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ABSTRACT

Based on interviews with those involved in the adoption and implementation of the Kentucky Education Reform Act (KERA) and its Youth Service Centers, as well as on analysis of program data gathered by state and local agencies, this first year assessment is intended to highlight successes in the early stages of implementation, raise appropriate questions concerning possible inhibiting factors, and discuss what lessons have been learned and what adjustments, if any, need to be made in KERA legislation or its administration at the state or local level as the program furthers the physical and emotional health and economic needs of children and families. Two general questions are considered: (1) whether the Interagency Task Force and local Centers are carrying out the legislative mandate and spending public funds as policy designers intended; and (2) whether Centers are having a positive impact on the well-being of needy families and children through increased access to new or improved health and social services. Although the program is complex and it is too soon to draw definitive conclusions, initial assessment suggests that answers to both questions are positive. (MSF)

ASSESSMENT OF FAMILY RESOURCE AND YOUTH SERVICES CENTERS: A FIRST YEAR REPORT TO THE PRICHARD COMMITTEE

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SUMMARY OF FINDINGS

This first-year assessment of Family Resource and Youth Services Centers is based on interviews with many individuals involved in the adoption and implementation of the Kentucky Education Reform Act (KERA) and the Centers, as well as analysis of program data gathered early in the implementation process by state and local agencies. The individuals interviewed represent diverse organizations and interests in state government and in selected local communities and school districts. Six Centers across the Commonwealth were site-visited by the author in May 1992.

This assessment attempts to provide a balanced, objective picture of the program as of the summer of 1992. It is intended to highlight successes in the early stages of implementation, raise appropriate questions concerning factors that might be inhibiting successful implementation, and discuss what lessons have been learned about Centers and what adjustments, if any, might need to be made in KERA legislation or its administration at the state or local level. The following summarize the findings of this initial assessment:

** The concept of locating Family Resource and Youth Services Centers in or near the schools is sound. The policy theory relating family and child well-being to student achievement is plausible.

** The policy proposal was developed carefully and thoroughly based on previous research and experiences in other states with similar programs. The Centers program within KERA is a well-designed component of the total education reform package.

** The policy has been implemented quickly but effectively. Early implementation has been relatively successful. Administration by the Cabinet for Human Resources (CHR) has been flexible, appropriate, and light-handed. The program is not a rigid, top-down system. Local autonomy is substantial and meaningful.

** The Interagency Task Force has been effective in setting policy and overseeing program implementation.

** Center Advisory Councils are in place with varying degrees of participation and leadership.

** Local Centers and Advisory Councils are exercising judgment and making decisions within the policy framework and these actions are encouraged and respected by the state agency. Few, if any, local respondents expressed concerns about this aspect of the program.

** Mandated services and optional services are being coordinated and delivered either directly or indirectly through Advisory Council and Center efforts. Councils and Centers have developed priorities based on community needs assessments and are investing resources based on those priorities. Services are being provided through advocacy and

coo-dination efforts of Centers with many success stories of children and families being helped.

** Parents and students involved with the Advisory Councils and Centers seem satisfied with the services provided or available.

** Teachers and administrators in schools with funded Centers are supportive of the program and its early implementation.

** State funding of Centers is viewed as adequate by most Center Coordinators.

** Councils and Centers have been relatively successful in developing and extending cooperative relationships with service providers in their communities and in acquiring additional resources from the community. Also, school districts and other local agencies have contributed much additional resources to the operation of the Centers.

** Coordinators and staff of the local Centers view state staff in the Family Resource Center (CHR) as helpful, flexible, and positive.

** Coordination, information sharing, and planning between the Cabinet for Human Resources, other state Cabinets and agencies, and the Department of Education have been free of any major problems. The relationship between CHR and DOE is evolving positively as each group learns of the expertise of the other.

** CHR Monitoring and reporting requirements, although not without some complaints, are not viewed negatively by Center Coordinators. Most Coordinators see the reporting as necessary and important, however they also see room for some improvements in the process.

** Although a formal evaluation plan relating program inputs to outcomes as part of an automated, management information system has not yet been developed, monitoring through quarterly reports is ongoing and effective. In addition, 33 Centers have been assessed through "in-depth monitoring" including site visits by a team of state officials. Planning for systematic, quantitative, and comparative evaluation is occurring through the Monitoring and Evaluation Committee of the Interagency Task Force.

** Although no problems or conflicts have been identified, there is not yet a policy or plan devoted to how Advisory Councils and Centers will relate to the site-based decision-making component of KERA. Specifically, how will Center Advisory Councils relate to School Councils? In those Centers located in schools with active School Councils, few problems have been identified. This appears to be due to some overlap in membership on the two "governing" or "policy-making" bodies.

"The family is nature's original department of health, education, and human services."

(Michael Novak. 1987. The New Consensus on Family and Welfare. Wash., D.C.: American Enterprise Institute, p.16)

POLICY BACKGROUND

The Kentucky Education Reform Act (KERA) of 1990 was designed as a multi-faceted, long-term solution to many interrelated and complex problems facing Kentucky's education system. Because the reform was not intended to be and could not be a "quick-fix," any early assessments of implementation must caution that for many questions and issues, it is "too soon to tell." Baseline data can be gathered, initial implementation processes and decisions can be evaluated, and preliminary judgments can be made, however any type of closure at this point would be premature and unfair. There are presently many more questions than answers, and the story of KERA continues to unfold.

This assessment examines only one of the many innovations in KERA - Family Resource and Youth Services Centers. In some contrast to the more direct educational components of KERA such as school-based decision-making, ungraded primary schools, performance assessment/rewards and sanctions, preschool for four-year olds and the like, Family Resource and Youth Services Centers deal with the physical and emotional health and economic needs of children and families.

There are two related questions to be answered in this ongoing assessment of Centers:

The policy implementation question is whether the Interagency Task Force and local Centers are carrying out the legislative mandate and spending public funds as intended by the designers of the policy?

The policy impact question is whether Centers are having a positive impact on the well-being of families and children through increased access to needed health and social services provided either through improved system coordination or creation of new services? [1]

Despite the many organizational and program complexities and the potential for problems in implementing Family Resource and Youth Services Centers in Kentucky schools, the initial assessment suggests the answers to both questions are positive. Why does the program seem to be working well, and how can initial success be maintained? What issues might cause difficulties in the future?

Defining Family Resource and Youth Services Centers

The KERA legislation states that Centers are designed to "ensure that needy children and families receive services to solve problems that prevent children from doing their best in school." The primary means to accomplish this goal is to "identify and coordinate

existing resources." The mission statement of the Interagency Task Force charged with responsibility for implementing and evaluating this component of KERA is:

"Promote the flow of resources and support to families in ways to strengthen their functioning and enhance the growth and development of individual members and the family unit."

What services to "solve problems" of children or to "strengthen family functioning" are to be coordinated by the Centers? The KERA legislation states that Centers must at minimum address the following components:

Family Resource Centers:

assistance with full-time child care for children ages two and three
assistance with after-school child care for children 4-12
health and education services for new and expectant parents
support and training for child day care providers
health services or referral to health services, or both
education to enhance parenting skills and education for preschool parents and their children

Youth Services Centers:

health services or referral to health services
referral to social services
employment counselling, training and placement for youth
summer and part-time job development for youth
substance abuse services or referral to such services
family crisis and mental health counselling or referral

Prior to and during operation of the Centers, needs assessments of families and students are to be conducted to help the local Advisory Councils, Center and school staff, and service providers develop and access programs and services most needed in the school and the community. Because of different needs across communities, Centers likely will vary in the mix of optional services offered beyond the required services listed above. Also, since the legislation does not specify how the mandated services are to be provided, it is also likely that Councils and Centers will vary in how they deal with the mandated services.

Centers are to be located in or near schools with at least twenty percent of students eligible for free or subsidized school meals. Family Resource Centers are to serve elementary school children and families, and Youth Services Centers are for middle and high school students and families. To implement and oversee this component of KERA, the legislation mandated that the Governor appoint a sixteen-member Interagency Task Force responsible

for developing a five-year plan of implementation, a process to award grants to school districts for initiation and operation of Centers, and a system of monitoring compliance and performance.

The Task Force has organized several Committees involving staff from numerous agencies of state government to accomplish these tasks. Committees such as Legislative, Program Design, Resource Identification, and Finance and Eligibility were initiated soon after the establishment of the Task Force in June 1990. A Committee on Evaluation and Monitoring was established in 1991. In addition, a Parent and Youth Advisory Committee to the Task Force has ben appointed with members nominated by the local Center Advisory Councils. The Task Force and Committees have met regularly to carry out the mission and functions.

Although funds for the Centers are appropriated to the Kentucky Department of Education (DOE) as part of KERA, the grants to operate Centers are administered by the Cabinet for Human Resources (CHR) under the direction of the Interagency Task Force. The CHR also staffs the Interagency Task Force and provides support and technical assistance as well as monitors and evaluates the Centers. A branch of the CHR - the Family Resource Center is the unit responsible for these tasks.

The Centers were appropriated $9.5 million in the first year of operation. Governor Jones' Executive Budget requested $18.9 million for the second year as proposed originally in the KERA legislation, however the 1992 General Assembly cut the Governor's request to $15.9 million. These funds as part of KERA go to the DOE and are transferred to the CHR. (Possible issues relating to this budgetary arrangement are discussed later in this report.)

One key component of program implementation is that school districts compete for these funds to initiate and staff the Councils and Centers. The more than 1000 schools eligible for Center funding are not mandated to participate in the first year of operation; instead, Centers will be brought on-line in stages. The implication of this staged implementation and competition decision is that early adopters are likely to be schools with enthusiasm for the concept and in some cases with experience in dealing with health and human service agencies in their community. Early adopters are more likely to be "ready" for the innovation, and the first stage of implementation is more likely to be successful.

As an example of the staged process, in the first year of funding (1991-92), 133 Centers serving 232 schools were awarded grants and began operations. The awards in the first year of operation ranged from $10,800 to $90,000 and averaged $68,100. The amounts awarded are based on a formula allocation of $200/year per student eligible for the subsidized lunch program in the school up to a maximum of $90,000.

Although not detailed in the legislation, the policy theory implied by this description of Centers is that these new "linking mechanisms" or coordinating entities located in or

near schools will help increase and improve the access of children and families to needed health and human services. More effective delivery of existing services and creation of new services will help improve the physical and emotional well-being of children and families which in turn will lead to improved student academic performance. Although there are several assumptions embedded in this policy theory, the most basic assumption is that **parents and families are key factors in student academic achievement.**[2]

ASSESSMENT OF LOCAL CENTERS

Although future assessments will rely more on quantitative program data as they are gathered over time by state agencies and by the Centers themselves, this initial assessment uses a case-study approach with several Centers selected for direct observation and analysis based on interviews with Center and school staff, Advisory Council members, and parents, students, and others in the community. There are several justifications for this approach. First, a comparative, quantitative approach is expensive and time-consuming for both the researchers and the subjects. Second, there is not yet any consensus on what objects or behaviors should be measured and why, how reliable and valid these measures would be, and how the data would be collected by evaluators (whether outside or inside the program) with minimal disruption of the activities and routines of the organizations.[3]

Which centers were selected for site visits and what is the rationale for the selection? It was decided that Centers would be selected based on size, geography (regions of the state and urban/rural) and types of Centers (Family Resource, Youth Services, or combined Centers). Consultations with knowledgeable observers of KERA and the Centers in and out of state government led to selection of the Centers in Tables 1 and 2. The Centers selected are not presented as a random or even representative sample of the population of 133 Centers, however they do meet the above criteria and provide many examples of important implementation issues.

TABLE 1
CENTER FINANCES[a]

Center	State Grant	School Contrib	Commun Contrib
Estes Elem (u)[b]	77,000	-	11,070
Porter Elem (r)	50,800	31,538	45,897
Breckinridge Elem (u)	52,600	13,900	8,725
Fulton County (r)	90,000	8,408	1,514
Caldwell County (r)	90,000	2,375	292
Fairdale H.S. (s)	90,000	37,525	22,185

TABLE 2
CENTER ACTIVITIES[a]

Center	Contacts Qtr Y/D	Partic Qtr Y/D	Households Qtr Y/D	Free[c] Meals
Estes Elem (u)[b]	300 967	89 289	96 300	385 (83)
Porter Elem (r)	278 1745	529 427	173 212	254 (46)
Breckinridge Elem (u)	68 182	42 107	22 57	277 (85)
Fulton County (r)	437 570	114 130	42 50	375 (57)
				92 (46)
Caldwell County (r)	2337 3759	115 176	51 83	199 (38)
				147 (28)
				117 (23)
Fairdale H.S. (s)	1012 2860	970 970	323 657	368 (36)
				154 (75)

a. The data are taken from the third quarter reports (Jan-March, 1992) and first-year grant proposals. Fairdale (Jefferson County) has a Youth Services Center, Breckinridge (Jefferson County), Estes (Owensboro) and Porter (Johnson County) have Family Resource Centers, and Caldwell County and Fulton County have Combined Centers.

b. u (urban), s (suburban), r (rural)

c. The column for Free Meals is the number of students eligible for the federally subsidized meal program (with percentage of the total student enrollment in parentheses). Multiple numbers indicate multiple sites.

Given that these data are from the first nine months of operation of a complex and innovative program, and given that several issues of reporting and monitoring are still being assessed and discussed by state and local staff, these data should be interpreted with much caution. For example, the issue of what is a participant and what is a contact is not without some ambiguity and confusion. Although there is nothing in regulations or practice that suggests a participant is more important or somehow "counts" more than a contact, some Coordinators are concerned over how these categories are differentiated and how the data might be used or interpreted.

When does a contact become a participant with an official record opened and a Household Profile completed? There are two related components of the issue - one relates to system or organizational politics and future program support, and the other relates to the intensity of interactions between staff and individuals and how this is measured or counted. In terms of territory or turf contests, the issue might be, "there may be plenty of contacts to go around, but only so many participants or families." In terms of helping families and gaining political support to preserve or expand needed programs, the issue might be "how do programs get credit for the time and energy devoted to working with complex cases that might not be reflected in these counts?"

These data, while providing some indications of Council and Center performance, do not always account for the full impact of Center programs, especially in regard to less tangible and more difficult to measure and count aspects such as student and staff morale, community support, service agency cooperation, student and family emotional and physical well-being, and the like. Collecting reliable and valid data in these areas over time for all Centers presents a major evaluation challenge for state and local officials.

Location of Centers

The Centers site-visited all are located in the school building or in an adjacent building that is easily accessible by students. Center staff interviewed believe this is the optimal arrangement, with all wanting Centers close to students and teachers (this view apparently is not unanimous in that some program participants, staff, and observers believe there are reasons to have a Center located near but not in a school). Center staff report and site-visits confirm the occurrence of regular "walk-in" traffic by students (and sometimes parents) needing immediate attention. In some cases, the Centers have separate phone lines and separate entrances so that participants do not have to go through the school office or the school phone system to gain access to the Center. These location-related decisions help to symbolize the separate identification and functions of the Centers within the school building, and also sometimes make it easier or less intimidating for students and parents to seek information or help from the Centers.

It should be emphasized that physical location is not the same as organizational

location. Although Centers should be in or very near the school building, they are separate organizationally. If Centers were a unit of the schools administered through the local school board and the DOE they likely would become absorbed into the existing school structure or culture which KERA is trying to modify or reform. They are an important component of KERA located in the schools but are not organizationally part of the school system.

Center Staff

Given the limited resources available, but potentially large demands and high expectations for Centers, the job of Coordinator is crucial to success. Writing a job description for a Center Coordinator poses a special challenge because of the many important roles they must play for the Centers to be successful. The following list of roles is not exhaustive and the roles overlap somewhat, but the brief descriptions give some idea of the complexities and demands of the job. What do Coordinators do in the course of a typical day or week?

They are parent and student advocates. Whether in the school or in the service network, families and children sometimes need someone to represent their interests in encounters with individuals and agencies with power over their lives. This sensitive and difficult role places some pressure on Coordinators who have to maintain positive relationships with school personnel and service providers as well as children and parents, however effective advocacy often can be done in subtle and non-threatening ways.

They assist educational team-members. A major goal of Center programs is to have reasonably secure and healthy children in the classroom ready to learn and succeed academically. Coordinators must work closely with professional educators in identifying, assessing, and solving problems that interfere with that goal. For this team approach to work, teachers must view Center Coordinators as competent peers working with them to help students and families.

They assist case-managers. Many children and families have multiple problems requiring the intervention of separate programs or agencies. Center coordinators as program generalists ensure that there is communication between the different providers and between the participant and family members to maximize effective treatment of the individual or the family. They do not duplicate the work of case-managers in service agencies already involved with children or families.

They are system facilitators or coordinators. Service agencies develop their own routines and behaviors, often focusing narrowly on their needs, programs, services, and clients. To bridge these gaps and interests and to link categorical programs to better serve families, a knowledgeable and energetic facilitator is needed.

They are system-builders. Not only must Coordinators induce existing providers and agencies to work together, share information, and share clients, but they sometimes must help create new services or new networks of service providers. For example, a commu-

nity might need a spouse-abuse center. The Coordinator has to know how to pull together many elements of the community to help initiate and plan such an undertaking.

There are many other related terms or descriptors that could be used for Center Coordinators including catalysts, community organizers, or problem-solvers, however these brief descriptions help to convey the complexity and challenge of these newly-created positions. As the descriptions suggest, it is not likely that someone with little job experience or little experience in the school system or the service network would be successful in these roles. Although a particular educational background is probably less important than these job experiences, coordinators tend to have backgrounds or college degrees in social work and teaching. Many of them stress the importance of gaining the trust and respect of school and service agency personnel, so these backgrounds help build these relationships.

Although sound hiring practices are important, most successful organizations recognize that background and educational experience are not sufficient to maintain and improve job skills. After skilled and experienced Coordinators are hired, training and technical assistance should be provided to gain new knowledge and expand or upgrade job skills. Coordinators indicate that some of this has been available and has been valuable for some. In addition to formal training, a strong, informal network of Coordinators has developed to also provide information, advice, and mutual support.

The need for knowledgeable, experienced, skilled, and committed individuals to work as Coordinators is apparent, and it will be important to assess the degree to which a sufficient pool of such individuals exists for future Centers. Also it will be important to assess the extent to which the complex demands of the job might lead to "burn-out" of committed and energetic individuals.

Advisory Councils

How have Advisory Councils been implemented and how much control do they have? What are expectations for them? Advisory Councils appear to be functioning as intended; that is, if the intentions of the legislation are clear. In the Centers studied, the Councils meet regularly and have the required mix of individuals including parents and representatives of local service agencies. In most cases they appear to be operating as policy boards and are not much involved in day-to-day management of the Centers, except that principals and some parents serving on the Councils often are involved in day-to-day activities. Certain issues of how they will deal with hiring decisions and how they will relate to School Councils have yet to be addressed by most Centers and Advisory Councils. For example, will the Advisory Councils hire Center Coordinators or other staff or are these decisions made by the school system and/or the school principal or the School Council (perhaps with Advisory Council involvement and approval)?

In practice, how do Advisory Councils relate to School Councils? In Fulton County,

there is a School Council as well as the Advisory Council for the combined Center, however not much planning has been devoted to this issue, probably for some very good reasons. First, there is overlap and communication between the two bodies with school principals serving on both along with one other staff person or parent. Second, staff involved with each body have many pressing tasks to complete, and are not likely to deal with organizational questions until they become issues affecting operations. In the case of Center Advisory Councils and School Councils, it may be a reasonable strategy to let the processes work themselves out and deal with problems as they emerge. It may not be possible or desirable for state staff or legislation to specify in any detail how the Councils are to operate. The present practice of state staff appears to be based on principles of organizational learning, decentralization, and empowerment of Advisory Councils.

Service Coordination and Provision

What services are being coordinated and how are they delivered? Who is being served by Center programs? The brief answers to these questions are that Advisory Councils and Centers are ensuring that mandated services listed previously (as well as certain optional services) are being provided and many children and families at-risk and needing help are being served.

Health care services not only are mandated by the legislation, but are identified through needs assessments as a priority by many Councils and Centers. Centers approach this priority in a variety of ways. Estes FRC has a "branch" of the local Health Department co-located within the Center. The Hager Foundation located in Owensboro and the Health Department fund a full-time nurse and secretary who do health education, physical exams, and the like for students. The Foundation and others involved expect this component to become self-supporting within a year or so using reimbursements for services by Medicaid and other sources.

Some Councils and Centers prefer that the local Health Department provide these nursing or health services at the local Health Department facility. Although some Centers go further and feel that even hiring a Center nurse would duplicate service offered by the Health Department, other Centers have hired a nurse as part of the Center staff and certain services are provided by that individual in the Center. Porter FRC has hired a nurse who performs many important functions within the Center, but still contracts with the Health Department for some services such as physicals and immunizations.

In terms of the pros and cons of these various approaches and the many complex issues of liability, training, equipment, transportation, and reimbursement for health care services, the concept of local autonomy would encourage each Council and Center to develop its own strategy for providing these important services.

Another example of variation in providing mandated services is child care. Family

Resource Centers are mandated to assist with full-time child care for two and three-year olds and after-school care for four to twelve year-olds, and Centers appear to be doing this as needed in their community. Some have day care on site. Porter School in Johnson County has day care for 2-3 year-olds. Other Centers worked to obtain more slots for child-care in the existing network of providers in their community.

Most Councils and Centers indicate the initial survey of needs was very important for setting direction of the Center. Although it seems obvious to say, if services being offered are not what students and parents need then Centers won't be successful. Despite the obvious nature of this statement, it appears that a few of the 133 Centers did not take it seriously or did not know how to do needs assessments and managed to get started without good information on community needs. Also, it may be that as more reluctant schools and districts obtain Center funding, they might be less willing and able to conduct effective needs assessments and more likely to struggle to fulfill an ambiguous mission.

There is variation in the types and quality of needs assessments performed by the various Councils and Centers. Some are sophisticated and effective and some simple and effective, and a few may be neither. The Interagency Task Force and state staff are discussing the extent to which more direction and assistance in needs assessment should be provided to existing and forthcoming Centers. Discussion is also occurring over the degree to which needs assessment should be included in the formal evaluation efforts.

Home visits are viewed as important by several Councils and Centers. They help get parents involved in their children's education and help Center and school staff understand some of the problems and difficulties faced by children and parents. Also, some Centers are becoming more involved in recreation activities, not only as an identified priority need but also as a means to get more children and families aware of and involved in Council and Center programs.

Cooperation and Collaboration

How are Councils and Centers working with the state staff in CHR, with the local school system, and with local service providers? What are the results of this collaboration? In successful Centers, there is a positive, cooperative relationship among all these actors which usually was already somewhat in place prior to KERA. In some Centers, earlier programs helped set the stage or provide a foundation for improved systems collaboration through the Centers. A primary example of such a program is KIDS - the Kentucky Integrated Delivery System. Three of the schools studied (Estes, Porter, and Fulton County) had this program beginning in 1988/1989.

The goal of the state-initiated KIDS Program was to coordinate community service providers and provide " intensive, direct services to targeted low-income families to promote school adjustment and progress and to reduce the drop-out rate." Inter-agency

agreements were established among local agencies to provide coordinated services to small numbers of at-risk families. "Agency representatives worked cooperatively to establish agency strengths and weaknesses in service delivery, surveyed the needs of the population in terms of resources and services, and developed a program of service delivery based on communication, cooperation, and collaboration of all agencies." It is apparent that schools that had been involved in the KIDS Program already had the collaborative system and referral patterns reasonably well-established in their community prior to implementation of a Center.

Also, the existence of the PACE Program (Parent and Child Education) in some schools helped ease the way for implementation of Centers (Fulton and Caldwell Counties and others have this program.) This program is designed to involve parents who had not completed high school in the education of their children. Through PACE, several schools developed a foundation of teacher and administrator involvement in and support for the broad notion of outreach and working with the health and human service systems in the community.

Despite these earlier programs, collaboration with service agencies has not always been easy to accomplish. One Center Coordinator noted that it "took hard work to convince local CHR people to be more cooperative. Much territoriality had to be overcome, but now the process is working much better."

Another indicator of collaboration and support for the Centers is found in Table 1 - contributions of local agencies and local school districts to Center operations. There are numerous examples of success in this area. For example, Porter FRC has a full-time secretary contributed by their local Community Action Agency. It was mentioned above that the Estes FRC has a nurse and secretary contributed by the Health Department and a local foundation. Breckinridge FRC has a part-time social worker contributed by the School Board. All the Centers have managed to acquire needed in-kind contributions such as clothing and eyeglasses for children, food for families, as well as equipment and furniture for their offices. Some Centers have been aggressive and successful in working with local businesses and churches. Fairdale YSC has gotten help from Community Ministries on energy assistance and a clothes closet. Breckinridge FRC has worked closely with local business associations and churches.

Most principals are very supportive of the program. One principal called it a "dream-come-true" for her school. With so many needs in the community and the school, the Centers are addressing basic human needs that are crucial to learning. This same principal who has been closely involved in the entire reform process believes that the Centers may be the most critical component of KERA (with the possible exception of assessment). Other principals are very positive and supportive of the Centers program.

One superintendent sees the Center as a mechanism to help increase parent involve-

ment in the schools overall and in School Councils. He feels that parents using the Center become more positive and supportive whereas normally they might distrust or fear the school system. Principals in other schools with Centers also see the Centers as an important vehicle to increase parental involvement.

In addition to the Centers and their communities, it is important to assess coordination at the state level. How are CHR, DOE, and other state agencies coordinating their activities? Staff of DOE and CHR agree that relationships are strong and cooperative between the two agencies as well as the various units within these and other state Cabinets. The primary means of coordination is the Interagency Task Force. What are the roles of the Interagency Task Force as a coordinating body and how this group performed? The Task Force developed the five year implementation plan and approves grant applicants. The Task Force also serves as a mechanism to help resolve issues that affect more than one agency of state government. The Task Force and Committees have met regularly since 1990 and it appears that the mission and functions have been performed quite well. With regular meetings and established patterns of communication, this group deals effectively with most issues of cooperation and coordination.

Monitoring and Reporting

As might be expected, Center staff have mixed opinions about reporting requirements recognizing that paperwork is difficult to avoid in a complex program with some political sensitivity and high expectations. Although most Coordinators are positive about state CHR staff and their willingness to help and listen, they still would like some changes in reporting requirements. Some are unsure of the purpose of certain reporting requirements and see the process as "cumbersome."

One individual familiar with the education and human services systems believes that educators are more used to broader, more simple reporting than the detailed, categorized reporting required for CHR programs. If these separate organizational systems have very different cultures and expectations for monitoring and evaluation, the Interagency Task Force and Centers will have to bridge an important gap in overall program evaluation.

Another potential problem in reporting and monitoring is the Household Profile. There are mixed reactions from Coordinators on this instrument. Some see it as no problem; some see it as merely inconvenient; while others see it as too intrusive in some areas. Presumably the intrusiveness is threatening to some potential participants. In addition to the question of what information needs to be collected from participants and why, the issue also relates to when a contact becomes a participant and how such things are counted for evaluation purposes.

The reporting forms used also generate mixed reactions with several Coordinators suggesting the inclusion in the quarterly reports of narratives with anecdotes about activ-

ities and "successes" in order to provide a better or more complete understanding of what Centers are doing for children and families.

Rural-Urban Differences

Are there differences in Center characteristics and behavior in rural or urban areas? The size of a community and the density of the service network(s) are likely to affect Center performance and success. Tables 1 and 2 only begin to suggest the wide variation among Centers in community and school contributions and contacts and clients. Data on referrals to local agencies also are collected in the quarterly reports. These referral patterns are important indicators of the extent to which the Center is involved in collaborative networks of service agencies. How will these and other data be used to measure and compare Center performance, and how will size and rurality affect measures of performance? For example, a smaller population in rural areas does not necessarily indicate that needs for services are less than in more densely populated urban areas. Also, the issue of the extent to which there is "slack" in these service networks is especially critical in rural areas. Are there sufficient service providers and other community resources to meet the new demands from the Centers?

Another issue is whether it would be useful or effective to allow more flexibility in meeting mandated services so that small Centers in rural areas can focus on a few needed areas and do well rather than struggle and expend much energy on areas that might not be a priority and are difficult if not impossible to provide. Since a key component of KERA is local control, some might question whether the stated intention of KERA to develop and support local autonomy contradicts the concept of services mandated by the state. In practice, the mandated service categories are fairly broad; they are obviously important to the concept of a family center; and the state has been flexible in dealing with Center responses to the required services. Practice may make the possible contradiction between local autonomy and mandated services somewhat moot.

Transportation of students and family members is an important but sometimes overlooked service, especially in rural areas. Center staff often transport children and families to services located in other communities. Transportation also is important in some suburban or urban areas. For example, in the Fairdale YSC, thirty percent of their students are bused from the inner-city which poses major problems for service coordination, contacts, home-visits, and the like. The Center is considering an additional site located in the area of the inner-city where most of these students live.

What Doesn't Work?

One Council and Center, although not site visited, was assessed through phone calls and other discussions with observers, and through analysis of the initial grant proposal

and quarterly reports. This case might serve an example of mistakes made in approaching the opportunity and availability of Center money, and also suggests potential problems as more reluctant or less prepared schools are brought into the system.

The Center in question was slow to get started and few services were being offered prior to problems that allegedly occurred between the Principal and the Center Coordinator leading to the resignation of the Coordinator. Although there are several potential explanations for the lack of success, it appears that lack of leadership and weak planning before and after the grant award played a role. The school district apparently took a somewhat centralized approach to the applications process and had only one center accepted out of many applications prepared by the central office.

School staff and community people had not been much involved in proposal development and consequently had not "bought into the idea" and were not well-informed about the concept. In addition, the Principal was relatively new to the school and although not negative about the concept, she had not been involved in the original proposal. The person hired as Center Coordinator had little or no experience in the school system or the local social service network and appeared not to understand the many roles of a Center Coordinator or the mission and functions of a Center. All this ambiguity and confusion occurred in a school district with serious management and leadership problems. The situation has been monitored closely by state staff, and corrective action is being undertaken. This example of problems encountered and the complexity of implementation of the Center concept is reflected in the "lessons" below.

CONCLUSIONS AND LESSONS

What are the lessons to be learned from this first-year assessment of Family Resource and Youth Services Centers implemented as part of Kentucky's school reform package?

1. Initiate the implementation process in well-planned stages. Begin with competition for the new Centers limited to only a portion of those schools eligible so that the probability is quite high that the most receptive, knowledgeable, and experienced schools will be first implementers. In other words, begin with schools and communities "ready" for the program. This strategy helps insure that initial enthusiasm and experience can help iron-out inevitable problems and later implementers can benefit from initial successes. More reluctant implementers in later stages of the process can see how Centers work and how they might benefit from the program. This strategy depends on the belief of implementers that the program will continue for some reasonable period of time and early implementers won't be left "holding-the-bag" of a successful program with high expectations but facing the loss of state funds needed to maintain the program.

2. Center resources must be sufficient and flexible. This is a fine line and difficult to specify in practice. Resources must be sufficient to hire basic staff and have a

place to "do business," however too many resources might lead Councils and Centers to ignore the important mandate to work with existing providers or help develop new service programs in the community. Center Coordinators must get out into the community and advocate on behalf of children and families rather than attempt to provide services in the Centers. At the same time, it is recognized that the problems of children and families are virtually limitless, so sufficient resources are needed to meet basic needs. Resources should be flexible enough so that local areas can respond to unique needs and situations, and responsible "entrepreneurial" behavior is not discouraged.

3. Program success depends on structured or constrained decentralization. Local people must have sufficient autonomy and control to solve their own problems and meet identified community needs, but state officials must set limits and monitor Council and Center activities to guard against abuse or deviations from the basic concept and guiding principals.

4. If Center services are to be mandated from the "top,' the service categories should be broad and relate directly to the well-being of children and families with minimal details about how the services are to be delivered. A long, detailed laundry list of mandated services will likely lead to excessive conflict and gaming behavior with subsequent delay, resistance, and possible implementation failure.

5. Center staff, especially the Center Coordinator, should be experienced either in the school system or the community social and health service network. The Center Coordinator must be able to understand and deal effectively with children, especially those with problems, as well as parents of those children, community leaders, teachers and principals, and service agency heads. A key to early success in implementation of Centers is commitment and enthusiasm of the Center Coordinator and other staff. Also, creativity and entrepreneurial skills are useful qualities. These sound like difficult if not impossible personnel requirements, but the Centers assessed for this report have staff with most if not all these desirable qualities.

6. Center staff must establish close working relationships with teaching staff, including school and district administrators. In successful Centers, Coordinators work with educational staff by being available during lunch periods and other times in teacher lounges, conducting one-on-one consultations, and by attending staff meetings and planning days and training sessions. A pattern of trust and teamwork must be established and maintained between school staff and Center staff. Effective communication patterns must be established and nurtured.

7. To be successful, Centers need support, cooperation, and leadership from the top officials in the school, the district, and the community. It is difficult to overestimate the importance of experience, commitment, and enthusiasm among all involved to make the Centers work. Can a good idea like the Center concept succeed in

a bad environment; that is, in a community without much experience or history of agency cooperation and collaboration or in a school with an "autocratic" culture or history of centralized control? It is not likely. Without very effective political and organizational skills and much effort by a Center Coordinator, as well as support and protection from a strong Advisory Council, it would be difficult to change attitudes and perceptions built up over many years in a school or school district. As with education reform in general, some superintendents, principals, and teachers will view Centers as a potential complication or even as a threat to the existing order.

8. Effective evaluation processes should be an integral component of the management and operations of Centers. It is important for the state to work with Council and Center staff to collect sufficient useful data to help evaluate Center performance. In this period of fiscal limits and some public suspicion of government programs, especially "public welfare," it is important that schools and Centers and state officials be able to justify their activities and services and document results of the investment of public funds. All this should be done in a spirit of cooperation with respect for reasonable mandates from the providers of funding and program support.

Some will say these lessons all sound obvious, simplistic, or even trite, but it is important to note how often many of them are ignored or forgotten in designing health, education, and human service programs, especially when the designers are at the "top" of a system and implementers are "below" them. These may be simple lessons, but they are not always easy to accomplish. In the case of Family Resource and Youth Services Centers as part of KERA, Kentucky has learned most of these lessons well.

Although initial implementation of the Centers policy has been relatively successful and problem-free, what about the future? What are some issues that might affect continued success of the program? One important issue involves financial resources. The issue of resource sufficiency and the future of Centers can be reduced to certain numbers and questions. If there are approximately 1000 schools that meet the criterion of 20 percent of students eligible for free lunches and each has a Center averaging $70,000 per year of funding from KERA, then the program will cost a minimum of $70 million per year. If fewer schools have Centers or schools combine Centers or if the state allocation averages less than $70,000 per year, then yearly costs could be reduced. For example, funding only 500 Centers with the same average allocation would cost $35 million/year. Forecasting program costs is difficult, however full implementation of the Center concept could cost $50 million per year and perhaps more.

Are these numbers that state policy-makers could support, especially as Kentucky faces a very uncertain fiscal future? Would advocates and beneficiaries of the Center concept be able to demonstrate benefits sufficient to make the allocation of such future

budgetary resources appear to be a good investment? These are questions that policy-makers, educators, the Interagency Task Force, and others will have to face in the very near future - certainly beginning in the next biennial budget process. Budgetary realities lead to issues of program advocacy.

The question of organizational "ownership" of the Center program (who is the primary advocate for the program - the Commissioner of Education or the Secretary of the CHR or someone else such as a powerful legislator?), and the budgetary numbers suggest two broad options for the future of the program. First, it could be decided that the program is a "pilot" and will not be implemented fully over the next 2-3 years. Assuming the pilot program is given sufficient time to demonstrate effectiveness, would school districts be willing to assume ownership of the program and continue or initiate Councils and Centers using local dollars? If districts see the value of the Centers, and if school based decision-making is working, and if the stated emphasis on local initiative and control is real and continues, then the program would stand or fall on its merits at the district level.

Another alternative is that the CHR could keep the Centers under its organizational "protection." The Centers would continue to be located in the schools, but be funded by the Cabinet with Center Coordinators acting as the local service managers for CHR. However, it may be that CHR is not organized in such a way as to maximize service delivery to families and children. Rather than separate Departments of Social Insurance, Health, Employment Services, or Medicaid Services, the Cabinet might be organized around certain client groups such as the elderly or children and families. If all health and social programs for children and families were located in the same department within the Cabinet (a Department of Children and Families within a reorganized Cabinet?), local providers as well as staff in Centers within schools might be better able to coordinate the complex mix of services needed by children and their families. This is a difficult and controversial organizational question and relates to political and fiscal issues including federal requirements as well as requirements of other funding sources.

The issue of budget sufficiency and full implementation relates to need and demand for Council and Center services and programs. Despite the initial enthusiasm and relative success of early adopters, what will occur when less interested and less positive school systems are brought into the program, when more demands for services are placed on existing providers, when more difficult and complex social and health problems must be addressed, and when more independent, territorial and complex social service systems must be accessed by the Councils and Centers?

How long and to what degree can Councils and Centers depend on some providers giving "free care?" Needs for services are likely to grow, but state resources may not. As more Centers come on-line, will existing provider networks be willing and able to provide increased services and levels of care? If service providers do not have sufficient resources to

meet the increased demands, would the General Assembly or the CHR allocate additional resources to health and human services for children and families?

The answers to these questions depend on how successful the Interagency Task Force and local Advisory Councils and Centers are in building and sustaining cooperative relationships among providers in their communities, and in developing an effective, statewide advocacy coalition. The intensity and political clout of competing claimants for limited state resources, as well as the strength of the future state economy also might constrain the future of the program.

ENDNOTES

1. The even more difficult and complex question of whether Center programs as one component of the educational reform package help to improve student academic performance is discussed in more detail in an accompanying report available from the Prichard Committee. The report is titled "Family Centers in Kentucky Schools: Politics and Policy in Education and Welfare Service Delivery."

2. The policy theory also is based on the many changes occurring in family structures in America and Kentucky. These include increased rates of divorce and single-parent families (female-headed), increases in mothers working outside the home, and increases in children born outside of marriage (often to teenagers). These and other demographic changes relate to increased numbers of children living in poverty and various social problems such as crime, substance abuse, and the like.

Another important assumption in the policy theory is that present systems for delivering health and human services to children and families in this nation are inadequate. The theory assumes innovation and collaboration between these complex systems are needed to serve children and families more effectively. These and other components of the policy theory are analyzed in more detail in the report titled "Family Centers in Kentucky Schools: Politics and Policy in Education and Welfare Service Delivery."

3. There are two broad approaches to analyzing organizations (Centers or schools) and evaluating the impacts of programs. A quantitative, comparative approach develops large-scale data-sets measuring things such as funding and budgets, class size, teacher salaries, client or student characteristics and other organizational "inputs" and "outputs." These data are usually analyzed using statistical techniques such as regression or factor analysis. Although these approaches sometimes gather data over time, usually the data are a "snapshot" of many units or subjects at one point in time. Tracking many subjects (individuals or organizations) and collecting extensive and useful data over time are difficult and costly undertakings. Much previous research also suggests that the quantitative approach often focuses on behaviors that are more easily measured (and collected) such as number of clients or number of staff, number of visits, and the like. Outcomes of educational or therapeutic interventions are complex and difficult to conceptualize and measure.

A case study approach uses direct observation and interviews (usually by an individual researcher) to gather qualitative data on a small number of subjects or units of analysis, often over time. Rather than emphasizing the counting and measuring of certain characteristics using standardized instruments, the focus is on understanding and evaluating individual and group behavior internal and external to the organization. Whereas the quantitative approach is concerned with generalizability based on a type of social science rigor, the case-study approach presumably sacrifices some generalizability to acquire more

in-depth knowledge and details about difficult to measure and quantify concepts such as leadership, morale, organization culture, commitment, family well-being, and the like for a small number of units.

Many Center staff recognize these distinctions and complexities. They understand and accept the need to complete forms and document activities through counting clients or contacts, and developing written cooperative agreements, but they also understand and experience on a daily basis the complexity of "helping" a child or a family and somehow measuring or accounting for the results of certain interventions. For some practitioners, the perceived need to generate numbers to justify the investment of public funds does not appear to diminish concern for the well-being of clients.