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ABSTRACT

One requirement of The California Children and Families First Act (Proposition 10) is "to facilitate the creation and implementation of an integrated, comprehensive, and collaborative system of information and services to enhance optimal early childhood development." This report provides policymakers and others with working information about family resource centers (FRC), provides information useful in shaping policy recommendations that may lead to higher levels of integration of various Proposition 10-supporting initiatives, and provides insight into possible paths to creating and implementing FRCs. The report defines FRCs and provides a rationale for such centers by examining whether they are effective, the attributes and core competencies of FRCs, and experiences with such centers in other states. Elements of financing FRCs are also explored. The report concludes with recommendations relevant to creating an integrated system of information and services in support of needs of families and young children; recommendations are in the areas of design and evaluation, funding, practice, and policy. Three appendices include relevant web resources, considerations when starting a family resource center, and a list of common family resource center funding sources. (Contains 45 endnotes.) (HTH)

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Building Community Systems for Young Children

Building Community Systems for Young Children is a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act. Each installment is written by a team of experts and provides comprehensive and authoritative information on critical issues concerning young children and families in California.

August 2001

Using Family Resource Centers to Support California's Young Children and Their Families

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Using Family Resource Centers to Support California's Young Children and Their Families

I. Introduction and Background

One requirement of The California Children and Families First Act is "to facilitate the creation and implementation of an integrated, comprehensive, and collaborative system of information and services to enhance optimal early childhood development. This system should function as a network that promotes accessibility to all information and services from any entry point into the system. It is further the intent of this Act to emphasize local decision-making, to provide for greater local flexibility in designing delivery systems, and to eliminate duplicative administrative systems."

In pursuit of this objective, this report has three purposes:

- To provide policymakers and others with working information about family resource centers (FRCs);
- To provide information useful in shaping policy recommendations that may lead to higher levels of integration of various Proposition 10-supported initiatives; and
- To provide insight into possible paths to creating and implementing FRCs.

As one portal of entry into an integrated system of services, and as a major mechanism for proactive, holistic, and efficient service delivery and integration, FRCs have the potential to play a significant role in enhancing access to services for families. Benefits to families may include: health, mental health, educational and recreational services; reduction in service duplication; community involvement activities; cross-generational interaction; large-scale volunteer opportunities; and a feedback mechanism for the community. More important perhaps is the potential for FRCs to become centers for community connectedness that can unleash the human and economic potential of communities in support of young children and their families. FRCs are an easy starting point to implement some of the systemic improvements required by Proposition 10.

FRCs are not yet mature, evidence-based vehicles for effective service integration, but they are growing in popularity and effectiveness. They offer a local structure for integrating new and existing family-centered programs. They provide a local organizational structure for family and community partnerships, local family-centered service development, and improved evaluation of service programs.

Why should Proposition 10 commissions use family resource centers?

Family resource centers can help commissions "hit the ground running." The Proposition 10 Commissions have an opportunity to capitalize on an existing infrastructure and existing capacity, and "hit the ground running" through the use of existing FRCs. Each community in California is in a different stage of development of its early childhood service system. Each community has different capacities. But in those communities with existing FRCs, communities and commissions can "jump

start" their system building efforts by allocating funds to leverage the existing investment in FRC facilities and services.

Family resource centers can help commissions link old and new programs. One challenge presented by the Proposition10 initiative is the apparent mandate to implement new programs in parallel with leveraging existing programs that have demonstrated effectiveness. Family resource centers can be both an engagement vehicle and a framework for the organization and integration of both new and existing programs into unified efforts. They can serve as platforms for direct service delivery and integrate multiple programs and initiatives with schools, county agencies, and private providers.

Family resource centers provide a structure for linking finance/administration and planning input. Proposition 10 commissions are charged with planning carefully for the future as they implement programs that produce discernible results today. This will require them to launch innovative programs while expanding existing programs that work. These programs will have to be linked administratively and fiscally to ensure that families with young children have a seamless system of appropriate and effective services from which to choose. Proposition 10 plans also require input from the communities they serve. The FRCs could not only provide a means for input to commission plans, but also could provide a local structure for community feedback, local development, and improved evaluation of programs.

One of the key challenges for Proposition 10 Commissions and local communities is to take advantage of the benefits of local community FRCs even though they are at different stages of development, use multiple implementation approaches, and have not yet been proven effective.

Many family resource centers are service delivery hubs already "in the business" of prenatal and early childhood development. The daily activity of FRCs is the delivery of integrated direct services, many of which are or can be focused on prenatal and developmental years. Not all FRCs are equally effective or efficient, but they do strive to provide a single point of entry to an integrated provider system that enhances access to information, education, and services designed to improve the lives and potential of families and young children.

While FRCs have great potential and, in some cases, a record of solid successes, they are relatively new and range in size and scope; they generally are not proven, well-documented, or failsafe investments with consistently good outcomes. Their success can be variable, their outcomes data inconsistent, and their evaluation difficult, and not all have a prenatal to age 5 focus. If they are not well focused and well managed, they can consume disproportionate amounts of time, co-locate services without integrating them, and fail to engage the neighborhoods and constituencies they serve. If not well designed, they can become an end in themselves rather than a means for building family-centered, community-based early childhood service systems.

While Proposition 10 provides an unprecedented opportunity to help communities develop, or advance, existing FRC efforts, there are some equally unprecedented challenges: to avoid fragmenting communities, to avoid encouraging "poachers" who enter the FRC field just because

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there is money available, to increase collaboration, and to firmly "plant" or support local control and voice. Commissions should consider the development of minimal standards and best practices for FRCs. They might also encourage funding recipients to develop an integral connection with local FRCs that meet appropriate standards in order to enhance local integration efforts and make more effective/efficient use of Proposition 10 and other funding.

The Rosa Hernandez Experience

Rosa came to California three years ago in response to stories of employment opportunity and medical care. With no financial resources, unable to speak English well, and without traditional, marketable skills, she quickly found herself in living conditions as difficult as those she left. Already a single parent, pregnant again, chronically ill, terrified about her immigration status, and unable to communicate effectively, she and her children quickly became isolated. She lived in a powerless converted garage attached to a run-down dwelling already housing nine people. Her life revolved around a daily struggle for subsistence out of the sight of most others as a way to minimize discovery. She avoided new relationships for fear they would compromise her immigration status. A community outreach worker from the local FRC and Healthy Start office discovered Rosa during a door-to-door outreach and education project. Recognizing Rosa was fearful of strangers, the outreach worker restricted her initial contact with Rosa to obtaining permission for a return visit to deliver food and clothing for Rosa and her pre-school child. After several brief visits to provide Rosa with other survival items, a minimal level of trust emerged. After months of service and assurance of confidentiality, the outreach worker was able to convince Rosa to accompany her to the local FRC. At the FRC, Rosa was treated with dignity in her own language and was assisted in enrolling in an ambulatory care program for chronic disease offered at a local public-private partner clinic, and paid for by the county health department. Rosa's child and newborn were immediately checked and immunized at Kids Kare-A-Van, a free mobile pediatric care van sponsored by a regional hospital system that provides initial service and then refers families to local pediatricians. An FRC staff person introduced Rosa to the on-site representative from the WIC program to provide nutrition education and food assistance for her and her children. Eventually, Rosa accepted an offer for free counseling at the center provided by a mental health agency. At about the same time she accepted a referral from center staff for free legal counsel to help her sort out her multiple legal and immigration issues. Once assured her legal exposure was minimal, Rosa volunteered to participate in the center's community outreach worker program for fellowship and in the hope that she might help others trapped in life-limiting conditions. Shortly thereafter, Rosa enrolled in the free Self-Sufficiency Program offered at the center that helped her with her language skills, employment skills, and provided day care and food during the four-week program. Three years later, Rosa is a success story. She's employed as a part-time school aide as a direct result of her Self-Sufficiency Program experience and the exposure she got while participating in the center's community outreach program. With the assistance of the staff at the center, her children are enrolled in the Healthy Families insurance program and both she and her children participate in the center's youth literacy program.

II. What Are Family Resource Centers?

The story above brings to life the potential and capability of one FRC. There is no single or common definition of what a FRC is; the FRC concept is both broadly defined and variably implemented; but FRCs are often the expression of community need and will, providing comprehensive core values and services as defined by the community. FRCs vary widely in philosophy, mission, size, service array, physical description, geographic scope, populations, and relationships. Some are school-based, some school-linked, some are municipality operations, some are service provider-linked, and others are independent non-profit service corporations.

FRCs do share a number of common attributes and, in general, strive to be "one-stop" community-based mechanisms or hubs designed to improve access to integrated information and direct or

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referral services for families and children. The common attributes they share may represent the natural evolution of successful family resource center initiatives and include, but are not limited to:

1. A community or neighborhood focus,
2. A high degree of collaboration (local, city, county, state),
3. Active inclusion of multiple constituencies (users, providers, schools, elected officials, and academicians),
4. Integrated services and case management, and,
5. An intensive, comprehensive view of children's needs in the context of family and neighborhood.[1]

FRCs can serve several critical functions for young children and their families. The first is efficient "one-stop shopping" for service needs. With the collaboration of relevant local agencies, schools, and community interests, the FRC is able to provide a single portal of entry into the network of support services, which minimizes the number of dropped "hand-offs" and the dropout rate as individuals transition from one program or office to another. Use of personalized assessment techniques, comprehensive intake procedures, coordinated case management, and advocacy efforts of local centers is likely to increase the utilization of appropriate services while reducing the use of inappropriate resources. The local nature enables centers to more easily and appropriately respond to the cultural and economic realities of families in a particular neighborhood. Transportation challenges are reduced when a single visit can provide access to needed services or programs without multiple visits. Co-location of staff, from multiple organizations, makes it easier to attain those goals while minimizing redundancy, reducing isolation, and facilitating redirection of resources to areas of greatest need.

The second critical function centers can play is to empower families through outreach and organized involvement. The one-stop model enhances access to services, while the focus enhancing family control over their lives provides processes to educate and encourage families to take responsibility for their own progress. Additionally, encouraging individuals and families to participate in outreach programs establishes a sense of ownership and a commitment to "give back." Families can learn how to better utilize existing systems of care, advocate effectively for the needs of their children, and learn how to meet more of their own needs.

The third critical function centers can play is to provide a collaborative forum for enhancing community input and integration of local agencies and interests. Active community involvement can help institutions become more responsive to community needs and lead to engagement of more community resources and members. The center can provide a "face" and voice for the needs of the community. FRCs can become a community checkpoint or endorsement center to be included in the review/funding/implementation process for other initiatives.

Often an FRC is small, community-based and housed in dedicated facilities of fewer than 4,000 square feet. Most FRCs offer a culturally and linguistically appropriate array of health, counseling, mentoring, tutoring, education, and social services. Many strive to be "one-stop" service and referral centers organized around collaboratives of state, county, regional, and city service providers and

community entities.[2]

FRC staff size and profiles vary depending upon funding sources, degree of collaboration with other partners, existence of other funded programs at the same site, and degree of subsidization and "in kind" participation. Some have steering committees or boards that establish policy and work to integrate neighborhood interests into planning for the operation. In many cases there is a lead person responsible for overall coordination of collaborating partners and who provides supervisory functions for two or three additional individuals. Additional full- or part-time staff may be out-stationed at the FRC by partner organizations.[3]

Funding streams for FRCs vary widely and can include federal and state grants, private foundation grants, municipal funds, and charitable contributions. A typical non-profit corporation or municipality-sponsored center may operate on an annual budget of $50,000 to $100,000, while a school-based site with a Healthy Start grant may budget $100,000 to $150,000. Other centers with a specific, hard-to-reach population or funded by a specific program/grant may have a budget from $100,000 to $500,000 yearly. Large centers with multiple ancillary operations such as shelters, homeless services, or large mental health programs may operate with budgets from $500,000 to several million dollars per year.[4] There is tremendous individual variation in the total budget within these groups with some centers gathering many times more funding than others.

A typical FRC focuses on providing core services to families and young children of the neighborhood or community, and referrals or "hand-offs" for other needs. Many offer:

- Core services on site (such as medical care, counseling, food assistance, clothing, transportation assistance, parenting classes, literacy classes, insurance programs, or education);
- Referrals for secondary services (such as shelter, utility assistance, day care, specialty medical, dental, and vision services); and
- Direct links with early childhood and child development programs (such as Head Start, Early Start, and home-visitation programs).

Types of family resource centers

FRCs are one key component of a larger, integrated system of care and can serve as service hubs with important collateral connections. Since different types of FRCs exist, we have created a descriptive typology to classify them. These types represent the range of FRCs that exist and are not mutually exclusive. We will discuss individual center examples, but we emphasize that none of them is truly a single, complete solution for all of the needs of all young children and families. Most examples are center-based and fall into one of two categories (though the categories are not hard and fast): geographic "community" centers and common need/interest "community" centers.

Geographic Family Resource Centers

One major group of FRCs primarily serves geographic communities and attempts to provide "one stop shopping" for local families. They tend to offer greater breath of activities without the special need/interest depth that is offered by specialized centers. These geographic centers vary tremendously in the type of on-site activities offered to families and may vary in the ages of young children whom they serve. Much of the variation appears to be based on the primary mission of the sponsoring agency or group.

Many of these FRCs are an extension of a lead agency and evolve as a logical expansion of their core activities. The agency platform influences who tends to use the FRC and the range of activities available on site. For example, when school district Healthy Start FRCs begin to implement early childhood activities, they usually focus on 3 and 4-year-old children and on parent education programs, which are extensions of their activities for school-age children to a younger population. Although there are Healthy Start sites that have home visiting programs for infants, they did not begin with that activity.

"Stand-alone" centers are often independent community-based organizations with a specific charter to improve access to multiple services through integration and coordination of local and regional service agencies. Funding is obtained from private foundation grants, local fund-raising, key community supporters, and local service providers. Often they started with a single core service mission (e.g., food, volunteer service, health promotion) and evolved into a broader service provider/referral point in response to the needs of their initial population.

School-based or school-linked centers are usually operations of the school and district and may have developed from grant programs such as Healthy Start, Even Start, and Perkins Act, from expansion of high school health clinics or from special education activities. Services are often focused on the children and families in the school or neighborhood.[5] School districts most easily expand FRC activities to younger children in four ways:

- They reach back to preschool children in the years prior to kindergarten.
- They expand and reorganize special education activities for children 0-4 years old.
- They provide education to the parents of young children through school district adult schools.
- They allow younger siblings of children in school to use school district health and social services.

The National Institute on Early Childhood Development and Education and the U.S. Department of Education published School Involvement in Early Childhood in July 2000. The document provides a national overview of school activities to support young children and families. Contact the U.S. Department of Education, ED Pubs, PO Box 1398, Jessup, MD, 20794-1398, (877) 433-7827.

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A major advantage of using schools as the platform for activities for young children is their presence in every neighborhood. Barriers to the success of such school-based programs frequently include lack of space and limited experience with infants.

The Family Resource Center at Elizabeth Learning Center
Cudahy, California

The family resource center at Elizabeth Learning Center in Cudahy, California is noted for its efforts to restructure and integrate school and community resources to improve the lives of children and their families. The center is a pre-K through 12th grade Los Angeles Unified School District (LAUSD) school located in the city of Cudahy, serving over 3,000 students.[6] Cudahy, one of the most densely populated cities in California, is also one of the most economically disadvantaged cities in the nation. In 1992, with funding by the New American Schools Design Corporation, Elizabeth Learning Center became the first site implemented by the Urban Learning Centers reform project.

Through key collaborative partnerships, including St. Francis Medical Center; California State University, Dominguez Hills (CSUDH); the Los Angeles Educational Partnership (LAEP); LAUSD; and the University of California, Los Angeles (UCLA), EFR is working to achieve a true system of integrated services. EFR is rooted in localized, collaborative decision making and accountability within the school community, particularly with respect to organization, management, staffing, budget, and curriculum and outreach activities.

One focus has been on programs and services for young children. Early childhood classes include a child care cooperative, four Head Start Classes, four State Preschool Classes, four LAUSD Preschool Classes (funded out of district integration funds), and an Early Literacy Program for children aged 3 and their parents.

The Family Resource Center provides health care services (including pediatric care, ob/gyn services, well child check-ups, immunizations, and other episodic care), mental health services, and access to 26 adult education programs during the day, evening, and on Saturdays. Other programs for families with young children include: Early Family Literacy and multiple parenting and child development programs. Families using the cooperative child care participate in a mandatory weekly parenting program.

The school-based health clinic receives Medi-Cal reimbursement, Children's Health and Disability Prevention (CHDP) funding, some insurance reimbursement, and a sliding-scale cash payment option, and St. Francis Medical Center underwrites some of the cost for those who are not covered by insurance and lack funds to pay for services. St. Francis Medical Center employs all clinic staff.

Mental health and community outreach activities, based in the Family Center, are provided using school Title I funds, district general funds, and university support. Interns from CSUDH; California State University, Los Angeles; and the University of Southern California provide much of the direct services. The city and a local community organization provide additional parenting classes and support groups.

Early childhood education is provided by the school district integration funds, a volunteer parent-operated childcare cooperative, Head Start funding, and the state preschool program.

Adult education, including parent education, is funded through the LAUSD adult school division funds with monies received for average daily attendance. Community organizations hold additional classes in citizenship and Spanish literacy. Parents and community members also organize their own classes in knitting, sewing and aerobics. Parents who use the on-site child care cooperative must attend weekly parenting classes. Parent advocacy-training classes and a follow-up support group are also provided onsite by community groups.

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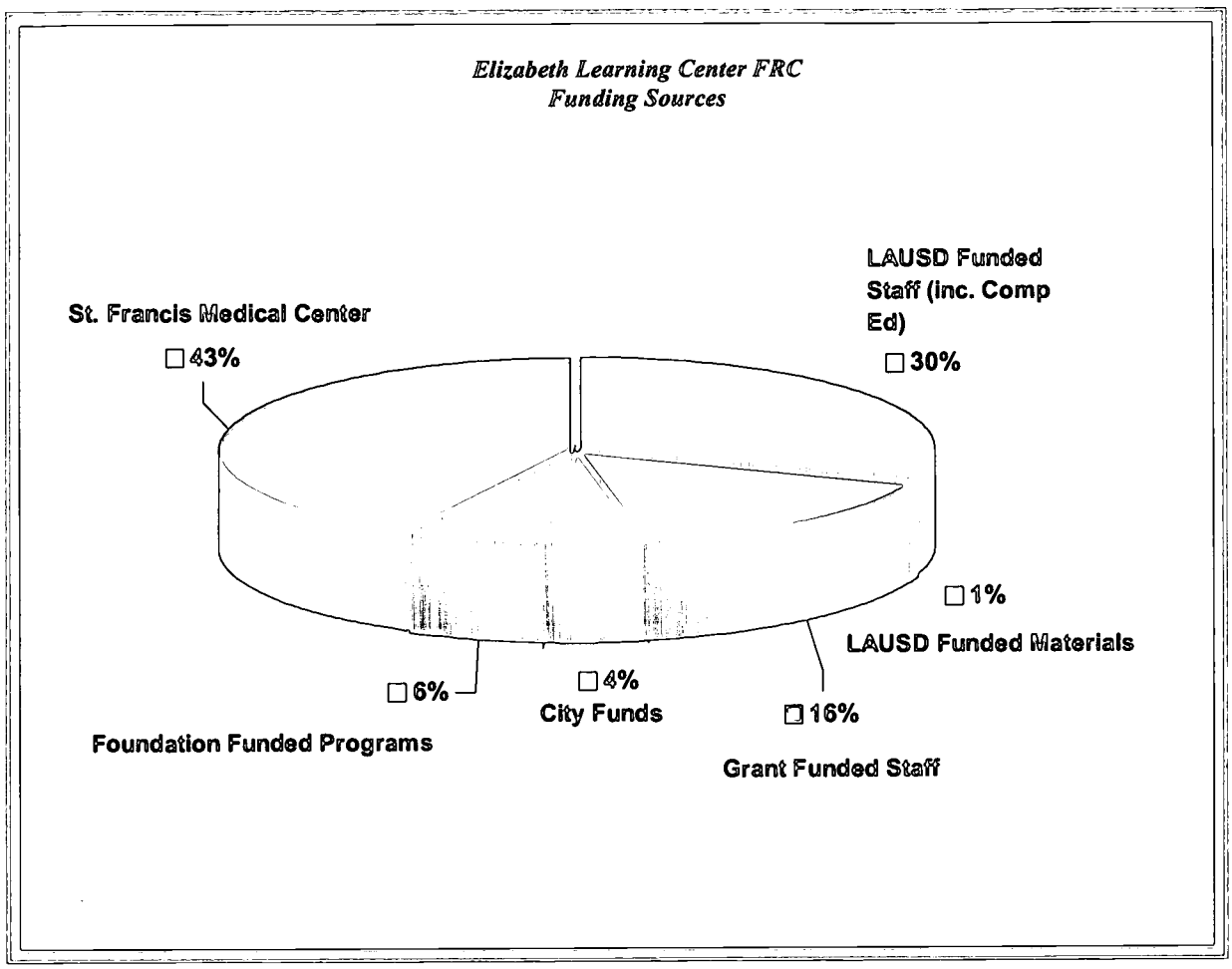

Provider-linked centers are logical extensions of a provider mission intended to improve access to provider services, extend market presence, or diminish the need for long-term provider services through early intervention, prevention, and access to other services that ultimately help reduce the need for the primary service. Funding and in-kind services are often provided by agencies sharing the same interest. Examples include health centers, hospitals, and mental health center-based operations. FRCs at birth hospitals have the potential to reach the majority of infants at the youngest ages and provide ongoing support to the family over time.

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The Hope Street Family Center
Los Angeles, California

The Hope Street Family Center provides comprehensive child development and family support services for over 400 low-income, at-risk infants, children and families residing in the Pico-Union/Westlake, Central, and South-Central Los Angeles communities. Located on the grounds of California Hospital Medical Center, the Hope Street Family Center was a collaborative design effort between the medical center and the University of California, Los Angeles, which now organizes multiple activities from many agencies and groups.[7] The center is part of a national effort to support young children and families by offering services that enhance children's intellectual, social-emotional, and physical development while also strengthening family stability and social and economic self-sufficiency. Hope Street psychologists, nurses, physicians, early childhood educators, and other professionals work in collaboration with a wide variety of community-based agencies, parents, and a broad-based community advisory board. Core services include case management, child development, health care, parent education/support/vocational training, and youth services.

Home Visits: Each family enrolled in the center is assigned a family service coordinator who works with family members on goal setting and assists with securing needed services. Home visits also provide a forum for individualized parenting education and child development-related activities.

Early Childhood Education: All Hope Street children, ages 0-3 years, participate in in-home early childhood education activities. Additionally, parents and children have the opportunity to participate in The Children's Place/Sala de Niños, two fully renovated classrooms where staff provide half-day early childhood education activities.

Child Care: Licensed child care for up to 42 infants, toddlers, and preschool aged youngsters is provided to enable parents to participate in program components, attend school, or work. In most cases, funding is subsidized through collaborative arrangements with community agencies. For parents who prefer family day care, Hope Street has developed a network of licensed family child care homes.

Child Development Screening and Assessment: Ongoing child development assessments are provided for all enrolled children and their siblings, with referrals for early intervention services.

Medical and Dental Services: All family members receive assistance in securing preventive and primary health care, including prenatal care, well-child care, dental care, and immunizations.

Mental Health Services: Mental health services are provided either by licensed Hope Street staff or referral to other local service providers. Other family members also receive counseling on how to cope with substance abuse-related turmoil and violence within the family environment.

Parenting Classes: Hope Street offers a series of on-site parenting classes open to center parents, California Hospital Medical Center staff, patients, and the larger community. In addition, the Hope Street Parent Council meets on a monthly basis, incorporating workshops on leadership, family development, parenting, and communications.

Adult Education/Vocational Training: Hope Street family members receive adult education (including adult basic education, ESL, and GED programs) and vocational training through collaborative agreements with Abram Friedman Occupational Center and Central Adult High School, among others.

Job Placement: Through collaborative arrangements with local employment/job cooperative agencies serving low-income clients, Hope Street staff help families develop job-search skills and obtain job placements.

Youth Services: Activities include tutoring, mentoring, after school programs, weekend recreation, summer camps, and a continuation high school class from the Los Angeles Unified School District.

Municipality/Community-sponsored centers are often extensions of city government and exist to

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serve a broad cross-section of community residents of all ages. While the local government may provide substantial funding, these centers are often collaborative in nature and receive both funds and in-kind support from other community agencies or groups. It is not unusual to find a high level of community volunteer participation at such centers.

Baldwin Park Family Service Center
Baldwin Park, California

The Family Service Center in Baldwin Park, California, opened in 1997, is a classic example of a community/municipality-sponsored center. Baldwin Park is a sprawling, predominantly Hispanic community of 80,000 people located about 20 miles east of the City of Los Angeles. It has a broad mix of commercial, industrial, residential, and retail areas. By most demographic and social standards, Baldwin Park is a "high-need" community but with promising potential. The center's mission is to provide a central facility where residents can find direct and referral services to help them "overcome life's daily challenges, achieve educational goals, and improve their quality of life."

Driven by the view that "if you build it, they (service providers) will come," Baldwin Park provided a spacious, newly refurbished building of over 3,000 square feet in the city's centrally located municipal center complex and park. With free space in the center available to providers, a wide variety of large and small service agencies have gravitated to the center to provide direct services on site or to set up referral centers. As the site of numerous community fairs, concerts, celebrations, and the Senior Center, and fed by the city's free bus system, the center draws a broad mix of families and individuals from all socioeconomic groups. The center also has established links with the school district, area churches, and both county and private medical providers. The one full-time and four part-time center staff members serve 3,500 individuals yearly.

In addition to assisting with basic needs (food, clothing, shelter, transit), the center offers case management, medical care, counseling, education, community outreach, immigration, computer training, and job training services on site. Youth Literacy and Book Exchange, Student Tutoring, Community Outreach, and Academic Mentoring programs operate weekly in partnership with city schools. Each week, Kids Kare-A-Van from Citrus Valley Medical Center visits the site for a day to provide free immunization and primary care services for young children. Various agencies offer a variety of free or low-cost counseling and support programs or classes.

The center typically operates on an annual budget of about $100,000, 75% of which comes from the city's General Fund. The balance is provided by a variety of major service providers (such as Citrus Valley Health Partners and Kaiser Permanente), the Family Resource Center Collaborative, and grants from foundation and private sources.

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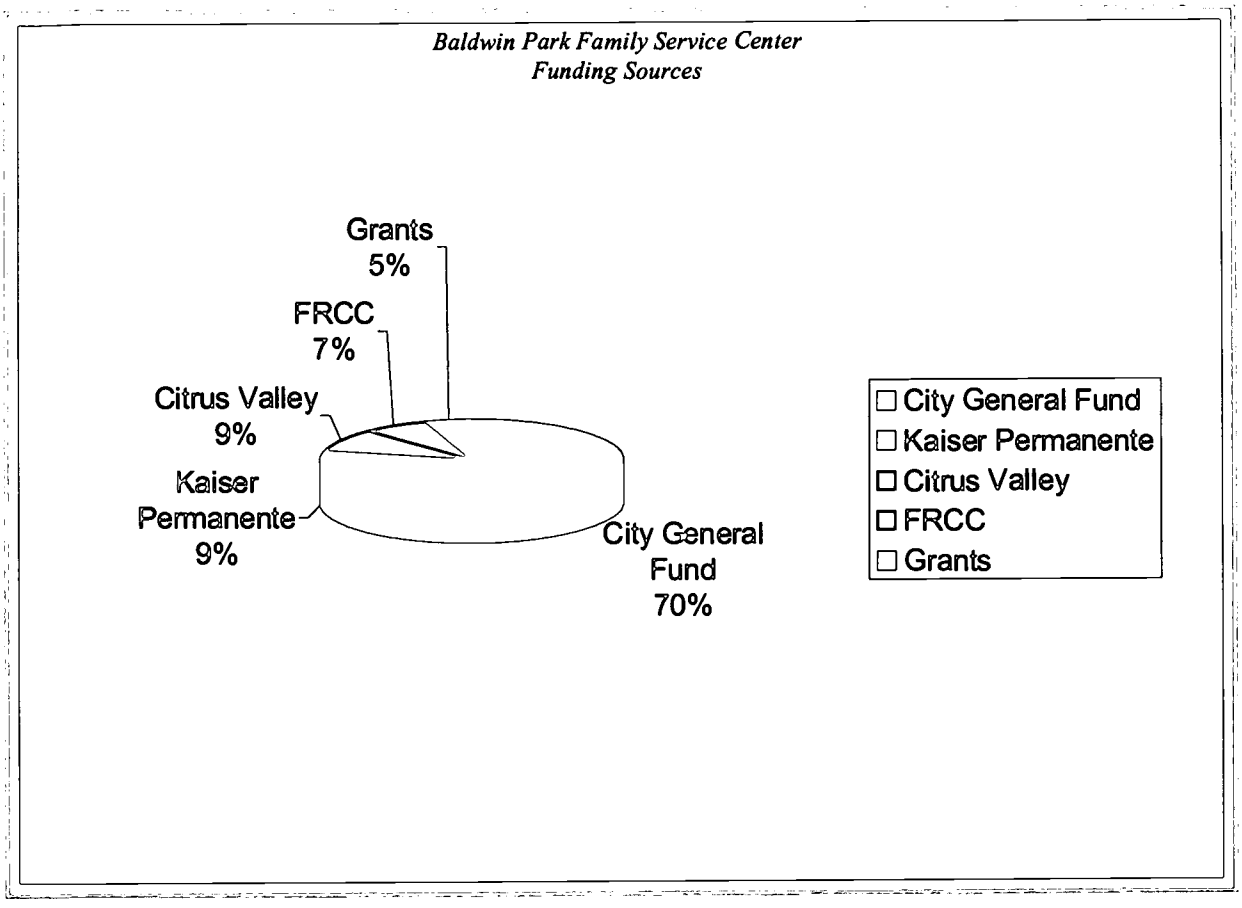

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Community-based centers focus on one or more specific common interests/needs of the community.

CalWORKs Mutual Assistance Network
Del Paso Heights, California

The Mutual Assistance Network (MAN) of Del Paso Heights, California, has shown a consistent commitment to building partnerships with organizations and individuals to become a change agent in an emerging community system working towards providing services to all residents.[8] Del Paso Heights is a high-risk community in North Sacramento characterized by high reliance on TANF, a violent crime rate that is nearly twice as high as that of Sacramento County, a rate of child abuse cases almost double that of the county at large, and a low number of jobs per residents. In 1992 the Sacramento County Department of Human Assistance developed a plan to consolidate and localize the many scattered programs into integrated neighborhood centers. MAN became an official non-profit organization in 1994.

The MAN organization attempts to 1) expand commercial, financial, and employment opportunities in the community; 2) improve physical and public safety and social conditions; 3) build self-help and mutual assistance programs; and 4) promote and operate programs, businesses, and other activities to achieve these goals.

Mutual Assistance Network services include the Block Grandparent Program that provides in-home visitation services; various support groups targeting grandparents, parents, and youth; the Youth Wellness Village to improve community health; Operation Graduation, which provides low-achieving students with social, emotional, and academic support; and a Welfare Reform Program targeted at the high number of adults in the CalWORKs program. There is also a child care training program to increase the amount of licensed child care spaces available in the area and to ease the transition of welfare recipients from dependence on government assistance to self-sufficiency. This program provides both jobs and support for families entering the workforce. Services include help with transportation, child care, budgeting, and time management, as well as the one-stop job and career center. MAN has a five-year contract with the Sacramento County Department of Health and Human Services that funds a program for mothers and their infants through age 5. Their contract with the Department of Human Assistance funds a job developer and welfare-to-work activities. Their third public funder is the Sacramento Employment Training Agency, which administers the Workforce Investment Act and the local one-stop centers. They have several private grants through local, state, and national foundations. These foundations include the Cowell Foundation, The California Endowment, California Works for Better Health (a Rockefeller Foundation project), the Sacramento Regional Foundation, the California Wellness Foundation, and the United Way.

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Common Need or Interest Family Resource Centers exist to serve the needs of a specific population. FRCs that specialize in a specific area of interest or need tend to serve much larger geographic areas, have greater depth of activities related to the area of need, and may have a narrower range of activities unrelated to the areas of primary interest. Some have the capacity to provide other agencies with technical assistance in their area of expertise, as well as support to families and children. Most receive targeted funding in the interest area. Examples of specialized centers include those focused on young children with disabilities, prevention of child abuse, and many FRCs related to CalWORKs implementation.

The Exceptional Family Support, Education and Advocacy Center

The Exceptional Family Support, Education, and Advocacy Center (SEA Center) is a designated California Family Resource Center and a federally funded Parent Training and Information Center serving children with special needs and their families in northern California.[9] It is one of nine such centers in California and one of 70 in the United States. Parent Training and Information Centers, with funding from the U.S. Department of Education, provide training in special education law, primarily the IDEA, and practices in order to help parents better advocate for their children's educational needs.

The SEA Center, opened in 1995, is a non-profit organization supported by grants, donations, and fundraising activities. It developed out of the Family Resource Network program established in 1989.[10] The state had just implemented the Early Start program that mandated intervention services for infants and toddlers, birth to age 3, with special needs. The State-funded Family Resource Center system was a product of this legislation. The center has a Family Resource Network that provides services to families with children zero to three who have been diagnosed with a disability or are at risk of developing a developmental disability as a result of certain risk factors. Services are provided to all of the nine counties served by the Far Northern Regional Center: Butte, Glenn, Tehama, Shasta, Trinity, Plumas, Lassen, Modoc, and Siskiyou. Services offered include First Connections, which matches new parents with experienced parents to provide support and information; Welcome Packets that provide information about the center, other helpful organizations, and articles on raising children with special needs; and Disability Packets that provide specialized information on a particular disability. The center also maintains a lending library and a referral system to connect families to valuable local, national, and international organizations.

The SEA Center's budget for FY 00-01 to date is approximately $246,000. Their primary funding sources are:

- The California Department of Developmental Services -- from Part C Family Resource Network, under the Early Start program (infants and toddlers with disabilities, birth to age 3).
- US Department of Education, Office of Special Education and Rehabilitative Services-- Parent Training and Information grant, to support and train parents of children receiving special education, birth to age 22.
- Far Northern Regional Center -- funding specialized activities and for parent scholarships so that parents can attend conferences.
- Sonoma State University (CalSTAT project) -- funding for 3 trainings including a Fiesta Educativa and to expand a Mentor Parent volunteer program.
- California Telehealth Foundation -- funding for an on-line computer for parental use to research medical conditions; also funds for training on how to use the Internet to obtain such information.

The SEA Center also participates in several collaborative projects, including Family Voices of California, a grassroots collaboration helping parents of children with health care issues to navigate health systems, including insurance, public health, SSI, and Medi-Cal. The center has numerous local partners who assist in securing funding and supporting their projects.

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III. Are Family Resource Centers Needed?

There are many compelling examples of the need for comprehensive, coordinated family support service programs or family resource centers.

- ***Young children and their families face numerous challenges.***

The Carnegie Corporation of New York noted that in 1993, almost half of infants and toddlers started life at a disadvantage and lacked the supports necessary to grow and thrive.[11] Changes in family structure, increasing numbers of working parents, more children living in poverty, more children in foster homes, discouraging health data, and rising rates of abuse/neglect/unintentional injury speak powerfully of the need for a focus on the conditions for our youngest children.

The pre-school years are a period of elevated vulnerability.[12] Poverty conditions during the first 5 years of life have been shown to be far more detrimental to completed years of schooling than later poverty. Persistent poverty has detrimental effects on IQ, school achievement, and socioemotional functioning. It is associated with higher rates of perinatal complications, reduced access to resources that mitigate the negative effects of these complications, and less home-based cognitive stimulation.

Poverty among families with children between birth and age 5 is also associated with lack of school-readiness, which is a strong indicator of future low levels of academic achievement and elevated school dropout.[13] The same children who are not ready for school entry are at higher risk for unemployment, social dependence, teen pregnancy, and poor parenting practices later in life, leading to an intergenerational pattern of disadvantage.

- ***Many existing programs and services are not family-friendly or accessible.***

There is a need to improve the lives of families with young children by helping them overcome a "disempowering, fragmenting, and confusing" system of social and developmental services.[14] The human services environment has been described as a system of overlapping or conflicting eligibility requirements with a complicated web of rules and regulations overseen by a bewildering array of seemingly autonomous bureaucracies. Furthermore, our social service systems are too complicated for the average user to navigate in a timely and effective fashion.[15]

There is obvious merit to situating intake and service delivery closer to the user of those services. The essence of an FRC is the pursuit of enhanced access to services for improved development with shared resources through collaboration.[16] Family resource programs are unlike traditional human service programs in that they are far less bureaucratic, holistic in orientation, and typically provide a range of services in the same nearby setting.[17] A review of various domestic and international family support movements noted that the common element of most family support initiatives or programs was an FRC.[18]

Locating services near areas of need and having access to venues like schools could improve use of key services. Having access to a school-based health center, for example, reduces barriers to health care access. One evaluation showed that children were twice as likely to visit a physician and had a 1.4 times greater likelihood of obtaining both routine dental exams and mental health services in the past year.[19]

- *Many existing programs and services are uncoordinated and fragmented.*

The emergence and potential value of integrated primary youth and family services as a cohesive, community-based infrastructure has been noted in the literature.[20] (Here primary services refer to those that address broad developmental outcomes rather than specialized problems.) The Children's Defense Fund recommends that all sources of child care and early education ensure that children have access to comprehensive services and that parents receive education and support services.[21] Yet most of the programs to promote the well-being of our children have been distinct and categorical, targeting particular populations, addressing specific needs, and being allocated to a limited number of providers. Throughout the last two decades the number of federally funded categorical programs for children's services has grown tremendously. Between 1980 and 1994 this number grew from 300 to nearly 500 programs.[22]

Categorical programs, which allow an immediate and acute response to emerging problems, often prove detrimental to the effectiveness of services. This is because categorical programs are typically small in scale, are narrowly focused on a single target group, and differ in eligibility rules and provider participation. [23] Accountability standards also vary tremendously, making it difficult to coordinate multiple programs under single governance. Because categorical funding applies only to specific problems and disorders within narrowly targeted populations, collaboration with other categorical services is often too complicated to attempt. Because of a lack of collaboration between categorical programs and provider agencies, support is provided on a piecemeal basis, leading to duplication and fragmentation of services.[24] For children, youth, and families with multiple and complex needs that require the use of several agencies and providers, the lack of coordination is a key barrier to receiving comprehensive care.

IV. Are Family Resource Centers Effective?

There is a long-standing concern about the scarcity of effective methods for determining the efficacy of family resource centers and other similar programs.[25] This is an area where the commissions can have significant influence by investing funds in the development and application of evaluation tools, and encouraging additional research. Some experts now agree that combined qualitative and quantitative findings demonstrate that some FRCs can be very effective in improving educational and civic performance. Significant positive relationships have been found between the degree of implementation and school-based family resource center outcomes as determined by the proportion of students who improved on pre-post teacher ratings.[26]

An evaluation of one school-linked FRC demonstrated statistically significant improvement in both

mean grade point average (GPA) and citizenship grades in a population of 223 elementary students using the FRC services and activities.[27] Students were followed for four semesters. Students who participated in more FRC services and activities generally demonstrated greater improvement. Children with lower GPAs and classified as low achievers demonstrated more significant improvement than the total group.

Children receiving interventions, including those that are center-based with trained staff who work directly with children providing direct educational experiences, show larger and more enduring benefits.[28] A combination of daily center-based intervention with weekly parent-oriented home visits resulted in significant cognitive gains for children.

Furthermore, it appears from these evaluations that attributes such as comprehensiveness, sensitivity to family context, and neighborhood and community involvement are crucial to long-term program effectiveness.[29] The well-being of children and that of families and communities are inseparable.

V. Attributes and Core Competencies of Family Resource Centers

A survey of FRCs and other initiatives working toward enhanced access to services for children and families seems to point toward 13 common attributes, or core competencies, that are deemed crucial to success.[30]

1. **Strategic Planning Process.** Strategic planning is easy to do and is the foundation for long-term success. Done properly, it systematically takes stakeholders through a structured process that encourages dialogue on key issues and leads to planned actions. The local community should be engaged in the design, implementation, and evaluation of programs for children and families.[31] This empowers the community and enhances the effectiveness of the program.

2. **Sustainability Planning.** Some centers have statutory funding streams that sustain them for long periods. Many initiatives, such as Healthy Start, are initially grant-funded for several years and must eventually become self-sustaining. The rush to "open the doors" and "show results" (deliver services) often leads to ineffective long-term planning for sustainability. Sustainability planning and action should be a key component of a sound strategic plan.

3. **Efficiency.** This refers to both service delivery and center/provider operations. Eliminating duplication in services offered and in administrative aspects of service delivery can preserve the precious resources of the service delivery agency for additional users and help eliminate unnecessary administrative costs associated with fragmented or duplicative intake, assessment, scheduling, overhead, etc.

4. **Effectiveness.** This refers to an FRC's ability to improve access to services and to be able to document its outcomes in ways that permit evaluation and accountability. A large gap exists in both literature and practice concerning outcomes and effectiveness. Even "successful" centers may be unable to provide evidence-based demonstration that the resources used have delivered demonstrable

results, or in a predictable manner. Anticipating that outcomes often take significant time to develop, FRCs should develop evaluation methods that permit showing interim success. Including the mechanism to conduct evaluation should be an integral component of the strategic planning process.

5. Empowerment. In one sense, empowerment refers to a conscious effort to provide users with the knowledge, tools, and coaching to enable them to take more responsibility for their own lives. In another, it refers to the philosophy and environment that permits users and other stakeholders to participate in the planning and operation of local agencies and groups. In this sense, empowerment is an element of community or neighborhood transformation that extends beyond services to economic development and investment in improved quality of life.

6. Trust Relationships. Such relationships are frequently described as the bedrock for development of an effective center. Development of trust is critical not only with users of center services, but also among the FRC's collaborators and stakeholders.

7. Training. Staffs that are trained in both subject matter (particular services) and also center operations are generally found at more successful centers. Such training can establish expectations for the type, responsiveness, and quality of the service that the staff is expected to deliver. Managerial, supervisory, and facilitation training can help accomplish the effectiveness, efficiency, and empowerment attributes and goals.

8. Community and/or neighborhood Focus. The FRC can be used as an elemental component of community transformation and can attract local ownership and participation in community improvement.

9. Context. Children are served in the context of their family and community. Centers see the individual child in a framework of the family system, the family needs, and their community. Providing support for the entire family can accelerate development of an improved environment for the child and the capacity for family self-sufficiency.

10. Comprehensiveness. This applies to both the degree of service support and also the nature of the operation itself. Effective FRCs strive to include as many key direct and support services as possible (the "one-stop" concept). But they might also strive for comprehensiveness in design, collaboration, stakeholder involvement, education, and economic development.

11. Collaboration. The degree and nature of collaboration are important to both center expectations and outcomes. Broad collaboratives of providers and stakeholders provide multi-level stability, depth of input, diversity, greater opportunity for empowerment, and breadth of commitment that can both enrich and sustain centers.

12. Competence. This refers to both the capabilities of the staff and the degree of commitment demonstrated to the success of the center. Competent, committed individuals should have clearly

defined skills and the training to succeed in service delivery and contribute to the center's success.[32]

13. Developmental Focus. Activities that are organized for young children should be based on both each child's cognitive and emotional level and on the primary influences on children of different ages. For example, programs for infants need to be oriented toward parenting skills and the home. As children become older, additional support must focus on child care provider skills and later on the growing toddler him/herself.

VI. Experience with Family Resource Centers in Other States

Nationally, major family support initiatives have appeared in Kentucky, Colorado, Hawaii, West Virginia, Minnesota, Vermont, Ohio, Michigan, Maryland and elsewhere. These state initiatives are important to examine because they suggest the role and benefit of statewide organization, innovation and financing in improvement of family support.

Each of the examples below is different in its approach, but all include a plan for statewide organization and partial financial support of these efforts.[33, 34, 35, 36] Although often driven by different issues (education reform, social services reform, community development, etc.), they usually call for center-based enhanced access to direct and support services, with the goal of improving the ability of young children, families and communities to function more fully.

Kentucky

Kentucky was one of the first states to implement FRCs on a large scale. Over 500 Youth and Family Centers were established as a direct result of the Kentucky Education Reform Act (KERA) of 1995, intended to correct or overcome some inequities in the educational system.[37, 38] Funding for the centers is provided by annual grants from the Kentucky Cabinet of Human Resources Funding at a rate of $200 for each child eligible for free meals, although services may be used by anyone in the community regardless of income. The act addressed reasons why students were not learning at planned rates, and addressed concerns such as health problems, family dysfunction, substance abuse, and poor parenting skills. Although FRCs were located in or near schools where at least 20% of the students qualified for free or reduced cost school meals, they are open to the community and have organized activities for infants, young children and families. The centers are comprehensive and intensive by design and include preschool education services and full-time child care. Families expecting children or who have very young children can receive basic obstetrical and pediatric health services at the centers, in addition to parenting skills classes. The centers provide referrals for mental health counseling, employment assistance, and substance abuse, as well as other services unique to the needs of the community or school site. Centers are open in governance and are operated by a trained coordinator who functions as a facilitator, integrator, and community liaison.

The Kentucky Family Resource Center evaluation found that, as a result of center services, classroom performance, academic achievement and academic proficiency improved at the elementary

level. At both the elementary and secondary levels, the data demonstrated an increase in the students' perceived amount of positive change, especially in terms of their ability to complete class work and homework, following directions, obeying rules, and remaining on task. Peer relationships also showed positive improvement.

The Kentucky experience is of interest to the Proposition 10 effort because it is a large-scale example of:

- The use of state legislation as an impetus to large-scale change.
- Centers that serve all families with all ages of children without any income or other requirements, even though the funding is based on family income.
- The use of schools as the agency focus in the effort to provide developmental services for very young children, including child care.

Hawaii

The seven Parental Information and Resource Centers (PIRCs) in Hawaii are one result of 1997 legislation which created new funding through a public-private partnership designed to help organize and expand early childhood activities.[39] PIRCs are interested in promoting parenting and family skills, volunteering, learning at home, building academic partnerships between schools and home, and establishing collaborations among community entities.[40] PIRCs are led by Parents and Children Together (PACT), a private, non-profit, family service agency recognized as a leader in the design and delivery of innovative social and educational programs. PACT focuses on early childhood education, child abuse and domestic violence prevention, mental health support, and community building.

The PIRC at Kuhio Park Terrace is run primarily by community members and is dedicated to connecting people with community resources. Neighborhood residents volunteer time to the center, and the center structure fosters a sense of ownership, autonomy, and being at ease when seeking services. In addition to early education support services, this center offers unique, community-specific activities.

The PIRC at the Kaneohe Community Family Center is a school-based center focused on promoting the academic success of community children. A broad range of family support services is available in addition to early education support. Families are encouraged to work together to incorporate literacy activities into their daily lives. The center serves as a community liaison between parents and their children's schools.

The effort in Hawaii is of interest to those working on these issues in California because these centers emerged using several different types of public and private lead agencies as platforms, with design support provided by the State in the form of statewide planning and organization of services.

Their example may be instructive of the need for organized technical support and information sharing for both Family Resource Center and other early childhood efforts.

Colorado

In the late 1980s Colorado established two initiatives (Bright Beginnings and First Impressions) to promote awareness of the importance of the first 5 years of life and to ensure that every Colorado child had access to health care and quality child care.[41] Those initiatives placed 16 family centers in communities that were at risk for poor family health and failure. In 1994, the state funded an additional 40 centers. These centers can be found in schools, churches, community centers, and malls. They address community issues such as maternal and child health, early childhood care, parent education, family literacy, coordination of community resources, and designing programs to address service gaps.

The Colorado Parent Information and Resource Center (CPIRC), funded by the Clayton Foundation of Colorado, was created to help families and schools work together to ensure the success of children. CPIRC consists of a network of statewide agencies and community organizations that represent urban and rural communities. Participating centers provide many of the same services as other FRCs with regard to accessing resources and support service. Additionally, they work to increase parent participation in schools by helping parents develop leadership skills and preparing educators for more parent involvement in the classroom.

Colorado is interesting both because of the success of its innovative early childhood programs and the effort to create a network of similar community organizations. We believe that the need for a mechanism for FRCs to network together, obtain technical assistance, and access training and support is critical to improvement of the quality and quantity of local FRCs. The same issues appear to be critical to the development of higher-quality child care and other programs as well. One place to start to examine the work in Colorado would be to access their website http://www.frca.org/fsa_states/ fsa_co.htm.

VII. Financing Family Resource Centers

The examples cited above from other states have in common that they were all organized as statewide efforts. Many FRCs in California operate independently and draw together funding from multiple sources to fund their activities. (Examples of funding sources are given in Appendix B.) In these cases, the funding is tracked and organized at the center, which must organize and account for all of the funding sources and their contradictory requirements. This makes it difficult for many of these centers to maintain stable funding over time. The task of applying for funds, linking each service provided with the appropriate funding stream and, finally, providing each funder with a tailored annual (or quarterly) report, requires each center to have significant expertise in "back office brokering" and fundraising. Restrictions placed on the use of funds and reporting requirements are meant to ensure that target populations are served and that agencies receiving funds are held

accountable, yet the burden placed on agencies may actually restrict the number of services that they are able to offer.

Family resource centers frequently have difficulty paying for, and therefore conducting:

- Center management and supervision;
- Expertise in the details of all of the available funding streams;
- Comprehensive evaluations;
- Staff training;
- County contract negotiation; and
- Inter-center organization.

The Finance Project in Washington D.C. and Carnegie Corporation of New York published Financing Family Resource Centers: A Guide to Sources and Strategies in April 2000. It provides an excellent overview of finance strategies and option. Contact the Finance Project, 1000 Vermont Ave. NW Suite 600, Washington, D.C. 20005, (202) 628-4200, www.financeproject.org

If Proposition 10 commissions wish to encourage the development and sustainability of FRCs as service delivery platforms, they might consider how to provide technical assistance and funding in these areas.[42]

As pointed out in the Attributes and Core Competencies section, sustainability is a crucial component of success. Another dimension of financing is to encourage thinking about sustainability in different, and perhaps more entrepreneurial, ways. Many FRCs are often funded through grants. Sustainability may be difficult if the grame of reference is limited to grant funding since grants are fixed and finite. As a part of a technical assistance effort, research might be considered on the existing range of methods of financing FRCs. A few FRCs have been reported to have reduced their reliance on grant funding by developing an internally generated or renewable funding source (an "economic engine") that sustains the center.[43] For example, there are FRCs in California that use their community outreach capabilities and programs as engines of self-sufficiency by charging others for the use of it. Under this dual-use approach, utilities, non-profit hospitals, marketing firms, and others pay commercial fees for FRCs to do marketing, education, and enrollment for them. Other examples include centers that run small business enterprises whose profits provide another funding stream for the center. Providing FRCs with an incentive and the ability to conceptualize/develop their own "economic engines" can reduce the long-term demand for Proposition 10 and other funds, can buffer against year-to-year funding fluctuations or interruptions, and can provide incremental funds for additional services.

VIII. Recommendations

The following recommendations have been developed with the assistance of many groups of FRC management/staff, policymakers, academicians, and users of family resource centers. They are not intended as "stand-alone" actions, but rather to support the creation of an integrated system of information and services in support of the needs of families and young children. They are categorized into subheadings of design/evaluation, funding, practice, and policy.

Design and Evaluation

1. **Create economies of scale and administrative streamlining.** Develop within a community, school district, region, or county a central purchasing system to create economies of scale. Groups of FRCs can then use this system to purchase equipment at a better rate. This would save time as single applications or reports could be filed on behalf of multiple sites.

2. **Develop a billing system.** A single "master contract" system, with participation of county government and local Proposition commissions, would facilitate integration of multiple funding streams and permit a simpler billing process with a single administrative procedure.

3. **Encourage an integrated information system.** Advocate for and fund, if necessary, the development of a standardized computer-based case management and outcome tracking system, linking data from community-based organizations, FRCs, and the county. It would organize support for individual families and provide a basis for comparative evaluation of results and determination of funding priorities.

4. **Develop evaluation tools.** Provide for the development of one or more simple outcome evaluation tools and templates to permit FRCs to more efficiently and effectively determine their impact on a continuous basis. Those tools and templates would both help focus on-going efforts as well as to permit faster and more effective start-up.

5. **Require evaluation.** Require FRCs to use an outcomes evaluation tool or template that permits both effectiveness evaluation of individual FRCs and comparison of multiple FRCs on a fair, consistent basis. Encourage use of baseline evaluations and continuing evaluation.

6. **Encourage sustainability planning.** Encourage sustainability planning as a standard component of FRC planning and operation. Long-term sustainability of FRCs (and other small community-based organizations) may require the State Commission to dedicate resources to developing the capacity to respond to FRC needs through the provision of technical assistance and tools (see recommendation #10).

Funding

7. **Leverage existing investments.** Develop funding priorities that would maximize use of existing physical and service capacities, and use new investments in ways that draw down monies from other funding sources.

8. **Make existing funds more accessible.** FRC personnel need training to help them access various funding streams, understand restrictions, and meet accountability requirements. Until a more coherent finance system is developed, expanded technical assistance is needed in areas such as health service design, billing systems, fiscal planning, risk management, marketing, and evaluation. Experts should be solicited from multiple fields to assist with such issues. In the long-term, policy initiatives are needed to achieve more flexible finance systems.

9. **Encourage matching.** Provide for incentive or incremental funding allocations for those FRCs that can obtain significant matching funds from other sources that move FRCs toward the blended funding model. The blended funding model stimulates integration, breaks down categorical barriers, minimizes duplicative administrative costs, and helps ensure sustainability.

Practice

10. **Provide technical assistance and tools.** The development of competent sources of research-based best practice, technical assistance and tools, in areas such as program development, finance, sustainability and evaluation, is critical to the long-term improvement of agency support for children and families.

11. **Develop expertise.** Provide for a pragmatic "institute" dedicated to teaching the stakeholders the basic skills needed for successful FRC development and operation. Those skills should include planning, facilitation, funding development, basic business management, supervision, program management, community integration and development, cultural competency, and collaboration.

12. **Improve local leadership.** Encourage and fund the growth of forums for developing community leaders, such as The Institute for Community Leadership in Los Angeles. Understanding the principles and practice of leadership in community integration and transformation is crucial to improving support for young children and their families.

13. **Encourage community outreach.** Through FRCs, fund community outreach initiatives that directly contact families and young children to bring them in touch with the services and programs available at the community and regional level. Such initiatives provide early intervention and education opportunities, as well as community feedback and community member participation.

14. **Promote prevention.** Encourage prevention and health promotion programs. Primary prevention at an early age reduces later intervention costs and helps more children achieve their potential earlier.

15. **Facilitate creation of multi-neighborhood partnerships.** Strong partnerships may be critical to improving county collaboration with local community-based organizations and FRCs, particularly in large counties. Rather than creating partnerships with individual sites, which are difficult to achieve because of limited resources and staffing, counties could facilitate multiple neighborhood partnerships.

Policy

16. **Advocate for family resource centers.** FRCs need to be recognized and included as part of the collaborative system of support called for in the Children and Families Act, and integrated appropriately into the activities of county departments and agencies. They are one viable method for increasing local access to services and integrating activities that support young children.

17. **Support creation of cross-constituency forums.** Call for, and participate in, the creation of new forums and inter-agency frameworks that permit or facilitate executive and policy-level collaboration, planning integration, policy development, and resource pooling and allocation among community, county and regional entities.

18. **Encourage use of FRCs as community integration points.** Consider using FRCs as community integration points for all Proposition-10 funded initiatives. Commissions can establish a basis for increased integration, access, synergy, and leverage by requiring that Proposition 10-funded initiatives coordinate with, and receive the active endorsement of, local FRCs.

19. **Stimulate links with counties and schools.** Encourage establishment of long-term links between FRCs, school districts, categorical programs such as Healthy Start or Early Start, and county agencies to permit FRCs to more effectively utilize public and private sources of funds. School and county resources can provide the means to sustain a full range of services at FRCs. More formal links can lead to higher levels of service, better service integration and coordination, and reduction in duplicative administrative functions. Policy changes in some states have made it possible for school district FRCs to bill, for example, for services provided to Medicaid eligible students and their families.

20. **Call for personnel certification.** Encourage and fund development of voluntary certification criteria, including continuing education and career development strategies, for professionals and paraprofessionals involved in the development and management of FRCs.

21. **Advocate for service program simplification and integrated access to information.** Advocate for simplifying eligibility/application criteria and documents for service programs at the state level, and for using standardized intake and case management systems at the local level. Additionally, encourage access to integrated information through such means as "warm lines." This would ease the marketing and administrative burden on program staff and increase use of available health and human services.

IX. Appendix A: Web Resources

Abt Associates, Inc.: http://www.abtassoc.com/newsroom/press-releases/pr-welfare-school
Abt Associates, Inc. is an international, research-based consulting company engaged in initiatives including healthcare, child education, and community involvement.

Afterschool.gov: http://www.afterschool.gov/
The goal of this site is to connect interested individuals to federal resources that support children and youth during out-of-school hours. There is a database of federal grant and loan programs, community success stories and network opportunities, and searchable categories like health and safety, learning, research, and technology.

California Center for Health Improvement: http://www.cchi.org/cgi-bin/cchi/default.asp
This site is home to the Prop.10 Technical Assistance Center, a resource for Prop. 10 Commissions. Offerings include promising and effective practices, publications, and links to other health sites.

California Department of Education: http://www.cde.ca.gov/index.html
A source for information on school finance, research and statistics; teaching, learning, and technology information on charter schools and an academic performance index; information on healthy children, youth, and families – family and community and school health connections; and legal and legislative issues, both at the state and federal level. The website is also searchable for other CDE sites.

Carnegie Corporation of New York: http://www.carnegie.org/
The Carnegie Corporation of New York is a charitable foundation geared towards doing "real and permanent good in this world." Education is one of their primary focuses. On this website you will find reports on various issues, such as meeting the needs of young children and community partnerships for children.

Child & Family Policy Center: http://www.cfpciowa.org/
CFPC's mission is to better link research and policy on issues vital to children and families. They provide information on projects of interest in Iowa and nationally.

ChildStats.gov – America's Children 1999: http://childstats.gov/ac1999/toc.asp
Contains data on many areas including population and family characteristics, economic security, health, behavior, and the social environment, education, and indicators of child well being.

Child Trends: http://www.childtrends.org/
Child Trends is a non-profit research organization studying children, youth, and families through research, data collection, and data analysis. They offer publications and information on school readiness, trends in well-being of children, and Welfare-to-Work strategies and their impact on children and families.

CYFERNet – Children, Youth, & Families Education Research Network: http://www.cyfernet.org
CYFERNet provides practical and research-based information on children, youth, parent and family, the community, resources for the professional, a chat room, evaluation, and community projects. There is a section on Community Information that focuses on community development, community asset development and assessment, citizen development, and current issues.

Family Support America: http://www.frca.org
This site focuses on disseminating resources on family support, issues, legislation, and policy. There are links to issues and news, publications, and information on the State Technical Assistance and Training for Effective Systems (STATES) Initiative. This initiative, currently active in eight states works to develop strategies for creating caring communities. There are program descriptions for each state.

The Finance Project: http://www.financeproject.org/
The mission of the Finance Project is to "support decision making that produces and sustains good results for children, families, and communities...develops and disseminates information, knowledge, tools, and technical assistance for improved policies, programs, and financing strategies." The Project website presents information from the Financing Strategies Group on financing education, family and children's services, and community building and development. Information from the Community Systems Group includes comprehensive community issues, especially child care and out-of-school time. The Project also maintains the Welfare Information Network (WIN) with a separate website focusing on broad issues around welfare reform.

The Future of Children: http://www.futureofchildren.org/
The focus of the Future of Children is to disseminate information on child well-being, both through their journal and their website. Each journal issue can be found on the website and is free. Topics include unintentional injury, domestic violence, home visiting, abuse and neglect, child poverty, child care, and special education.

National Child Care Information Center: http://ericps.ed.uiuc.edu/nccic/index.html
This site is a resource that links information and people concerning the child care delivery system.
National Maternal and Child Health Clearinghouse: http://www.nmchc.org/
This site offers a searchable publications catalogue, maternal and child health state resource sheets, forums, and links to other sites.

The Promising Practices Network: http://www.promisingpractices.net/
This website highlights programs and practices that effectively help children, families, and communities. The site is organized around nine result areas: healthy children, children ready for school, children succeeding in school, children safe at home, strong families, self-sufficient families, strong communities and neighborhoods, new forms of governance, and results-based accountability. Benchmarks are given with lists and descriptions of model programs.

UCLA Center for Healthier Children, Families, & Communities: http://healthychild.ucla.edu

The Center is a joint program of the UCLA School of Medicine, Department of Pediatrics, and the School of Public Health. The Center is charged with improving children's opportunities for health and well-being. It is the umbrella for many programs including the Los Angeles County Prenatal and Early Childhood Nurse Home Visitation Project, the National Center for Infancy and Early Childhood Health Policy, the Program for Integrated School and Community Solutions, TIES for Adoption, and the School District Infant and Family Support Program. There is a wealth of information available here on a wide variety of children's issues and links to many other UCLA and non-UCLA resources.

US Department of Education: http://www.ed.gov/news.html
Offers current information on Department of Education programs and initiatives with news on publications, events, speeches, testimony, and letters from the Secretary and senior officers, press releases and statements from the White House. The site also contains research and statistics, funding opportunities, and monthly newsletters highlighting how various communities have improved their schools.

X. Appendix B: Considerations When Starting a Family Resource Center

The following tasks are integral to developing and implementing a family resource center.

◊ CONVENE – It all starts with relationships. Bring together critical stakeholders, including those with the power over resources you will need. Build a broad collaborative of those served, those who serve, and those affected. Include not only providers, but also enablers and influencers. Include community members from the start. Build a strong "web" of those committed to success. Establish a pattern of regularity for meetings and other convenings so that a pattern or expectation is created and a discipline evolves. Identify a small number of "godfather" stakeholders who have the passion, commitment, and resources needed to sustain and stabilize the initiative through slow phases and difficult periods. Get the active buy-in of those served and serving.

◊ COMMUNICATE – Begin to build a "culture of conversation" that encourages and validates open and honest discussion of all the issues. Facilitate open dialogue and encourage the consideration of new and non-traditional ideas and views. Use neutral third parties or professional facilitators initially if needed. Obtain the buy-in and active involvement of those served and affected. Begin to formulate a common vision through communication. Effective communication will permeate and persist for the duration of the initiative. Expectations must be clear and reasonable since each entity operates under different constraints that will affect participation in the collaborative effort.

◊ ARTICULATE A VISION – Agree on a common purpose for your collective actions that permits others to rally to the cause and provides a "hook" or handle for individual stakeholders to latch on to and become part of the whole. This can extend beyond a common purpose to include a vision of how you would like all the parties to behave or be affected and a view of how the FRC would actually operate.

◊ CREATE A CULTURE – Think and act in ways that will create a culture of philosophy, behavior, expectations, process, attitude, and courage to do the right thing. Consider adopting a "virtual" mentality free of need to own physical things or space and certain positions or "turf." That minimizes the anxiety of change and can head off conflict. Operate by principles of openness and inclusion. Establish an air of continuous improvement and egalitarianism. Help all parties understand that you are running a "business," and that a business operates by principles such as efficiency, effectiveness, goals, measurements, and procedural practices. "Doing good" for others does not mean random behavior or indiscriminate use of precious resources that jeopardizes the existence and mission of the enterprise. Embrace a philosophy of inclusion that permits stakeholders to come, go, and return to the collaborative effort as their interests, capacities, and conditions fluctuate.

◊ DEVELOP A STRATEGY – A strategy or enterprise concept is often misunderstood and does not have to be complex or sophisticated to be helpful. A strategy or enterprise concept is an explicit statement of the vision, how the enterprise reacts to its environment. Strategy is the

process of thought leading to WHAT to be or WHERE to be at some future time, and centers around a "driving force" or "reason for being" that provides the means to achieve it. Planning is HOW the entity will act in a tactical sense in order to realize the strategic vision. Strategy can become a "filter" or "screen" which thinking, decisions, and actions have to get through before they are implemented, and can result both in alignment of activities or behaviors within an organization and in efficiencies. Strategy must be "living" because change occurs continuously and a change in any condition that is a component of strategy development can result in a change in expectation, outcome, or success.[44] Strategic success often turns on just a few key factors... things that differentiate you from the others who do what you do, or things that will determine that you will succeed.

◊ PLAN – Establish a process that captures the energies and capacities that emerged in initial communications in the form of frameworks for action and development... things that will become blueprints later. Encourage early action on those things that can be readily addressed and/or are needed immediately so that a sense of action and accomplishment is created quickly to sustain and validate the value of planning. Capture early the issues and tasks that will be critical to long-term success, even if not worked on until later. Include needs assessment, capacity analysis, sustainability planning, determination of desired outcomes, indicators of success, and progress evaluation capability. Ensure that needs and outcomes are linked. Ask critically if there really is a need for the proposed efforts in a given area. Determine and define early those two or three critical factors that success will turn upon and focus energies on those. If those are done well, other factors will fall into place. Ensure that your plan logically moves to your desired outcomes.[45] Commit the plan to paper with detailed priorities, action steps, timelines, and accountabilities so that people can visualize the initiative, their role in it, and see that progress is being made. Establish rules of operation and governance during early planning in order to clarify expectations and provide reference guidelines.

◊ SELECT YOUR "VEHICLE(S)" – Identify a program, grant, or other initiative (a mission, opportunity, need, community program, etc.) that will become the initial rallying point and carrying "vehicle" for your efforts. Examples might include a Healthy Start or other grant or a fundable program that could provide a logical focus and evolutionary vehicle for your collective vision.

◊ SET GOALS AND EXPECTATIONS – Put the vision, strategy, and plan into action by articulating some of the early expectations of the group through a ready, aim, fire process rather than random events and actions. Define the expectations in specific terms so that others may understand them, support them, and agree when they have been achieved. Be prepared to declare victory early and often in order to sustain and invigorate efforts. Also consider specifically when, and for how long, the efforts of certain individuals or groups will be needed.

◊ CREATE A CHANGE PROCESS – Establish early that change is inevitable and can be positive. Change is constant and is an opportunity for learning and improvement. The anxiety that accompanies change can be harnessed for positive purposes if the expectation for change is built in at the beginning. Anticipate change and define when and where feedback, evaluation, and

re-planning could be helpful. Understand that change occurs at multiple levels, and establish appropriate expectations. Transformational change and reform require knowing that the interrelated components of the system or initiative require change simultaneously. Change must be implemented at both the administrative and staff levels to be effective, because it is those on the "front line" handling daily activity who determine if change really occurs.

◊ SELECT STAFF AND LEADERSHIP – Recognize that a blend of talents and abilities will be required for success, and work to accommodate that. Select staff for their competencies and ensure that they are trained and expected to deliver what the initiative envisions in a business-like fashion. Avoid the urge to take what's available or to feel obligated to reward individuals or organizations for their contributions. Align staff selection with the two or three critical factors you have decided will determine success. If the communication is effective and the organizational culture appropriate, staff selection should not become an issue. Create clear position guides and measurement objectives up front. Include description of the "customer service" attitude and behaviors expected. Ensure that staff and leadership have common training/ knowledge of the professional attributes needed for the mission and for managing a business enterprise.

Planning for the incorporation of community volunteers can be a key component of long-term success based on the published experience of some initiatives and the anecdotal experience of others. Volunteers can extend your influence and presence in the community. Active volunteer involvement not only provides "adjunct staff" and extra resources, but it provides the center with a built-in feedback opportunity. Volunteers can provide support for centers and often are in contact with those who may receive services, and can be a conduit for information on performance and meeting expectations.

◊ DETERMINE NEEDS AND SERVICE DESIGN – Clearly articulate, quantify, and prioritize the needs and opportunities for your initiative. You can't be and do all things. Give substantial consideration to the assets and capacities of the community and permit community members to participate in defining both capacities and needs/opportunities. Provide for a balance between qualitative and quantitative inputs so that a community voice is heard.

Beware of the temptation to offer too broad an array of services or programs. Don't offer them just because you can or because a need exists. Force those program and service selections through your strategic filter and act only on those that are central to your strategy and reason for being. Also beware of the temptation to take on too large a mission. Balance your selection and mix of initiatives with realistic expectations and community capacities/acceptance. Again, use your strategy to screen out tangential activities in order to ensure a higher potential for core success.

If the FRC that you are creating is to be a "one-stop" center, strive not only for comprehensiveness, but also play close attention to the mix of direct, referral, and preventive services. Overemphasis on direct care can perpetuate the need for that care, and bleed critical resources away from trying to eliminate or reduce the root cause for that care through preventive

services and support efforts. By the same token, trying to provide too much direct service without prioritization, referral, or selectivity, can also consume space and critical resources needed to attack the causes of the problems driving the need for that care.

◊ LOCATION - As in real estate, location is crucial. Give strong consideration to your providers, your community, transit services, the population you wish to serve, and where you should be located. For vulnerable populations, a half-mile difference in distance could be critical in determining whether or not your services are accessible. An uninformed or compromise decision here could be a critical strategic factor that determines the success or failure of your efforts.

◊ PLAN FOR SUSTAINABILITY – One of the most commonly overlooked or poorly executed elements of success is early planning for financial self-sufficiency. The passion and excitement of opening for business and helping people can result in forgetting about or overwhelming the effort critical for the very survival of the entity. All too often the magnitude of work needed to get started leads to insufficient early planning and action to ensure continuity of funding. By building this element into formal planning and assigning it a priority and human resources you can minimize the potential for cyclical operations that destroy effectiveness and morale. If necessary, use some of the initial funding to "protect your investment" by paying for professional assistance to ensure that you actively address this issue years before your funding cycle dries up.

◊ COLLABORATE HORIZONTALLY AS WELL AS VERTICALLY – In addition to building the collaborative for your initiative, seek out other centers or similar initiatives to collaborate with to maximize learning, avoid pitfalls, extend resources, and provide the all important mutual support needed to avoid burnout. If an institute or association of like entities or initiatives exists, they can often provide policy and development counsel or other support that could prove valuable to your initiative.

XI. Appendix C: Common Family Resource Center Funding Sources

The most important factors related to an FRC's financial stability are the leader's ability to (1) identify valuable local resources and key partners, (2) initiate and build relationships with these partners, and (3) solicit public and private funding. The following are potential sources of funding and other types of support.

- Community Partnerships

Successful FRCs will draw on existing community resources. By engaging other local service providers in the planning process, the FRC can get help in identifying community needs while establishing partnerships for the provision of needed services. Community partners with shared goals often include hospitals, health care providers, mental health agencies, universities, and non-profit groups. Co-location of staff or direct service programs will bring multiple services under one roof without significantly increasing the FRC's operational expenses since these entities have their own financial support. (When co-location of medical services is not an option because of structural limitations or the geographic location of the FRC, mobile medical, dental and vision units can be used to provide services on site.) Joining together in the planing process helps planners eliminate the duplication of services, making investments of limited funds more meaningful. Typical services offered by community partners include Early and Periodic Screening, Diagnosis, and Testing (EPSDT), mental health, case management, family support, and adult education programs. The creation of quality partnerships will give programs the stability needed to ensure long-term program sustainability. Not only are private providers helpful in coordinating staffing and procedures, and providing supplies and equipment, but they also have well-established billing processes in place. Many have already tapped into the financial resources discussed below.

- City Partnerships

Some of the most effective support for program expansion comes from city resources. Programs not only benefit from representation and advocacy from city leaders, but they may also receive substantial financial support from city categorical and general funding. These sources range from economic development money to funding for after-school programs. Frequently used city funding sources include the HUD Block Grant, Parks and Recreation Funds, and the General Fund. For instance, through a partnership with the City of Carson, the Carson Family Resource Center acquired funding for case management, referral services, counseling, mental health and social services, health care, parent education, and family support programs. The cities of Azusa, Baldwin Park, and Covina, for example, provide staff, funds, in-kind services, and/or physical facilities for the FRCs operating in their communities.

- Existing Funding Sources

A wide array of funds dedicated to the types of services that FRCs provide is available through federal, state, and local programs. In addition, private foundations offer several short-term funding possibilities. Unfortunately, this financial network is so complex that few are able to take advantage

of all the funds for which they qualify. Most sources are capped, providing limited funds for a limited number of sites. Federal and state investments are typically categorical in nature and linked to specific types of services or eligibility criteria. This limits the number of families that can be served and increases the complexity of reporting requirements for FRCs. The following examples identify specific funding streams and the types of services they support.

Medicaid/Medi-Cal (Title XIX of the Federal Social Security Act) provides one of the most sustainable funding streams for FRC health and mental health services. As one of the few remaining entitlement programs, reimbursements may be given for services provided to all qualifying clients. Funds are allocated to "match" the investment of the state or local entity. Different components of Medicaid provide funds for a wide array of services centered on child and family physical and mental health. Reimbursement rates depend on which entity "bills" Medi-Cal. The Local Education Agency (LEA) Medi-Cal Billing Option was created by the California Department of Education (CDE) and the California Department of Health Services (DHS) to allow any local education agency to be enrolled as a Medi-Cal provider. Enrolled LEAs can bill for a wide range of services and screenings delivered to Medi-Cal eligible clients. These services include physical and mental health evaluation, health education, physical and occupational therapy, speech and audiology services, counseling, medical transportation, and targeted case management. Although LEA Medi-Cal billing has the potential to significantly enhance the sustainability of services, numerous staffing and eligibility rules make it very difficult for sites to coordinate service delivery around billing parameters. The system also requires a tremendous amount of paperwork and staff time devoted to carrying out the reimbursement process, placing additional strain on already overburdened staff. Staff members also must receive special training to coordinate the reimbursement process. FRCs can receive higher reimbursement rates directly by contracting with the county to provide medical services, or indirectly, through partnering with hospitals that have already established set reimbursement rates and billing processes. In addition to funding direct service, Medi-Cal also provides funds for administrative costs.

Medi-Cal Administrative Activities (MAA) provides funding for administrative activities that support and facilitate the delivery and management of all Medi-Cal services. These include Targeted Case Management for Local Education Agency (TCM-LEA) and Targeted Case Management for Local Government Agency (TCM-LGA). Administrative activities funded by MAA include: salary surveys, program planning, billing, Medi-Cal outreach, and Medi-Cal application assistance and training. Schools receive MAA reimbursement via an MAA contract with the MAA county coordinator. Funds are limited to administrative activities supporting Medi-Cal services to eligible clients.

State Preschool funds. To facilitate intellectual, social and emotional development, State Preschool funds are used to support educational activities for low-income children ages 3 to 5. State-funded services are co-located at Head Start sites. Funding is allocated by state taxes and is passed on to county offices of education through the California Department of Education Division of Early Childhood Education. Because of resource limitations, only 20% of eligible children are served.

Head Start (Grant). Federally funded by the U.S. Department of Health and Human Services Administration for Children and Families, Head Start provides comprehensive developmental and social services for low-income *preschool* children ages 3 to 5 and their families. Head Start programs place a heavy focus on parent and community involvement. Resources available to qualifying families include medical and dental care, social services, substance abuse abatement, education to promote intellectual, social and emotional growth, mental health counseling, nutrition education, literacy instruction, and disabilities services. Sites are required to meet a set of performance standards mandated by the U.S. Department of Health and Human Services. Performance data are monitored by the site's governing council. Programs are required to raise an additional 25% of the total amount allocated by federal funds. In FY1998 there were 57 grantees serving 86,000 children across the state with a budget of $528 million.

Early Head Start (Competitive Grant). In response to evidence showing that the period from birth to age three is most important to healthy development, Early Start was initiated in 1994 to serve low-income families with infants and pregnant women. Focusing on child and family development, staff development and community outreach, programs provide the following resources: early education (on-site and in-home), home visits for families with newborns, parent education, parent-child activities, comprehensive health services, nutrition education, case management, and peer support. Sites are required to meet a set of performance standards mandated by the U.S. Department of Health and Human Services.

Even Start (Competitive Grant). Authorized in 1988 as Part B of Chapter 1, Title 1 of the Elementary and Secondary Education Act, Early Head Start intends to, "...help break the cycle of poverty and illiteracy by integrating early childhood education, adult literacy or basic adult education, and parenting education...." Programs must be implemented through cooperative projects that build on existing community resources to create a new range of services. To be eligible for Even Start, a parent must be eligible for services under the Adult Education Act or within the state's compulsory education age. (P.L. 103-382, Sec. 1201) States, who are awarded federal funds for Early Start based on the Title 1 allocation formula, hold competitive grant competitions to make sub-grant awards to local programs. In 1997, 650 projects were funded nationally.

Individuals with Disabilities Education Act (IDEA) allocates money for education and support services for children with disabilities. The relative population of children determines the amount given to states ages three to five. Funds do not go directly to programs providing services. Rather, activities are organized by the California Department of Education Special Education Division through Special Education Local Planning Areas (SELPAs). Although special education funds traditionally targeted school aged children, the benefits of early intervention have motivated increased funding for programs that reach back first to preschool aged children, and more recently to infants and toddlers. Regional Special Education Centers, created to focus on the needs of young children, sponsor a number of FRCs with limited services. Typically, these centers serve in a case management capacity, assessing client needs and referring them to off-site providers. Some of these FRCs provide direct service in the form of parenting classes.

Family Preservation and Support. The 1993 Family Preservation and Support Act (Public Law 103-66) provides federal funds to state child welfare agencies to use for in-home and community-based preventative services (family support) and intervention services for families at risk or in crisis. The services must "promote the well-being of families to increase parents' confidence and competence in their parenting abilities, to afford children a stable and supportive family environment, and otherwise to enhance child development." Examples of services include home visits, parent support groups, respite care, structured parent-child activities, information and referral services, and early development and screening of children to assess their need for special services. Funds are administered by the Administration for Children, Youth and Families in the Department of Health and Human Services. In California, the Department of Children and Family Services administers the program. There was a $225 million national allocation for FY1998.

Healthy Start Support Services for Children Act (Ch 759/91 [SB 620, Presley]), a California initiative designed to bring integrated services to school-age children and their families, supports a variety of school- or district-based FRCs. These sites may provide an interesting platform, for early childhood services, as supportive programs (ranging from on-site medical clinics to parent support groups) are already operational on site. Healthy Start sites receive planning grants up to $50,000 and three-year operational grants up to $400,000 through the State Department of Education. After the three-year period, these sites must become self-sustaining through partnership and the utilization of other funding streams. Adding early childhood programs to other existing sites would automatically link families with young children to multiple services. As of the fall of 1999, there were 470 operational Healthy Start Sites in California.

Non-Profit Hospital "Community Benefit" Funds. By law, non-profit hospitals located in California are permitted to spend a portion of their resources on the development of programs and services that benefit the overall health of the community. Citrus Valley Health Partners and Kaiser Permanente, for example, were some of the first non-profit hospital systems to invest in the creation of, and partner with, FRCs as a way to expand access to health care and social services for children and families. Not only do non-profit hospitals have discretionary funds, but also they also often make excellent community partners able to attract other resources and providers that can contribute to the stability of an FRC and its service mission.

Child Health and Disability Prevention (CHDP) provides low-income children with complete health assessments on a regular basis for the early detection and prevention of disease and disabilities in children and youth.

Mental Health Rehabilitation Option allows county Mental Health Departments to provide mental health services to Medi-Cal-eligible clients at school- and community-based sites. Reimbursement is available for clinical assessments, rehabilitation, evaluation, therapy, and follow-up. Centers cannot bill directly but could receive reimbursement for service via a contractual agreement with the county Mental Health Department.

Title 1 of the Elementary and Secondary Education Act. Title 1 intends to improve the opportunities of educationally deprived children. Children are eligible for Title 1 prekindergarten programs if they live in Title 1 attendance areas. Title 1 attendance areas are calculated by determining the average amount that the state spends on each student and the numbers or percentage of children age 5-17 from families with incomes below the poverty line. The types of services provided might include education/child development, screening for disability, direct health or dental services or referrals, speech and hearing assessments, and direct social services or referrals.

TANF/CalWORKs. Recent reforms in welfare policy set aside funding for both parent education/job training and for child care services. Through contracts with the county, FRCs could receive reimbursements for providing these services. In addition, up to 30% of CalWORKs funds could be transferred into the Child Care and Development Block Grant, which primarily provides child care subsidies to recipient parents but also supports early childhood education programs and child care quality improvements.

Grant Funding. Several private foundations issue grants to programs supporting early childhood development. Grants are typically more flexible, short-term sources of funding that should be applied to short-term expenses not addressed by federal and state funding streams. For example, the start-up phase of a project requires a significant investment in staff for program development, coordination of funding streams, and collaboration between existing agencies. While grants may be used to support these initial activities, once programs are established, many administrative expenses can be billed through federal grant or entitlement programs like the Medi-Cal administrative billing option. In addition, grants can be used to fill the gap in federal/state funding in the area of capital development.

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