distribution of county trust monies for the development of low-income and special needs housing for the City and County of Napa.
- The coalition has been asked to designate a representative to fill several permanent “coalition seats” created by local task forces, boards, and commissions, including the Health Care Task Force, Proposition 10 Commission, and City of Napa Affordable Housing Task Force.
- Several foundations, including California Endowment, Marin Family Trust, United Way, Headlands Foundation, and Gasser Foundation have requested the coalition’s assistance and input in the decision-making about the distribution of their fund in Napa.

Dealing with the Challenges

- The most significant challenge faced by the committee was linking the collective vision to a shared sense of responsibility for services that address client needs.
- The committee’s relationship with the county has also become a challenge, especially when communication breaks down or disagreements do not get addressed. As the committee grows and succeeds, the role of the county becomes less clear. When is the county a funder, partner, advisor or non-participant?
- While some committee members felt that the coalition facilitator’s ability to generate interest, resources, and publicity for the committee was a strength, some also felt it slowed the committee’s progress, especially when unannounced guests arrived or extra agenda items were added at the last minute. On many occasions, sensitive/confidential agenda items had to be postponed, due to the presence of an unexpected visitor. While new agency directors were regularly invited to expand the partnerships and scope of services, committee meetings had to devote more time to review the past in order to bring new members up to date and include their services/programs into the continuum.
- The committee has struggled with its identity. It shifted from mental health to behavioral health and, with The Front Porch program, may shift back to mental health. Additionally, while its focus is on non-profit agencies, the county health and human service agency has become increasingly involved as a partner in recent projects. How can the committee and the coalition as a whole maintain an identity that is separate from the county, while acknowledging its role as a partner?

- Maintaining licensed staff members has posed a challenge for most participating agencies. While the system relies upon its well-trained community volunteers, student interns, and paraprofessionals, licensed professional staff are essential.

Lessons Learned

Lesson #1

- *Coalition building takes time* and will most likely be difficult. It helps if you have a respected leader and facilitator with a clear vision, the ability to remind members of that vision as regularly as necessary, and the capacity to help group members build trust and relationships. When there are resources and funds involved, interest follows.

Lesson #2

- *It is critical to establish, as early as possible, policies and procedures for managing meetings*, so that all coalition members understand and work within those policies. A key policy is to ensure that minutes are thorough and complete so that information can be shared.

Lesson #3

- *It is critical to involve as many community agencies in the process as possible*. Increased membership and agency “buy-in” strengthens the system of care. It is essential that new members understand and support the vision, and not just search for more funding to support their own agencies.

Lesson #4

- *County health and human services agency support is essential*, not just for financial resources but also for the encouragement and partnership development. It is possible for non-profits, local funders, and a county agency to develop a sustainable partnership based on addressing the needs of the community.

Lesson #5

- *A coalition of non-profits can wield much economic, social, and political power in a community*. In terms of numbers alone, its cur-

rent membership is 50 agencies; with their boards of directors, staff, and clients, it is clear that the coalition impacts thousands in Napa. As a result of its visibility and growing degree of influence, the coalition has continued to grow in membership and is increasingly called upon to provide input on a range of city and county issues. Coalition members have written letters, attended city council meetings as a group to demonstrate support and advocate for issues that interest them, influenced funding decisions at the county level, developed alliances with other coalitions, and raised funds through local foundations. Coalition participation in local decision-making has led to systemic and long-term changes in Napa County.

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