no. 14

FAMILY SUPPORT:
Fostering Leadership and Partnership to Improve Access and Quality

LISA THOMPSON, MPH

KIMBERLY UYEDA, MD, MPH

**UCLA CENTER
FOR HEALTHIER CHILDREN,
FAMILIES AND COMMUNITIES**

**ASSOCIATION OF MATERNAL
AND CHILD HEALTH PROGRAMS**

**JOHNS HOPKINS
BLOOMBERG
SCHOOL of PUBLIC HEALTH**

**WOMEN'S AND CHILDREN'S
HEALTH POLICY CENTER**

This series of reports is designed to support the planning and implementation of the Maternal and Child Health Bureau (MCHB) State Early Childhood Comprehensive Services (SECCS) initiative. The reports are written by a team of experts to provide guidance on state policy development within this initiative. The policy reports on cross cutting themes include strategic planning, communications strategies, financing, results-based accountability, cultural proficiency, and data analysis and use. The policy reports on programmatic topics include medical home, parenting education, family support, infant mental health, and dental health.

The National Center for Infant and Early Childhood Health Policy supports the federal Maternal and Child Health Bureau and the State Early Childhood Comprehensive Systems Initiative by synthesizing the policy relevance of important and emerging early childhood health issues, conducting policy analysis on systems-building and programmatic issues, and disseminating the latest research findings to increase the visibility of early childhood policy issues on the national agenda.

Table of Contents

Introduction

Purpose of Paper

The federal Maternal and Child Health Bureau (MCHB) launched a five-year initiative that will support state efforts to build comprehensive early childhood service systems. This initiative – the State Early Childhood Comprehensive Systems (SECCS) Initiative - provides planning and implementation grants to the state and territory Maternal and Child Health agencies for the purposes of coordinating, integrating, improving access to, and improving the quality of health, early education and family support services for young children and their families. In their Strategic Plan for Early Childhood Health, the MCHB outlined two goals for this initiative:

- Goal 1. To provide leadership in the development of partnerships that integrate service systems designed to enhance young children's ability to enter school healthy and able to learn.
- Goal 2. To help states and communities build early childhood service systems that provide access to comprehensive pediatric care services and medical homes; early care and education; parenting education; and family support and other programs that support socioemotional development of young children.

This paper addresses the family support component of the SECCS Initiative.   Successful early childhood initiatives acknowledge the needs of and demands on families today, as well as the key role that families play in children's health and development. However, because family support is the broadest domain of the components outlined in Goal 2 [1], with services that are widely dispersed across various sectors and disciplines, no one agency has consistently taken ownership in advancing its goals and objectives. For instance, although some family support efforts are located within Title V and Part C of IDEA, many others are spread among a wide variety of public and private agencies from the health, education and social service sectors. Therefore, MCH agencies have an opportunity to play an important role in ensuring that SECCS Initiatives have a strong family support component and potentially serve as a nexus for similar comprehensive family support efforts at the state level.

The goal of this paper is to provide a framework for thinking about family support first in terms of its philosophy, relevance to the early childhood field, strategies and service delivery platforms. Secondly, we summarize what is known about the effectiveness and funding mechanisms for key family support strategies. Lastly, a number of recommendations are made regarding how SECCS Initiatives can play an important role in developing partnerships and leadership that enhance access, integration and quality of family support services, as well as help link these efforts with the other components of the SECCS Initiative.

Families Today

SECCS Initiatives that are attempting to provide and link with a system of family supports begin with the simple question, "What is a family?" This paper offers the following adapted definition [2]

> Families are big, small, extended, nuclear, or multi-generational, with one or two parents and /or grandparents. They live under one roof or many and can be as temporary as a few weeks or as permanent as forever. Individuals become part of a family by birth, adoption, marriage, or from a desire for mutual support. A family is a culture unto itself, with different values and unique ways of realizing dreams. Together, families become the source of rich cultural heritage and diversity and are what create neighborhoods, communities, states, and nations.

A profile of families in the U.S. today reveals both encouraging and discouraging trends for children and their families during the 1990s. The 2002 National Survey of America's Families (NSAF) indicates that the proportion of children five and younger living with single mothers declined from 21 percent in 1997 to 17.3 percent in 2002.[3] Additionally, the NSAF found that between 1999 and 2000, the number of uninsured children under age 19 fell from 9.6 to 7.8 million and the uninsured rate among low-income children declined by nearly 6 percentage points.[4] Despite these gains, in an analysis of the 2000 Census, the Annie E. Casey Foundation found that the number and percentage of children and adults living in severely distressed neighborhoods increased by nearly a third between 1990 and 2000.[5] They defined "severely distressed neighborhood" using an index of hardship characterized by high levels of poverty, high proportions of single-parent households, high school drop out rates, and high male unemployment. Specifically, they found the number of children living in severely distressed neighborhoods rose from 3.4 million in 1990 to 4.4 million in 2000 and the number of adults rose from 7.7 million to 10.0 million during the same time period. As might be expected, this analysis also found that minority children constituted the overwhelming majority of children living in these neighborhoods. Black and Hispanic children together account for about one-third of all children in the United States, but they make up more than three-fourths of children living in severely distressed neighborhoods.

This mixed portrait of families indicates that many young children live in circumstances where they face incredible odds. These stressors, along with the fact that all parents (regardless of socio-economic status) struggle with the normal responsibilities of raising young children, jeopardize a family's ability to provide a warm and nurturing environment that assures optimal developmental outcomes for children.

Background

Origin of Family Support

The context for raising young children in the United States has changed over the generations, forcing systems for delivering services to evolve and mature. Although the family support movement has existed in some form throughout history, the modern concepts and strategies arose in the late 1970s as a grass-roots movement organized around a common set of principles to serve entire families in a non-judgmental and highly inclusive way.[6]

Private support for needy families has its origins in many religious traditions, and the public form of family support that developed in the US evolved from the English Poor Laws that codified how needy families would receive community support. The First White House Conference on Children in 1909 that gave rise to the federal Children's Bureau (the predecessor of the MCHB) also helped launch the first government sponsored family support programs. These programs included Widows and Orphans pensions that in 1935 would become the Aid for Families with Dependent Children (AFDC) Program. AFDC provided economic support for single mothers and their children and was the dominant form of family support for several decades.

It was not until the 1970's when changing family demographics and the full impact of women entering the workforce was appreciated that family support policy began to change. AFDC was representative of the traditional income support, but new types of programs emerged to include child care, health care, family leave and other forms of instrumental support.[7] During this period a number of family support initiatives were launched, though most of these programs functioned independently of one another with few opportunities for linkages. They were largely built around specific "high risk" populations such as children with disabilities, families in poverty or parents with substance abuse problems.

More recently, with the development of a family support movement nationally and internationally, a more integrated and comprehensive set of services are being offered both to targeted populations and universally to all parents. These services may be delivered through "one-stop" service and referral centers organized around collaboratives of federal, state, county, regional, city, and community entities.[8] As will be discussed later, there has also been a growing trend for communities and agencies to create family resource centers, which resemble in form and function the settlement houses that sprung up in major cities at the turn of the 20th century to support immigrant families transitions into life in America.

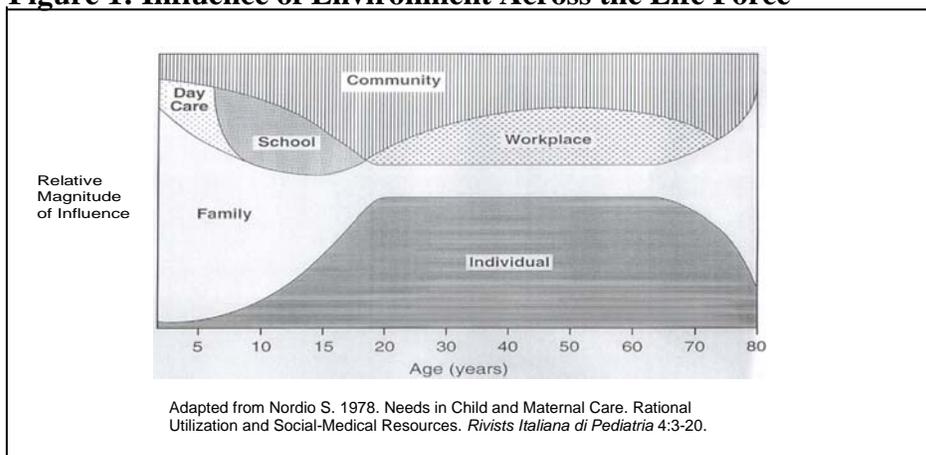### *Relevance of Family Support to the Early Childhood Field*

Family support services and programs are important to improving outcomes for young children because families play such a critical role in a child's health, development, and

well-being. Family support programs have been found to improve a family's ability to provide a positive environment for children.

Environmental influences of young children

The primary influences on a child include their families, schools, and communities.[9] In the early years, the greatest influence on children's development comes predominantly from parents and caregivers. As children grow, the influences of schools and communities begin to have a larger impact. **Figure 1** depicts how the relative magnitude of individual and environmental influence changes as a function of age.

Figure 1: Influence of Environment Across the Life Force

Adapted from Nordio S. 1978. Needs in Child and Maternal Care. Rational Utilization and Social-Medical Resources. *Rivists Italiana di Pediatria* 4:3-20.

Resilience in young children is comprised of multiple factors that determine a child's ability to respond to adversity – a child's coping ability. Studies of resilient infants, young children, and youth consistently identify the most important protective resource as a strong relationship with a competent, caring, positive adult – most often a parent.[10]

These important family relationships should also be viewed in the context of broader environmental influences. Brofenbrenner's ecologic model underlies the principles of integrated and comprehensive family support. While young children are viewed as primarily influenced by family, the family is embedded in the context of a community and larger policy environment. [11] A simple depiction of this model is illustrated in **Figure 2**. More specific neighborhood, community and societal influences on families and their children are discussed in greater detail in the next section.

Figure 2: Family Relationships in Community Contexts

Child

Family

Community

Policy
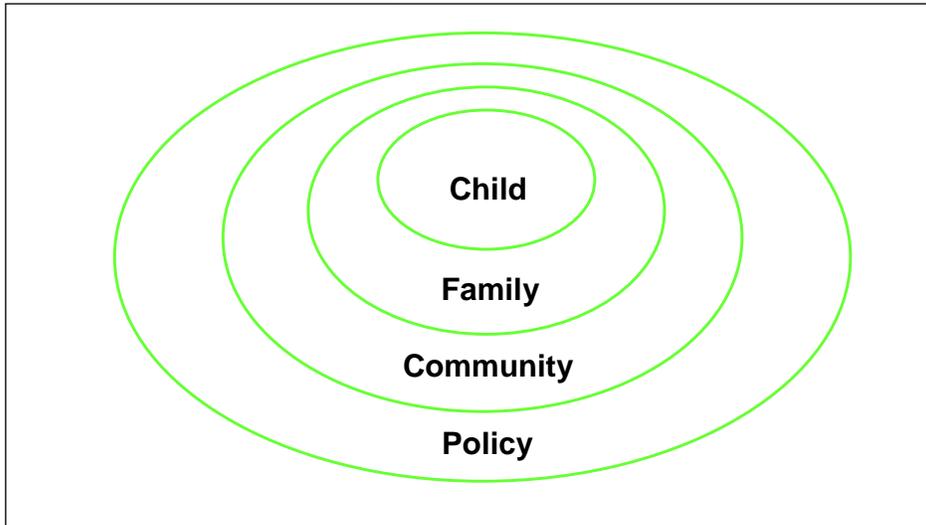
Factors that impact effective parenting

Effective parenting practices are tied to several factors such as the individual's work, educational level, marital status, psychological well-being, and cultural values and practices.[12] **Figure 3** depicts the complicated process by which neighborhood, community and family-level influences impact a child's developmental process. These influences work through key socio-economic risk factors that can impact on effective parenting.

Figure 3: Development Processes

Parent- and Family-Level Predictors
of Income And Hardship
• Parent Work Status
• Job Prestige
• Education Level
• Parent Marital Status
• Race-Ethnicity

Family Income Poverty

Financial Hardship

Parent Investment

Parent Behavior

Parent Distress

Child Physical Development

Child Cognitive Development

Child Social-Emotional Development

Neighborhood- and Community-Level Influences

Adapted From National Center for Children in Poverty

Several studies have found that economic factors, such as a family's ability to purchase services and goods (e.g., health care, food and clothing) has a strong impact on child development. [13] When compared to children of more affluent families, low-income children have poorer nutritional status, more physical health problems, lower cognitive test scores, and increased risk of emotional and behavioral problems.[14] Parental education level predicts some of the knowledge and skills that parents bring to their decision making about parenting behaviors. The correlations between parental educational attainment and the children's achievement and behavior are among the most substantial and replicated findings in child development.[15]

**Figure 4** examines the influences on family functioning which ultimately have an impact on individual health status. These include characteristics of the family, their community, society and culture, and their life cycle. Three specific factors have been found to consistently foster effective parenting: reciprocity, social networks for parents, and an involved father.[10]

Reciprocity, or the building of mutually satisfying relationships between the developing infant or young child and the parent, influences both behavioral and emotional development. Infants of parents who can interpret and adjust their behavior and respond appropriately to their children are more advanced on assessment scores of development and cognitive status.[16] A substantial body of research has also found that psychological resources of parents, such as their emotional, cognitive, and behavioral factors, have an important influence on child development. For instance, the ability of parents to provide a warm and nurturing environment for children during the early years is central to healthy brain functioning in infancy.[16] Further, parents' mental and emotional health influence child rearing practices. Mothers with depressive symptoms are twice as likely to become more frustrated with their children's behavior and are more likely to yell, spank, forego reading, and not maintain regular routines with their children.[17]

Figure 4: Family Pathways to Health
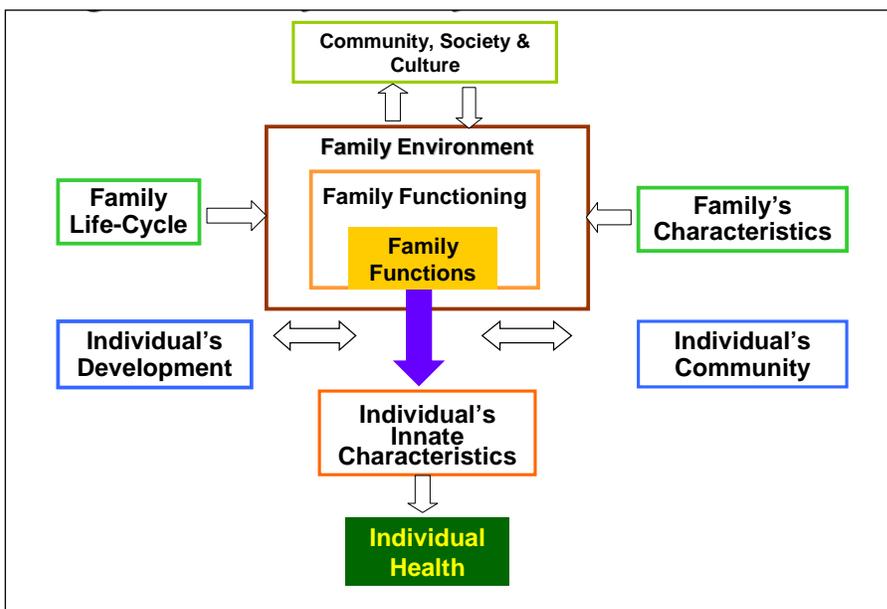
Parents' social networks include people who "engage in activities and exchanges of an affective and or material nature with members of the immediate family."[18] The presence of extensive and supportive social networks has also been linked to effective parenting.[19] Parents reporting weak social networks have been found to have more depressive symptoms. When mothers have few or no sources of help, their odds of depression are two times greater than those with support.[20]

The significant role of fathers merits discussion as it is less frequently addressed in parenting literature, where the focus in more often on the mother-child relationship. Decades of research on fathers' involvement with young children has found that men nurture, interact, and rear children competently, but in a manner different from women.[21, 22]. The differences in how fathers interact with children offer unique opportunities for expanding the infant's experience base, and appear to be mutually appreciated by the child, father and mother.[23]

Within family support agencies there is a growing emphasis on fatherhood as an important and essential component to program success. The U.S. Department of Heath and Human Services (DHHS), National Fatherhood Initiative website can help to inform SECCS Initiatives about best practices across the states and existing and potential partnerships within each state. [24] Sylvester and Reich of the Social Policy Institute have developed a guidebook that details six steps policymakers can consider to promote father involvement, especially among low-income, unwed men.[25] Each of the six steps listed briefly in Table 1 include a set of policy options, examples of what states and communities are doing nationwide, and contacts and resources to learn more.

Table 1: Six Steps for Father Involvement [25]
1) Teach men to be good parents
2) Help fathers improve relationships with their children's mothers
3) Remove barriers to work for low-income fathers
4) Use federal funds to fund fathers' programs
5) Make the child support system work for families
6) Campaign to reinforce the message that "fathers matter"

Family Support – Framing the Issue

Family support can be characterized in terms of its goals and set of guiding principles and can also be defined by the strategies and service delivery platforms used to achieve its goals. [26]

Goals & Guiding Principles

The goal of family support is to help parents develop and utilize available intellectual, emotional and material resources that enable them to nurture and support the healthy development of their children.[27] Family support seeks to enhance parents' skills, social networks, social supports, and community linkages that serve as buffers against stress and isolation.

Family support encourages public and private agencies to become more effective by working together and becoming more preventive, responsive, flexible, family-focused, strengths-based, and holistic in nature.[8] Programs that embrace the principles of family support:

1) Operate from an ecological perspective that recognizes the interdependent nature of families' lives;
2) Recognize that all families deserve support in raising their children;
3) Seek to complement and network with existing services;
4) Work in partnership with families and are community-based;
5) Focus on the promotion of wellness and the prevention of problems; and
6) Promote equality and respect for diversity. [26]

Services and Strategies

The types of family support strategies that appear to be most effective are those that start early, are comprehensive, and address individual, family, and community level factors. Services that are most effective will engage families in places where they are most available and at times when they are open to change. Services should not only assist with parenting skills but also help parents with their own well-being and personal development.

Perhaps most importantly, family support services must be provided in a way that respects the values and cultures of all families. The changing demographics of the American population has created more diverse communities. Successful family support programs acknowledge and welcome this diversity and are competent in addressing the unique perspectives, behaviors, needs and priorities of these diverse communities. Anderson has described the following components of a culturally competent service:

1) Culturally diverse staff;
2) Providers or translators who speak the family's language;
3) Training for providers about diversity, culture, and the uniqueness of populations being served;
4) Signage and instructional literature that are consistent with cultural norms and language; and culturally relevant service settings.[28]

Appendix A provides a list of web resources for family support.

Family support strategies include but are not limited to:

- health care
- public assistance
- child care
- employment development
- transportation
- translation
- family court services, family advocacy, and legal assistance

- case management
- parent support groups and parenting education
- mental health
- domestic violence & substance abuse counseling
- family and adult literacy
- resource and referral services

Supports and messages should be reinforced at multiple settings including homes, hospitals, schools, churches, and other community sites. Furthermore, mechanisms for coordinating, interfacing and integrating family support services are also critical to an effective, accessible, and efficient delivery system for families. Lastly, individual services and integrated delivery systems should remain faithful to the principles of family support reviewed earlier such as respecting the diversity of families and providing services in a non-judgmental, culturally appropriate and highly inclusive way.

A compelling argument exists for why all family support programs serving low-income families should include a component that links families to income and work-support services.[29] Work supports alone without income assistance may address long-term self-sufficiency but it does not address the immediate needs of low-income families that are often dealing with meeting the basic needs of their families such as food, clothing, and housing. Likewise, income support alone will not assist families to deal with the obstacles they are facing toward long-term self-sufficiency.

A recent report from the GAO discusses the types of services, funding and delivery structures used by states in recent years [30]. This report may be a valuable snap-shot of existing work- and income support-related activities, as well as a source of background information and information about the use of blended funding methods. The report can be located at: http://www.gao.gov/new.items/d04256.pdf

The report states that work supports for low-income families are increasingly available from states, and these differ from income supports. Work supports include subsidies for child care, transportation, job retention and advancement services, and utility assistance. Income support includes cash assistance, state tax credits, and Medicaid/SCHIP. In addition, may states report co-locating the provision of information to potential clients and co-locating the identification of clients. The report also discusses the use of coordinated case management for both work- and income-related supports.

Considerable improvements need to be made in order for families to benefit from the quality improvements that co-location and other coordination efforts offer. The GAO report cites several barriers to accessing work support services, including insufficient state or federal funding, insufficient service provision, or physical or logistical barriers faced by the family. "For nearly every type of support [examined by the authors], an official in at least one state reported that less than half of eligible applicants received that type of support." With access to services centralized at a given location, if a family faces

an access barrier for one support they are likely to face the same barrier for others: if a family is not receiving work supports, they may be facing barriers to receiving income supports, as well.

Finally, the creation of one-stop service centers provides an opportunity to link parents to other elements of the broader network of child and family services: information can be passively made available to parents, case workers can actively share information with parents, care coordinators could be trained to actively identify additional needs and make appropriate referrals, and other early childhood services could be co-located in these service centers.

Integrated Service Delivery Platforms

Family support is increasingly defined by the service delivery platforms used to deliver and integrate a comprehensive, community-based, and culturally competent set of services for families. Morrill reviews the major impediments to service integration and outlines key strategies to address these barriers.[31] He finds that the service delivery system for families, made up of three components (health, education, and social services), is fragmented, highly specialized and overly complex. He advocates for strategies that link or integrate these systems in order to emphasize prevention, deal with children and families holistically and promptly, and to manage families' needs effectively.

Service integration does not imply a specific model of service delivery. In fact, there are a variety of models now being undertaken that vary in the composition of services, the target population, mode of delivery, and type of sponsoring organization. Considerable empirical research is still needed to determine whether there is a single or more likely a collection of service integration models that can provide improved family support services.

Home visiting
Special attention is given to home visiting because as a strategy it has the unique ability to reach socially- and geographically-isolated populations, gain a more realistic and complete picture of the home environment and the nature of family relationships and circumstances, and to link families in need with coordinated and comprehensive services. Besides visits to a family's home, home visiting is defined here as a family support strategy that is preventive in nature, that begins either prenatally or during the early years of life and is sustained over an extended period during the child's first five years. Even within this narrow definition, home visiting programs vary greatly in their target populations, staffing models, and curricula and they encompass a broad range of primary secondary, and tertiary prevention strategies targeted at health and development, education, and family support outcomes. [32] Specific interventions taking place in the home often include some combination of the following services: assessments and problem identification, early childhood education, parent education and instruction, counseling and mental health services, health care, advocacy, case management, treatment services, care coordination and referral assistance.

Many organizations create their own unique home visiting program models based on agency experience, local best practices, and the needs and input of local community members. Other programs replicate or adapt known statewide or national models that may have shown some degree of success in supporting families. Appendix B outlines a set of best practices for improving the quality of home visiting programs.

Effectiveness of Home Visiting Programs [33-35]

The Spring/Summer 1999 issue of *The Future of Children*, published by The David and Lucile Packard Foundation, describes the characteristics and evaluation findings of six home visiting program models that have been replicated nationally:

- The Nurse Home Visitation Program;
- Hawaii's Healthy Start Program;
- Parents as Teachers;
- Home Instruction Program for Preschool Youngsters;
- Comprehensive Child Development Program;
- Healthy Families America (HFA).

Editors of this issue reviewed the evaluation findings for these six programs and found the results to be mixed and, where positive, often modest in magnitude. Their review of the studies revealed some benefits in parenting practices, attitudes, and knowledge. The benefits for children in the areas of health, development and abuse and neglect rates were more elusive. Gomby et al. reported that only the Nurse-Family Partnership (referred to in 1999 as the Nurse Home Visitation Program), consistently revealed marked benefits in maternal life course. When focused on low-income and unmarried women, the Nurse-Family Partnership (NFP) was found by a RAND Corporation study to produce the largest economic return to government and society of all the major early childhood programs that have been carefully studied to date. Gomby et al. found that among the six models, when benefits were achieved, they were often concentrated among particular subgroups of the families, but there was little consistency in these subgroups across sites that implemented the same program model. In most of the studies described, programs struggled to enroll, engage, and retain families. When program benefits were demonstrated, they usually occurred only for a subset of the families originally enrolled in the programs, they rarely occurred for all of a program's goals, and the benefits were often quite modest in magnitude. The editors made four conservative recommendations:

- Any new expansions of home visiting programs should be reassessed in light of the findings;
- Existing programs should focus on efforts to improve service implementation and quality;
- Practitioners and policy-makers recognize the inherent limitations in home visiting programs and embrace more modest expectations for their success; and
- Home visiting services are best funded as part of a broad set of services for families and young children.

Family resource centers

Family resource centers have also emerged as a key platform for delivering family support services in an integrated fashion. Family resource centers can be located in schools, hospitals or a variety of community-based settings such as churches, housing projects, and recreation centers. They serve as "one-stop" community-based hubs that are designed to improve access to integrated information and to provide direct and referral services on site or through community outreach and home visitation. **Figure 5** illustrates service organization and range of services that can be provided by a family resource center.

Figure 5: Family Resource Center Service Organization
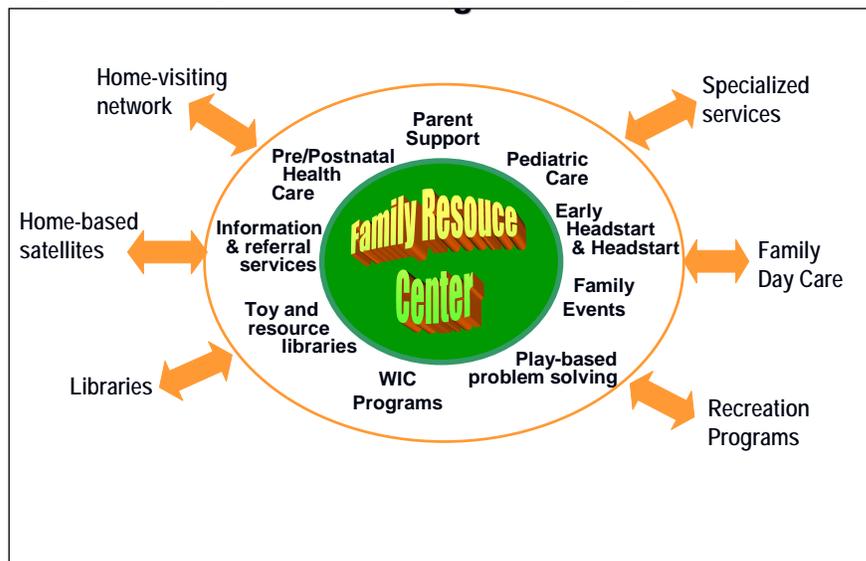
Studies have identified the following potential benefits to increasing the use of family resource centers. [36]

- They provide a local structure for integrating new and existing family support programs, and developing partnerships among public, private, and community organizations;
- Addressing multiple needs at one site enhances families' access to and utilization of services by decreasing the effect of transportation challenges;
- They improve coordination of services through the use of comprehensive intake procedures, coordinated case management, and advocacy efforts. Co-location of staff, from multiple organizations, makes it easier to address family needs while minimizing redundancy, reducing isolation, and facilitating redirection of resources to areas of greatest need.
- They increase community engagement, cross-generational interaction, and volunteer opportunities by building community capacity and appropriately responding to the cultural and economic realities of families.

Although there is still a lack of empirical knowledge regarding the effectiveness of family resource centers, some experts now agree that the limited qualitative and quantitative findings indicate that some family resource centers can potentially be very effective in improving educational and civic performance.[36] Significant positive relationships have been found between the establishment of a school-based family resource center and the proportion of students who improved on pre-post teacher ratings.[37] Children receiving direct educational interventions from center-based trained staff show larger and more enduring benefits.[38] A combination of a daily center-based intervention with weekly parent-oriented home visits resulted in significant cognitive gains for children. Furthermore, it appears from these evaluations that program features

such as comprehensiveness, sensitivity to family context, and neighborhood and community involvement are crucial to long-term program effectiveness. [39] Appendices C to E describe three local best practices that exemplify the principles of family support and provide comprehensive, integrated services using center-based and or home visiting strategies.

Financing Family Support Services

Local agencies receive funding to operate family support programs often through a combination of contracts, grants, fees for service, and charitable donations. Funding organizations might include
1) Local, state, and federal departments of health, mental health, education, social services, and probation;
2) Health plans, Medicaid and SCHIP;
3) Voter initiatives and special taxes;
4) Private foundations;
5) Non-profit organizations;
6) State litigation such as the Tobacco Settlement; and
7) Individual donors.

Many of the funding streams that are available to family support programs are categorical in nature and therefore can create barriers to providing a set of different, but integrated, services to children and their families. Categorical funding streams target narrowly defined aspects of family life, and have specific requirements regarding program design, curriculum, staffing, evaluation, and eligible target populations. As a result, family support programs, particularly those delivered through family resource centers, often operate programs using a patchwork of categorical funds that try to meet the full range of families' needs.

A number of recent publications have been developed to help policy makers and program planners identify, pool, and leverage the various funding sources available for family support. For instance, Prevent Child Abuse America, which administers the Healthy Families America (HFA) home visiting program model, offers several publications from their website (www.healthyfamiliesamerica.org) on financing family support programs aimed at reducing child abuse and neglect. These publications provide information on how to access funds from a variety of sources such as Medicaid, State Child Health Insurance Program (SCHIP), State Tobacco Settlements, and the Temporary Assistance for Needy Families (TANF) Program.

Another source of information regarding the financing of family support programs is The Finance Project, a non-profit organization dedicated to promoting more effective financing of family and children's services. The Finance Project has developed four key publications to aid in the financing and sustainability of family support programs.

The Finance Project report *Strategic Financing: Making the Most of the State Early Childhood Comprehensive Systems Initiative* is designed specifically for the SECCS Initiative audience and discusses key approaches to strategic financing. The report is available on the Internet at www.healthychild.ucla.edu/nationalcenter.

Federal Funding for Early Childhood Supports and Services: A Guide to Sources and Strategies by Fisher, Cohen, and Flynn is designed to help policymakers and program managers take advantage of federal funding opportunities.[40] It identifies and summarizes nearly 60 federal programs that have the potential to fund components of family support.

Financing Family Resource Centers: A Guide to Funding Sources and Strategies by Watson and Westheimer describes the characteristics of family resource centers (FRCs), principles and strategies for financing them, and current financing sources.[41] This paper also discusses potential reforms for improving the financing environment, offers tools for tracking staff positions that are allocated to different funding sources, and ways to diversify funding based on reconciling program and funder needs. There is a particular emphasis on the role of FRCs as service providers funded under TANF.

The Finance Project's report titled *Financing Early Childhood Initiatives: Making the Most of Proposition 10* by Hayes provides a thorough discussion of financing early childhood development programs as it relates to the California Proposition 10 Children and Families First Initiative.[42] This paper also describes the funding sources for early childhood initiatives, including federal funding streams that support programs for young children and their families.   This paper also provides a series of case studies that demonstrate the ways communities are finding sustainable financial resources within the limitations imposed on them by categorical funding streams.

Role for SECCS Initiatives in Family Support

Of the five components of the SECCS Initiative (medical home, early care and education, mental health and socio-emotional development, parenting education and family support), family support is the broadest, has the least defined margins, and implementation of family support services is the most dispersed across service providers and organizations. State MCH agencies may target family support efforts through Title V and Part C of IDEA, but no one agency provides all aspects of family support throughout a state. Therefore, the first and perhaps most essential task of SECCS Initiatives might be to map-out the family support activities within each state in order to determine who is already doing the work and what strategies are most appropriate in each region. In particular, an asset-mapping activity that determines the "who, what, where, when and how" of family support is the first step toward integrating family support into the SECCS Initiative and building a more integrated early childhood service delivery system.

The more thoroughly SECCS Initiative partners consider the current state and local landscape of family support, the more active and productive role they can take in

improving the quality of and access to family support programs. After each SECCS Initiative has fully assessed the scope and nature of family support in their region, they can strategically pursue active partnerships and leadership building in the following five areas:

1) Data collection and evaluation;
2) Standards and policy setting;
3) Best practices and community building;
4) Provision of services; and
5) Advocating for innovative financing mechanisms.

Data Collection and Evaluation

SECCS Initiatives can play an important role with data gathering, analysis, and dissemination. Although these activities have been seriously undermined from budget cuts, initiative partners are uniquely positioned to access and link data from the major sectors of family support (health, education and social services). For instance, MCH could provide health data for identifying cases for targeted prevention and treatment efforts. A more ambitious step might involve the partnering of the health and education sectors to link and track birth certificate data over time, with assessments conducted during the prenatal, preschool, and kindergarten periods in order to assist with strategic planning and evaluation activities. Lastly, strengthened efforts to coordinate the messaging and dissemination of existing data on the status of families and the importance of support services for all families can help to motivate communities and garner political support.

SECCS Initiatives can also help to build an evaluation infrastructure among family support programs by establishing or participating in collaborative efforts to identify shared outcomes and indicators, standardize evaluation guidelines and tools, provide training on evaluation methods, and the use of data for strategic planning and quality improvement activities. For instance, MCH programs can establish and track family support indicators within their own five-year strategic plans. Defining, building consensus around, and placing increased emphasis on family support outcomes and measurable indicators will help align SECCS Initiative partners. These will also help ensure that partners track the extent of their individual and cumulative contribution to family support goals.

Developing Standards and Policies

Perhaps most easily, SECCS Initiative partners can affect policy by making family support more explicit in their own agency strategic plans. SECCS Initiatives can also work with national organizations, state governments, and local programs to adopt guiding principles for family support to ensure that all sectors and services adhere to a commitment to the underlying philosophies of serving families. Partnerships can be forged to establish legislative statutes, administrative regulations or policies, or procedural guidelines to reflect the best standards of care and best practice models for

family support programs. Finally, SECCS Initiatives can collaborate with professional groups to jointly administer licensure and certification programs for family support staff, such as home visitors, in order to ensure a multidisciplinary approach and the quality of service delivery.

Best Practices and Community Building

SECCS Initiatives can provide or participate in efforts to foster the use of best practices in the family support field. SECCS Initiatives can participate in technical assistance centers or partner with organizations to create state/local capacity where none exists. Technical assistance centers can bring local family support programs together with policymakers, funders and evaluators from various sectors to serve a wide variety of functions. These include:
- Coordinate training and research activities;
- Provide key forums for developing collaborative planning;
- Serve as a clearinghouse for information;
- Develop clearly defined roles and responsibilities between agencies;
- Establish inter-agency referral procedures;
- Conduct community-wide needs assessments and assets mapping;
- Institute accrediting programs;
- Develop standard mechanisms to evaluate and analyze programs; and
- Create research networks to collect and disseminate the most up-to-date information regarding what has been shown effective in the field.

SECCS Initiatives can also offer a range of community building tools so that local entities and statewide initiatives all have access to the most effective and up-to-date resources that will help them achieve their goal. There are many competencies such as asset based planning, strategic planning, coalition building, evaluation, financing, etc., that communities need to acquire in order to build successful and sustained systems of family support. SECCS Initiatives can help to ensure that those doing the work have easy access to the tools they need. Increasingly, comprehensive toolkits are being made available over the internet or through academic and non-profit institutions. Providing access to community building tools helps to promote a greater degree of equity amongst regions, sectors, and populations.

Provision of Services

The initiative was not created as a method of delivering the many services needed by families, nor supplanting existing service funding. However MCH agencies and partners of the Initiative can create more and coordinated funding efforts to address gaps in the current fragmented service system. For instance, Title V programs may directly fund, or through third party contracts, the service centers that do or could become more comprehensive, integrated service delivery platforms. The MCH investment could be leveraged by education, social service, mental and other health sectors. MCH can also continue to play a direct role in the provision of home visiting programs that either operate through or independently from family resource centers.

Facilitate Interagency Coordination

Services for families with young children are currently delivered through multiple agencies that often operate in relative isolation from one another. Departments of Education and Mental Health, welfare agencies, Medicaid programs, and social service agencies all provide some component of family support. SECCS Initiatives can play an important role in facilitating interagency coordination by creating more defined pathways of care within communities between the family support service providers. For instance, children with special health care needs have been increasingly cared for in the context of a medical home. MCH agencies have been on the leading edge of establishing medical homes throughout states, and a major component in the SECCS Initiative is access to these services. Yet, young children continue to experience discontinuity and barriers to care, partly because the connectedness of the medical home (physician's office) and the broader community supports (including family support services) is not always well defined.

MCH agencies can play a pivotal role in engaging their traditional partners in the medical community including private practice pediatricians, obstetricians, community clinics, hospitals, and health plans. Linking these medical providers to community supports through referral or co-location options helps families access the services that may ultimately result in a better health and development outcome. Coordination between entities, such as physician offices and family support services, may be as formalized as a contract or MOU, or simply knowledge of each organization's services. While family support providers can be health care advocates and improve access to care, health care providers' offices can serve as a platform from which to identify and refer clients to local family support services. In turn, family support services can increase the effectiveness of the health care sector by providing supplemental services that are often not covered by managed care or medical insurance plans.

Advocating for innovative financing mechanisms

SECCS Initiatives can help address the funding gaps, and inflexible funding categories that impede the sustainability of family support programs. As a preliminary step, programs can be supported in refining existing methods of coordinating multiple funding streams. This includes looking closely at the existing sources of funding, the services and infrastructure that need funding, and the gaps between them. Long-term funding resources, although increasingly hard to come by, are better suited for operations and salaries than short-term grants. On the other hand, one-time gifts and investments might be best suited for equipment or a time-limited improvement.[42]

SECCS Initiatives may also concentrate efforts on maximizing the leveraging opportunities for family support. These may come from traditional matching opportunities, such as those afforded through health programs (Medicaid and SCHIP), as well as other options within entitlement programs, such as claiming for administrative activities related to Medicaid.[39]

Other options that require action from leadership and policymakers might include the "pooling" of funding streams. Pooled dollars may come from several categorical sources, but are combined together at a local or state level to be distributed with greater flexibility and opportunity to meet specific local needs. Pooled dollars can often be used to fund family support activities that normally cannot be funded directly from restrictive funding streams such as collaborative community-wide planning and data collection efforts, and technical assistance initiatives. By working on and advocating for different approaches to funding, the SECCS Initiatives can be the catalyst for comprehensive and integrated family support systems, while confronting the longer term issues of program and system sustainability.

Conclusions

The goal of this paper has been to inform SECCS Initiatives as they build partnerships and leadership and foster collaboration around services that enable families to support the needs of their children. While this paper offers potential areas where SECCS Initiatives can focus efforts to build partnerships and foster leadership, the authors acknowledge the barriers associated with this task. Any collaborative effort is confronted with limited funding, staff resources and time, and potential conflicts in turf or personality. These issues are not unique to the family support movement however, and this paper attempts to underscore the incentives to engaging in such a challenging process.

The family support movement can help to focus SECCS Initiatives on the needs of young children and their families, and SECCS Initiatives can help family support services evolve into more integrated systems of service delivery. SECCS Initiatives can leverage their expertise and resources by continuing to partner with other family support sectors and by learning from the family support movement in terms its philosophy, multidisciplinary perspectives, ecological model, and diverse array of services. Likewise, SECCS Initiative partners can lend their political support, agency infrastructures, expertise, and institutional flexibility to help build the capacity of this fragmented and disconnected field. Making this level of commitment is needed to address the stressors of parenting for all families and the complex set of needs found in every community.

Family Support America:
        http://www.frca.org
Family Support Council:
        http://www.fscouncil.org
National Center for Family Support:
        http://www.familysupport-hsri.org
Pew Partnerships:
        http://www.pew-partnerships.org
Family Resource Programs (FRP) Canada:
        http://www.frp.ca
Richmond County Community Support Center:
        http://www.richmondsupportcenter.com
New Hampshire Children's Trust Fund:
        http://www.nhctf.org
National Center for Early Development and Learning:
        http://www.ncedl.org
National Network of Family Resiliency:
        http://www.unt.edu/cpe
National Parenting Information Network:
        http://www.npin.org
Parents as Teachers National Center, Inc.:
        http://www.patn.org
Ready to Learn:
        http://www.pbskids.org
Step by Step: Parenting Birth to Two:
        http://www.parenting.umn.edu
Zero to Three:
        http://www.zerotothree.org
Center for Effective Parenting:
        http://www.parenting-ed.org
Child Trends:
        http://www.childtrends.org
Child Welfare League of America:
        Family-Centered Practice Program: http://www.cwla.org
National Center for Children in Poverty:
        http://www.nccp.org
National Center for Family Literacy:
        http://www.famlit.org
The Finance Project:
        http://www.financeproject.org
UCLA Center for Healthier Children, Families, & Communities:
        http://www.healthychild.ucla.edu

Appendix B:
Home Visiting Best Practices

Improving the Design of Home Visiting Programs: Olds et al. emphasize three essential principles that should be addressed in designing home visiting program interventions for young children and their families.[35] First, home visiting program interventions should be grounded in epidemiology and developmental research to help identify the adverse outcomes a program seeks to address and to understand the modifiable risks and protective factors associated with these outcomes. Second, program interventions should employ a theory of behavior change such as self-efficacy theory or attachment and object relationship theory. Third, home visiting programs are much more likely to be effective if they are perceived as relevant and needed by the community being served.

- Well-Defined Program Protocol and Curriculum: Effective home visiting programs demonstrate that they have a well-defined and documented program protocol and curriculum that allows flexibility to individualize activities to respond to specific client needs or family crisis.
- Intensity of Services: Although no studies have determined the optimal frequency and duration of program services, the intensity of services should be considered in light of program goals and family needs. Some researchers have suggested that at least four visits or at least three to six months of service are needed before families can benefit.[3]
- Staff Qualifications: Although research has not yet delineated the best qualifications of staff, decisions about the educational, professional, and personal qualifications and standards are pivotal and dependent on each individual program's target population and goals.
- Training and supervision: Home visitors need regular, formal and reflective supervision to provide them a safe time and place in which they can candidly discuss the families with whom they are working from both objective and subjective points of view.[42] This is particularly important to home visitors because home visitors work in isolation during much of the day.
- Program Evaluation: Conducting program evaluation for home visiting programs is essential for tracking the outcomes experienced by clients in a project, determining if the program is being implemented as intended, if staff is meeting their objectives, and where program improvements are needed. Although each program collects data that assesses the success of its unique goals and corresponding intervention strategies, community wide evaluations and comparisons are facilitated by the use of standard measurement tools that have been tested and proven reliable and valid. A comprehensive list of measurement tools used in recent program evaluations is found in the 1999 home visiting issue of The Future of Children.[33]
- Embedding home visiting programs in comprehensive family resource centers is believed to improve program effectiveness on a variety of other levels.[43] For the home visitors, having a program that is integrated with the activities of a family resource center helps to increase opportunities to consult with multidisciplinary staff. For the clients, combining home visiting with center-based activities helps

to reinforce the educational efforts of both program components. For the parents, combining home visiting with a center-based component can help to reduce social isolation and can introduce them to additional resource staff. Combined, these factors help to increase family engagement in home visiting programs and reduce family attrition.

Appendix C:
Model Program – Ounce of Prevention

The Educare Center [44]

The Educare Center in Chicago represents an example of how private dollars can leverage public commitment – The partnership which includes Irving Harris, The Ounce of Prevention Fund, the Head Start program, Chicago Public Schools, and other State level and private donors, has developed a multi-service center that enrolls children and families in an array of early childhood development, health, nutrition and family support services.

The Educare Center links childcare and preschool with other services provided in the community to create an integrated, comprehensive early childhood system of care. The Educare Center offers children under six a full-day childcare program and connects families to an intensive home visiting program and a health clinic. Credentialed teachers work with young children on language and early literacy skill building as well as encourage socioemotional development. Linkages to health and social services show that the childcare center connects young children and their families to needed services.

The program has an emphasis on language and socioemotional development and supports the ability of young parents to stay in school or to move from welfare to work. Families enrolled in the Educare Center have access to the centers parent support groups, and self-sufficiency and adult education series. The Educare Center also includes: low child/staff ratios, literacy development, an arts program, infant mental health services, nutrition consultation, primary care health services for children and families,

Appendix D:
Model Program – The Hope Street Family Center[45]

The Hope Street Family Center was established in 1992, as a collaboration between the University of California, Los Angeles and California Hospital Medical Center. Located at a large birth hospital in downtown Los Angeles, Hope Street is a family resource center that integrates home visitation with comprehensive center-based early childhood education, childcare, parenting, health services, adult education, and family literacy services. The Hope Street home visitation program is part of a national effort to promote the overall health, social, emotional, cognitive, and physical development of children, zero to five years of age, while simultaneously enhancing family self-sufficiency and the capacity of families to nurture and care for their young children. The target population for home visitation services includes pregnant women, infants, toddlers, and pre school-aged children, who meet federal low-income guidelines, and live within the service area of central Los Angeles.

Qualities and characteristics used to guide staff hiring include: (a) linguistic and cultural competence, (b) an understanding of how to serve young children within the context of their family, (c) experience in providing home-based services, and (d) a willingness to acquire new skills and expand one's area of expertise. Home visitors are required to have a minimum of a bachelor's degree in the areas of early childhood education, social work, psychology, nursing, or a related field. The program also utilizes a supervisory team with master's degrees in psychology, social work, early childhood education, and nursing. This mix of backgrounds and areas of clinical expertise encourages staff to employ multidisciplinary approaches in planning, developing, and implementing home visitation services.

The home visitation program utilizes a locally developed curriculum that draws heavily upon the Partners in Parenting (PIPE) and Creative Curriculum (Trister-Dodge). The content of the home visit is the result of weekly planning between the parent and the home visitor and is based upon an assessment of family interests, needs, and strengths in the areas of health and nutrition, child development and parenting, education and training, family relationships and community supports, and the physical home environment.

Many of the fathers in the families who receive home visitation services are working and therefore unable to participate in home visits conducted during the day. Through the Daddy and Me playgroups and the Dads and Kids Saturday activities, the program makes a special effort to ensure that fathers have opportunities to spend time with their young children, in ways that strengthen the development of healthy, positive relationships. The Hope Street Family Center is supported by funds from the U.S. Department of Health and Human Services, Head Start Bureau; California Department of Education; City of Los Angeles; Los Angeles County Children and Families First, Prop 10 Commission; California Hospital Medical Center Foundation; UniHealth Foundation; Catholic Healthcare West Southern California; and a variety of private donors and foundations.

Appendix E:
Model Program – Nurse Home Visitation Program[46]

The Nurse Home Visitation Program (recently named the Nurse-Family Partnership - NFP) was developed by Dr. David Olds and is a two-year nurse visiting program targeting low-income first time mothers. NFP aims to improve pregnancy outcomes, child health and development, and maternal life course and is being replicated nationwide by the National Center for Children, Families and Communities (NCCFC). Currently over 22 states operate programs. The NFP is guided by a strong theoretical orientation and consists of intensive and comprehensive home visitation by nurses during a woman's pregnancy and the first two years after birth of the woman's first child. While the primary mode of service delivery is home visitation, the program depends upon a variety of other health and human services in order to achieve its positive effects.

The program is designed to serve low-income, at-risk pregnant women bearing their first child. Nurse home visitors work with families in their homes during pregnancy and the first two years of the child's life. Typically, a nurse visitor is assigned to a family and works with that family through the duration of the program.

A major program of research at the Center has been the administration of three large scientifically controlled studies of this model - first in Elmira, New York, then in Memphis, Tennessee, and most recently in Denver, Colorado. In the studies, pregnant women were randomly assigned either to this program model or comparison services and then were evaluated from the standpoint of the program's goals and assessed over time (e.g., though adolescence). The studies are designed to determine whether the provision of prenatal and infancy home visits improves maternal, child, and family health and well-being as the children mature. The Nurse-Family Partnership program produced consistent benefits for low-income mothers and their children through the child's fourth year of life in women's prenatal health (especially use of cigarettes); injuries to children; rates of subsequent pregnancy; and use of welfare.

In a 15-year follow-up of the Elmira sample, among low-income unmarried women and their children, the program also was found to have produced: a 79 percent reduction in child abuse and neglect; 44 percent reduction in maternal behavioral problems due to their use of alcohol and drugs; 69 percent fewer arrests among the mothers; 54 percent fewer arrests and 69 percent fewer convictions among the 15-year-old adolescents; 58 percent fewer sexual partners among the 15-year old adolescents; 28 percent fewer cigarettes smoked and 51 percent fewer days consuming alcohol among the 15-year old children; and four dollars saved for every dollar invested

The cost of the program was recovered by the first child's fourth birthday. Substantial savings to government and society were calculated over the children's lifetimes. In 1997, the two-and-a-half-year program was estimated to cost $3,200 per year per family during the start-up phase (the first three years of program operation) and $2,800 per family per year once the nurses are completely trained and working at full capacity.

References

1.   The five SECCS Initiative components are: early care and education; medical home; family support; parent education; and mental health and socio-emotional development.

2.   Adapted from the Task Force on Young Children and Families, a legislative committee established by the New Mexico state legislature.

3.   Acs, G., Nelson, S., *The more things change? Children's living arrangements since welfare reform.* Snapshots 3 of America's Families, 2003. 10.

4.   Kenney, G., Haley, J., Tebay, A., *Children's insurance coverage and service use improve.* Snapshots 3 of America's Families, 2003. 1.

5.   O'Hare, W., Mather, M., *The growing number of kids in severely distressed neighborhoods: Evidence from the 2000 Census*, in *KIDS COUNT/PRB Reports on Census 2000.* 2003, The Annie E. Casey Foundation and the Population Reference Bureau, *www.kidscount.org*.

6.   Kagan, S., Neuman, M., *Family Support: Program, Philosophy, Approach, or Movement? www.ed.gov/offices/oeri/eci/newsletters/96spring/familysupport.html*, 1996.

7.   Halfon, N., Taaaffe, M., Schuster, M., *Child Rearing in America: Challenges facing parents with young children*, N. Halfon, Taaffe, M., Schuster, M., Editor. 2002, Cambridge University Press: Cambridge. p. 367-412.

8.   *Putting families first: America's family support movement and the challenge of change.* Kagan, S., Weissbourd B. 1994, San Francisco: Jossey-Bass.

9.   Kilburn, R., Wolfe,B., *Resources devoted to child development by families and society*, in *Child Rearing in America: Challenges facing parents with young children*, N. Halfon, Taaffe, M., Schuster, M., Editor. 2002, Cambridge University Press: Cambridge. p. 367-412.

10.   Osofsky, J., Thompson, D., *Adaptive and maladaptive parenting: Perspectives on risk and protective factors*, in *Handbook of Early Childhood Intervention*, J. Shonkoff, Meisels, S., Editor. 2000, Cambridge University Press: Cambridge.

11.   Bronfenbrenner, U., *Ecological systems theory.* Annals of child development, 1989. 6: p. 187-249.

12.   Belsky, J., *The determinants of parenting.* Child Development, 1984. 55: p. 83-96.

13.   Brooks-Gunn, J., Brown, B., Duncan, G. Moore, K., *Child development in the context of family and community resources: An agenda for national data collection.*, in *Integrating federal statistics on children, report of a workshop.* 1995, National Research Council and Institute of Medicine: Washington D.C.

14.   Brooks-Gunn, J., Britto, R., Brady, C., *Struggling to make ends meet: Poverty and child development.* Parenting and child development in "nontraditional" families, ed. M. Lamb. 1999, Chicago: University of Chicago Press.

15.   Werner, E., *Protective factors and individual resilience*, in *Handbook of Early Childhood Intervention*, J. Shonkoff, Meisels, S., Editor. 2000, Cambridge University Press: Cambridge.

16.   *From Neurons to Neighborhoods: The Science of Early Childhood Development*, ed. J. Shonkoff, Phillips, D. 2000, Washington D.C.: National Academy Press.

17.   Taaffe Young, K., Davis, K., Schoen, C., *The Commonwealth Fund Survey of Parents with Children*. 1996, The Commonwealth Fund: New York.

18.   Cochran, M., Neigo, S., *Parenting and social networks*, in *Handbook of parenting*, M. Bornstein, Editor. 1995, Mahwah, NJ: Erlbaum. p. 393-418.

19.   Burchinal, R., Follmer, A., Bryant, M., *The relations of maternal social support and family structure with maternal responsiveness and child outcomes among African American families.* Developmental Psychology, 1996. 32: p. 1073-1083.

20.   Lyons-Ruth, K., Wolfe, R., Lyubchik, A., Steingard, R, *Depressive symptoms in parents of children under age 3: Sociodemographic predictors, current correlates, and associated parenting behaviors*, in *Child Rearing in America: Challenges Facing Parents with Young Children*, N. Halfon, Taaffe, M., Schuster, M., Editor. 2002, Cambridge University Press: Cambridge.

21.   Pruett, K., *How men and children affect each other's development.* Zero to Three, 1997. 18(1).

22.   Yogman, M.W., B.M. Lester, and J. Hoffman, *Behavioral and cardiac rhythmnicity during mother-father-stranger infant social interaction.* Pediatric Research, 1983. 17(11): p. 872-6.

23.   Yogman, M.W., D. Kindlon, and F. Earls, *Father involvement and cognitive/behavioral outcomes of preterm infants.* J Am Academy Child Adolescent Psychiatry, 1995. 34(1): p. 58-66.

24.   *http://fatherhood.hhs.gov/index.shtml*, U.S. Department of Health and Human Services.

25.   Sylvester, K., Reich, K., *Restoring fathers to families and communities: Six steps for policymakers*. 2000, Social Policy Action Network.

26.   *The Guiding Principles of Family Support*, Canadian Association of Family Resource Programs (FRP) www.frp.ca.

27.   Weissbourd, B., *The evolution of the family resource movement.* Putting families first: America's family support movement and the challenge of change, ed. S. Kagan, Weissbourd, B. 1994, San Francisco: Jossey-Bass.

28.   Anderson, L., Scrimshaw, S., Fullilove, M., Fielding, J., Normand, J., *Culturally competent healthcare systems. a systematic review.* American Journal of Preventive Medicine, 2003. 24(3): p. 68-79.

29.   Gardner, S., *The future and sustainability of family resource centers: Asking the hard questions about family support programs in California - Draft*. 2002, Children and Family Futures: Irvine.

30.   *Supports for Low Income Families; States Serve a Broad Range of Families through a Complex and Changing System*. GAO-04-256: Washington DC. January 2004

31.   Morrill, W., *Overview of service delivery to children.* The Future of Children, 1992: p. 32-43.

32.   Johnson, K., *No place like home: state home visiting policies and programs*, in *Healthy steps for young children*. 2001, The Commonwealth Fund: New York.

33.   Gomby, D., Culross, P., Behrman, R., *Home visiting: recent program evaluations - analysisi and recommendations.* The Future of Children, 1999. 9.

34.   Karoly, L., Greenwood,P., et al., *Investing in our Children*. 1998: RAND.
35.   Olds, D., et al, *Update on home visiting on pregnant women and parents of young children.* Current Problems in Pediatrics, 2000. 30(4).
36.   Waddell, B., Shannon, M., Durr, R., *Using family resource centers to support California's young children and their families*, in *Building Community Systems for Young Children*. 2001, UCLA Center for Healthier Children, Families and Communities.
37.   Kaplan, D., Brindis, D., Phibbs, S., Melinkovich, P., et al., *A comparison study of an elementary school-based health center; Effects on health care access and use.* Archives of Pediatric Adolescent Medicine, 1999. 153.
38.   Ramey, S., *Head Start and preschool education.* American Psychologist, 1999. 54(5).
39.   Schorr, L., *Common Purpose*. 1997, New York: Anchor Books.
40.   Fisher, H., Cohen, C., Flynn, M., *Federal funding for early childhood supports and services: A guide to sources and strategies*. 2000, The Finance Project: Washington, D.C.
41.   Watson, S., Westheimer, M., *Financing family resource centers: A guide to sources and strategies*. 2000, The Carnegie Corporation of New York & The Finance Project: New York.
42.   Hayes, C., *Financing early childhood initiatives: Making the most of Proposition 10*. 2000, UCLA Center for Healthier Children, Families and Communities & The Finance Project: Los Angeles.
43.   Thompson, L., Kropenske, V., Heinicke,C., Gomby, D., *Home visiting: A service strategy to deliver Proposition 10 results*, in *Building Community Systems for Young Children*, N. Halfon, Shulman, E. et al., Editor. 2001, UCLA Center for Healthier Children, Families and Communities.
44.   *www.ounceofprevention.org*
45.   Personal and written communication with Vickie Kropenski, Director of Hope Street Family Center, 2000.
46.   *www.nccfc.org*, National Center for Children Families and Communities.