FINAL REPORT

Services for Migrant Children in the Health, Social Services, and Education Systems

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Glossary of Acronyms

ABE	Adult Basic Education
AFDC	Aid to Families with Dependent Children
AFOP	Association of Farmworker Opportunity Programs
AIDS	Aquired Immune Difficiency Syndrome
ASPE	Assistant Secretary for Planning and Evaluation
BCRR	Bureau of Community Health Services Common Reporting Requirements
BOCES	Board of Cooperative Educational Services
CAMP	College Assistance Migrant Program
CHC	Community Health Center
CPS	Current Population Survey
CRESS	Clearinghouse on Rural Education and Small Schools
DHHS	Department of Health and Human Services
ECMHS	East Coast Migrant Head Start
EFNEP	Expanded Food and Nutrition Education Program
ELPA	English Language Proficiency Act
ERIC	Educational Resources Information Center
ESC	Education Service Center
ESL	English as a Second Language
FHA	Federal Housing Administration
FTE	Full-Time Equivalent
GAO	General Accounting Office

GED	General Educational Development
HCHC	Hidalgo County Health Care Corperation
HEP	High School Equivalency Program
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IDEA	Individuals with Disabilities in Education Act
IMEC	Interstate Migrant Education Council
IRCA	Immigration Reform and Control Act
JTPA	Job Training Partnership Act
LEA	Local Education Agency
LULAC	League of United Latin American Citizens
MEP	Migrant Education Program
MH	Migrant Health
MHC	Migrant Health Center
MHS	Migrant Head Start
MSFW	Migrant and Seasonal Farm Workers
MSRTS	Migrant Student Record Transfer System
NCCP	National Center for Children in Poverty
NCME	National Council on Migrant Education
NEIS	National Evaluation Information System
NSCHC	National Association of Community Health Centers

NACMH	National Advisory Council on Migrant Health
NASDME	National Association of State Directors of Migrant Education
NAWS	National Agricultural Workers Survey
NMRP	National Migrant Resource Program
PASS	Portable Assisted Study Sequence
QALS	Quarterly Agricultural Labor Survey
SCEAP	Secondary Credit Exchange and Accrual Project
SEA	State Education Agency
TAAS	Texas Assesment of Academic Skills
TMC	Texas Migrant Council
TMIS	Texas Migrant Interstate Program
UI	Unemployment Insurance
USDA	United States Department of Agriculture
WIC	Supplemental Food Program for Women Infants and Children
WIRS	Weld Information Referral Service

SERVICES FOR MIGRANT CHILDREN IN THE HEALTH, SOCIAL SERVICES, AND EDUCATIONAL SYSTEMS

I. INTRODUCTION AND STUDY PURPOSE

In addition to the many challenges faced by all children in poverty, migrant children face mobility, language, and cultural barriers to obtaining educational, health, and social services. Migrant farmworkers are generally defined as persons who cross a prescribed geographic boundary and stay away from their normal residences overnight to perform farmwork for wages. The purpose of this study is to identify the needs of migrant children, to examine how these needs are being met in selected sites, and to identify successful models of service integration that might be more widely adopted. As our population becomes more multicultural and multiethnic, programs that have been successful in serving migrant farmworkers may be instructive to other service providers and program planners who must learn how to overcome language and cultural barriers.

An assessment of services for migrant children requires an approach that cuts across federal programs and traditional categories and disciplines. Because of this, examining the needs of migrant children is a useful way of studying evaluation and policy issues related to services for children and youth--issues of concern to the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (ASPE/HHS), which sponsored this study.

Current Interest in the Migrant Population and in Family Service Integration

Recent national interest in migrant farmworkers, in children and families, and in service coordination underscores the timeliness of this project. There is now the feeling, particularly at the federal level, that it is time to assess services for migrant farmworkers in this country. This interest is signaled by benchmarks such as the 30th anniversary of the Migrant Health Program, the 20th anniversary of the National Health Service Corps (an important source of health professionals serving migrants), and the completion of the work of the National Commission on Migrant Education, which was established by Congress in 1988 to study the issues related to the education of migrant children and report their findings to the Secretary of Education and Congress. Over the past year alone, the findings of a number of important federally commissioned studies on the migrant population have been published.[1]

[1] See, for example, "Integration and Coordination of Services at Migrant Health Centers" (National Migrant Resource Program 1992), sponsored by the Health Resources and Services Administration (HRSA); "Hired Farmworkers: Health and Well-Being at Risk" by the U.S. General Accounting Office (1992); "Coordination of Migrant and Seasonal Farmworker Service Programs" (Martin and Martin 1992), conducted for the Administrative Conference of the United States; and "Invisible Children: A Portrait of Migrant Education in the United States" by the National Commission of Migrant

This project also dovetails with the current federal focus on children and families and service integration. The Departments of Health and Human Services (HHS), Education, Labor, and Housing and Urban Development are all interested in comprehensive service integration efforts. These efforts center on strengthening families faced with challenging social, economic, and health problems (Behrman 1992). The creation of the National Center for Service Integration, which received initial funding from HHS, was due in part to this interest in service integration. So, too, was a recently completed study for ASPE/HHS, which focuses on comprehensive services integration programs for at-risk youth (Burt, Resnick, and Matheson 1993).

Interest in services integration extends beyond the federal government. Richard Behrman, of the Center for the Future of Children, notes that "proposals to link health and social services to schools are at the forefront of the policy agenda for children." For instance, in January 1991 newly elected California Governor Pete Wilson signed an executive order creating a cabinet-level position--Secretary of Child Development and Education--and mandating the presentation of recommendations regarding "the integration of social, health, mental health, and support services in the schools" (Behrman 1992). A small but insightful body of literature has emerged from this interest.[2]

Project Objectives

This project, carried out from June 1992 to February 1993, aims to meet the following objectives:

- Identify six exemplary programs for migrant children that are successfully integrating two or more services;
- Identify factors that facilitate integration both at the program, local agency, and community levels and at the state and federal levels;
- Identify gaps in services at the sites studied;
- Identify barriers to successful, comprehensive service delivery for migrant children; and
- Identify research and evaluation issues for the future, including evaluation design options, measurement opportunities, and data collection needs.

Education (1992).

[2] See, for example, "Integrating Human Services: Linking At-Risk Families with Services More Successful than System Reform Efforts" (GAO 1992e); and "Serving Children and Families Effectively: How the Past Can Help Chart the Future" (Edelman and Radin 1991), which is a report done for the Education and Human Services Consortium.

Sites Selected

Sites were selected to represent a range of factors, including geographic location, programs involved in the service integration effort, ages of the children served, and grower involvement or support. Each site evidenced good coordination between at least two of the major federal programs serving migrants (i.e., Migrant Education, Migrant Head Start, Migrant Health). The methodology used to select sites for this study is described in Appendix A. The six sites selected were:

- Brockport, New York (Monroe County);
- Greeley, Colorado (Weld County);
- Stockton, California (San Joaquin County);
- Woodburn, Oregon (Marion County);
- McAllen, Texas (Hidalgo County);
- Belle Glade, Florida (Palm Beach and Hendry Counties).

Site visits were conducted by a two-person team, and included interviews with representatives of key programs serving migrants, as well as a variety of community agencies. Managers as well as service providers were interviewed during three-day visits. Visits also included on-site observations of program operations, tours of migrant housing facilities, attendance at parent or community meetings, and informal discussions with migrant students and parents. A summary description of each site is included in Appendix E. Detailed case studies of each site are available upon request.

Outline of This Report

Part II of this report describes the migrant population examined. Part III discusses the service needs of migrant children, and updates information provided in the background paper prepared for this project (Pindus et al. 1992).[3] Part IV examines services integration and service delivery issues, providing the conceptual framework for the cross-site synthesis in Part V. Part VI updates findings concerning evaluation issues that were addressed in our background paper. Part VII presents policy issues and implications for further research. Appendices to this report include: a description of the study methodology, the site visit discussion guide, a summary of federal programs serving migrant families, a discussion of data sources and limitations, summaries of each of the sites visited, and a bibliography.

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[3] The background paper reviewed the literature, identified service needs of migrant children, and described essential components of an ideal program integrating services for migrant children. The background paper was used to clarify study issues and refine the study plan.

II. DESCRIPTION OF THE MIGRANT POPULATION

Data on the demographic characteristics of migrants are very limited. Below we discuss some key definitional concerns that have shaped data collection and reporting, identify available data sources, and broadly describe the demographic profile of the migrant farmworker population.

Definitions

The geographic profile, distribution, and size of the migrant population differs depending on how "migrant" and "farmworker" are defined. For example, according to the United States Department of Agriculture's (USDA) Hired Farm Worker Force (HFWF) survey, farmworkers are mostly white teenagers (Martin and Holt 1987).[4] By contrast, most program data and the more recent National Agricultural Workers Survey (NAWS) characterize migrant farmworkers as adult, Hispanic, male, and foreign-born (Mines, Gabbard and Boccalandro 1991). This divergence stems at least in part from a difference in the definition of "migrant farmworker" used, as well as from biases in the data. For example, in the HFWF survey, the USDA defined migrants as persons who crossed county or state lines and stayed away from home at least one night during the year to do farmwork for wages. Since this definition of migrant farmworker imposed no occupational, earnings, or legal status criteria, Iowa teenagers who lived and worked on an uncle's farm in another county during the summer could be migrants, as well as teenagers in Hispanic families who migrated from Texas to Michigan. Similarly, the definition includes veterinarians as well as field hands (Martin and Martin 1992). In contrast, the NAWS is limited to field workers, and excludes workers such as secretaries and mechanics who are employed in seasonal agricultural services (SAS).

Migrant farmworkers are not identified as a separate group in federal labor force data, because migrant is not an occupation, but a characteristic of a subgroup of farmworkers. Thus, migrants are estimated as a subset of all farmworkers. Another subset of farmworkers are seasonal agricultural workers, whose principal employment is in agriculture on a seasonal basis. Depending upon the data source or program definition, seasonal agricultural workers may include migrant farmworkers, or the classification may be limited to those workers whose seasonal farmwork does not involve overnight travel or change of residence.

The definition of farmwork, the length of stay requirements, and the traveling distance needed to qualify for migrant status all differ among data sources. Some definitions require an overnight stay, some longer periods. Some require workers to cross county lines, others school district lines. Some farmwork definitions include only crop farming and agricultural services, while others include livestock work, fisheries, packaging, canning, or transporting of agricultural products. Our site visits also revealed that definitions vary from location to location, and from

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[4]The Hired Farm Worker Force survey was based on the agricultural supplement to the December Current Population Survey.

program to program. These differences depend on federal and state program requirements, local needs and interpretations, and differing jurisdictional boundaries.

One important definitional issue that arises in the context of program eligibility is the "look back period," or the length of time after migrating that a person continues to be considered a migrant farmworker. The major federal programs serving migrants have different requirements in this regard (see Appendix C for descriptions of these programs). For example, Migrant Head Start defines an eligible family as one that has migrated for the purpose of farmwork in the past 12 months, while Migrant Health requires employment as a migrant farmworker in the past 24 months. Migrant Education serves "currently migrant" children, those whose families have migrated in the past 12 months, as well as "formerly migrant" children, those whose families have migrated in the past five years.

Data Sources and What They Tell Us About the Population

The existing employment and wage data pertaining to migrants are somewhat better than data covering other demographic characteristics of migrants, and have been collected regularly for some time. Some of these data are collected quarterly by the U.S. Department of Agriculture (USDA), and some are collected every five years by the Bureau of the Census in its Census of Agriculture (for a more detailed discussion of data sources and limitations, see Appendix D).

Estimates of the number and distribution of farmworkers in general, and migrants specifically, vary widely. The estimate for the number of migrant farmworkers ranges from 115,000 (Slesinger 1984) to more than 1.5 million migrants and dependents (Martin and Holt 1987). Sources that estimate totals between two and five million may include seasonal agricultural workers as well as migrants (National Commission on Migrant Education 1992; Interstate Migrant Education Council 1992; Mobed, Gold, and Schenker 1992).

The best demographic data available on farmworkers are from the National Agricultural Workers Survey (NAWS). The drawback to these data for our purposes is that they cover all perishable crop farmworkers, but neglect livestock and farm service workers. In addition, they do not distinguish between migrants and nonmigrants. Based on data collected by NAWS, migrants represent approximately 42 percent of the estimated 2 million U.S. crop farmworkers. An analysis of the NAWS data collected during fiscal years 1989, 1990, and 1991 indicates that migrants differ from settled farmworkers in many respects (Mines, Gabbard, and Samardick 1992). Eighty-two percent of migrant farmworkers are men, compared to 66 percent of nonmigrants. Hispanics, including those who were born in the United States, make up 94 percent of the migrant group. Eight out of ten migrants were born in Mexico. While migrants are just as likely as nonmigrants to be married, they are more than twice as likely (59 percent vs. 28 percent) to be separated from their families during periods of seasonal agricultural services (SAS) work.

Other information available from NAWS pertains to all SAS workers, not specifically to migrant farmworkers. Social and economic characteristics of this group are: lower than average educational levels, lack of English fluency, low income levels, low level of participation in needs-based social service programs, and a high incidence of supplemental income from non-farm employment. Almost half have eight years of education or less, and fewer than half can speak and read English (Mines, Gabbard, and Boccalandro 1991). Half of SAS worker families have incomes below the poverty level, yet only 18 percent are recipients of needs-based social services, the most common of which is Food Stamps (Mines, Gabbard, and Boccalandro 1991). It is estimated that only 3 percent of migrant farmworkers participate in the AFDC program and only 16 percent receive Food Stamps (National Commission on Migrant Education 1992). Over one-third of SAS workers spend time doing non-farm work (Mines, Gabbard, and Boccalandro 1991).

With respect to the numbers of migrant children, 54 percent of SAS workers have children, almost 80 percent of whom reside with their farmworker parent at the work site (Mines, Gabbard, and Boccalandro 1991). Each year, approximately 587,000 children who are currently migratory are in the United States. Of this number, 382,000 (65 percent) below age 22 travel with their parents but do not do farmwork; 36,000 (6 percent) travel with their parents and do farmwork, and 169,000 (29 percent) travel on their own to do farmwork (P. Martin 1992, cited in National Commission on Migrant Education 1992).

It is estimated that 40 percent of SAS workers spend some time abroad (this is mainly workers going home to Mexico for some time during the year). This estimate (Mines, Gabbard, and Boccalandro 1991) is the only measure of migration currently available, and the figure only captures farmworkers who travel from another country, not those who only migrate from state to state or between counties.

Richard Mines, an economist with the U.S. Department of Labor, estimates that one-third of all farmworkers are "shuttle migrants" who go back to Mexico for a month during the year, while 13 to 14 percent are "follow-the-crop migrants" who work in two or more counties. He also suggests that significant overlap exists between these two groups. Approximately two-thirds of migrant children are shuttle migrants (National Commission on Migrant Education 1992).

The demographic profile of farmworkers has changed since the inception of many of the federal and local programs that serve them. In the past, farmworkers were more likely to be white, younger, and slightly better educated. On the east coast, migrant farmworkers were more likely to be blacks who were born in the rural south. Additionally, the proportion of farmworkers who traveled long distances bottomed out during the high gasoline prices of 1979-1980 and has recovered somewhat, but not to the levels of the early 1970s (Martin and Holt 1987). Migrant Student Record Transfer System (MSRTS) data reveal that the proportion of currently and formerly migrant children has changed as well. During the past decade, the number of currently migrant children increased by about 17 percent, while the number of formerly migrant children increased by 42 percent (P. Martin 1992, cited in National Commission on Migrant Education 1992). While the total of formerly and currently migrant children in Migrant Education is about

evenly distributed nationwide, states vary widely in their proportions. For example, the percentage of children in Migrant Education who were formerly migrant was as little as 3 percent in North Dakota and as high as 79 percent in Massachusetts. In the six states visited, the percentage of children in Migrant Education who were formerly migrant was as low as 33 percent in Colorado and as high as 62 percent in California (P. Martin 1992, cited in National Commission on Migrant Education 1992).

A number of smaller studies provide profiles of migrant farmworker populations in subsections of the country. While these data are "snapshots" because they are one-time only studies of specific locales, they do provide additional detail on the demographic characteristics of the migrant population. For example, Dever's (1991) study of farmworkers in the midwestern migratory stream, which looked at demographic characteristics in homebase areas in Texas as well as non-homebase areas in Michigan and Indiana, found that homebase households were poorer and had more children than households in non-homebase areas. As many as 58 percent of all households in migrant homebase areas in Texas are below nationally defined poverty levels, compared with only 1.4 percent of all households nationally. The homebase counties included in Dever's study had more children under 15 and fewer elderly over 65 than either the United States in general or non-homebase migrant areas. Over 20 percent of households in the homebase area had incomes of under $7,500; households with incomes under $7,500 in non-homebase areas ranged from 7 percent to 14 percent.

III. THE SERVICE NEEDS OF MIGRANT CHILDREN

Below we discuss the education, social service, and health services needs of children of migrant farmworkers. This information is based on the research literature's descriptions of the experiences of service providers and on areas of need that were identified during our site visits. The discussion which follows highlights the multiple needs of migrant children, and points out that the needs of children are best met through efforts to meet the needs of the entire family. A family's access to housing or emergency shelter, food, child care, and other forms of assistance directly affects the welfare of migrant children. Each of the sites we visited stressed the importance of focusing on the family unit in order to effectively address the needs of children and adults. This requires that agencies and providers, representing a range of services and disciplines, must work together to address the needs of each family.

Education Service Needs

School-age migrant children are at a disadvantage due to a variety of factors, not the least of which is their poverty and living situation. Migrant students are frequently limited in their English language proficiency, they maintain cultural values different from those of the majority culture, they are residents of rural areas (which are less likely to have social, psychological, and family services), and live in abject poverty. The families of migrant students are likely to have economic, health, dental, and housing needs. A recent national study (National Commission on Migrant Education 1992) revealed the following education-related problems among migrant children:

- More than a third are at least one grade below the grade level appropriate to their age;
- Approximately 40 percent lack fluency in English to such an extent that it interferes with their classwork;
- Some have had little or no exposure to formal education;
- More than 40 percent are estimated to read below the 35th percentile; and
- Approximately 90 percent qualify for a free or reduced lunch.

While these factors are similar to the disadvantages faced by many at-risk students, the problems are exacerbated by migrant families' mobility and the limited English proficiency of migrant parents (National Commission on Migrant Education 1992; Interstate Migrant Education Council 1987). Some educators view both currently and formerly migrant children as having greater needs than other disadvantaged populations (G. Muniz, cited in National Commission on Migrant Education 1992). Families may move several times during a school year as adults search

for employment, resulting in irregular school attendance. In addition, students may work in the fields to help support their families (National Commission on Migrant Education 1992; Serrano 1980).

As a result of these factors, migrant students tend to start school well behind the general school-age population, and continue to fall further and further behind as their lifestyle hinders access to and continuity of appropriate education. Although there are no reliable statistics monitoring the dropout rate among migrant students, it has been acknowledged that these students have the lowest graduation rate of any student population (National Commission on Migrant Education 1992). Barriers to school completion include limited English proficiency, poverty, and grade retention. At the secondary level, both interstate and intrastate movement may mean that students become unable to complete the appropriate number of course credits required for high school graduation in any of the districts of attendance (see Appendix C for programs that aim to help migrant children complete high school).

Our site visits confirmed the need for additional educational resources, including teachers, preschool programs, supportive services, and literacy classes for migrant parents. A Migrant Education program in New York noted that, by the time migrant children reach middle-school age, their low self-esteem hinders class participation. It was found that one-on-one tutoring was most successful in engaging these students in academic work and keeping them on task. In several Florida communities, the limited capacity of preschool programs results in reliance on babysitters who lack training in child care, leave children unattended while they run errands, and provide little or no activities for the children.

A recurrent theme on all site visits was that many children are in need of supportive services such as eyeglasses, warm clothing, and medical care, that directly impact on their ability to learn. Service providers in Hidalgo County, Texas noted the important effect that parents' illiteracy has on their children and on parents' ability to serve as educators of their children. An evaluation of a Migrant Head Start Program in Florida makes an important point about parent involvement: "The greatest barrier we encountered for parents to become partners in the education of their children was their belief that they had nothing to offer" (Poblete 1990).

Recent studies of migrant students suggest that there have been some changes to the profile of this population that may result in increased school success. Marks (1987) reports that educational interruptions have lessened due to two factors. First, more families are settling out, that is, establishing permanent residences in communities where they have worked. Second, children seem to be present for more of the school year, with a number of students moving only during the summer months. Site visit and interview findings reported by Marks (1987) were supported by national data from the Migrant Student Record Transfer System (MSRTS). Less discontinuity of services should lead to increased achievement. Our own site visit findings indicate that both Migrant Head Start and Migrant Education staff find that there are a growing number of migrant parents who understand the importance of educational continuity, and who have begun to take a more active role in assuring their children's education. A group of migrant parents we spoke with in Florida included several parents who had either been in Migrant

Education themselves or who had older children who were "graduates" of Migrant Head Start or Migrant Education.

Special Education

Migrant children with disabilities are protected by the same laws that govern state and local school district services to all children with disabilities (U.S. Department of Education 1991b). As a result of the Individuals with Disabilities in Education Act (IDEA), states that receive federal funds under this act must ensure that all children, regardless of the severity of their disability, receive an appropriate public education at public expense. The states must comply with specific directives concerning testing, consulting with parents during the screening process, developing individualized services, providing an appropriate classroom placement, and informing parents of the procedures for challenging decisions regarding their child (National Commission on Migrant Education 1992).

Accurate identification of migrant children with disabilities is difficult. It appears that their numbers are underrepresented, depending on practices in a state or locality. While estimates suggest that at least 10 percent of this population would be part of the special education population, only about 3 percent, or 13,500 were documented through Special Education Contact Data (Kane and Trevino 1989, cited in Interstate Migrant Education Council 1992). Data from MSRTS and a national study found that only 6 percent of children in Migrant Education were identified as disabled (National Commission on Migrant Education 1992).

The identification process becomes problematic given the short length of time many students stay in a particular school district. The special education identification and assessment process can be lengthy and costly; it may not be complete by the time a migrant student transfers to another district. Further, the eligibility criteria may differ between districts. As a result, migrant students with disabilities tend to be identified at later ages than their non-migrant counterparts (California Policy Workshop on the Special Education Needs of Migrant Handicapped Students 1986), and tend to be under-identified among the general population (Interstate Migrant Education Council 1992). Yet, the hazards of agricultural work (in particular to pregnant women and young children), limited health care, poor sanitation in field and work camp facilities, poor diets, and exposure to pesticides, suggest that migrant students are at particular risk for physical disabilities and learning problems that may affect school success (Reynolds and Salend 1990).

Lack of knowledge, lack of resources, and cultural beliefs lead to a number of disabling conditions being unidentified and/or untreated. For example, Schneider (1986) reports that many migrant parents believe the defect is "an act of God," or, more commonly, that it is caused by something the mother believes she dreamed, by something she saw or did during pregnancy, or that it is "a cross they must bear." Untreated conditions include deafness, blindness, cerebral palsy, severe retardation, clubfeet, and hip displacements.

On the other hand, the executive director of Migrant Legal Action notes that sometimes migrant children are placed in special education classes unnecessarily. Special education classes

can be misused as a way to segregate children who are different from the majority population. The Interstate Migrant Education Council (1992) echoes this concern, recommending that educators and other providers "proceed with caution," and protect against segregating migrant or any other children with disabilities from the mainstream population and opportunities.

Our interviews at six sites revealed many of the same difficulties in diagnosing disabilities and obtaining special education services as reported in the literature. In Stockton, California, for example, students coming through the Migrant Head Start program are not in the system long enough to be referred and have assessments completed in time to receive services. In addition, parents do not always accept referrals to special education because they have to spend too much time away from work to be part of the process. In locations such as Woodburn, Oregon, however, timeliness in completing referrals is not a problem because families remain in the area longer. In some communities such as Belle Glade, Florida, specialized diagnostic services may be an hour-and-a-half away.

Social Service Needs of Migrant Children

In this section, we review available information on a wide range of services provided to migrant families. Included in this broad categorization of social services are public welfare programs and other programs which address basic subsistence needs; substance abuse treatment; mental health services; housing services; and a variety of supportive services such as medical supplies, transportation, and advocacy services. The social and economic profile of the migrant population suggests that migrant children are in need of public welfare services to meet even the basic needs of food, clothing, and shelter. Nevertheless, few federal resources in this area are targeted to migrant children and their families. Although migrants are likely to be eligible for Medicaid, Aid to Families with Dependent Children (AFDC), and services available through programs such as the Community Services Block Grant, none of these funds is earmarked specifically for services to the migrant population. The mobility of this population makes it difficult for them to learn about and gain access to such services.

This lack of targeted funding, coupled with the difficulty in collecting information on the characteristics of the migrant family, makes it difficult to determine the social service needs of the population. For example, is the need for alcohol and drug abuse treatment programs among migrants more or less prevalent than in the general population? Would foster care respond to a need of the migrant family if, for example, a child were unable to travel with his/her family due to illness or disability? At best, only anecdotal information is available to answer these questions.

For school-age migrant children, the Migrant Education Program (MEP) is probably the best source of services that would come under the rubric of social services. As mentioned in Appendix C, most of the services provided through Migrant Education programs are instructional, but support and supplemental services are also allowable. There is an assumption that the provision of support services will aid in increasing student attendance and attainment. The needs

of the population can be gleaned from the types of services provided through MEP, as described below.

A relatively recent study completed for the U.S. Department of Education (Rudes and Willette 1990) reported that all of the 16 sites visited took a holistic approach to serving the needs of migrant children and their families. That is, projects tried to address the ability of the children to participate in and benefit from their schooling by providing a wide range of services. These included advocacy, general assistance, and referral of migrant families and students to educational, health care, and social services available in the community; personal and career counseling for students; direct health care services for students; nutrition services; transportation; and coordination with other community organizations and agencies serving migrants.

Marks (1987) also reported that a wide variety of support services were provided to students participating in Migrant Education programs. Although instructional services were paramount, support services provided included guidance and counseling, health screening, medical and dental treatment, transportation, employment, and clothing. Decisions about the exact services to be provided were made locally, on an as-needed basis. The provision of such support services was reported by Rudes and Willette (1990) to be an important component of effective migrant education practices. Our site visit findings confirm this locally tailored approach. For example, in addition to more traditional services, the Brockport, New York Migrant Education Program also provides training in motor vehicle registration and arranges for the services of a paralegal to address immigration questions or problems.

Literature in the health field identifies a number of social service and mental health needs of migrant farmworkers. A broad-based needs assessment of migrant farmworkers in Western Oregon (Decker and Knight 1990) found that drug abuse, especially cocaine and crack use, was a rapidly growing problem in this population. Alcohol, drug abuse, and family violence are not uncommon among migrant families (Smith 1986, cited in Decker and Knight 1990). In Western Oregon, most crime in the migrant labor camps was related to drug abuse and prostitution. The workers spend long hours in the fields and most are separated from their homes and families. Leisure activity includes heavy alcohol intake, which is a recurrent problem (Decker and Knight 1990). While these problems are more prevalent in the predominantly male migrant labor camps rather than where migrant families reside, the alcohol abuse, AIDS and other sexually transmitted diseases, and interpersonal conflicts affect teenagers and children as well.

A survey of migrant farmworkers in Tulare County, California found that 29 percent suffered from some form of mild psychological distress, and 1.4 percent had serious mental problems (Mines and Kearney 1982, cited in Trotter 1988). A survey of Wisconsin migrants found that 4 of the 10 most commonly mentioned health conditions were nervousness, irritability, insomnia, and depression (Slesinger 1979, cited in Trotter 1988). However, the Wisconsin study also found that migrants indicated virtually no interest in having access to three types of services: alcoholism services, family planning services, and mental health services. This, despite the fact that one-fifth of migrants were found to be suffering from some type of psychological distress. The finding is interesting in light of comments from a service provider in one of our site visits. She noted that one of the reasons Hispanic farmworkers are reluctant to seek mental health

services is because there is not an equivalent expression for mental health in the Spanish language.

The need for social services, particularly mental health and substance abuse services, exists and appears to be growing. While attitudes may have changed since these surveys were conducted, there still appears to be a substantial need to develop services that are sensitive to the cultural factors that lead to the reluctance of migrants to seek help. There is also a need to educate migrants about the value of such services and how to access them. At each of the six sites visited, service providers repeatedly voiced their concerns about the need for mental health services and drug and alcohol abuse programs. In addition, these sites reported that remote rural areas especially suffer from a lack of qualified, bilingual staff to provide these services.

Taking a broad view of social services, one must also consider environmental, housing, and child labor issues as important service areas to address, because they impact directly on the health, mental health, and educational needs of migrant children. The decision to migrate as a family is often determined by the number of family members who will be able to travel north ("upstream") to work, either in the fields or in nearby packing and canning sheds. Since growing seasons are short, the family must maximize the income they can earn, which includes the wages of children above the age of 10 or 12. State child labor laws are frequently ignored both by migrants and growers (Trotter 1988).

Our visits to six sites revealed that migrant families experience the social service needs and limited access to many services described in the literature. In each of the sites, severe shortages of affordable housing, limited funding for transportation assistance that would enable migrant farmworkers to get to their jobs and to services, and lack of child care for non-Head Start eligible children were major barriers for migrant families. Despite tremendous efforts on the part of service providers, there are never enough resources to keep up with demand.

Housing was identified repeatedly as an area of critical need. In Stockton, California and Hidalgo County, Texas, for example, the local housing authorities have excellent reputations for well-built, well-managed, low-income housing, but insufficient resources to build enough low-income housing units to meet the huge demand. Thus they must turn away dozens of families each year. In Greeley, Colorado, and Brockport, New York, two small college towns, college students and migrant farmworkers must compete for limited affordable housing. Local service providers in Greeley noted that as a result of these shortages, they have noticed more and more migrant families sleeping in cars and under bridges. Economic problems, exacerbated by poor growing seasons and the recession, have been severe enough in localities such as Stockton and Hidalgo County that many migrant workers are either unable to find jobs or can only find part-time work.

Health Needs of Migrant Children

Migrant children frequently have health needs that go unmet due to fragmented care caused by their mobility, lack of medical and financial resources, substandard living conditions,

language barriers, limited health education, and superstitions related to health and well-being. A number of studies have documented the health needs of sample populations of migrants and migrant children, using record reviews, utilization data of Migrant Health centers, and interviews with migrant families and service providers. Information collected on our site visits confirmed the existence of a variety of health needs that are prevalent among migrant families.

A study of a representative sample of migrant families in Wisconsin supports the view that migrant farmworkers are at substantially greater risk of health problems and early mortality than the general population (Slesinger, Christenson, and Coutley 1986). The study's findings concerning Wisconsin's migrant children include:

- Fewer than half of migrant children under age 16 received the recommended annual physical checkup;

- Only one-third of migrant children under age 16 had received an annual dental checkup compared to 50 percent of children in the total population;

- A rough comparison between levels of chronic health conditions for migrant children and those reported for children in the National Health Interview survey suggests that the incidence of chronic conditions is several times greater among migrant children;

- Childhood mortality among migrants appears to be 1.6 times higher than that of the U.S. population.

Schneider (1986), reporting on experiences treating migrant families in eastern Washington State, finds that common health problems of migrant children fall into four categories: diseases and conditions caused by overcrowded and poor living conditions and frequent moves to new climatic areas with different water supplies and native viruses; nutritionally related conditions; untreated congenital anomalies, inherited conditions, and allergies; and neglect and lack of adequate medical treatment.

These findings are supported by other studies. Dever (1991) sampled utilization data from four Migrant Health centers in Texas, Michigan, and Indiana, finding that clinic visits for children ages one to four are mostly for infectious and nutritional health problems. Health problems for ages five to nine are also primarily infectious. Viral and bacterial infections, especially upper respiratory infections and gastroenteritis, spread rapidly in crowded migrant camps. They frequently occur when the migrants first arrive in an area where the climatic conditions and water supplies are different from what they are used to. Bacterial diarrheas such as shigella can spread rapidly in labor camps and daycare centers. Viral Hepatitis A, which occurs often in migrant centers, can be spread to daycare workers through improper handling of dirty diapers. One physician's assistant at a Migrant Health center in Colorado began his coordinated working relationship with a Migrant Head Start program after tracing several cases of diarrhea seen at the health center to the same Head Start site (National Migrant Resource Program 1992).

Information provided through our site visits to Migrant Health Centers revealed that migrant children entering health clinics suffer from common health problems such as iron deficiency anemia, diarrhea and dehydration, dental caries, giardia (intestinal parasites), lice, gastrointestinal illnesses, upper respiratory problems, and dermatitis.

The incidence of tuberculosis and positive TB skin tests is also high among migrants (Schneider 1986). This was the case among the migrant populations served by the programs we visited, and is of increasing concern as drug resistant strains of the virus proliferate. Trotter (1988) notes that diseases of yesteryear, dominated by infectious diseases, are commonly encountered in the migrant population. In addition to the parasitic diseases and other gastrointestinal infections which abound in the migrant population, other exotic diseases are not uncommon. For example, most polio cases encountered in the United States in the past 10 years have been found in the migrant farmworker population, with the majority coming from Texas migrants. One migrant health center in South Texas reported 10 cases of yellow fever in a single year (Trotter 1988). Certain groups in the migrant population such as Haitians and Southeast Asian workers have active cases of diseases that have not been seen in the United States since widespread immunization programs were begun. They may also carry diseases that were common in their homeland but are rare in the United States. The crowded and unsanitary living and working conditions of migrant farmworkers, combined with the mobility of these populations, facilitate the spread of these diseases throughout the migrant population. Toilets and running water are often not available in fieldwork sites, and bacterial contamination of wells at migrant labor camps is a common problem.

Another environmental concern affecting the health of migrant children relates to the farmwork environment. Farm labor is one of the top three occupations with the highest rate of occupationally related injuries and illnesses. Occupational hazards include trauma from farm vehicles and machinery and exposure to the sun or to pesticides. Children are particularly at risk in farm work environments. When they work with their parents in the fields, they are exposed to the same occupational hazards that adults face, but have less experience in avoiding problems and are more sensitive to the effects of pesticides. Pesticide exposure for pregnant women who work in the fields often affects two children--the infant and the young mother--since Mexican and Mexican-American women tend to marry and/or bear children beginning at ages 13 to 17 (Decker and Knight 1990; Mobed, Gold, and Schenker 1992; U.S. Department of Labor 1990, cited in Mobed, Gold, and Schenker 1992).

A study of mothers and their children up to age five in North Carolina supports Schneider's observation of nutritionally related conditions in migrant children (Watkins et al. 1990). Twenty-six percent of children one year and older were found to be at risk for anemia. Infants and children fell below the 5th percentile of height-for-age at more than twice the rate expected. Eighteen to 20 percent of the children were obese. In terms of nutrition, only one-third of the infants and children received 90 percent or more of the recommended daily allowance (RDA). Diets appeared most deficient in the recommended servings in the fruit and vegetable group, and only one-fourth of the children had the recommended three servings from the milk group. Decker and Knight (1990) reported that 18 percent of the children screened in their study in western Oregon had low hematocrit levels.

Slesinger, Christenson, and Coutley (1986) found that 10.9 percent of migrant children were reported by their mothers as having some type of chronic health condition. The most frequently reported conditions were: trouble breathing, asthma, trouble hearing, heart trouble, and orthopedic conditions. The authors found that migrant families who spoke English were more likely to report that a child had a chronic condition. A possible interpretation is that women who do not speak English may not label various childhood conditions as chronic illness. Thus, chronic conditions may be substantially under-reported among migrant children.

The final category of health problems, those due to neglect, lack of treatment or inadequate treatment, is demonstrated in the areas of immunization status and dental disease. Trotter (1988) notes that, "There is probably no other population in the United States that has had simultaneously high incidence of both over-immunization and under-immunization of children. Many pediatric migrant patients have been immunized four or five times in the same season, due to the problems of continuity of care, while others have been missed completely for the same reason." Watkins et al. (1990) reported that only 41 percent of children served by a North Carolina Migrant Health Center in 1985 were adequately immunized for their ages. In 1986 and 1987, when a program was implemented to provide comprehensive services to mothers and children at this center, more than 60 percent of children had complete immunizations.

In analyzing preventive care for migrant children, Slesinger, Christenson, and Coutley (1986) found that younger children are more likely to receive checkups, while older children are more likely to receive immunizations. The authors suggest distinguishing between two types of preventive care: one under the direct control of the family, and the other controlled by the schools. Since immunizations are given to migrant children in schools, the older or school-age children are more likely to be immunized or even over-immunized.

Schneider (1986) reports that the most common untreated health problem among migrant children is dental caries. Dever (1991) found that dental problems first appear as a presenting condition in children ages five to nine, and that dental disease is the number one health problem for patients aged 10 to 14. Dental disease is also the number one health problem for males age 15 to 19 (for females in this age group the most frequently presenting health condition is pregnancy). "Baby bottle mouth" syndrome, where children's teeth are rotted to the gum line due to the practice of frequently offering sugary liquids in baby bottles, is very common (Schneider 1986; Decker and Knight 1990). These and other dental problems were reported by all of our case study sites as being among the most prevalent of health problems among migrant children.

The literature indicates that a comprehensive, culturally sensitive approach is required to meet these health needs. Comprehensive health care for migrant families and their children includes:

- Diagnosis and treatment of common illnesses, infections, and infestations within the family's meager economic means;

- Referrals for congenital anomalies, chronic conditions, and those conditions requiring additional or specialized health services;

- The adaptation of teaching programs for the child and his/her parents, including hygiene, immunization status, growth and development, stimulation, nutrition, and so on (Schneider 1986). Migrants have consistently shown interest in further health education, and especially in information that would give them more individual control over their own health (Trotter 1988).

Clearly, the components of comprehensive care discussed above extend beyond the health center setting, and should involve educational, environmental, mental health, as well as many other community resources.

Our site visits also revealed that access to adequate health care is limited for migrant families in many remote rural areas. For example, in Hidalgo County, Texas, private dental providers meet the need of only 17 percent of the population. An assessment of primary care also found that the region needed an additional three to four dozen primary care physicians to keep up with demand for services. Access to specialty medical care, mental health care, and substance abuse treatment is especially limited. Service providers see a need for more preventive services such as immunizations and a need for culturally specific research on health behaviors to see why migrant farmworkers do not seek care. In Woodburn, Oregon, health needs and poverty have increased, due in part to a growing number of undocumented workers and workers from remote areas in Mexico and Central America. In these and other sites such as Belle Glade, Florida, the problem is not that services do not exist, but rather that health providers--due to lack of funding and staff--are unable to meet fully the ever-present needs of an enormous migrant population. The executive director of the Hidalgo County Health Care Corporation, a community/migrant health center, described a situation which, unfortunately, is not unique to his community: "We are overwhelmed daily with uninsured patients far exceeding our capacity to care for them. We face an ever-increasing number of new patients, in particular the new poor and those with HIV/AIDS, who see us as the only source of care left to them."

In summary, migrant farmworker families have multiple service needs, many of which have reached a critical level. As noted by the National Advisory Committee on Migrant Health (1992), "the harsh realities of life in the migrant stream include poverty, hard manual labor, unsanitary living conditions, lack of medical insurance or access to care facilities, high rates of illness, early death, economic uncertainty, and personal humiliation. The same issues which affect migrant farmworkers as individuals impact them as families as well." Meeting the educational, social service, and health needs of this population requires the involvement of multiple service arenas. Our existing service delivery systems must adopt an integrated approach that focuses on the family unit and accommodates a migratory work pattern. Agencies and providers must work together to meet the challenges of serving this population.

IV. SERVICE INTEGRATION AND SERVICE DELIVERY ISSUES

In this section we discuss our working definition of "service integration," outline the ideal integrated services model and the factors that enhance coordination, describe how integrated service delivery actually works among the sites visited, and identify barriers to providing comprehensive services and gaps in services.

Operational Definition and Conceptual Framework

The term "service integration" is widely used today to describe the way services should be provided for a wide range of groups with multiple service needs, including children with disabilities, the mentally ill, at-risk youth, and the homeless. As described earlier, migrant farmworker families readily qualify as a group with multiple service needs that can benefit from service integration. Treating one problem while ignoring others may be ineffective. Examples range from placement of a parent in a job training program when there is no access to child care, to treating a child for a gastrointestinal disorder but not addressing the problem of contaminated drinking water in the camp where she lives (National Migrant Resource Program 1992).

Despite widespread agreement on the need for service integration, there is no standard definition of the term. The terms "coordination," "collaboration," and "integration" are often used interchangeably. For this study, a conceptual framework was needed in order to identify exemplary practices through site visits, and to translate site visit findings into models and policy recommendations with wider applicability.

The basic concept of service integration at the federal level can be traced to initiatives launched in 1971 by Health, Education, and Welfare (HEW) Secretary Elliot Richardson. Although the concept has been evolving and service integration initiatives have waxed and waned over the past decades, the definition provided by Richardson is still very informative:

> Services integration refers primarily to ways of organizing the delivery of services to people at the local level. Services integration is not a new program to be superimposed...rather, it is a process aimed at developing an integrated framework...Its objectives must include such things as (a) the coordinated delivery of services for the greatest benefit to people; (b) a holistic approach to the individual and the family unit; (c) the provision of a comprehensive range of services locally; and (d) the rational allocation of resources at the local level so as to be responsive to local needs (Richardson 1971).

This definition recognizes that service integration involves multiple and possibly competing objectives that may vary in importance among different groups and organizations involved (Institute of Medicine 1982).

Over the past twenty years, the basic concept of services integration has changed very little, but experience has identified barriers and problems in our existing system, and has improved our understanding of what does and does not work. Moreover, as this report hopes to point out, successful service integration requires more than simply the presence of some of the activities typically associated with service integration (e.g., written agreements, interagency coalitions, case managers). These activities need to form a coherent whole that focuses on the client and a set of goals for that client.

The Ideal Integrated Services Model

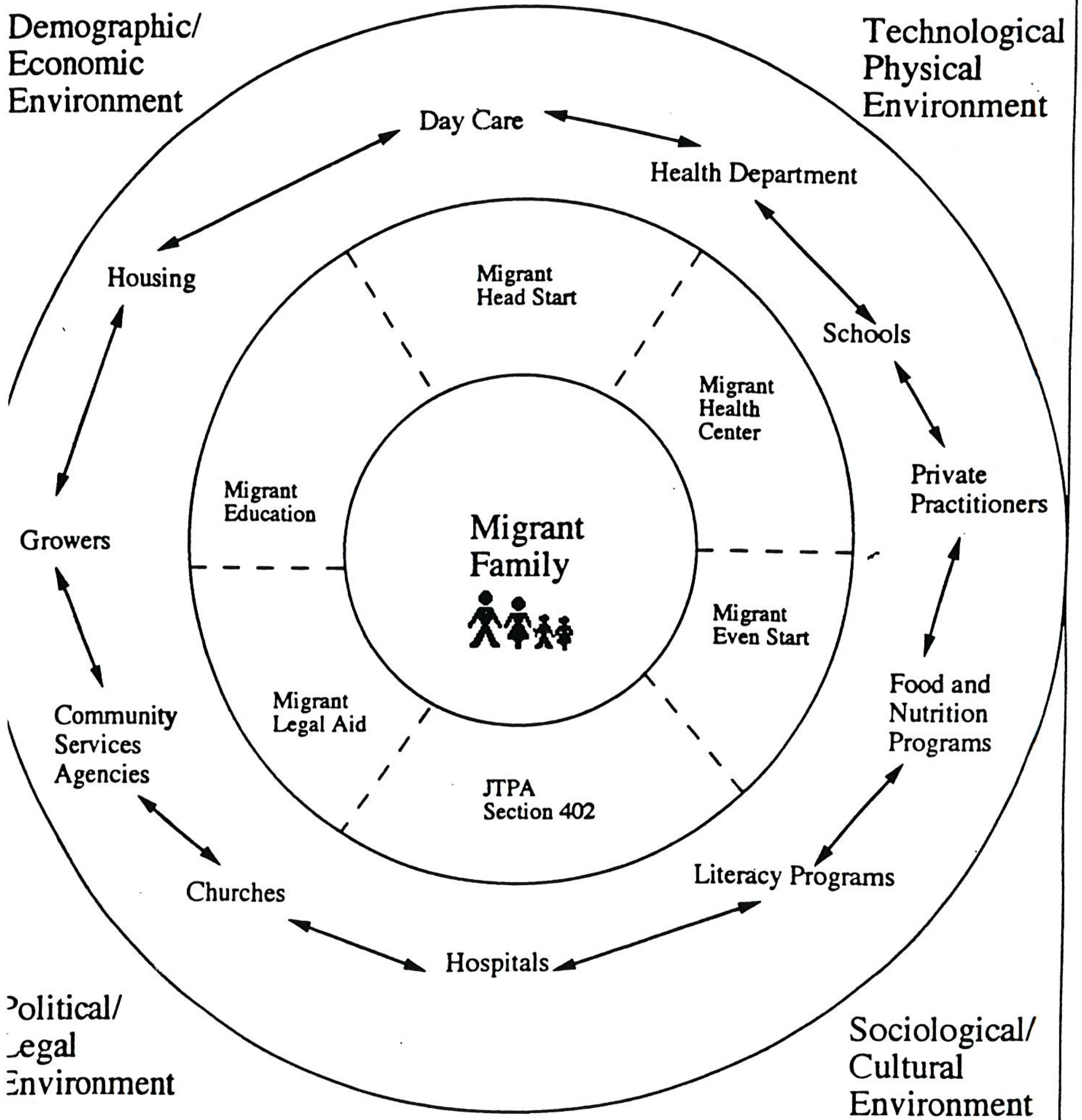
In practice, service integration efforts operate at two levels: the service (or case) level, and the system (or administrative) level. A recent U.S. General Accounting Office report (1992e) found that although system-oriented initiatives had some success, an ideal integrated service delivery system will include both service-level and system-level efforts. Several of the communities visited in this study had concurrent service- and system-level initiatives. For example, a Head Start Parent Involvement/Social Services coordinator might work at the service level to complete a family assessment and develop a social services plan with a family, as well as negotiate agreements with community social service agencies. At the same time, the Head Start director for the region might work at the system level to participate in a regional coalition of agencies serving migrant farmworkers, to identify service needs and gaps in the community and develop a community plan for meeting those needs.

We view the implementation of system integration as a continuum, characterized at one end by a fragmented system that addresses specific needs of the clients without an overall assessment, moving toward coordination of services for the client, with the ultimate goal of integrated service. From the client's point of view, the ideal integrated system would be perceived as one program or system, even if the services are not all located in one place. From the service provider's standpoint, the ideal integrated system provides for an overall assessment of the client's needs and the necessary knowledge and relationships established to assure that clients receive the services they need, regardless of which community agency offers the services.

A graphic presentation of our integrated service model is presented in Exhibit IV-1. It shows that there are many types of services and a great number of organizations to consider in serving clients with multiple needs. The migrant family is at the center of this model, surrounded by the major programs established specifically to address the needs of migrant farmworkers and their families. In each community, there are a number of other services, providers, and community groups which assist migrants. Finally, the service integration configuration in each community is shaped by its economic, physical, political, and cultural environment. Integration is an ongoing process, and even communities that demonstrate successful service integration still strive to encompass more services in their network. For example, our site visits exemplify excellent approaches to service integration between Migrant Head Start and health providers; schools and Migrant Head Start; among Migrant Head Start, JTPA, and migrant education, as well as some very promising examples of system integration.

INTEGRATED SERVICE MODEL
Migrant Children and Families

Exhibit IV-1



Adapted from NMRP, 1992

Some of the case- or service-level strategies to foster service integration observed in our study include the use of case managers, migrant coordinators/advocates, co-location/on-site services, extended hours so that access to programs can be better coordinated, transportation, portable records, culturally relevant programs in order to increase acceptance of a wide range of services and providers, translation services that improve access to more programs, community functions, home visits that address family needs for a wide variety of services, and coordinated outreach.

System or administrative strategies identified in the communities visited for this study include: interagency coalitions, written agreements or memoranda of understanding between agencies or providers (such as between Head Start and private physicians, dentists, and migrant/community health centers, or between Migrant Education and the county health department), regionalization/umbrella organizations, participation on boards of other community organizations, and joint fundraising activities. These strategies will be explained more fully in the following section and in Part V, the cross-site synthesis.

Factors that Facilitate Service Integration

In addition to identifying models of service integration, our site visits indicate that there are some more general factors that facilitate services integration.

Sharing Information and Resources. Sharing information and resources is often a first step toward services integration, as well as a mechanism for maintaining the momentum of group efforts. In Colorado, the Weld Information Referral Service (WIRS), a United Way funded agency focused on services for the homeless and those at risk of homelessness, publishes a directory of available services in Weld County. Two hundred agencies providing over 400 programs are listed in the directory. The directory is used extensively by agencies providing services to migrant farmworkers and their families. Similarly, the parent involvement coordinator in one of the Head Start centers in the Brockport, New York area has developed a resource list for parents that provides the names of contact persons who are bilingual, and includes everything from health and social services providers to Spanish-language church services and auto parts stores. The centers also have a parent handbook in both English and Spanish, and produce a monthly newsletter. The Texas Migrant Council provides families with directories of services in Michigan, Indiana, and Minnesota.

Jointly sponsored activities are another way of sharing information and resources. The State of Oregon funds a migrant education technical assistance center run by the Marion Education Service Center (ESC). The Marion ESC employs a health coordinator who assists in procuring health resources for the education programs, and has most recently focused on the Migrant Even Start program. One recent successful activity has been a health fair that employed the use of volunteers for medical screenings and tapped additional resources from the medical community to provide health services to children and families enrolled in the Even Start program. Community celebrations are another opportunity for outreach and information sharing. Programs serving migrants work with other community groups in Brockport, New York to host a

Bienvenida celebration, a welcome ceremony and fiesta at the beginning of the migrant season in June. The annual Black Gold Festival in Belle Glade brings together service providers, community groups, and businesses.

Holistic/Family-Centered Approach to Case Management. Integrated service delivery appears to be greatly facilitated when a family-centered approach is taken by the agencies providing services, particularly when case management is used. In the Woodburn, Oregon area, for example, the North Marion Consortium was formed last year by the migrant Head Start delegate agency, the county health department, the Salem childbirth education association, the child care information service, and the migrant health center to write a competitive grant application for funding of the Great Start Settled Migrant Child Care Program. The program takes a case management approach to providing comprehensive services to prenatal and postpartum families to enhance their ability to reach self-sufficiency. Each of the agencies received funds through the grant to hire specific staff for unique purposes such as outreach, childbirth classes, parent education, child care, and so on. A family can enter the program through any of the agencies, where a needs assessment is completed and referrals are made for services. On a weekly basis, case managers meet to discuss the needs of the families and the services being provided. The target population is high-risk, low-income families with children birth to three years old. Because of these criteria, most clients served are from farmworker families.

State Funding. State support of services to migrant farmworkers and their families greatly facilitates comprehensive and integrated services to this population. There were dramatic differences observed in the amount and quality of services available to families across sites in which state support was available. Services integration is generally easier where there are more services available (although successful services integration requires more than just increased service capacity). For example, child care for children of agricultural workers has been mandated and funded by New York State since 1946. The state support enables child development centers to serve all migrant children and to serve children for up to five years after the family has migrated. This reduces eligibility barriers and differences between Head Start and other programs for migrants. Whereas we commonly observed waiting lists for Head Start services in other states visited, in the New York site all eligible children are served. The availability and high quality of these services bring migrant families back to New York season after season.

In Oregon, although child care services are not mandated, the state does fund a preschool program that is available to children of migrant farmworkers when migrant Head Start programs are not in operation, or when families do not meet the narrow eligibility requirements for the migrant Head Start program. Similarly, California funds child development centers that provide preschool programs to children from low-income families, and funds infant and preschool programs that are co-located at two of the migrant housing camps.

Colorado's state migrant health program is another example of how state support facilitates services integration. For example, in the Greeley, Colorado area a strength of the Head Start program is the health component, which is in part staffed by health professionals employed

by the state migrant health program, but is located at the various Head Start programs in the area. These on-site medical staff work with the local health center staff to provide immunizations and health screenings. Similarly, dental staff are hired by the state to be on site at the migrant education summer program.

Integrated Service Delivery Scenarios

The site visits in this study were to communities identified as having exemplary programs for service integration for migrant children *of all ages*. Thus, by definition the site visits did not involve a visit to single programs, but included interviews with many different community agencies. Below, we present three scenarios to describe ideal types of service delivery systems: services for the preschool child (centered around Migrant Head Start); services for the elementary school child (centered around Migrant Education); and services for the high-school age child (centered around Migrant Education and JTPA). For each age and program, service integration for migrants must also address intra- and interstate coordination to assure continuity as families move for farm employment during the growing season and return to their homes in the winter months. These scenarios are drawn from our site visits, but do not describe what was encountered in any single site visit. No single site had all of the elements of an ideal site.

Integrated Services for the Preschool Child

The service delivery system for preschool-aged children of migrant farmworkers centers around the Migrant Head Start program. The typical program runs for a full day (6 a.m. to 5 p.m.) with transportation provided to and from the program. Many children ride the bus to the program for well over an hour. The program operates only during the growing season (May through August) and includes all of the federally required components--education, social services, parent involvement, and health.

Both parents must be working or in school for their child to be eligible for the program, must have migrated within the past 12 months for purposes of farmwork, and must meet low-income eligibility requirements. Children from birth through age five are served by the program.[5] Priority may be given to single-parent families. Families who do not meet the eligibility guidelines are referred to migrant preschool programs operated in some school districts through the Migrant Education Program, to the regional Head Start program that usually operates only for a half day, or to state-funded child development programs that may be available. A few communities may also have a Migrant Even Start program, an early intervention program which includes parent training and family literacy. All of these programs will refer families to Migrant Head Start if it is determined that the families meet the eligibility requirements. Most of the

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[5] Migrant Head Start Centers are authorized to serve children from birth to five years, and often offer full-day programs to cover the entire time that parents are working in the fields. In contrast, Regional Head Start programs serve children ages three to five, and operate on a half-day basis.

other programs do not serve children under three years of age; where services are not available, someone in the family will have to stay home to provide child care.

Just prior to the growing season, the outreach coordinator for the Migrant Head Start program distributes fliers to the growers to notify them of the availability of the program. Similar fliers will be distributed throughout the community. After families begin to arrive, the outreach coordinator goes to the migrant housing camps in the evening to talk to families about the program, and to notify them of several evenings when they can come to the center to enroll. Although not typical, in the well-coordinated program, arrangements are made with the migrant health center to provide staff at these times who can perform the physicals and immunizations required for enrollment in the program. Parents are requested to provide any medical records provided to them in former sites, but often these records are not available. If the Migrant Head Start program is affiliated with the East Coast Migrant Head Start Project, requests for these records will be made through the central office in Arlington, Virginia.

At the same time parents are enrolling their children in the center, the social services coordinator is completing a family needs assessment. Parents are then referred to other agencies that may be able to meet their needs in areas such as housing and training. If the need for food or clothing is acute, parents may be referred to a food bank or other church or community organization. A resource directory of services, along with names of bilingual contacts is provided to the parents. A log of referrals is kept by the social services coordinator and follow-ups to the agencies are made in a few days to determine if parents requested and were able to receive the services. If not, the outreach coordinator may be dispatched to determine the status of the family and how their needs may be met. For example, it may be possible that the family did not have the transportation required to get to the agency or the agency was only open during the day when parents were in the field. Parents are requested to join the parent advisory committee, and meetings are held every other week with a focus on some sort of parent training activity such as health or nutrition.

An individual learning assessment is completed for each child within 30 days of enrollment in the Head Start program. This assessment starts the process of identifying any students with special needs. Based on the assessments, individual activity plans are developed for each child, addressing the child's need for other health and social services. Activity plans are reviewed with parents and are updated regularly. Home visits are made within one month of each child's enrollment in the program. If health needs are identified, students are referred to the migrant health center or the county health department. Some migrant health centers and some county health departments have mobile medical units that come to the Head Start site to conduct physicals or provide immunizations for Head Start children. At least once during the summer, children are taken to the migrant health center for dental screening and fluoride treatment. Sometimes arrangements are made for the dental screening to be conducted at the Head Start center. Children identified with more complex dental needs are referred to local practitioners who will provide services at a reduced rate.

When a child with special needs is identified through the assessment process, a referral is made to a regional early intervention program that performs formal diagnostic services for the Head Start program if the child is under the age of three. If the child is over the age of three, a referral is made to the special education program at the local school district. Parents are required to participate in the process of identification and assessment that occurs in either the early intervention or special education program. Because of the time commitment involved, many parents are unable to participate, and decline to have the evaluations completed. In other cases, because of the lengthy time period involved in completing the assessment process, the family moves before the services can be provided. This can be particularly problematic with the special education program, which may not be fully operational during the summer months of the typical growing season.

Once special service needs are determined and a service plan is developed, services are either provided at the Head Start program or the child is referred to a program for children with special needs. Contracts between the Head Start program and local programs serving children with special needs are formalized on an annual basis to allow these referrals to occur. If services are to be provided at the Head Start program, the program contracts with the service provider such as a speech pathologist to come to the program to deliver the required services.

At the completion of the program, if families remain in the area, they will be referred to other agencies (e.g., regional Head Start) that may be able to meet their needs for child care programs. If the child is old enough to attend elementary school, a session will be held for parents to introduce them to the elementary school system. A field trip to an elementary school may be taken with the children to introduce them to the school environment. The elementary schools will also be notified that the children will be attending in the fall. Student records will be provided to the parents who will be relied upon to bring them to the school when the child is enrolled.

If a family's plan to leave the area is known by the program staff ahead of time, records will be provided to the parents. If the program is part of the East Coast Migrant Head Start Project, hand-held continuity records will be provided to the parents and will also be sent to the central office to be entered into their computerized record-keeping system.

Integrated Services for Elementary School-Age Children

Services for children of elementary school age are provided by local school districts through the federally funded migrant education programs. Children of migrant farmworkers are eligible to participate in the program for up to six years, although currently migrant students (those whose families have moved during the past year) are given priority for services as funds are not available for all eligible students. Although programs are typically organized on a regional basis within states, each school district usually operates its own program depending on the needs of its students. School districts with a large population of "settled out" migrant families (that is, formerly migrant families that have made the community their permanent home) may operate migrant education programs during the entire school year. In communities that

experience more mobility in the migrant population, the program will run only during the growing season, or only during the summer.

As with Migrant Head Start, the Migrant Education Program also has an outreach coordinator who goes to the camps to recruit eligible students for the program at the beginning of the growing season. Certificates of eligibility are completed for each student and this information is submitted to the Migrant Student Record Transfer System (MSRTS). If students have been previously enrolled in a Migrant Education Program, health and educational records will be available through MSRTS and requests for these records will be made to facilitate program planning for students. However, it typically takes several months to receive the information, which by that time is often far too late to be useful. Moreover, if there was no Migrant Education Program in the student's former school, no records would be available through MSRTS. More often than not, staff of Migrant Education programs contact staff in the student's previous school to determine what the student's needs may be. In many cases, a well-established network has developed among school personnel who can furnish the required information quickly. In the best cases, advance notice has been provided that students will be arriving and records and other helpful information are sent ahead of time.

Most communities offer both summer-school programs and school-year programs. The bulk of the services provided for elementary school-age children occurs during the summer-school program. These programs tend to be more concentrated and comprehensive because they are full-day supplemental programs, while school-year programs tend to be more tutorial in nature. The summer program usually runs for about six weeks and takes a holistic approach that may include opportunities for participation in sports and scouting as well as classroom instruction. The instructional portion of the program is coordinated with the child's local school in concurrence with each school's curriculum. Typical project goals include improving reading, math, and communication skills; improving English-language proficiency; and increasing parent involvement.

Transportation to summer school is provided by the Migrant Education Program. Arrangements are made with the local migrant health clinic to provide physicals, immunizations, and dental and vision screening. Through arrangements with migrant health centers or private providers, many programs are able to arrange for dental sealants to be applied for school-age children. Services are provided on a sliding fee scale, and are billed to third party payers whenever possible. A network of private practitioners typically has been identified to provide more complex services at a free or reduced rate. The regional migrant education agency may maintain an umbrella fund that is available to provide emergency services to the migrant students in the constituent school district. These services could include medical and dental services, as well as clothing, food or other expenses such as student body fees.

During the school year, instructional aides may be provided to work with migrant students in the classroom to support the regular school program; pull-out services, where students are taken out of their regular classes to participate in remedial programs, are discouraged. Each school may also have a home-school consultant who provides support services to the family during the school year, conducts home visits when necessary, assists with referrals to other

agencies for services, and provides transportation when required. The school-year program also has a supplemental after-school tutoring component for students who need additional help with their school work. When students leave school after the growing season, staff will contact the next school if they are aware of where the parents are going. However, since the families do not always get to where they intended to go, staff usually wait for the next school to contact them.

Integrated Services for Individuals of High-School Age

The service system for individuals of high-school age also centers around the Migrant Education Program. Additional services for this population are available through the Job Training Partnership Act (JTPA), a federal program funded by the Department of Labor. As for students of elementary-school age, both summer-school programs and school-year programs are available, and outreach workers from the Migrant Education Program are responsible for recruitment of students and completion of certificates of eligibility.

For secondary school age students, the Migrant Education Program tends to focus on tutorial programs, dropout prevention, outreach, and dropout retrieval. Summer-school programs for these students are focused on credit accrual and credit exchange among schools in varying jurisdictions. Educational services available to this age range also include information on nutrition, AIDS, family planning and substance abuse, as well as career counseling, immigration, and motor vehicle training. Other programs include retreats and self-esteem building activities.

In some instances, individuals are assigned to schools with high migrant concentrations to serve as student advocates. Through this program, students are made aware of college scholarship opportunities, gainful employment opportunities, and linkages with community support service agencies. If students of this age range have already left the school setting, efforts are made to counsel the students in obtaining a high school diploma through alternative routes, such as the high school equivalency project (HEP) or the GED certificate. Staff of the Migrant Education Program try to guide students in a way that will best prepare them for self-sufficiency and improved employment opportunities. Students who continue to be enrolled in school are eligible for health screening and other services if they are eligible for the Migrant Education Program. Once they drop out of school or obtain their GED certificate, these additional services are no longer available.

The inherent problems associated with interstate credit transfers for students of this age range who are enrolled in school make it very difficult to coordinate with schools across different jurisdictions to ensure that students can amass enough credits to graduate. Staff of the Migrant Education Program have negotiated agreements with other states for secondary school credit transfer, but continue to be stymied by changing state requirements such as standardized tests for high school graduation. A lot of effort is required to navigate through each state's system to determine what each student needs to meet high school graduation requirements in the home state. A number of endeavors have been initiated with states to address these issues and improve service continuity in the interest of improving the graduation rate of migrant students of secondary school age. For example, an "800" number was installed in one state to assist any

school in the country with credit accrual data for migrant students. Arrangements have been made with other states to send certified testers to administer state tests required for graduation, and extensive parent training may be conducted to keep parents informed of graduation requirements.

Programs funded under JTPA also offer opportunities for training and services for young adults who want to settle out of the migrant stream and enter a new job market. To help these individuals take part in the program, basic skills training, ESL classes, and GED classes are all available through JTPA over and above on-the-job training, other job skills training, and financial aid. Secondary school age students who have either graduated or dropped out of school are eligible to participate in these programs if they have done farmwork in the last 24 months and meet specified low-income requirements. Support services are also available through the agencies offering JTPA, such as provision of gas and food vouchers, and referrals to social service agencies for other needed services.

For students who have received a high school diploma or a GED certificate and wish to attend college, the college assistance migrant program (CAMP) is available through local universities. This program helps to support migrant students by providing intensive preparation, assistance in securing financial aid, and some funding for purchasing books and supplies.

Barriers to Provision of Comprehensive Services

Despite the diversity of programs and communities visited, a few barriers to services integration were identified repeatedly. Probably the most often noted barrier was ***insufficient resources***. While it is true that limited funds have brought community agencies together to try to do more with less, this approach can only go so far in bringing about services integration. Many of the communities visited are overwhelmed by the number of families in need of services. In Hidalgo County, Texas, agencies exhaust their annual funds for supportive services such as emergency housing, rental assistance, and truck repairs within months of receiving them. Belle Glade, Florida's population increases five-fold during the growing season, stressing the capacity of every program. Even an excellent system with a strong referral network and easy access to a wide range of community agencies cannot overcome this barrier. For example, in Belle Glade many schools are over capacity by the time some migrant families arrive in mid- to late November. Children are assigned to whatever schools have places available. As a result, children in the same family may attend different schools, which makes providing a range of services for that family much more difficult.

Differences in eligibility requirements for programs and in definitions of "migrant" create barriers to service integration (for a thorough discussion of this issue, see Martin and Martin 1992). The differences are confusing, not only to migrant families, but to service providers of other agencies as well. This confusion leads to a hesitancy on the part of providers to make referrals, since they are not sure that the family is eligible for the services. This situation can also create distrust between clients and service providers (e.g., "if you could serve my family last year, why can't you this year?"). Head Start provides an important example of

the problems that can occur due to definitional differences. Migrant Head Start can serve children from infancy through age five, but serves only currently migrant families. Thus, if a family has "settled out" and has not migrated in the past year, their child is no longer eligible for Migrant Head Start. But traditional Head Start programs serve only children ages three through five. If the child of this "settled out" family is two years old, there is no Head Start program available to her. If the child is disabled, the consequences of this definitional barrier are particularly severe. Another example is the student who had been eligible for Migrant Education Services and finds he is no longer eligible for such services, not even supportive services, after completing his GED.

An important concern about the differences in eligibility requirements and definitions among programs was that it created misunderstandings among service providers. Members of the "Working Together Group" in Brockport, New York indicated that before they started meeting together regularly, there was a lack of understanding of the mission and limitations of each program involved. Understanding that certain activities or services are not offered because they are outside the scope of a program is somehow more acceptable then believing the services are not offered due to prejudice or lack of concern for this population.

Closely related to differences in eligibility requirements and definitions, which are largely federal decisions, is the impact of ***state and local administrative structures***. In some cases, it isn't that federal guidelines create barriers to service integration, but rather that state interpretations of those guidelines create barriers. Local administrative structural barriers seemed to be greatest in the area of Migrant Education. Although administered at the state level, Migrant Education services are most often located organizationally within the local school system bureaucracy. As a result, many decisions affecting migrant children are not the direct responsibility of Migrant Education staff, but are made by other employees of the school system. Rules regarding school capacities, bus routes, school hours, dress codes, testing requirements, and a host of other matters sometimes impact migrant children more adversely than other children, yet Migrant Education must work within the existing system.

Service Needs/Gaps

There is tremendous consistency across sites in the service needs identified. *Every* site visited specifically noted either significant inadequacies or a lack of the following services:

- Transportation;
- Mental health and substance abuse treatment; and
- Housing.

There is no public transportation system in any of the communities visited. Many providers have vans or school buses, but in most cases the demand for transportation far exceeds the available resources, and it is not possible to provide van service for all appointments. Mental health and substance abuse services are generally scarce in rural areas, and the communities we visited are no exception. Mental health and substance abuse services are more likely to be

located in nearby cities (usually about an hour's drive), but these providers are less likely than local providers to offer bilingual, culturally sensitive services. Housing is a critical concern for migrant farmworker families. The shortage of housing and the substandard quality of some of the housing available poses health risks, impedes the ability of migrant children to learn, and limits the accessibility of other services needed by migrant farmworkers.

Every site except Texas noted a need for bilingual and bicultural staff. In upstream sites, it has been a particular problem as the composition of the migrant farmworker population has changed. The training, recruitment, and hiring practices of many upstream communities have not yet caught up with the increasing number of Hispanics in the migrant labor force. A particular need is for bilingual staff in "gatekeeper" positions in clinics and social services agencies, as well as in the area of mental health services, where treatment depends on good communication.

Shortages of health care providers, including primary medical care, dental care, and specialty care were frequently noted. Recruitment of health professionals for practice in remote rural areas is difficult, and the need for services continues to increase. Assessment and services for children with disabilities also suffer from the shortage of professionals in these communities. Although these services are available to the communities visited, their limited capacities make timely assessments and referrals a serious problem for migrant children. There are also shortages of Migrant Education teachers in some areas, and a need for more Head Start, pre-kindergarten, and daycare programs.

An important need identified by several sites is for parent advocacy training. It was pointed out that many migrant parents and young adults are unaware of their rights, allowing others to easily take advantage of them. While this is particularly true of undocumented workers, many parents are victims of unfair or illegal discrimination in areas such as housing and traffic enforcement. Parents also need training in understanding the educational rights of their children in this country. It was noted that those young parents who have been through the system themselves are more aware of available services and are better advocates for their children.

V. STUDY FINDINGS: CROSS-SITE SYNTHESIS

Below we provide an overview of the sites visited, and examine in detail promising models of service integration and coordination that might be adopted more widely.

Overview

The six communities visited for this study of services for migrant children represent a range of demographic characteristics and provide a wide range of services to migrant farmworker families. The sites vary in the length of their growing seasons, size of migrant population, and types of services, but they all share problems associated with attempting to provide comprehensive services to a large, economically deprived, mobile population. As discussed in Appendix A, these sites were chosen to represent both upstream and homebase programs and were identified as locations in which services for migrant children are well-represented and provided through a well-integrated process. The sites are:

- Brockport, New York (Monroe County)
- Greeley, Colorado (Weld County)
- Stockton, California (San Joaquin County)
- Woodburn, Oregon (Marion County)
- McAllen, Texas (Hidalgo County)
- Belle Glade, Florida (Hendry and Palm Beach Counties)

Exhibit V-1 provides a statistical profile of each of the communities, including data on population characteristics, birth and infant mortality rates, race and ethnicity, and income and employment. Comparable data are presented for the United States, in order to better understand the context in which each of the communities strives to serve migrant farmworkers. Each of these communities covers a large land area, provides a fertile agricultural environment, and has a large proportion of young, poor, Hispanic, migrant farmworkers. While the overall numbers of migrant families who pass through a particular community may seem relatively small over the course of a year, they comprise a significant proportion of the population during peak growing seasons. It should be noted, however, that data are presented at the county level. Statistics reflect the entire surrounding county, and may not fully reflect the predominantly poor areas in which most migrant farmworker families reside. For example, Monroe County, New York includes the city of Rochester, and Palm Beach County includes Palm Beach and West Palm Beach, Florida.

As illustrated in Exhibit V-2, a wide variety of agencies in each site provides services to migrant families directly and indirectly. At each site, Migrant Head Start, Migrant Health Centers, and Migrant Education are represented and are the predominant sources for

Exhibit V-1:

OVERVIEW OF COMMUNTITES VISITED

COUNTY	United States	Monroe, NY (Brockport site)	Weld, CO (Greeley site)	Marion, OR (Woodburn site)	San Joaquin, CA (Stockton site)	Hidalgo, TX (McAllen Site)	Hendry, FL (Belle Glade Site)	Palm Beach, FL (Belle Glade Site)
Total Population	248,709,873	713,968	131,821	228,483	480,628	383,545	25,773	863,518
Land Area/KM²	9,159,116,046	1,707,564	10,341,289	3,069,124	3,624,078	4,063,898	2,985,493	5,268,925
Population 0-21 Years Old	75,928,520	221,883	48,093	72,890	170,381	247,335	9,576	203,273
Number of Live Births[a]	4,041,000[b]	10,743	2,319	3,276	7,582	7,450	481	8,977
Birth Rate[a]	16.3[b]	15.3	17.4	15.4	19.0	21.5	21.9	12.9
Infant Mortality Rate[a]	9.8[b]	9.8	10.3	11.9	9.1	10.3	20.8	12.4
Percentage: White Black Hispanic	80.29 12.57 8.99	84.34 11.84 3.46	89.04 .40 20.83	91.53 .88 7.64	73.52 5.59 22.66	74.76 .27 85.24	71.97 16.80 21.97	84.90 12.38 7.53
Estimated Migrant Population at Peak Season	600,000[c]	5,000	8,000	13,000	62,000	117,000		16,000[e]
Per capita income	$14,420[d]	$16,162	$11,350	$12,228	$12,705	$6,630	$10,035	$19,937
Unemployment rate	6.3[d]	5.0	5.7	6.3	8.8	14.3	7.9	5.2

SOURCE: Except where noted, all county level information: Census of Population and Housing, 1990: Summary Tape File 3A [machine-readable data file]. Prepared by Bureau of the Census. Washington, DC: The Bureau, 1992. U.S. information: Census of Population and Housing, 1990: Summary Tape File 1C [machine-readable data file]. Prepared by Bureau of the Census. Washington, DC: The Bureau, 1992.

GENERAL NOTES: Birth rate is computed per 1000 population, infant mortality rate is deaths of infants less than one year old per 1000 live births, unemployment rate is persons 16 years and older in the civilian labor force. Except where noted, estimated migrant population at peak season was given during site visits.

[a] All county level information taken from: County and City Data Book, 1988: Prepared by Bureau of the Census. Washington, DC: The Bureau, 1988.
[b] U.S. Bureau of the Census Statistical Abstract of the United States: 1992 (112th Ed.) Washington, DC, 1992.
[c] Martin, Philip L. and J.S. Holt. 1987 Migrant Farmworkers: Number and Distribution. Legal Services Corporation.
[d] Press release based on Summary Tape File 3A for United States. STF3AUS.ZIP [machine-readable data file]. Prepared by Bureau of the Census. Washington, DC: The bureau, 1992.
[e] Includes both Hendry and Palm Beach counties.

Exhibit V-2:
Programs or Service Providers Included in Each Site Visit

	Brockport, NY	Greeley, CO	Stockton, CA	Woodburn, OR	Hidalgo Co., TX	Belle Glade, FL
Migrant Head Start	X	X	X	X	X	X
Migrant Health Center	X	X	X	X	X	X
Migrant Education	X	X	X	X	X	X
JTPA	X	X	X	X	X	X
Legal Aid		X			X	
Health Department						X
Housing Authority			X		X	
Grower						X
Even Start			X	X	X	
Private Medical/Dental					X	
WIC, EFNEP, other USDA	X	X	X		X	X
Other Community Based Organizations	X	X			X	X
Universities, Other Higher Ed.	X	X			X	X
Church Affiliated	X	X				

provision, coordination, and integration of services. An exception to this is in Stockton, California, where the county housing authority has taken the lead in coordination efforts, and organizes and facilitates monthly interagency meetings so that local service providers can maintain regular contact and maximize resources. Other agencies, individuals, and services that we contacted include Job Training Partnership Act (JTPA), including services to the general population as well as JTPA Section 402 services, which target migrant farmworkers; legal aid and similar migrant advocacy groups; local health departments; local housing authorities; growers; Migrant Even Start, which is represented in three of the sites; private physicians and dentists; WIC; the Expanded Food and Nutrition Program (EFNEP); other community-based organizations such as United Way, the Salvation Army, Planned Parenthood, and Girl Scouts; universities and other institutions of higher education, which provided consultants, training, classroom space, College Assistance Migrant Program (CAMP) services, and other arrangements with local service providers; and church-affiliated groups such as Catholic Charities and local parishes.

Summaries of each of the site visits are included in Appendix E. The purpose of the site visits was to identify promising models of services integration that could be used by other programs serving migrant farmworkers. These promising models are discussed below.

Promising Models

Across the six sites visited, a number of models of service integration were identified that could be adopted by other sites interested in improving coordinated service delivery. Each of the models fits the concept of service integration described in Part IV, although each model may focus on different services or different groups within the target population. For example, some focus on the needs of the preschool child and his/her family, while others address the needs of high school students. The setting and organizational locus of the models vary as well, and include the Head Start Centers, elementary schools, college campuses, and migrant housing projects. While most of the models demonstrate a service-oriented approach, some models (i.e., the first two below) with a system-oriented approach were identified. As will become apparent in the descriptions that follow, some models combined these approaches.

Regional Coordination/Umbrella Organizations (System-Oriented Approach)

For Head Start children who migrate along the east coast of the United States, the process of coordination among programs is greatly facilitated by the East Coast Migrant Head Start Project (ECMHSP). ECMHSP is an umbrella organization that provides fiscal and administrative services to Head Start delegate agencies in 12 east coast states. A primary goal of the project is to promote continuity of Head Start services to migrant children and their families along the east coast of the United States. ECMHSP provides program and fiscal monitoring and training and technical assistance at the center level and promotes staff development activities on a regular basis. The ECMHSP model was unique among Migrant Head Start providers when it first began in 1974. This umbrella organization enables sites to serve families and teach children, while the central office takes on administrative tasks such as payroll, purchasing, negotiating for space or

resources, and arranging training for staff. ECMHSP also facilitates continuity as families move from one site to another through a continuity record provided to parents. Each Head Start program that is a part of ECMHSP uses the same forms to provide health and developmental records that parents can take with them when they travel. Student records are also sent to the main office of ECMHSP in Arlington, Virginia so that any other ECMHSP center can request the file if the family does not have it upon arrival. Other administrative records are also standardized across programs, as is an annual program evaluation procedure.

While many of the sites visited also delivered services through regional consortia, they were operated within the state and rarely worked as effectively as the larger umbrella organization of the East Coast Migrant Head Start Project. For example, in California, Migrant Head Start was operated as part of an in-state regional consortium of agencies. While some activities such as staff training were conducted on a regional basis, this arrangement could not assist with continuity in service delivery from site to site. In addition, the record keeping was not centralized as it is in the ECMHSP. Although the consortia had developed forms for each of its programs to use, local programs also used their own forms to keep records on clients and services provided, creating added administrative burden.

Community Coalitions (System-Oriented Approach)

A number of the coalitions encountered in our site visits were service-oriented in that their primary purpose was to link their clients to other services in the community. However, some coalitions were attempting to assess the overall needs of their communities and plan together for meeting those needs. Two related efforts in Brockport, New York, one in Stockton, California, and one in Hidalgo County, Texas exemplify this latter approach.

The Coalition of Migrant and Farmworker Services. A coalition of agencies that serve farmworkers was started in the late 1970s. Its focus, then and now, is on coordination. Agencies in this coalition include: Brockport Migrant Education, Oak Orchard Community Health Center, Agri-Business Child Development, Foodlink (a food distribution program), the local office of the New York State Department of Labor, the Hispanic Migrant Ministry, and Rural Opportunities, Inc. This is the forum where providers can bring up gaps in services. Participants have found that this approach works better than questioning individual providers directly.

The "Working Together Group." The Working Together Group, which is an outgrowth of the above coalition, has been meeting for about three years. It took time to get all groups to participate, but they have now been meeting regularly every two to three months. The chairmanship and location rotate among the different agencies. The Working Together Group has taken a structured, head-on approach to resolving their philosophical differences. For example, they hired a paid facilitator to work with them to help develop trust among the various individuals and organizations represented. A three-day racism training session took place the week before our site visit. As pointed out by the health center executive director, in these times of flat federal funding and state budget shortfalls, collaboration and coordination are a necessity. The survival of their programs depends on working together. In the past, there had been competition between providers serving migrant families and sensitivities concerning who was

responsible for providing and paying for particular services. Now organizations serving farmworkers are working on breaking down those barriers.

The impact of these efforts in Brockport has been seen across all services. Members of the Working Together Group have collaborated on grant proposals, staff training, and parent education. Members of these organizations serve on the boards of directors of other organizations in the coalition. Each program indicates that it has gained an understanding of the missions and limitations of the other agencies. It was noted that the Coalition of Migrant and Farmworker Services and the Working Together Group allowed providers to express their concerns about the need for bilingual and culturally sensitive staff at other agencies. Partly in response to this improved understanding and communication, Spanish-language training was provided for health center staff several years ago with foundation funding. A cultural sensitivity class, led by a facilitator, was also provided for health center staff. All of the agencies in the Working Together Group have made a deep commitment in the past few years to hiring minorities and striving for cultural diversity in their staffing.

Stockton, California, Informal Interagency Council. Another effort at interagency coordination using a coalition approach was observed in the California site, which has an informal interagency council currently chaired by the deputy director of the Housing Authority of San Joaquin County. Although it has been in existence for many years, the council is a very informal group that meets semi-monthly during the growing season at one of the three migrant housing centers provided by the Housing Authority. The council is essentially open to anyone interested in attending, and there are currently over 20 agencies involved, representing virtually all of the state and local agencies providing services to migrant families. At the meetings, statistics are shared on the number of children and families needing and requiring services, and each council member describes the resources available and any particular needs that clients may have such as jobs, child care, ESL services, and so on. Statistics and notes from the meeting are written up by the chairperson and distributed to participants prior to the next meeting. The statistics are useful for agency planning, and the sharing of program information helps agencies to make the most efficient use of scarce resources.

Hidalgo County, Texas, Partners for Self Sufficiency. Although it is relatively new, the Partners for Self Sufficiency in Hidalgo County, Texas holds promise as a model for a system-oriented approach to service integration. Sponsored by the Texas Department of Human Services, Region 8, the Partners for Self Sufficiency is a two-part initiative to address immediate and long-term needs in the *colonias*, the rural, underserved subdivisions where many migrant farmworkers live. For short-term needs, an intensive case management system links residents to services for which they are eligible. The Coalition of Community Service Agencies was formed to implement the business and community partnership which will address long-term needs related to employment, infrastructure, education and training, health care, and human services. Project staff are invited by residents of the *colonias* to help organize groups of residents and to conduct an extensive survey of the needs in the *colonia*. Residents are involved in each step of addressing these needs. Examples of the types of activities undertaken at the suggestion of residents include installation of mailboxes and public phones, diabetes screening, ESL classes, and nutrition classes.

Relationships with Colleges and Universities and Other Educational Institutions

Across sites there were a number of models observed in which the various programs or agencies serving migrant farmworkers and their families had developed special relationships with local colleges and universities that enabled them to either expand their programs, or somehow capitalize on the resources of the colleges and universities. A commonly observed practice in the sites visited was a well-developed relationship between the health centers serving migrant families and nearby medical schools. For example, the Migrant Health Center in Greeley, Colorado--Sunrise Community Health Center--has a formal agreement with the University of Colorado's family practice residency program. This program sends medical students to Sunrise as part of their residency requirements. In addition to providing extra staff to the health center, the residency program draws recent medical school graduates into rural and underserved areas. A similar relationship exists in the Woodburn, Oregon area that draws medical students from Oregon Health Sciences University in Portland. The Hidalgo County Health Care Corporation collaborates with the University of Texas Medical School in San Antonio to provide pediatric subspecialty clinics in Pharr, Texas, and operates a women's cancer treatment program jointly with the University of Galveston.

A different arrangement was seen in the Brockport, New York site, where the Migrant Education Program has been located on the campus of the State University of New York (SUNY) at Brockport since 1974. That year the New York State Department of Education established centralized outreach centers throughout the state that were based at state universities or other regionally based local education agencies. The Migrant Education Program in Brockport runs both summer and year-round programs for migrants on the SUNY Brockport campus. The college campus setting for the program benefits both the Migrant Education Program and SUNY Brockport. The college provides office, resource/library, and classroom space in addition to four vans to transport students to and from the night school. The campus setting exposes migrant students to higher education and life on a college campus. The setting also facilitates the use of college students such as work study students, student teachers, and those participating in the Literacy Corps as tutors. Benefits for the college include placements for student teachers and education administration interns, as well as a wide range of opportunities for those interested in using and practicing Spanish, studying alternative approaches to education, and learning concepts of multicultural education. The Migrant Education project also recruits migrant students and staff to SUNY Brockport. This helps the college meet its goal of a diverse student population. At the time of the site visit, about six migrant students were enrolled at the college; two additional students enrolled at local community colleges are expected to transfer to SUNY Brockport in the future. In 1991, two migrant students graduated from the college.

A different type of relationship exists between Migrant Head Start and a vocational training program in Florida that could be adapted to other sites. In the Florida site visited, the West Tech Vocational School in Palm Beach County is one of three technical education centers in the county. The school offers a number of vocational courses and an ESL program, as well as assistance with obtaining a GED to both adults and high school students. A program of particular interest is the child care assistant program, which places some of its students at the Migrant Head Start centers and at the Migrant Education pre-K programs for practical training.

While West Tech is thus provided with a training opportunity for some of its students, this arrangement also provides Migrant Head Start with much needed child care workers.

Grower Support

Very limited examples of grower support in providing and improving accessibility and integration of services were observed in the six sites visited. The most notable example occurred in Florida at the Shannon Center, a Migrant Head Start center located on the property of A. Duda and Sons (DUDA), one of the large growers in the area. This center serves 100 children, most of whom are infants and toddlers. The parents of most of the children served by the Shannon Center work for DUDA, although children of other migrant families in the community are also eligible to be served there. Families return to work for DUDA each season because of the benefits provided by this grower. As a result, 80 percent of the families at the Shannon Center return each year. Partly because of this return rate, parents are very involved in the center, helping out in the classrooms and with repairs when time is available. For example, parents raised money to build a paved path in the playground area for riding toys. Some of the parents work for the Migrant Head Start grantee and travel upstream during the summer to work at other centers. In addition to providing land for the Head Start center, DUDA also provides farmworker housing. Because of the commitment to their employees and the services they provide, DUDA achieves a 95 percent return rate of employees from year to year.

The creation of the Shannon Center was a joint effort by the DUDA employee relations manager and staff of the East Coast Migrant Head Start Project (ECMHSP). The Center offers advantages for both growers and families. The advantages for the grower are that the land provided for the center couldn't be used for anything else; parents can drop off and pick up their children on their way to and from work, thus improving worker satisfaction and punctuality; and the site is convenient for parent meetings, since it is close to where families live. The employee relations manager indicates that this arrangement has eliminated travel and babysitting problems for workers. DUDA provides all maintenance and security for the site. The location of the center has also encouraged family involvement. Parents can easily come to the center during slow work periods, and can attend evening parent meetings and education sessions at the center.

The excellent working relationship between DUDA and ECMHSP is bringing other benefits to workers. For example, DUDA is working with Palm Beach County Migrant Education to try to establish an after-school tutoring program at the migrant camp. DUDA also provides space for the migrant health center's mobile van so that health screenings can be conducted on site. Through collaboration with the health center, WIC vouchers are issued at the DUDA migrant camp. DUDA also provides space and security for the ECMHSP Family Literacy van, which is equipped with up-to-date computer workstations and audio equipment for learning basic literacy skills, English language, and GED requirements. During part of the growing season, the van was on site at the Shannon Center, providing an accessible learning center for migrant parents. The van travels to other Migrant Head Start sites upstream in the late spring and summer months.

The relationship between growers and those who provide services to migrant farmworkers in the Belle Glade community is unique. Some of the impressive support and cooperation can be attributed to economics--the growers need reliable and healthy workers, and large growers in South Florida have the advantage of a long growing season and a diversity of crops. Nevertheless, the key role that growers play in facilitating integrated services for migrant farmworkers demonstrates an enlightened approach and an attitude that goes beyond economics. For example, DUDA managers regularly travel to Texas and Mexico to visit their Florida migrant employees in order to better understand their needs and encourage them to return to Florida for the next growing season. There appears to be a real "meeting of the minds" between growers and representatives of ECMHSP and Migrant Education concerning the desirability of co-locating of work, housing, and child development for migrant families. In addition, there is a willingness on the part of growers to contribute substantial resources for this purpose.

In New York, support by growers is not as visible in terms of direct services, but is clearly a key factor in the excellent child development services available for migrant children. The Agri-Business Child Development Program was started in 1946 by rural missions caring for migrant children. Through the efforts of these missions, a state law was passed requiring child care to be provided for all children of agricultural workers. Funding for child care is supported by growers. Most of the board members of the Agri-Business Child Development Program are growers or processors.

Farmworker Housing

Perhaps the most pressing problem identified by respondents in the sites visited was a lack of affordable, quality housing for migrant farmworkers and their families. A number of efforts were identified to provide housing to this population in a manner that also enabled integration of services by providing space for co-location of services with housing units. One such effort has been in place in California since 1966, when the Housing Authority of the County of San Joaquin began providing housing for migrant farmworkers in response to squalid living conditions among migrant families. The Housing Authority in San Joaquin County manages, owns, or leases approximately 5,000 rental units throughout the county for migrants and other agricultural workers and low-income families. The state regulates the conditions of operation for the housing centers and negotiates with the Authority for rehabilitation and repair of the units. The housing for migrant farmworkers is subsidized by the State Office of Migrant Services, which contracts with housing centers across the state. Rental housing units in the San Joaquin Valley are provided to 288 migrant families at three state-owned centers, which are open 180 days per year--usually from May to October, depending on the growing season in a given area. Funding also comes from HUD, FHA, and rent from tenants.

Migrant families are eligible for the housing in San Joaquin County if at least half of their income is earned through agricultural work, but they are *not* subject to income limit requirements. Priority for the units is given to reliable tenants from the previous year through a pre-registration process; about 80 percent of families are repeat renters. Once the units are filled, waiting families have few low-cost alternatives, as growers in the area typically provide housing only for

single men. The Housing Authority also provides space on the premises of the migrant housing camps to various agencies that serve migrant families. At the time of the site visit, space was being provided in one center for Head Start classrooms, and in the other two centers for state-funded daycare programs. Space is also made available for community organizations and agencies interested in bringing services to the migrant families such as the Girl Scouts or agencies providing GED or ESL classes. All of these programs and services are co-located at the migrant housing facilities. The existence of facilities in which services can be co-located provides the opportunity for coordination and integration among agencies. The existence of these facilities is also a catalyst for the success of the interagency council that exists in San Joaquin County.

Interstate Coordination

Continuity of services for migrant families is a primary concern as families move across state lines where different types of programs and services are available. The issue is particularly acute for children in the education system, where curriculum and graduation requirements vary from system to system. Interstate coordination is particularly critical for promoting service continuity and ensuring that students benefit from the educational and developmental services available. All of the sites visited were involved in efforts to promote interstate coordination. Below we highlight a few of these efforts, which may serve as models for others.

Migrant education staff in the Stockton County, California area have taken a unique approach to the need for information to facilitate program continuity. Since most of their students migrate to and from Mexico, they negotiated a binational agreement with Mexico that provides written documentation (in both English and Spanish) of students' current educational status. The document provides summary information on the student's level in school and academic information, including specific objectives by subject area. A grade point average is also provided, as is a space for teacher comments. The written document also helps students gain entrance into school in Mexico. School officials in Colorado have recently begun similar work to develop a binational accreditation project with Mexico.

The Texas Migrant Council (TMC), the grantee for Migrant Head Start programs in Texas, has a well-developed model of interstate coordination, although it is currently in transition. Up until last year, TMC operated programs upstream in the primary receiving states for migrant farmworkers from Texas. Each year about 600 TMC employees relocated to upstream sites in Ohio, Wisconsin, Illinois, and Washington for the summer months. This assured continuity for families from Texas, but had the disadvantage of discouraging states from developing their own capacities to serve migrant children and families. Also, as farmworkers moved to different communities, this model was difficult to maintain. Last year, the federal Migrant Head Start program required that TMC delegate its upstream operations to other provider agencies. TMC is now responsible for monitoring these subgrantees. Although it is still early in this transition, it appears that continuity and communications between homebase and upstream will continue to work well, and will improve under the new model.

TMC staff ask Head Start parents where they will be moving, and attempt to contact grantees in other states to link up with them. TMC staff belong to a migrant task force in Indiana and Ohio and attend meetings there. They also have an agreement with a Head Start grantee in Minnesota that involves sharing of health information and reimbursement for medical expenses. Health records of Head Start children in Texas are computerized, and TMC mails copies of the records to Minnesota and to sites in other states if requested. Hand-held copies of medical records are provided to families when they leave. The Minnesota grantee maintains a computerized list for follow-up services needed. TMC attempts to follow up on the children on the list or sends a social service/parent involvement specialist to families to provide referrals for them. Details of this follow up are then shared with staff in Minnesota. TMC staff also train parents in Minnesota and other states and work with East Coast Migrant Head Start to coordinate efforts for Texas-based families who migrate to east coast sites.

The Texas Migrant Interstate Program (TMIP) has an extensive program of interstate communications for older children (in grades 7-12). TMIP sends staff to New York, Washington, Georgia, and Michigan (and sometimes Ohio and Indiana) to work with staff in other states and with students from Texas. A Program Coordination Center at Texas A & I University pays for sending staff to other states. TMIP maintains a consultant pool for this purpose that includes counselors and teachers who are willing to travel to other states. Respondents at the Brockport, New York site reported that they had worked extensively with Texas staff over the past 8 to 10 years. They have worked out an arrangement where Texas schools now accept New York's recommendations for secondary school credit transfers. They have paid for counselors from Texas to spend 6 weeks in the state to review student records, and are investigating ways to work with Texas personnel on the issue of a required standardized test for secondary students--the Texas Assessment of Academic Skills.

Communication between Florida Head Start centers and points north in the eastern stream is structured under the administrative umbrella of East Coast Migrant Head Start (ECMHSP), as described above. All ECMHSP centers participate in the computerized continuity record system. Each child's record contains health and developmental information. The continuity record is sent with the family when they move upstream from Florida. The continuity record is also kept on the central computer system at ECMHSP headquarters in Arlington, Virginia. If the family has misplaced the record, a call to headquarters can retrieve the needed information.

For school-age children in Florida, the Eastern Stream Advance Notification System is used. Migrant Education makes extensive use of the telephone and FAX to obtain information on individual student requirements. Upstream sites also typically send lists of students expected to be coming to Palm Beach County to the county Migrant Education office. Although many families in Palm Beach County travel up the east cost, most travel to Texas. Migrant Education therefore makes an effort to educate parents about the need for accurate records. Parents receive a brochure listing records and information that should be obtained from the school to bring to their child's new school.

Transition Across Programs

During the growing season, children of migrant farmworkers may need to move from one program to another. The most frequently encountered example is the transition from Migrant Head Start to elementary school. Across the sites visited, several developing transition models were identified; most respondents were aware of the need to expand and formalize some of the existing processes.

Colorado has a well-developed early childhood program--Family Connects--which addresses the transition needs of young children who stay in the area and move from Migrant Head Start programs to elementary school. Family Connects is a comprehensive early childhood development project focusing on community outreach, coordination of services, family support, and parental involvement as teachers in their children's lives. The family support component helps families with transition planning for their young children.

The approach in the Migrant Head Start centers in Florida is somewhat more formalized. These centers have an arrangement with local elementary schools to assist children in the transition process. Head Start instructors observe elementary school classrooms so they know how to prepare the children. They also take the children to visit an elementary kindergarten class and have lunch in the cafeteria. Another method used to ease the transition to elementary school is the "All About Me" book, prepared by the Migrant Head Start staff for the elementary school staff. This book, which displays the child's picture on the front, lists family information, medical information, and strengths and weaknesses of the child. An identical copy of the book, in Spanish or Creole, as appropriate, is sent home to the parents.

Promotores/Lay Educators

The *promotores* model, providing training to residents of the *colonias* who then serve as lay educators and organizers in their communities, has been implemented successfully in Hidalgo County by both Planned Parenthood and the Expanded Food and Nutrition Program. The lay educators are well-received in their communities, thus providing an effective means of educating residents. The *promotores* model is an example of service integration because it taps various community resources for training and program implementation, and attempts to address a wide range of needs identified by residents. Planned Parenthood's education department in Hidalgo County, Texas recruits women from the *colonias* and trains them in various topics related to family planning and women's health. The program "Entre Nosotros" currently has 18 trained *promotores* who are paid a $50 monthly stipend and are reimbursed for gasoline. The Expanded Nutrition Program, part of the Texas Agricultural Extension Service, has been providing training and education programs that have served the rural *colonias* since 1968. Headed by a home economist, the program has 20 paraprofessional teachers who provide training to residents of the *colonias* and other rural areas. They provide formal training programs for classes of 10 to 20. The programs are six to eight months long and include training in basic skills, food preparation, menu planning, budgeting, and self-esteem. Although not intended as employment training, these

programs have enabled women to obtain employment as cafeteria workers, and have encouraged home-based employment such as home daycare, catering, and flower arranging.

The Hidalgo County Health Care Corporation (HCHC) is currently planning an interagency project that involves the efforts of Valley Interfaith (a nonprofit, community-based organization centered around area parishes and churches), the Texas Migrant Council, and the County Health Department to train residents to act as lay educators. The program plans to recruit residents of *colonias* who will be provided with four months of training as community health aides. Individuals will be trained to conduct screening for Medicaid eligibility and outreach, and to discuss the availability of services at the health center and through other community agencies. The programs also serve as a means for individual residents to gain confidence and skills in order to better themselves and their communities. The *colonias* project of the Texas Department of Human Services--Partnership for Self Sufficiency--is a more recent initiative with broad support from community agencies. This project holds promise for mobilizing private support and for coordinating the many efforts to serve *colonias* residents that are either underway or in the planning stages.

The Woodburn, Oregon site has a similar effort in the area of health education, called La Familia Sana. This program, funded through a grant from the Offices of Rural Health and Minority Health, trains lay farmworkers to educate the farmworker community on health issues. The program has expanded available resources to the community with very little expenditure of funds. It has also been an effective way to reach community members who may not otherwise be as responsive to outsiders. The grant was awarded to a consortium of three health providers in the region.

"One-Stop Shopping"

One difficulty associated with service delivery to migrant families is the large number of agencies involved in the provision of services and the limited time and transportation available to migrant farmworkers to avail themselves of these services. The "one-stop-shopping" model has often been touted as one way to address these time and transportation issues. A successful version of this model was observed in the Brockport, New York site where the Oak Orchard Community Health Center uses its mobile van to provide a variety of services to families eligible for migrant Head Start services during the summer season. Before the season begins, the health center works out a schedule of visits with the Migrant Head Start provider in the area. The van, staffed by a nurse practitioner, a nurse, and a community health worker/translator who is authorized to complete WIC certifications, comes to the Head Start center and provides physicals, health screenings, and immunizations for the children, and Medicaid enrollment and WIC certification for the families. The Head Start center's health coordinator facilitates this process by preparing the necessary forms for each child/family before the van arrives. Other communities such as Belle Glade, Florida are also making use of mobile health units to facilitate "one-stop shopping." The co-location of farmworker housing and daycare, social services, or adult education, as described earlier, are other examples of "one-stop shopping" models.

VI. EVALUATION ISSUES

This part briefly addresses key issues relevant to evaluation of programs striving for service integration to meet the needs of migrant children and families, including potential obstacles to evaluating these programs. There are special challenges to evaluation posed by the circumstances of migrant populations and by the nature of service integration. The programs involved cross jurisdictional as well as professional boundaries as migrants move between school districts, counties, and states. We divide our discussion as follows: evaluation issues specific to programs serving a migrant population; evaluation issues specific to service integration efforts; and assessing evaluability of programs serving migrant families.

Evaluation Issues Specific to Programs Serving Migrant Populations

Evaluations can generally be divided into two types, depending upon their purpose. Process evaluations describe the services provided and who received the services, documenting and quantifying program activities. This requires management and activity data, as well as client demographic and service utilization data. Outcome evaluations seek to determine whether the services provided made a difference and to measure the extent to which program goals have been met.

In our site visits we came across very little evaluation, either descriptive process evaluation or outcome evaluation. Programs such as Migrant Head Start and Migrant Education are required to conduct evaluations. Service integration efforts are documented as required in these evaluations, but there is no attempt to conceptualize the system which shapes these efforts. Evaluation of the impact of these efforts is even less evident. Through informal meetings, both within programs and across agencies, the success of collaborative efforts is reviewed, but no formal evaluation is ongoing. Mary Lou de Leon Siantz, a researcher at Indiana University, is currently conducting a longitudinal study of Mexican-American migrant mothers and children in collaboration with the Texas Migrant Council. This is the only example of an evaluation research effort encountered during our site visits. Siantz notes that, to date, research has yet to examine systematically over time the impact of Migrant Head Start on migrant children and their families (Siantz 1991).

The major evaluation tasks specific to programs serving migrants are:

- Measuring baseline service needs and gaps;
- Specifying goals and outcome measures; and
- Following clients over time.

Measuring Baseline Service Needs and Gaps

In order to determine whether a program was successful in meeting a need, that need must be identified. Although some work has been done in this area, most needs assessments

concerning migrant families are both very local and program specific. For example, health needs will be assessed by a Migrant Health grantee and educational needs will be addressed by a local Migrant Education Program or in a state education agency's annual report. Localities that take a broad view of the total needs of migrants in their community are the exception rather than the rule. However, we did encounter a few system-oriented approaches to services integration that are beginning to address community-wide needs assessment. Examples include the Coalition of Migrant and Farmworker Services in Brockport, New York; the Glades Interagency Network in Belle Glade, Florida; and the Colorado Migrant and Rural Coalition and the Northern Area Migrant Coalition in Greeley, Colorado. Since the clients as well as the services overlap for many of the programs serving migrants, it can be difficult to clearly assess and quantify the needs to be addressed, but it appears that communities are beginning to recognize the importance of this baseline data.

Specifying Goals and Outcome Measures

Once a baseline has been established, progress cannot be measured without some articulated goals. While most programs do have broadly stated goals, these goals are rarely translated into specific objectives or measures of success. Programs serving migrants often find themselves responding to crises, such as finding emergency food or housing for a client. As a result, they do not step back and evaluate how each of their efforts on behalf of a family combines to achieve the overall program goals.

A few process variables lend themselves to quantification, and may be available for evaluation purposes. For example, a comparison of the numbers served and the number of individuals or families eligible or in need of services, if tracked over time, would be a useful indicator of access to such programs as Medicaid, Head Start, and WIC. Quantitative indicators of service delivery can be augmented with qualitative and observational methods. Qualitative descriptions of the referral network and changes in utilization patterns, as well as observations of the flow or clients and information, can be critical to interpreting quantitative service data.

Collaborative efforts are sometimes a response to funding cuts, where "success" means continuing to serve the same proportion of families with more limited resources. For some programs serving migrants, the amount of time the program has to work with the family is quite limited (e.g., a six-week harvest season). Therefore, it is important that expectations and outcome measures are realistic.

Outcomes are what one expects to happen to families as a result of the program. Outcome measures look beyond the resolution of immediate crises and relate to each of the areas addressed by the program and included in the program goals. Examples of health outcomes include: increase in the number of children who are up-to-date on their immunizations; improved nutritional status using standard anthropometric measures; and improved dental health. Educational outcome measures include: increased percentage of students performing at grade level; improved scores on standardized tests; and an increase in number of students completing high school. Other outcome measures should also address various aspects of living conditions

such as reduction in the number of families living in substandard housing and increased parental involvement in children's health, education, and daycare programs.

Following Clients Over Time

Obtaining follow-up information on migrants is particularly difficult, because not only does it involve following participants across programs and across time, but also across geographic boundaries. Transfer of information as the migrant moves is a difficult problem. For example, Migrant Education staff interviewed during our site visits indicated that obtaining MSRTS data in a timely manner was problematic, and that there were a number of instances where information was incomplete or inaccurate. Health centers also have standardized record systems, but the systems vary enough to produce some confusion. Most centers provide migrants with small health record cards or with copies of their own charts to take along with them. While many migrants keep those cards for years, some are lost immediately (Trotter 1988). Some centers send automatic letters to the next most probable location, although many times a migrant may never get there because plans changed. A pilot study of a family-carried growth and nutrition record for children in North Carolina used a record designed to appeal to parents, and provided education to parents on its use. Follow up was coordinated with counties in Florida, since it was assumed that a majority of migrant families returned yearly to Florida. Among the 29 counties responding to a survey two months after implementation of this record, only 2 reported seeing a migrant child with one of the records (Young et al. 1990). After tracking birth outcomes of pregnant women participating in this project, it became apparent that families traveled to many other states during the winter months.

Without follow-up information, it will be difficult to evaluate an important aspect of services integration--continuity of services between programs and localities serving migrants in their home base and upstream.

Many outcome measures require longitudinal information. Improvements in health status, dropout rates, or academic achievement do not happen overnight. Young et al.(1990) note that collecting reliable follow-up data on migrants requires multistate monitoring and a large sample of participants to compensate for high rates of attrition.

Evaluation Issues Specific to Service Integration Efforts

Evaluation of social programs is always a challenge. This challenge is made more difficult because of the flexibility and variation of integrated programs. Ideally, each effort is shaped according to the needs and resources of the community, as well as the needs of the individuals served. Thus, by definition, each integrated service effort differs, both in terms of services offered and administrative structure. In the case of school-linked services, for example, multi-agency collaborations coordinate multiple education, health, or social services at or near the school site. These efforts usually have several goals that include not only improving student outcomes such as reduced dropout rates, improved academic performance, and decreased

substance abuse, but also family outcomes such as improved parent-child relationships, and systems outcomes such as better working relationships among education, health, and social services agencies (Gomby and Larson 1992). In a recently completed study of services integration programs for at-risk youth, Burt et al. (1993) describe several evaluation issues. Below we review those that are equally relevant to service integration efforts for migrant families.

The Family as "Client"

Ideally, service integration efforts address the needs of the family. For example, while the child is the focus of a Migrant Head Start program, the program also strives to involve parents and to provide parents with information and skills that will enable them to serve as advocates for their children and partners in their education. How then, does one count activities that involve parents but not children? In evaluating outcomes, does one include measures of the child's success, measures of the parent's success, measures of the success of the family as a unit, or all of the above?

Neighborhood or Community as "Client"

Even further from the "standard" service delivery model is the situation in which a program is trying to change conditions in a whole community. Some programs serving migrants may target more than one community, as they try to address needs in both home and upstream locations. If a program's target is a neighborhood or community, it may not be at all appropriate to use an evaluation design based entirely on the experiences of individuals who are in direct contact with the program. Rather, some type of community survey or aggregated data of community indicators might be more appropriate to measure system change. Surveys could assess changes in parental participation in PTAs, attendance at community meetings, availability of services, extent of participation of key agencies in community coalitions, and so on.

Documentation of Service Delivery

It is relatively common for programs to refer their clients to other agencies for needed services without having any system in place to get feedback from the referral agencies as to the client's actual receipt of services. In these programs, there is no file that contains all information about a given client's receipt of services. It is critical that the evaluators of service integration efforts develop a mechanism for obtaining feedback from referral agencies about the actual delivery of services. It is, of course, also essential that programs maintain accurate records of their own service delivery. The program's current practices and future ability to record service delivery on a client-by-client basis would be examined during the evaluability assessment stage.

Non-client Outcomes of Interest

Documentation of service integration efforts includes an assessment of the effectiveness or efficiency of the referral network. Many of the programs involved in services integration rely

heavily on informal or institutional linkages with existing service agencies; other linkages are formal and explicit. Restrictions associated with client eligibility, requirements imposed by funding sources, and program guidelines, often affect the extent and the formality of the referral process. The ability of agencies to work out more flexible procedures and overcome barriers to integration will certainly affect service delivery and will probably also affect client outcomes. Documenting how the agencies in the network developed more flexible procedures (if they did), and describing changes that resulted, is an important part of the evaluation of integrated programs.

Variability in Community Service Networks

Burt et al. (1993) found in studying services integration programs for at-risk youth, that integrated service efforts are developed in idiosyncratic ways, often beginning with informal relationships among agency directors. Our interviews with those providing integrated services for migrant families confirmed this finding. This means that attempts to adapt or replicate successful service integration efforts in other communities may be hampered because services differ from those in the model community. It may be important to document what is missing from the service integration package in any given program, either because the service or resource is unavailable, or because a relationship with appropriate agencies had not yet been developed.

Assessing Evaluability of Programs Serving Migrant Children

In planning evaluations, the commitment to evaluation, the role of the evaluator, and the "readiness" of the program for evaluation must all be considered.

Successful evaluation requires a deliberate commitment to the effort as well as a belief in the value of evaluation. Evaluation can be used to improve programs, target resources, and justify the need for additional resources and/or collaborative efforts. Program managers should keep in mind that much can be learned from process evaluation, and that what is learned about process can also be used to plan and understand results of future outcome studies.

Programs serving migrants seem to have a wealth of recordkeeping requirements, but a dearth of evaluation data or ongoing studies. This is not really surprising, because evaluation and data collection/monitoring are quite separate activities. While resources are specifically provided for data collection (and resources are often tied to compliance with monitoring requirements), evaluation rarely receives the same recognition in terms of resources or commitment of staff time. For this reason, it is generally recommended that program staff should not be expected, on top of their regular duties, to conduct the evaluation. They do not have time and they will always (and appropriately) place a higher priority on responding to the needs of clients.

This means that evaluators should be outsiders. However, this raises the concern that the evaluator may not really understand the program. For the evaluation to be a good one, the

outside evaluator needs to take the time to get to know the program and work carefully with program staff to develop mutually agreeable arrangements for conducting the evaluation.

As noted by Burt et al. (1993), a preliminary evaluability assessment is an essential beginning point for any evaluation of service integration efforts. During the evaluability stage, researchers identify the services available in the network, the existence and nature of the links between program components, and the program's expectations for how these components will affect client outcomes. This set of clear predictions lets the evaluator distinguish between intended and unintended program benefits. Specifying the exact services which comprise program "components" also lets the evaluator track the operation and implementation of these components during the formative evaluation stage.

All service agencies that are part of the service integration network should share roughly the same ideas about what services are being offered and how these services fit into the overall design of program inputs and outputs. However, when many and diverse agencies are involved, it may be difficult to develop this common understanding. An evaluability assessment may reveal important differences of opinion among the coordinating agencies, and these may have short-term negative impacts on service delivery and planning. The evaluator who works with the program to develop its evaluation plan must anticipate these problems and be sensitive to any unintended consequences of the evaluation itself on the cooperating agencies (Burt et al. 1993). Table VI-1, adapted from Burt et al.(1993), summarizes the evaluation issues of concern in studying service integration for migrant children and families.

Readiness for Evaluation

The preceding discussion notes the difficulties in evaluating service integration efforts for migrant families and the limited extent of existing evaluation activities. The six communities visited are exemplary in their service delivery efforts. It is realistic to assume that the programs in this study represent some of the best efforts in establishing services integration for migrant populations. Yet, the readiness of even these exemplary programs for impact evaluation is marginal.

Impact evaluation requires a well-established program with stable operations and good documentation of procedures and services. While individual organizations at some of the sites visited would fit this description, the subject of evaluation for this study is the integrated services configuration. Of the communities visited, the programs in Brockport, New York and Belle Glade, Florida, are the most ready. These sites are potential candidates for impact evaluation because they have good documentation of procedures and services. They have well-established integrated service configurations for a few programs. However, these communities are in the process of expanding their service configurations and developing a systems approach to assessing and addressing service needs.

Some of the communities visited such as Stockton, California and Greeley, Colorado have migrant coalitions that have been in existence for over 15 years. However, these have

operated on an informal basis with limited documentation. A process evaluation might be feasible for theses sites because there are staff members who have long experience with the participating programs and could work with an evaluator in documenting service systems, procedures, and changes over time.

Even a formal process evaluation may not yet be appropriate for some of the communities visited. Their service integration models are in the early implementation stages (for example, the Partnerships for Self-Sufficiency in Hidalgo County, Texas). Ideally, an outside evaluator should work with these communities to help formulate the appropriate questions and build in data collection methods in the early stages of program implementation. Even documentation of procedures and periodic qualitative assessment of the implementation will set the stage so that the program is ready to conduct evaluation as the model matures.

EXHIBIT VI-1: SUMMARY OF EVALUATION ISSUES AND IMPLICATIONS

ISSUE	IMPLICATIONS
Measuring baseline service needs and gaps	Work with other participating providers and community agencies to obtain baseline data that cuts across specific program boundaries and disciplines. Use a systems-oriented approach to assessing needs.
Specifying goals and outcome measures	Outcome measures should reflect the major goals and activities of all key participating agencies. Expectations and outcome measures must be realistic. Outcomes selected for measurement may pertain to individual clients, their families, or the community as a whole.
Following clients over time	Next to an appropriate comparison group, nothing is more important to the integrity and persuasiveness of an evaluation than obtaining adequate longitudinal data. Given what has already been invested in the evaluation, it is worth considerable trouble and expense to follow clients. For programs serving migrants, this involves an investment in multi-state client monitoring efforts.
Documenting the program, for impact analysis and process analysis	Any good evaluation, process or outcome, must include the capacity to document what each client gets, including services and activities, whether delivered by the program itself or through the program's network of referrals and interagency associations. It is also important to document the process through which services were delivered.
Non-client outcomes of interest	If evaluation is interested in system change and its impact, plans must be made to assemble and analyze evidence of such change.
Conducting evaluations	In general, outsiders should conduct evaluations, with extensive interaction and participation of program personnel. Programs must be ready for evaluation, by being willing to cooperate, being interested in the results, and having systems in place to collect and process the necessary data.

Adapted from Burt et al. 1993.

VII. POLICY ISSUES AND IMPLICATIONS FOR FUTURE RESEARCH

Federal Policy Issues

The needs of migrants cannot be adequately addressed without consideration of inter-state issues. Removal of barriers to access that result from differing definitions and eligibility requirements, and promotion of regional efforts to better serve farmworkers are appropriately addressed at the federal level.

The various ***definitions*** of migrant farmworker have created barriers to services integration. Often clients who are eligible for one service such as Migrant Education may not be eligible for other services such as Migrant Head Start or migrant health services. The definition of migrant farmworker for most federally funded programs excludes vast amounts of agricultural employment in some states. For example, in Oregon there is a lot of seasonal fishing and nursery work available, but workers do not qualify for migrant programs when employed by these businesses. Immigration laws have resulted in a large number of undocumented workers who do not qualify for services. This stresses the available resources of the community and makes it hard to provide needed services to everyone.

Program ***eligibility requirements*** and definitions should be reviewed to identify specific gaps created by the lack of uniformity. The previously noted problem of the formerly Migrant Head Start child who is too young for regular Head Start is an example. These gaps and others should be addressed primarily by mechanisms that increase flexibility. Federal officials should convey their commitment to service integration to state and local administrators, and provide a clear mandate for flexibility in order to promote service integration. This flexibility should include granting waivers and giving states more autonomy in defining migrant and seasonal farmworker, so that they can better meet the needs of the workers in their communities through existing programs.

Regionalized efforts, most notably those undertaken by the East Coast Migrant Head Start Project, the Texas Migrant Council, and Texas Migrant Interstate Program, are an effective means of providing continuity for migrant children. Despite the success of these examples, efforts to promote applications of this model are limited.

The federal government should encourage such efforts throughout the country for all programs serving migrants. The federal government might also provide incentives for growers and other businesses and providers in the community to participate in such regional networks. For example, some of the factors that make the partnership between growers and service providers work so well in Belle Glade, Florida could be expanded to other communities with federal encouragement. Federal and state policymakers should encourage grantees to take note of the employers of the families they serve, and tabulate this information. If hard data can be provided on the number of families employed by particular growers, this may establish an excellent starting point for collaboration. Policymakers should provide incentives for cooperation

among growers to assist in service integration for migrant families. Joint efforts might enable small growers to overcome the economic barriers posed by dependence on a few crops or a short growing season, so that they can begin to offer some of the support that the larger growers in South Florida are able to provide.

A lack of quality ***housing*** exacerbates health and other needs of farmworkers. Many problems could be eliminated in the long term if more affordable housing and better environmental health services were made available. An opportunity for more service integration at the federal level clearly exists. The Department of Housing and Urban Development, the Department of Labor, and the Environmental Protection Agency need to be brought into the mainstream of some of the federal service integration initiatives that impact directly on migrant families. While each of these agencies has some involvement now, this tends to be for specific services provided independent of other agencies.

Factors to be Considered at Federal, State, and Local Levels

Some lessons learned in this study should be considered at all levels in planning services and programs for migrant families.

- Any national or state policies or evaluations must consider issues of scale. The numbers to be served, the extent of the need, and the difficulties in coordinating a great number of programs dispersed over a wide area distinguish communities such as Hidalgo County, Texas from smaller communities that serve migrants, particularly those in upstream locations.

- Serving the family unit and meeting basic needs of the family are essential components of programs serving migrant children. Parent education, housing, job training, and other adult services are as important to the child's success as health screening and education. A holistic approach to serving the family results in better services to all family members, including children.

- An increasing number of migrant parents have themselves been served by Migrant Head Start and Migrant Education. This is a new phenomenon that policymakers may wish to consider. Parents are aware of programs available to their children and know of the value of these programs. They do not attach a stigma to seeking help from these programs, as earlier generations may have. Current and future migrant parents can be expected to be more sophisticated, demanding, and involved consumers.

- Immigration laws and economic conditions, among other factors, impact the demographics of the migrant population. These changes affect the skills needed by service providers, the types of services required, and the procedures needed for interstate coordination. For example, it was noted that one impact of the Immigration and Reform Act of 1986 was an increase in Hispanic families in the migrant labor stream. Many communities are seeing greater numbers of families from rural Mexico and Central America who speak dialects unfamiliar even to bilingual staff.

Implications for Future Research

This study was limited in time and scope. A task order of this type has the advantage of identifying good practices and offering recommendations quickly, when the subject of the study is still of great interest to its audience. On the other hand, issues are identified that warrant further study but cannot be addressed within the present effort. The following suggestions for further research would enhance understanding of the impacts of service integration on migrant families and provide better information for planning and policymaking:

- Information technology should be investigated for streamlining data collection by programs serving migrants, facilitating information sharing across programs, and developing a research-oriented database. This could represent a significant investment, and one that may seem less pressing in light of the acute service needs of migrant families. Therefore, we suggest exploration of this issue with small grants for pilot programs that evaluate the benefits of technological improvements. This is an ideal area for public-private partnerships.

- Outcome research is very much needed, both to document the efficacy of existing efforts and to lead the way toward improvements in services. However, such research will not happen if it must be "squeezed out" of existing program dollars or out of service provider staff time. The studies must be separately mandated and funded.

- The migrant population is constantly changing. It is affected by climatic, economic, and political conditions in this and other countries. These changes impact on where services are needed, what services are needed, and specific training (such as language) requirements for providers. Therefore, ongoing demographic analyses and research are needed. The results of this research should be provided to states and local agencies in a form that they can use for planning future services.

APPENDIX A
METHODOLOGY

APPENDIX A: METHODOLOGY

Below we discuss the methodology used in this project, including preparation and site visit planning.

Appointment of Federal Working Group

At the outset of the study, we convened a working group of representatives from federal-level programs serving children of migrant farmworkers (a list of Federal Working Group members appears at the front of this report). This group advised the project staff on identifying program and service issues, assisted in site selection, and provided general background and knowledge of programs and the target population. The Federal Working Group included representatives from each of the following organizations: the Migrant Health Program, HHS; the Migrant Head Start Program, HHS; the Office of Migrant Education, Department of Education; the National Commission on Migrant Education; and the East Coast Migrant Head Start Project. Working group members reviewed the background paper, the site visit report outline, and the discussion guide prepared by project staff.

Discussions With Experts

In addition to seeking guidance from the Federal Working Group, project staff also consulted with experts in the field about migrant farmworkers and the programs that serve them. These individuals included academics, congressional representatives, federal- and state-level administrators and policy analysts, representatives of advocacy organizations, and state- and local-level service providers (see Exhibit A-1 for a list of experts consulted).

Background Paper

The main purpose of the background paper was to identify issues and provide a structure or "road map" for guiding the project's subsequent tasks. The background paper built on existing work, including a thorough background description prepared by the Government Project Officer that was included in the Scope of Work for the delivery order for this project.

The sources of information for the background paper were a review of the literature and discussions with experts in the field, as described above. In addition to the list of references supplied by the ASPE Project Officer and bibliographies generated by previous projects on related subjects, we conducted a CD-ROM key word search of the Educational Resource Information Center (ERIC), Popline, and the National Library of Medicine's Health Plan.

The literature review process and discussions with experts continued throughout the study so that ideas could be refined, and suggestions for places and issues to pursue in site visits could be obtained.

Site Visit Plan

The site visit plan consisted of two phases: selecting the sites, and developing a site visit discussion guide.

Site Selection

The site selection process was initiated at the first meeting of the Federal Working Group. Factors to consider in site selection were discussed, and criteria for identifying exemplary or best practice sites were chosen. Six exemplary sites were to be selected to represent a range of factors. The following factors were considered in site selection:

- Continuity between homebase and upstream destinations, including use of record systems that facilitate continuity;
- Age of children served (with particular attention to transition ages such as between Head Start and elementary school or elementary school and middle school);
- Grower involvement/support;
- Geographic location;
- Documentation of formal (written) agreements;
- Involvement of non-federal programs;
- Age of program;
- Size and complexity of program (dollars, number served, etc.);
- Locus of program (e.g., school-based, health center, early childhood program);
- Coordination between several of the following programs: Migrant Health, Migrant Head Start, Migrant Education, Migrant Even Start, and JTPA.

The following criteria were suggested for identifying exemplary or best practices sites, recognizing that no single site would fulfill all of the criteria listed:

- Sharing information/records, staff, facilities, and other resources such as transportation across programs;
- Referral/communication procedures;
- Written agreements;
- Coordinated outreach;
- Case manager or contact person designated for coordination;
- Joint applications for funding;
- Coordinated scheduling of appointments;
- Coordination of transitions between programs (e.g. Head Start to elementary school);
- Involvement of family;
- Local interagency council;
- Evaluation of integrated activities and sharing of evaluation information;
- Procedure for assuring continuity when the family moves--both at arrival and departure.

Once the site selection factors and the criteria for identifying exemplary or best practices sites were established, the project team reviewed materials obtained for the background paper and other materials suggested by the working group, and contacted individuals and organizations familiar with programs for migrants. This process resulted in the identification of 30 potential programs, including local, statewide, and interstate efforts. These candidate sites were discussed at a second meeting of the Federal Working Group, and recommendations were made for narrowing the list.

Project Staff proceeded to gather additional information on programs in the following target states suggested by the Federal Working Group: Florida, New York, Texas, Oregon, Washington, Colorado, Arizona, and California. We contacted the HHS Regional Program Consultants for Regions II, IV, VI, VIII, IX, and X for recommendations. In addition, we contacted the three Migrant Education regional stream coordinators, the National Migrant

Resource Program, and others. We attempted to include an equal number of east coast, midwest, and western states. Since only six sites could be included in the study, the final sites selected in no way imply that other sites investigated were considered to be unacceptable or "not exemplary."

The six sites selected for visits were:

-- Brockport, New York (Monroe County);
-- Greeley, Colorado (Weld County);
-- Stockton, California (San Joaquin County);
-- Woodburn, Oregon (Marion County);
-- McAllen, Texas (Hidalgo County); and
-- Belle Glade, Florida (Palm Beach and Hendry Counties).

The matrix in Exhibit A-2 lists the six sites and their key features with respect to the site selection factors and criteria.

Site Visit Discussion Guide

The site visit discussion guide was designed to address the key issues identified and described in the background paper, and to obtain a fuller understanding of the features characterizing exemplary programs.

Because these issues span a broad range of children's ages and services, the site visit discussion guide was open-ended to accommodate the variety of situations we expected to encounter. In order to explore all possible approaches to coordination, we suggested the following typology of activities that would be key components of services integration:

- Outreach;
- Service accessibility;
- Eligibility determination and referral;
- Follow up and monitoring of clients;
- Sharing of staff and resources;
- Planning, evaluation, and data management;
- Professional education and training.

The site visit discussion guide (included in Appendix B) addressed each of these areas, with particular attention to the issues identified in education, health, and social services. For example, the referral discussion with a Migrant Head Start director may have probed for approaches to coordinating the transition from Head Start to elementary school. The discussion of planning, evaluation and data management with a Migrant Health center environmental health coordinator may have included specific questions about relationships with local growers and housing authorities. In discussing outreach with Migrant Education program staff, interviewers asked about special efforts or innovative programs to reach those who have dropped out of school

or to coordinate with JTPA programs. In addition to a description of the coordinated service activities, the site visit discussion guide explored the development of cooperative relationships and lessons learned that may be helpful to other programs. Respondents' views were sought concerning key issues such as gaps in services and strategies for the future.

Conduct of Site Visits

The site visit strategy included pre-visit, on-site, and post-visit activities. Pre-visit activities began once the formal selection of sites had been made, and included the scheduling of site visits, and staff training and assignments.

Site Visit Scheduling

For each site selected, we determined the appropriate procedure for obtaining the site's participation in the study. The protocol varied depending on the sponsorship of the program. HHS Regional Offices and the appropriate state agencies were contacted first to inform them of the planned site visit, seek guidance as to protocol, and request background data available at the state level.

A member of the project team assigned to visit a site telephoned the program. Once the site agreed to participate, a liaison from the site was designated to make appointments for the project team and serve as coordinator for the site visit. The role of the liaison varied from site to site. In some cases, the liaison actually arranged the appointments for the meetings; in other cases, the liaison simply provided names and telephone numbers to project staff.

Once a date for the site visit was agreed upon, we mailed a confirmation letter to the site visit liaison and others designated by the liaison, such as the program's executive director. In addition to confirming the dates of the site visit, this mailing included a brief description of the project, site visit objectives, the topics to be addressed, and the types of staff members and agency representatives we wanted to meet. This step was designed to help the site prepare for the visit by retrieving and organizing materials needed by the site visit team and arranging staff schedules to accommodate the visit. Working with the site visit liaison, a tentative schedule of on-site discussions was prepared. The week prior to the site visit, the site visit team leader contacted the liaison to confirm all arrangements, including who would be invited to the kick-off briefing and wrap-up meeting.

Staff Training

Since there were only four site visit team members, all of whom had been involved in the project from the start, a brief training session was sufficient to assure that all staff were familiar with the discussion guides and the procedures to be followed on site. The training session also ensured consistency in the approach to the site visits and reporting procedures. A half-day project team meeting was held to review the purpose of the site visits, the mechanics of site visit scheduling, the case study process, site visits skills, and study products. The

discussion guides were reviewed and any ambiguities clarified at the meeting. Other topics covered in the meeting included: handling scheduling conflicts, typical site visit agendas, and any areas of known political or cultural sensitivity. Tentative assignments to sites and teams were made and all required pre-visit preparation activities were specified.

On-Site Activities

The site visits were conducted by two-person teams. For each site visit, one person was designated as the team leader. This person was responsible for schedule changes, trouble shooting, and assuring timely completion of the site visit report. Each site visit was planned for three days and began with a briefing of the program director and other key project staff. Based on the model of service coordination and the interorganizational relationships at each site, we interviewed selected members of the program staff (e.g., the Migrant Education program, the Head Start program, or the Migrant Health center) and representatives of other organizations involved in the coordinated service activity. This process often involved visits to other local agencies or service sites. During the visit, the two-person team split up as needed, each collecting information from different offices and staff members. Our on-site activity also included observation of day-to-day operations and collection of any reports or other printed materials documenting the activities studied.

Although not a formal part of the site visit protocol, site visit teams sought to obtain input from migrant farmworkers and their families on topics such as satisfaction with services provided and the availability and accessibility of services (e.g., how hard or easy has it been to get needed services? what services are hardest to find or not available?). Such discussions took place as informal interviews in waiting areas or meetings that took place during the period of the site visit.

At the end of each day on site, the site visit team met to review and compare notes, highlight key findings, and identify information still to be collected and items requiring further follow up. At the conclusion of the site visit, each team held a wrap-up meeting with the program director and other staff to provide a summary of observations and to obtain any additional information needed.

Site Visit Reports

When staff completed a site visit, they reviewed and fleshed out their notes and made a list of questions remaining about the site. If necessary, follow-up calls were made to the site. Each site visit team reviewed the site visit report outline and agreed upon responsibilities for completing each section.

Once completed, each report was sent to designated individuals at the site for review. Comments and corrections provided by these individuals were used in finalizing the case study reports before they were sent to the Project Officer at ASPE and members of the Federal Working Group.

Synthesis

Debriefing sessions were held with the complete project team after the first site visit and after all six visits were completed. At the meeting after the completion of the first site visit, materials were revised and adapted. In particular, the site visit report outline was revised. Also at this meeting, on-site experiences were shared in preparation for future site visits. The team meetings were particularly helpful for identifying missing information and synthesizing common themes which emerged from the site visits.

Exhibit A-1: Experts Consulted

<u>Name/Organization</u>

Philip Martin, Ph.D.
Department of Agricultural Economics
University of California, Davis
Davis, CA

Richard Mines
Economist
U.S. Department of Labor
Washington, DC

Diane Mull
Executive Director
Association of Farmworker Opportunity Programs
Washington, DC

Roger Rosenthal
Executive Director
Migrant Legal Action Program
Washington, DC

E. Roberta Ryder
Executive Director
National Migrant Resource Program
Austin, TX

Karen Mountain
Director
Migrant Clinicians Network
Austin, TX

Spencer Salend
State University of New York at New Paltz
New Paltz, NY

Les Wallace, Ph.D.
Signature Resources, Inc.
Denver, CO

Criteria	BROCKPORT, NY Migrant Education Head Start	BELLE GLADE, FL East Coast Migrant Head Start	GREELEY, CO Migrant Education	WOODBURN,OR Migrant Education	STOCKTON,CA Interagency Council	HIDALGO COUNTY, TX Migrant Head Start
Use of coordinated record systems	Yes/Yes	Yes	No	No	No	Yes
Age of children served	School Age/0-5 years	0-4 years	school age	All ages	All ages	
Grower involvement/support	some for Head Start	Excellent--Operate a center on grower donated property	No	No	Limited	No
Local, State, multi-State	State/part of ECMHSP	14 centers in 9 counties in FL; part of ECMHSP	8 school districts, largest in the state	Local	Local	Local, State
Geographic location	East Coast, upstream	East Coast, home base	Central, upstream	West Coast, upstream/home base	West Coast, upstream	Central, homebase
Involvement of non-Federal programs	Public schools, colleges, churches	West Tech Vocational School, Migrant Education	University of Colorado at Boulder, Bueno-HEP/CAMP	Chemeketa Community College, United Way		UT, San Antonio, Legal Aid, Planned Parenthood,
Documentation of formal agreements	Yes/Yes	Yes	Yes	Yes	Mostly informal referrals	Yes
Age of program	Tutorial: late'60s; evening program: mid '70s; child development since 1946; ECMHSP delegate agency 13 yrs.	9 years	23 years		25 years	over 10 years
Locus of program/initiator of coordinated service	Migrant Education/Migrant Head Start	Migrant Head Start	Migrant Education	Marion ESD	Housing Authority	Migrant Head Start
Other agencies involved	Oak Orchard Health Center, Rural Opportunities, Inc.	Brumback Health Center, Clewiston Health Center, HIV Prevention Center	Migrant Head Start, Rocky Mountain SER, Migrant Health	MIC, Salud Medical Center, Oregon DHR	Migrant Farmworker Housing, MHS, ME, MHC, JTPA, Legal Services	Migrant Education, Migrant Health, JTPA, WIC
Number served	Migrant Ed. Largest in New York (650); Head Start several hundred	4 centers in Belle Glade, about 100 per center	1290	2986		35,000 eligible families, 6000 children per year

APPENDIX B
SITE VISIT DISCUSSION GUIDE

APPENDIX B: SITE VISIT DISCUSSION GUIDE

Services for Migrant Children in the Health,
Social Service, and Educational Systems

This discussion guide is to be used to stimulate discussion and to serve as a checklist to ensure that all critical topics have been covered. The items included in each discussion, and their order, will vary for each participant.

Respondent Name: ________________ Site: ________________

Respondent Title: ________________ Interviewer: ____________

Organization: ________________ Date: ________________

Telephone Number: ________________

INTRODUCTION

Migrant children have multiple problems and service needs, and they face many challenges in obtaining education, health, and social services. Coordination among health and human service organizations is often critical to serving this population effectively. The purpose of this site visit is learn about service coordination efforts that work--how your program operates, barriers that have been overcome, lessons to be learned, and impacts of coordination. By coordination, we refer to activities such as referrals among providers, the transfer of information between providers, avoidance of unnecessary duplication of functions, the scheduling of services in a way which does not interfere with other programs serving the same population, and joint planning for service delivery or special programs. Integration refers to a set of services which is operated and perceived from the client's point of view as one program. Sometimes called "one-stop shopping, " integration implies co-location, sharing of staff, sharing of records, etc. In some settings, particularly sparsely populated rural areas, integration is not possible, but good coordination exists, which gets people the services they need. We want to learn about all of these activities that apply to your program.

A. General/Organizational Information

- Personal background for each respondent: official title, length of time in the position, length of time with the program/agency; relevant training, academic background, or past experience.

- Review organization chart and contact information provided by the agency. What are the specific job responsibilities of the respondent? Determine staffing patterns and whether specific individuals are shared between programs.

- Sources and amounts of funding; sponsorship of the program.

B. Coordination Overview

- Obtain an understanding of the program or organization's concept of service coordination for children of migrant farmworkers.

  -- Does anyone in the organization have specific responsibility for seeking out and negotiating services integration arrangements or coordination arrangements? If yes, what is their position? Is this responsibility included in their job description?

- Role of local level migrant coordinating council or equivalent.

- State level migrant coordinating council, commissions, or other organizations which specifically deal with migrants.

C. Historical Development

- Who initiated efforts for the coordinated relationships?

- When did these efforts begin? Who was involved (any outside organizations or third parties)? Who made the decisions? What were the incentives to pursue coordination?

- Were there particular issues meant to be addressed, e.g., special education, grade retention, dropout prevention, poor nutrition, substance abuse, etc.?

- Did you use any models or guidelines to assist in structuring the program or negotiating agreements? Describe any formal agreements in place (e.g., contracts, memoranda of understanding, etc.).

- What were the initial barriers and how were they overcome? (impact of politics, customs, etc.)

- What facilitated the arrangement (e.g. support of Board or of community groups)?

- How have the arrangements evolved over time? What changes have been made and why? Current strengths and weaknesses of these arrangements.

D. Overview of Operations/Service Accessibility

- Determine what services are offered by the program and what arrangements are made for services not offered. (Refer to the attached services checklist which will have been mailed to sites in advance). Determine operating schedules for services (e.g., months open during the year, hours and days of the week, frequency of special clinics or other specialized services).

- Describe how the coordinated program works, (e.g., what is the typical sequence for a client who seeks services)? Review client flow, staffing, information flow. (If applicable, obtain copies of agreements, referral forms, flow charts, etc.)

- Are there any reimbursement arrangements for the coordinated services (if so, who is reimbursed and how much?)

E. Outreach

- Major outreach activities. Are these directed at potential clients or at other agencies? Are any of these activities undertaken jointly with other providers serving migrants and/or children? (Probe for: advertising campaigns, flyers, public service announcements, speaking at meetings of community groups, information booths at fairs, distribution of literature on the program, resource directories, networking informally among local providers, home visits, etc.)

- Barriers to conducting outreach activities.

- How are children potentially in need of services identified? Problems, if any, in identifying eligible children, determining their needs, or recruiting them into the program.

- Are any particular groups of participants or types of agencies targeted for outreach activities? (e.g., particular ages, children with disabilities, etc.)

- Does your program regularly provide updated information to providers on hours of service, locations of clinics, educational programs, etc.?

- Does your program provide information and application forms for other services available to migrant families with children?

- Innovative methods for promoting outreach, e.g., mobile vans, laptop computers, videos, etc.

F. Eligibility Determination and Referrals to Other Providers

- Procedures for referring children to other health/education and/or social service providers (e.g., verbal communication with family and/or with provider; written information to family and/or provider; telephone referrals and/or scheduling of outside appointments). Who makes referrals?

- Criteria used to determine when to make a referral and what type of referral to make.

- Documentation of referrals or follow-ups in children's/family's records.

- Do you keep track of or count how many or what types of referrals you make? What referrals are most frequently made by your staff?

- Are staff of your program knowledgeable about the eligibility requirements of other programs of interest to migrant families with children?

- How have definitional differences between programs been resolved?

- Are there established procedures for referring to services at the family's next destination?

- Gaps in services, e.g., referrals that can't be made because the services are not available.

G. Referrals from Other Providers

- Are there any special procedures followed when a client is referred to your program by other education/health/social service providers?

- Does your program provide referral forms to be completed by referring providers? What information is requested from referring providers?

- Are screening and assessment procedures coordinated so that repeat screenings are not required for various programs?

- Can other providers/staff of other programs determine eligibility for this program?

H. Follow-up and Monitoring

- Does anyone follow-up on referrals? Are follow-up procedures a routine practice or are they used on a selective basis? (e.g., for particularly high risk participants or for particular types of referrals; probe for criteria used).

- Is there any one person in your program or in a program you coordinate with who is responsible for assuring that the client's identified needs are met through on-site or referral services (e.g., case manager)?

- Do you ever meet with other providers to discuss an individual client or family?

- Is any clinical information ever shared with other providers?

- For co-located programs, is one record maintained for each participant? If not, are client data readily available to staff of the co-located programs? Are client data systems shared?

- Are there established communication channels between home base and upstream programs?

I. Sharing of Staff and Resources

- Are any of your program's services provided by staff of other programs?

- Are these services routinely provided by other staff or only on an as-needed basis (such as during peak periods)?

- What organizational and/or funding arrangements make this possible?

- Is there a fee to your program for any service provided by other providers? If yes, list the services and fees.

- Describe any services that your staff provide to other programs. Are there fees for these services?

- Are any facilities shared with other programs? (e.g., co-location, shared office space, shared equipment, etc.)

J. Service Accessibility

- Do most of your clients have a regular source of health care? Do clients in need of other services (e.g., children with disabilities, those with mental health needs) have a regular source of care or case management? How do they pay for these services?

- Is the source of care routinely recorded in the participants' records?

- Does the program work with others serving migrants to improve access to services for migrants, such as locating services near migrant housing or near the fields where migrants work, sharing transportation, or sharing services of interpreters?

- Are appointments ever coordinated between various services so that a client can receive several services in the same visit or around the same time? Why or why not?

- Can your staff make appointments for clients for other programs? If so, please specify which services and describe the process.

- What are the Medicaid-eligible guidelines in your state, and how does this affect access to health care, AFDC, WIC, and other services for migrant families?

K. Planning, Evaluation and Data Management

- State-mandated or initiated joint planning activities for services to migrants or to at-risk children which have involved this program. Locally-initiated or voluntary planning activities which have involved this program.

- Long range planning activities (i.e., a time horizon of more than three years): Who participates in the process? Does the planning include coordination issues? Is there a written long range plan?

- Evaluation of coordination activities (e.g., evaluation of referral procedures, impact of coordination, etc.). Method or methods are used (e.g., numbers served, school attendance, student performance on tests, health status indicators, surveys of participants, progress measured against specific goals, outside evaluations, etc.).

- How are changes/improvements made? If you have suggestions for improvement, what do you do?

- Have there been any locally initiated studies concerning coordination of services? If so, can we have a copy or a reference so that we can get a copy?

- What is the extent of data sharing between your program and other service providers? Does your program participate in data collection systems used by other education, health and/or social service agencies?

L. Professional Education and Training

- How do staff of your program learn about other local health, education and social service resources for migrant families with children?

- Is information on local services updated regularly through in-service training?

- Are in-service programs planned with other health or social service providers in the community?

- Are staff cross-trained in the eligibility requirements and enrollment procedures of other programs serving migrant families with children?

- Have there been any requirements for additional staff training or credentialling related to the coordination of services.

- Are there areas of training for your staff that need to be emphasized?

M. Achievements/Impacts

- Utilization of the coordinated service/program.

- Costs (generally speaking) of coordination for the program and for the other programs involved, both economic costs and non-economic costs.

- Has there been elimination of duplication of efforts? Increased efficiency?

- Are the services self-supporting? If not, how are they funded?

- Benefits to clients, to the program, to other programs/service providers?

- Describe how the coordinated program has affected the quality of services provided.

- Are there any other impacts we haven't covered (e.g., impact on staff, image in the community, etc.)?

N. Conclusions and Recommendations

- Please describe any aspects of service coordination at your local agency which you feel are exceptional and that other agencies might be able to adapt for their programs.

- Are there any changes that you would recommend in your agency's current procedures or activities with regard to coordination of service?

- How well has this coordinated program worked over time? Why does it work well?

- What lessons or advice should be passed on to others seeking similar arrangements to coordinate services for migrant children (or other special populations)? (e.g., critical elements for success, short cuts, things to avoid)?

APPENDIX C
EXISTING PROGRAMS SERVING MIGRANT FAMILIES

APPENDIX C: EXISTING PROGRAMS

The bulk of services designed to meet the health, education, and social needs of migrant children is funded by a dozen or so federal programs targeted to migrants and youth. Delivery of these services is further shaped by the specific priorities, resources, and structure of state and local agencies. The primary federal programs developed expressly for migrants are Migrant Education, Migrant Health, and Migrant Head Start. Each of these programs was established in the 1960s and has its own funding stream and eligibility requirements. These programs, along with a JTPA program for training youth (Section 402), account for more than $500 million of annual assistance to migrant and seasonal farmworkers and their children (Martin and Martin 1992). An additional $70 million in federal funds is also available through the following programs: Special Supplemental Food Program for Women, Infants and Children (WIC), Migrant Legal Services, Section 514 migrant and seasonal farmworker housing loans and Section 516 housing grants, Community Services Block Grants, migrant vocational rehabilitation, the high-school equivalency program (HEP), the College Assistance Migrant Program (CAMP), and Migrant Even Start (for an extensive legislative history of federal programs for migrants, see Martin and Martin 1992). States and localities may also offer a number of social services and supplements to these programs for which many migrants and their dependents are eligible. Exhibit C-1, adapted from Martin and Martin 1992, summarizes the major programs described below.

Migrant Education

By far the largest of the federal education programs for the school-age migrant population is the Chapter 1 Migrant Education Program (MEP), authorized under the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 (P.L. 100-297). This program provides grants to state educational agencies (SEAs) to fund programs that meet the special educational needs of children of migratory agricultural workers and fishers. MEP also helps coordinate local migrant education projects with similar programs and projects in other states, including the transfer of school records and other information about eligible migratory children. Programs can be provided during the school year, year-round and during the summer. The types of services that may be provided under MEP include both instructional and support services, although the vast majority of services provided are instructional (Marks 1987).

SEAs have considerable freedom in structuring services and deciding which particular services to provide. Allowable activities include: acquisition of equipment and instructional materials, including books and school library resources; employment of special instructional personnel, school counselors, and other pupil services personnel; employment and training of instructional aides; training of teachers, librarians, and other instructional and pupil services personnel; coordination with similar programs and projects in other states, including the transfer of school records; support services such as health, counseling, food and transportation; parental involvement activities; construction of school facilities, if necessary; and evaluation of MEP projects (U.S. Department of Education 1991b).

Grants to states are allocated on the basis of the number of their eligible full-time-equivalent migrant children. A SEA may operate a Migrant Education project directly, or may contract with school districts or public or nonprofit private agencies for program operations. In general, most migrant services provided through the Chapter 1 MEP are delivered through SEA subgrants to operating agencies (typically local or regional educational agencies) (Marks 1987). In addition to Chapter 1 monies, the Migrant Education statute provides funding for the collection of data under the Migrant Student Record Transfer System (MSRTS). Originally designed as a way to track migrant students' school records from district to district, the MSRTS has also become a means of developing a census count of eligible children (Martin and Martin 1991). However, it is estimated that only about two-thirds of migrant children enrolled through MSRTS actually participate in Migrant Education programs (National Commission on Migrant Education 1992).

Children are eligible for the special services of Migrant Education under Chapter 1 if they move across school district boundaries because a parent is in search of agricultural employment. In addition to being eligible for the services in a migrating year, these children are eligible for five years after the last move as "formerly migrant" children. Migrant Education defines farmwork as crop and livestock agriculture as well as dairy and fishery work. Aside from workers involved directly in farmwork, it also extends benefits to children of parents involved in packaging, processing, and transporting in these industries (National Commission on Migrant Education 1992).

Estimates of the number of children served nationwide by the Migrant Education Program range from approximately 250,000 to more than 600,000. There is some uncertainty concerning these estimates due to the possibility of double counting when students move to other school districts or enroll in summer school programs. Additional funding is available for tracking migrant students through MSRTS (Martin and Martin 1992). For the 1990 calendar year, the MSRTS reported that 433,628 full-time-equivalent students were served under MEP school-year and summer school programs. State-reported data indicate that half of the Chapter 1 MEP participants are formerly migrant (Henderson, Daft, and Gutmann 1990). A recent MSRTS printout from March 1992 documented 628,150 currently and formerly migrant children between the ages of 3 and 21 (National Commission on Migrant Education 1992). In an earlier study of MSRTS data, approximately 530,000 migrant students were enrolled in school in 1988 (Kane and Trevino 1989, cited in Interstate Migrant Education Council 1992).

Several programs within Migrant Education specifically serve older students. The *High-School Equivalency Program (HEP)*, originally established under the Office of Economic Opportunity in the late 1960s, is now administered by the U.S. Department of Education's Office of Migrant Education, under Section 418A of the Higher Education Act. HEP provides grants to colleges and universities or nonprofit organizations that work with these institutions, to help migrant and seasonal farmworkers or their dependents--age 17 or older--to obtain a high-school equivalency diploma. These funds may be used for outreach and recruitment, educational services, and a variety of supportive services such as counseling, placement services, health services, room and board, financial aid, and weekly stipends. Grants are awarded competitively on a three-year cycle. FY 1990 funding totaled $7.9 million for 23 grantees, serving

approximately 3,000 annually (National Commission on Migrant Education 1992; Martin and Martin 1992).

In New York and many other states, the *Portable Assisted Study Sequence (PASS) program* enables students to gain credit through correspondence courses. New York also supports an *Adolescent Outreach Program* to assist students in transferring credits across schools (Martinage 1986). A *Mini-PASS* program is available for sixth, seventh, and eighth graders in Colorado, Idaho, Illinois, Michigan, New York, and Wisconsin (National Commission on Migrant Education 1992).

The *National Secondary Credit Exchange and Accrual Project* (SCEAP) provides counseling to create a national system for credit exchange and accrual and help more migrant students graduate from high school (National Commission on Migrant Education 1992). The Texas Migrant Interstate Program (TMIP) coordinates credit accrual and credit exchange efforts between Texas schools and schools in upstream states and sponsors dropout prevention activities. These include offering alternative methods of awarding high school credits including correspondence courses through the University of Texas, credit by exam, and a tutorial program; training counselors to work with students; operating a toll-free number so that schools in Texas can inquire about credit accrual; and sending bilingual staff to states such as New York, Washington, and Michigan to work with students from Texas. TMIP also has computer terminals that are linked to MSRTS; this enables office staff to help any school in the country with credit accrual data for migrant students. The relationship between Texas and New York school officials has exemplified improved interstate efforts in this area. To facilitate secondary credit transfer, Texas now accepts New York's credit recommendation. New York also pays for counselors from Texas to spend six weeks in western New York to review student records. In California and Colorado, migrant education administrators are working with Mexican officials to develop a binational agreement to facilitate placement of students as they move back and forth between the two countries.

The *College Assistance Migrant Program (CAMP),* established in 1972 and funded through a process similar to HEP, is the only national-level program that is directed solely at assisting migrant students in college. The program assists eligible migrant and seasonal farmworkers and their dependents in making the transition between high school and college. Funds may be used for outreach and recruitment, and educational and supportive services. FY 1990 funding totaled $1.7 million for six grantees (Martin and Martin 1992).

Migrant Health

Due to widespread agreement that migrants and their families are at greater risk for various health-related conditions, Congress has appropriated money for the funding of special health centers to serve the needs of the migrant farmworker population. The bulk of the Migrant Health program money provides funding to the Migrant Health centers; some also provides funding for special projects with wider impact such as the National Migrant Resource Program (NMRP), which houses a library of studies and articles relevant to migrant health and sponsors the Migrant Clinicians Network (Martin and Martin 1992).

Migrant Health funds 103 Migrant Health centers, which operate more than 400 clinic sites in 43 states and Puerto Rico. Most of these centers also rely on other state and private sources of funding, federal public health funding, and collection of fees such as patient and third-party payments (Martin and Martin 1992). Migrant Health centers serve about 500,000 migrant and seasonal farmworkers annually (Salend and Reynolds 1991; Rust 1990). A 1991 survey of Migrant Health centers found that the centers either provided directly or coordinated with other agencies to provide a variety of health and social services, either through a formal arrangement or informal referral (National Migrant Resource Program 1992). These services included primary prevention; episodic and chronic medical care; family planning; obstetrics (prenatal and delivery); outreach; transportation; emergency and after-hours care; hospitalization; pharmacy; lab; X-ray; health education; WIC; nutrition education and counseling; emergency food; dental care; and HIV screening, counseling, outreach, and treatment.

The definition used by Migrant Health centers to determine eligibility includes both migrant and seasonal farmworkers (usually defined as persons performing less than 150 days of farmwork in a year), though priority is to be given to migrants. Any migrants--and their dependents--who set up a temporary abode for the purpose of performing farmwork away from their usual place of residence, are eligible for health services and continue to be eligible for 24 months after the last move. Farmworker families may also continue to be eligible for services as seasonal farmworkers long after the 24-month look-back period. Migrant Health defines farmwork as crops only and does not include livestock, though packaging, processing, and similar activities are included under some circumstances (Martin and Martin 1992).

Migrant Head Start

Special programs for the children of migrant farmworkers were begun in the early days of Head Start. Migrant Head Start (MHS) provides Head Start component services--education, nutrition, health, parent involvement, and social services--to approximately 27,000 children (including 9,500 infants and toddlers) in 33 states through 28 grantees and 40 delegate agencies. Thirteen percent of Head Start funding is reserved specifically for the children of migrant farmworkers and American Indians. Unlike typical Head Start centers, which serve only children from ages three to five, and operate on a half-day basis, Migrant Head Start (MHS) centers are authorized to serve children from birth to five years and often offer full-day programs to cover the entire time that parents are working in the fields. Recently, 35 percent of enrollment in MHS consisted of infants and toddlers. This daycare component to Migrant Head Start is often the only source of daycare that migrants can afford. Thus, there are often long waiting lists for MHS programs (Martin and Martin 1992).

The Migrant Head Start eligibility definition is vague, stating only that the migrant family must have moved in connection with agricultural employment within the last year. Only the production and harvesting of tree and field crops count as agricultural labor and the family's primary income must come from these activities. Children of seasonal farmworkers are not eligible for Migrant Head Start.

Migrant Even Start

Even Start is a relatively new, two-generation family literacy program that was first funded by the U.S. Department of Education in FY 1989. The program is authorized by Chapter 1 of the Title I Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 (P.L. 100-297). The purpose of the Migrant Even Start Program is:

> to support grants to eligible SEAs for the cost of providing family-centered education projects to help parents of currently migratory children become full partners in the education of their children, to assist currently migratory children in reaching their full potential as learners, and to provide literacy training for their parents (*Federal Register* 34 CFR Part 212, June 19, 1992).

The legislation requires that 3 percent of funds appropriated for Even Start be reserved for programs for migrant children, conducted through the Office of Migrant Education. The initial program competition was held in 1989, resulting in three grant awards. In FY 1990, the three original grants were continued and one additional grant was awarded. In FY 1991, the second competitive funding cycle, $1.4 million was available for the four continuation grants and five new grants. Grants are awarded on a four-year cycle, based on annual satisfactory performance.

Project components include three core services--early childhood education, adult education, and parenting education--as well as support services such as child care, transportation, assistance in dealing with social service agencies, and other services aimed at reducing barriers to participation. Even Start activities include reading and storytelling, developing school readiness skills, social development and play, development of gross motor skills, work with numbers, and arts and crafts. Even Start legislation requires grantees to collaborate with other agencies such as Head Start, Chapter 1 preschool, and local adult education programs. This collaboration involves arrangements with other departments in public schools, local governmental agencies, postsecondary institutions, community-based organizations, and Head Start.

The National Evaluation of the Even Start Family Literacy Program, required by Even Start legislation, requires programs to collect data on program participant characteristics; characteristics of core program services offered; support services and other special activities; recruitment, screening, and assessment; staff characteristics and staff development; cooperative arrangements, and factors influencing implementation. This information is recorded on National Evaluation Information System (NEIS) forms so that common data can be collected on all Even Start programs across the country. As part of the evaluation, Even Start programs also must conduct biannual testing of parents using the CASAS (a competency-based literacy assessment instrument) and testing of three- and four-year-olds at six-week intervals using the Spanish Peabody Picture Vocabulary Test and the Preschool Inventory.

JTPA 402

The Job Training Partnership Act (JTPA), enacted in 1982, is the primary federal funding source for 28 different services providing employment and training for economically disadvantaged youth and adults and displaced workers, as well as targeted groups such as migrant and seasonal farmworkers. The U.S. Department of Labor program was designed as a partnership between state and local government and private industry, and includes both state- and nationally administered programs. Titles II and III are allocated to the states. Title II-A is the primary component for year-round training of disadvantaged adults and youth; local programs must spend at least 40 percent of Title II-A funds on individuals age 16-21. National programs, under Title IV, provide funding to special targeted groups such as Native Americans and farmworkers; Section 402 is targeted to migrant farmworkers (Association of Farmworker Opportunity Programs 1991). In FY 1991, Congress appropriated $70.3 million for JTPA 402, out of a total of slightly more than $4 billion appropriated to the entire JTPA. JTPA 402 funds are allocated to states based on population figures estimating the number of farmworkers in each state, and are then distributed to nonprofit and state agencies through competitive grant awards (Martin and Martin 1992).

The types of training that are offered through JTPA include on-the-job training, work experience, job search assistance, and basic education and occupational skills training in the classroom. Section 402 programs also provide training-related assistance for program participants. This assistance includes food, clothing, transportation, child care, and special training equipment. Similar support services are provided to JTPA participants not in training. Section 402 also funds special youth services to farmworkers ages 14 to 21, including dropout prevention, drug and alcohol education, Upward Bound, teen pregnancy prevention, and summer youth employment and training programs. Training, which must comprise at least half of a grantee's budget, is designed to assist migrant farmworkers who choose to remain in agriculture, as well as those individuals who wish to develop skills so as to move out of the migrant cycle (Martin and Martin 1992).

Migrant Legal Services

Migrant legal services, provided through the Legal Services Corporation, exist in 46 states. Services are funded by the federal government, which appropriated $10.8 million to this program in FY 1992. Legal assistance is limited to civil legal services for farmworkers with legal immigration status (Martin and Martin 1992). Most programs are administered through grants to large organizations, although two states, Michigan and New York, have freestanding Migrant Legal Aid organizations. The national Migrant Legal Aid Program assists the over 100 field offices and 49 organizations providing migrant legal services.

Farmworker Housing

There is limited assistance available for farmworker housing through programs administered by the U.S. Department of Agriculture. Section 514 of the Housing Act of 1949 provides loans on favorable terms to farmers, farmers' associations, states, and nonprofit agencies to build or rehabilitate farmworker housing. Section 516 provides grants to nonprofit agencies for farmworker housing. Federal funding for these programs was $27.3 million in FY 1992 (Martin and Martin 1992).

Special Supplemental Food Program for Women, Infants, and Children (WIC)

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is a grant program administered by the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA). It was designed to respond to concerns that women with inadequate diets during pregnancy were at higher than average risk of miscarriages and other health risks. Infants without adequate nutrition during their mother's pregnancy were found to have lower than average birth weights, stunted growth, and smaller head circumferences. WIC was first authorized in 1972 (P.L. 99-433). The program was most recently reauthorized for five years, through 1994, with enactment of the Child Nutrition and WIC Reauthorization Act of 1989 (P.L. 101-147). The program has undergone considerable expansion since its inception. Monthly participation increased from about 200,000 persons in FY 1974 to over 4 million in FY 1989.

Through grants from USDA, states administer programs that provide supplemental foods, nutrition services, and access to health care through local WIC agencies. Eligibility for WIC benefits is based on income (below 185 percent of poverty) and documentation of nutritional risk. PL 101-147 specifically requires enhanced outreach to migrants as a target population.

Exhibit C-1: FEDERAL PROGRAMS SERVING MIGRANT FARMWORKERS

Program	Agency/Department	Target Population	Funding Mechanism/Services Provided
Chapter 1 Migrant Education(ME)	Education	Children of migrants ages 3-21. Eligible during migrating year and for 5 years after the last move.	Funds to state education agencies (SEAs) for instructional services and materials, support services, coordination with programs in other states.
High School Equivalency (HEP)	Education	MSFWs and their dependents age 17 and older.	Grants to colleges and universities or nonprofit organizations to provide assistance in obtaining a high school diploma or equivalent, including outreach, education, counseling, placement, and supportive services.
College Assistance Migrant Program (CAMP)	Education	MSFWs and their dependents.	Grants to colleges and universities or nonprofit organizations to provide assistance in making the transition between high school and college, including outreach, education, and supportive services.
Migrant Health(MH)	HHS	MSFWs and their dependents.	Grants for health centers to serve MSFWs. Services include primary health care, preventive health services, prenatal care, dental care, case management, etc.
Migrant Head Start (MHS)	HHS	Migrant children ages 0-5. Family must have migrated in the past year.	Grants to programs providing early childhood education. Full-day programs including all Head Start component services: education, nutrition, health, parent involvement, and social services.
Migrant Even Start	Education	Migrant children and parents.	Grants to SEAs for family-centered education projects including early childhood education, adult education, and support services; focus on family literacy.

Exhibit C-1 (continued): FEDERAL PROGRAMS SERVING MIGRANT FARMWORKERS

Program	Agency/Department	Target Population	Funding Mechanism/Services Provided
Job Training Partnership Act 402 (JTPA 402)	Labor	MSFWs and their dependents.	Funds allocated to states for grants to nonprofit and state agencies providing on-the-job training, work experience, skills training, job search and placement services, as well as supportive services.
Special Supplemental Food Program for Women Infants and Children (WIC)	U. S. Department of Agriculture (USDA)	Pregnant and postpartum women, infants, and children through age 5; eligibility based on income and nutritional risk.	Grants to states. States administer WIC services provided by local agencies. Services include supplemental food and nutrition education, and enhanced outreach to migrants.
Migrant Legal Services	Legal Services Corporation	MSFWs with legal immigration status	Grants to nonprofit organizations to provide civil legal services.
Section 516 Housing Grants	USDA	MSFWs	Grants to nonprofit organizations for farmworker housing.
Section 514 Housing Loans	USDA	MSFWs	Loans to farmers and nonprofit organizations for farmworker housing.

Notes: MSFW = Migrant and Seasonal Farmworker

This list is not exhaustive. There are other federal assistance programs that might meet the needs of migrant families. For example, individuals or families might participate in Food Stamps, AFDC, literacy programs, bilingual education, low-income home energy assistance, free or reduced price school lunch, etc.

Source: Martin and Martin 1992, supplemented by background research for this study and interviews with program representatives.

APPENDIX D
DATA SOURCES AND LIMITATIONS

APPENDIX D: DATA SOURCES AND LIMITATIONS

Below we discuss the data sources for studying services for migrant farmworkers, the limitations of each, and suggestions in the literature on how data might be improved.

Wage and Employment Data. The Quarterly Agricultural Labor Survey (QALS) is conducted by USDA every quarter for the purpose of tracking farm labor data. QALS is the best source of wage and employment estimates available. It is a survey of 5,000 to 10,000 employers of farmworkers. This survey estimates 1.5 million farmworkers during the peak season (telephone conversation with R. Mines June 29, 1992).

There are other sources of wage and employment data, namely administrative data such as Unemployment Insurance (UI) data and Workers' Compensation data, but because farmworkers are not universally covered by these programs, the data are often inadequate.

Data on Demographic Characteristics. The Hired Farm Workers Force (HFWF) data was an analysis of the Current Population Survey (CPS) data that is collected in December every other year. The USDA has stopped this survey and relinquished responsibility to the Department of Labor, which has replaced CPS with the National Agricultural Workers Survey (NAWS). The major inadequacies often cited with respect to the CPS data on farmworkers are 1) December is the month least likely to find farmworkers performing agricultural work; and 2) gathering data on farmworkers, many of whom are migrants or seasonal workers, is very difficult to do from a household survey, because many farmworkers live in temporary housing units and are not covered by the CPS (telephone conversation with R. Mines June 29, 1992).

The National Agricultural Workers Survey (NAWS) is a targeted farmworker survey that is an expansion of the HFWF, in response to the Immigration Reform and Control Act (IRCA) of 1986. IRCA charged the secretaries of Agriculture and Labor with annually determining if there is a shortage of workers performing Seasonal Agricultural Services (SAS). The NAWs randomly selects farmworker employers, and then randomly selects workers at each site for interviews. The survey is conducted in three 6- to 10-week cycles to ensure seasonal sensitivity. By conducting the interviews at the work site and in cycles, some of the problems noted with the CPS data are avoided (telephone conversation with R. Mines June 29, 1992).

Program Data. Migrant Education and Migrant Health both collect information on farmworkers and their family members who receive services. Migrant Health centers report aggregate patient profile and utilization data under the Bureau of Community Health Services Common Reporting Requirements (BCRR) system. While these data are often a good source of information on program participants, the main drawback is that only data on migrant and seasonal farmworkers who receive services are collected. Individuals who do not receive health and educational services, but who may fit the definition of migrant farmworker, are not surveyed.

At our site visits we observed a proliferation of record-keeping requirements, some required by federal agencies, some required by state agencies, and some implemented by programs themselves to improve client tracking and follow up. The sad fact is that no one data

collection system can meet everyone's needs, and consolidation of reporting would require a substantial investment in time and technology.

The Migrant Student Record Transfer System (MSRTS) is one source of information used by projects to access data on the needs of students. MSRTS is a national database that stores academic, health, and other education records on migratory children participating in the Migrant Education program. MSRTS was originally designed to assist in the transfer of required schooling information to those involved in the education of migrant children. The uses of MSRTS have been expanded since its 1969 inception. In 1974 Congress allowed the MSRTS database to be used to estimate the number of migrant children in each state. These statistics continue to be used as the basis for calculating state allocations for Migrant Education program funds.

According to a recent study of MSRTS, the student record increased in size over its 20-year history, but its utility to local educators actually decreased. As the record became more detailed and the number of students increased, paperwork became a burden and records became less accurate and timely (National Commission on Migrant Education 1991). Thus, the current ability of the MSRTS to provide complete, timely, and up-to-date information on the needs of migrant students is questionable. Our site visits confirmed some of these problems. Although MSRTS is still heavily used for lack of any other reliable sources of information, staff of Migrant Education Programs noted that obtaining MSRTS information in a timely manner was problematic, and that there were a number of instances where information was incomplete or inaccurate. Apparently, states vary in their requirements for completion of MSRTS, and all information is not completed by every state. Another problem is that if the child attended a school that does not have a Migrant Education Program, no MSRTS data will be available on that child.

In addition to the problems already mentioned, there are problems common to all data collection with respect to migrant farmworkers. The main problem with standard survey and census data is that there is no distinction made between migrant and non-migrant. While farmworker is a standard occupational classification, migrant is a characteristic of a subset of these workers. Different methods of estimating the number and distribution of migrants from existing data have been put forth, though no method is unanimously supported. When estimates are made by data that are flawed to begin with, the errors are magnified. Estimates from the most current and reliable data, the NAWS, have yet to be cleared for publication.

The most important issues when considering the data sources to use are:

- Are the data relevant to the group or individuals being considered?
- Are migrant and farmworker described in a way that is consistent with the purpose of the study?
- Was the data or analysis sensitive to the fact that migrants are a difficult population to reach?

Recommended Improvements in Data

In their report for the Administrative Conference of the United States, Martin and Martin (1992) recommend the development of a uniform core definition of migrant/seasonal farmworker. They suggest that this core definition be used initially for the development of a single, reliable federal census or estimation system, independent of any of the current programs serving migrants/seasonal farmworkers. This core definition requires agreement on a number of parameters: the type of work included; the number of days annually employed in the qualifying type of work; the definition of "migrant"; and the look-back period (i.e., how long one is considered to be a migrant after a qualifying move). Even if a uniform definition is adopted, collection of data presents unique challenges. Traditional methods of household surveys are likely to miss a large number of migrant farmworkers, and seasonal differences will be significant. Richard Mines (telephone conversation June 29, 1992) suggests that alternative, non-traditional methods such as worksite interviews must be utilized to capture information on this hard-to-reach population.

APPENDIX E
SITE SUMMARIES

SITE VISIT SUMMARY: BROCKPORT, NEW YORK
(Monroe, Orleans, and Niagara Counties)

BACKGROUND

This site visit focused on coordination of services for migrant children of all ages in the Brockport, New York area. The visit centered around the Migrant Education Program housed at the State University of New York (SUNY) Brockport, and programs which participate in the "Working Together Group," a local coalition of agencies serving farmworkers. Coordination of services in the Brockport area is accomplished by a network of migrant and agricultural worker programs as well as community-based groups, including churches and service organizations.

The following programs and agencies were visited:

- Migrant Education Program (SUNY Brockport Campus)
- Agri-Business Child Development Program
- Orleans Child Development Center
- Batavia Child Development Center
- Oak Orchard Community Health Center
- Niagara County Migrant and Rural Ministry
- Rural Opportunities, Inc.

Brockport, in Monroe County, is located approximately 25 miles from metropolitan Rochester. Albion, in Orleans County, is approximately 15 miles west of Brockport, and is a designated medically underserved area (MUA) and a Health Professional Shortage area. The area is characterized as rural/suburban, and land usage is 50 percent to 60 percent agricultural. The main crops are apples, other orchard fruits, and large cabbage. The area is served by country two-lane roads and state roads. There is no public transportation available. Racially, the area is predominantly Caucasian; Caucasians comprise 93-99 percent of the population in the area's towns and villages. Approximately 5,000 migrant and seasonal farmworkers and their families come to western New York each year. The migrant worker population is approximately 65 percent Hispanic, 20 percent black, and 15 percent white or other. The largest influx of migrant workers occurs in May; most workers leave in November. At the peak of the season, there are about 950 migrant children in the Brockport area.

Over the past five years, there has been a change in the demographics of the migrant population in western New York. There has been an increase in the number of Hispanic families and an increase in the number of families from Texas, rather than from Florida or other southeastern states. This change has been attributed, in part, to the Immigration Reform and Control Act of 1986, which provided amnesty for seasonal agricultural workers.

EXEMPLARY EFFORTS

- New York State has a longstanding commitment to child development services for children of migrant farmworkers. It is the significant amount of state support, both financial and regulatory, that has facilitated comprehensive and coordinated services for young children. The state support enables centers to serve all migrant children and to serve children for up to five years after the family has migrated. This reduces eligibility barriers and differences between Head Start and other programs for migrants. The affiliation of the Agri-Business Child Development Program with the East Coast Migrant Head Start Project has enhanced staff skills and the services provided. The family-centered approach of Head Start is taking hold in all programs serving migrant children.

- Service providers found that they received greater cooperation from growers by toning down and shifting their approach in order to assume a less adversarial position. Growers, in turn, have begun to recognize that it is to their advantage to take an active role in assisting the migrant population.

- The Coalition of Migrant and Farmworker Services focuses on coordination of services and has been a useful forum for providers to bring up gaps in services. Participants have found that this approach works better than questioning individual providers. Agencies in the coalition include: Brockport Migrant Education, Oak Orchard Community Health Center, Agri-Business Child Development, Foodlink (a food distribution program), the local office of the New York State Department of Labor, the Hispanic Migrant Ministry, and Rural Opportunities, Inc.

- The "Working Together Group," an outgrowth of the Coalition, has taken a structured, head-on, approach to resolving philosophical differences among agencies. For example, it hired a paid facilitator to help develop trust among the various individuals and organizations represented. The group meets regularly every two to three months; chairmanship and location rotate among the different agencies. Members of the "Working Together Group" have collaborated on grant proposals, staff training, and parent education.

- The establishment of mutually beneficial relationships between service providers and programs of higher education is noteworthy. Programs serving migrants provide excellent training opportunities for students in child development, education, and health. These trainees enable programs serving migrants to better meet their seasonal staffing needs. The location of the Migrant Education Program on the SUNY Brockport campus is an excellent example of this kind of relationship.

- The wide range of community groups tapped by service providers in the Brockport area serves migrant families well. Churches, service organizations, police,

farmers, colleges, and private practitioners have all contributed in some way to support programs for migrant children and their families. The Brockport Ecumenical Outreach Committee is composed of church representatives, farmworkers, farmers, and representatives of agencies who work with farmworkers. Its goal is to improve communication and promote dialogue and mutual understanding between farmworkers and Brockport residents.

SERVICE NEEDS

Gaps in services for school-age and migrant children and young adults exist in the area of psychological/mental health services.

With regard to children with special needs, child development providers noted that it is sometimes difficult for providers of other agencies to understand the urgency of the migrants' schedule.

Transportation is a problem for many families because there is no public transportation in the community.

There is a need for bilingual staff in many agencies that provide services for migrants as well as in county social service agencies, health departments, the courts, and in public elementary schools.

Finally, it was suggested that parent training include issues of rights and advocacy so that parents can better advocate for their children in school and become aware of their own rights when they are the victims of unfair or illegal discrimination.

SUMMARY

The availability and high quality of services brings migrant families back to New York season after season. The number of migrant families arriving each year is significant in relation to the small size of the western New York communities, but it is "manageable" in that the numbers are small enough to permit individual tracking and a "personal touch." When state or private funds are available to fill in the gaps in federal programs, more coordination and comprehensive services can be provided. However, migrant students are adversely affected by local autonomy and state differences in educational requirements. Further, it should be noted that changes in immigration laws may cause the demographics of the migrant population to change, thereby affecting the skills needed by staff of service organizations and the procedures needed for interstate coordination.

BROCKPORT EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
Migrant Education Program	Migrant Education, Chapter 1	Both summer and year-round program, tutorial program, ESL, support services.	Located on SUNY Brockport campus, staff member on board of community health center.
Agri-Business Child Development Program	Migrant Head Start, New York state agricultural and market funds, and the United Way	Early childhood education, outreach, referral to social services.	Child care mandated by state, no waiting lists for migrant children.
Oak Orchard Community Health Center	Migrant Health (Sections 329, 330, PHS)	Clinic services, mobile van, nutrition education, Medicaid eligibility interviews.	Mobile van that goes out to work sites, open late hours to accommodate migrant farmworkers' schedules.
Rural Opportunities, Inc.	JTPA, Title IV, Section 402	On the job training, classroom training, work experience, literacy , job readiness, HIV prevention and pesticide safety education.	Involved in advocacy and substance abuse issues, places workers at child development centers.

BROCKPORT EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	Agri-Business Child Development Program	Migrant Health	Social Services
Services	Early childhood education, outreach, referral to social services.	Comprehensive medical care, mobile van services, screening, immunizations, WIC.	Emergency food, shelter and clothing.

Elementary and Middle School Child

Program	Migrant Education	Migrant Health	Social Services
Services	Both summer school and year-long program, tutorial program.	Clinic services, mobile van services, screening, immunizations.	Emergency food, shelter, and clothing.

High School Student/Young Adult

Program	Migrant Education	Migrant Health	Rural Opportunities	Social Services
Services	Both summer school and year-long program, tutorial program, ESL, GED, transition to college, paralegal, and other advocacy services.	Clinic services, mobile van services, Spanish-language health and nutrition education.	On the job training, classroom training, literacy, job readiness, HIV prevention, and pesticide safety education.	Emergency food, shelter, and clothing.

SITE VISIT SUMMARY: GREELEY, COLORADO
(Weld County)

BACKGROUND

This site visit studied services for migrant children of all ages in Greeley, Colorado. It focuses on the relationships of the Northern Colorado Migrant Coalition, a network of local agencies that provide services to migrant farmworkers and their families. The visit studied the relationships that have developed, formally and informally, among community agencies and federal, state, and local programs.

The following agencies were visited:

- Sunrise Community Health Center;
- Weld Board of Cooperative Educational Services (BOCES);
- Family Educational Network of Weld County (FENWC);
- Rocky Mountain Service Employment Redevelopment (SER);
- Employment Services Division of Weld County;
- Catholic Community Services; and
- Weld Information and Referral Service (WIRS).

Greeley, the significant population center in the area, is located in Northern Weld County, approximately 50 miles north of Denver. Weld County is a predominantly agricultural area, consisting of row crops such as sugar beets, potatoes and onions, and agricultural processing of beef and other products.

Weld County is home to nearly half of all migrant farmworkers in Colorado, most of whom are Hispanic. An estimated 8,000 migrant adults and children come through the area each year. One-third of the total population of Weld County is Hispanic; many are employed in agriculture or other related industries.

Migrant farmworkers and their families begin arriving in Weld County in April of each year and many stay as late as October or November. Most of the migrants travel from their homebase in Texas. Many continue on to Idaho, Washington, and possibly as far away as Montana.

EXEMPLARY EFFORTS

The state of Colorado stands out in its commitment to serving migrant children. It is unique in that state-level formal agreements facilitate the provision of health, education, and social services. Increased educational achievement and access to health services are high priorities, as reflected in agreements between Migrant Health, Education, and Head Start. Some of these efforts follow:

- Migrant Health has agreements with local health centers, giving migrant children access to dental care, physical examinations, nursing services, medical treatment, and pharmacy services.

- To improve academic achievement and prospects for employment, formal agreements exist between Rocky Mountain SER and BUENO-HEP (Bilingual United for Educational Opportunity-High School Equivalency Program) and Vocational Rehabilitation Services.

- The Colorado Migrant and Rural Coalition, a state-level interagency committee, and the Northern Area Migrant Coalition, a local committee, were established to set goals, assess and address needs, and promote outreach.

- The Northern Area Migrant Coalition is the main source for development of agreements and is seen as one of the key components for success of service integration efforts.

- Private and nonprofit organizations such as Catholic Community Services and churches provide food, shelter, and clothing to migrant families when they first arrive in the area.

- An informal communication network has developed with similar agencies in the migrant stream outside of Colorado.

- The Migrant Education program has a formal process for ongoing coordination with the homebase sites in Texas. Students in the migrant summer program are able to receive credits in Texas.

- A binational high school accreditation project with Mexico has been developed and will begin soon.

SERVICE NEEDS

Affordable housing was identified as a problem of extreme magnitude for migrant families. Much of this problem is caused by increased enforcement of building codes, which has priced many migrant farmworkers out of the market. Adding to this problem is the lack of housing

caused by the increase of the student body at the University of North Colorado. Because of this shortage, migrant families often sleep in their cars or under bridges.

Mental health services are limited and frustrate attempts to provide comprehensive services. On top of the lack of services and funding, additional problems are encountered because of cultural resistance and lack of bilingual providers.

Lack of access to transportation is a problem in an area as large as Greeley. Migrant families do not have the financial resources (especially upon arrival) to buy gas or make needed automobile repairs. The programs that provide gas vouchers are limited.

SUMMARY

This successful migrant youth project is marked by formal agreements around health, education, and Head Start providers, and informal agreements and a cooperative effort and commitment by local providers and community agencies. The local Northern Migrant Area Coalition has been the catalyst in bringing together a large number of agencies to improve the lives of migrant workers.

GREELEY EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
Weld BOCES	Migrant Education, Chapter 1	Recruitment/ outreach, summer school and regular year program, individualized instruction and plans, bilingual ed and testing.	Bi-national accreditation agreement with Mexico, credit transfer with Texas school districts.
Family Education Network of Weld County	Migrant Head Start	Health, early childhood education, referral to social services.	Ten sites throughout Northern Colorado (plus Alamosa), joint planning with Migrant Health.
Sunrise Community Health Center	Migrant Health (Sections 329, 330, PHS)	Dental services, health screening and immunizations on site and at camps, late hours during peak season, referrals to specialists and non-health services.	Agreements with Head Start, Migrant Education, WIC, University of Colorado Family Practice Program.
Rocky Mountain SER	JTPA, Title IV, Section 402	Vocational and on the job training, GED preparation, dropout prevention.	Agreement with Division of Vocational Rehabilitation Services.

GREELEY EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	Migrant Head Start	Family Connects	Migrant Health	Medical Providers	Social Services
Services	Early childhood ed, referral to social services.	Early childhood ed, transition to elementary school, referral to social services.	Screening, immunizations, clinic services.	Specialized problems.	WIC, Food Stamps, emergency food and shelter.

Elementary and Middle School Child

Program	Migrant Education	Migrant Health	Medical Providers	Social Services
Services	Summer school and regular year program, individualized planning and instruction, bilingual instruction.	Clinic services, immunizations, health screening, referral to specialists.	Referral, outreach.	Food Stamps, emergency food and shelter.

High School Student/Young Adult

Program	Migrant Education	Migrant Health	Rocky Mountain SER	Medical Providers	Social Services
Services	Summer school and regular year program, individualized instruction and planning, bilingual instruction.	Clinic services.	Vocational and on the job training, dropout prevention, college assistance migrant program, high school equivalency program.	Referral, outreach.	Food Stamps, emergency food and shelter.

SITE VISIT SUMMARY: STOCKTON, CALIFORNIA
(San Joaquin County)

BACKGROUND

This site visit focused on the coordination and integration of services for children of migrant farmworkers residing in the San Joaquin Valley area, with a particular focus on the city of Stockton. Nearly all of the programs visited were part of a regional operation that covered a much larger geographical area, but the focus was on Stockton and the surrounding area.

During the site visit meetings were held with:

- the executive director and staff of the Migrant Head Start program in Stockton;
- the deputy director of the Housing Authority of San Joaquin County who also chairs an interagency council for migrant service providers;
- the coordinator of the Migrant Education program;
- the director of the Migrant Education Even Start program; the director of the Migrant Education Event Start program;
- the director of the Stockton area California Human Development Corporation, which administers the JTPA 402 program;
- the director and staff of the Agricultural Workers' Health Clinic of San Joaquin County.

In addition, site visitors attended the final meeting of the season for the interagency council chaired by the Housing Authority, at which staff from over 20 agencies serving migrant families were represented.

San Joaquin County, stretching across a 2,500-square-mile swath of mostly fertile farmland in central California, includes pockets of suburban wealth, inner-city poverty, and rural migrant labor camps. The area is a temporary home to approximately 50,000 migrant farmworkers and their children each year. An estimated 24,800 migrants live in the county at any one time. During the peak summer months, up to 62,000 migrant and seasonal farmworkers, or 13 percent of the population, reside in the county. While more than 90 percent of farmworkers were born in Mexico, other ethnic groups including Southeast Asians and Punjabi Indians have settled in the region in recent years. Whites comprise a minority of the population. A variety of crops are grown in the region, including grapes, cherries, almonds, tomatoes, and

asparagus. The busiest season is May through October, after which many families move on to Oregon and Washington.

EXEMPLARY EFFORTS

Although the coordination of services for migrant families in the San Joaquin Valley is primarily informal, there are a number of models that illustrate exemplary use of resources in the provision of efficient and effective services. These include informal agreements among agencies, an informal interagency council that meets semi-monthly to discuss service needs and available resources, a state-funded program that provides housing specifically targeted to migrant families, and co-location of services at the migrant housing camps.

- Interagency Council. The most effective coordinating mechanism in the San Joaquin Valley is the interagency council currently chaired by the deputy director of the Housing Authority. The council is an informal group that meets semi-monthly during the growing season at one of the three migrant housing camps provided by the Housing Authority. The council is open to anyone interested in participating, and there are currently over 20 agencies involved, representing virtually all of the state and local agencies that provide services to migrant families. At the meetings, statistics are shared on the number of children and families needing services, and each council member describes the resources available and any particular client needs such as jobs, child care, ESL, etc. This sharing of information helps agencies to make the most efficient use of scarce resources.

- Housing Centers. The migrant housing camps established by the Housing Authority have been the key to the viability of San Joaquin County's interagency council and service integration efforts. The existence of housing centers that include facilities for the provision of services such as child care, community group meetings (e.g., Girls Scouts) or programs and services (e.g., ESL, Immunizations) enables services to be integrated and coordinated among providers. By providing services where migrant families live, the housing centers assist in overcoming the barriers of transportation and timing that prevent many migrant families from obtaining services.

- Binational Agreement with Mexico. A binational agreement negotiated between Mexico and the Migrant Education program facilitates the appropriate placement of students as they move back and forth between California and Mexico, and assists in the efficient delivery of services.

- Resource Sharing. Agencies are beginning to share resources in a more formalized way. The best example of this is a grant that will fund outreach workers to coordinate health services through the Migrant Health Center for families identified by the Migrant Head Start and Migrant Educations programs.

Sharing of resources is also facilitated by the active involvement of staff in other community groups such as by serving on boards of other agencies.

SERVICE NEEDS

Most of the gaps in services for migrants in San Joaquin County stem from insufficient resources to keep up with the demand of the large migrant population.

Dental care poses a big problem because of huge demand, high cost of setting up and operating dental care facilities, and clinics' limited capacity to develop large programs.

There is a lack of resources for mental health care, child care, and a lack of substance abuse programs.

Accessibility of services is limited to migrants; transportation and timing are barriers for many migrant families.

There is a shortage of housing in the area. The Migrant Housing Camps operated by the Housing Authority cannot keep up with the demand each spring, and there are no alternative sources for low-income rental housing.

Service providers also point to the following barriers to efficient delivery of services: 1) different definitions of "migrant"; 2) separate administration of services across counties; 3) limited English proficiency among migrants; and 4) difficulty with continuity of services because of insufficient tracking methods.

SUMMARY

California's heavy reliance on agriculture has translated into a strong commitment to the provision of services to migrant farmworkers and their families. Most efforts at coordination and integration of services are informal, such as between the health center and the Migrant Head Start programs, and between the Housing Authority and other state-funded health programs. The availability of appropriate facilities to provide services is key to integration and coordination of services. While the provision of state funds for services to migrant farmworkers and their families is instrumental in helping to cover gaps in services offered by federal programs, it is also clear that administrative structures of the various agencies involved create barriers which can impede the integration of services.

STOCKTON EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
Migrant Education/Migrant Even Start	Migrant Education, Chapter 1, and Migrant Even Start	Regular school year and summer school program, independent study, Portable Assisted Study Program (PASS), ESL, tutors, emergency health services, outreach, and adult literacy.	Binational agreement with Mexico facilitates placement of students, part of coordinated outreach effort.
Stockton Migrant Head Start Child Development Council	Migrant Head Start	Early childhood education, outreach, assessments for children with special needs.	Co-location at migrant housing camp, part of coordinated outreach effort.
Agricultural Workers' Health Clinic of San Joaquin County	Migrant Health (Sections 329, 330 PHS)	Three clinic sites, health education, outreach, access to specialist services.	Outreach workers coordinate health services for families identified by MHS and MEP.
California Human Development Corporation	JTPA, Title IV, Section 402	Vocational training, on the job training, GED, ESL, job survival skills.	Also provides emergency shelter, medical attention, and food distribution through supportive services.
Housing Authority of San Joaquin County	State Office of Migrant Services, HUD, FHA	Provides and manages low-income housing for migrants.	Co-location of Migrant Head Start and state-funded preschool programs.

STOCKTON EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	Migrant Head Start	Migrant Even Start	State Funded Preschool	Migrant Health	Social/Community Services
Services	Early childhood education, outreach, assessments for special needs.	Early childhood education, adult literacy, outreach.	Early childhood education.	Physical exams, screening, outreach.	Migrant farmworker housing, with co-location of Migrant Head Start and state-funded preschool, WIC.

Elementary and Middle School Child

Program	Migrant Education	Migrant Health	Social/Community Services
Services	Regular year and summer school program, tutoring, ESL, outreach, emergency health services.	Physical exams, screening, outreach.	Migrant farmworker housing, girl scouts, boys and girls clubs.

High School Student/Young Adult

Program	Migrant Education	Migrant Health	JTPA, Section 402	Social/Community Services
Services	Regular year and summer school program, tutoring, ESL, outreach, emergency health services, PASS.	Physical exams, screening, outreach.	Vocational and on the job training, GED, ESL, job survival skills.	Migrant farmworker housing.

SITE VISIT SUMMARY: WOODBURN, OREGON
(Marion County)

BACKGROUND

This site visit focused on the coordination of services for migrant children of all ages in the Marion County/Woodburn, Oregon area. Some of the programs participating covered a larger geographic location, but the focus is on Woodburn and the surrounding area.

The following programs and agencies were visited:

- Marion County Education Service District (ESD); Migrant Education program, the Migrant Even Start program, and a Migrant Preschool program;
- Salud Medical Center;
- Migrant and Indian Coalition (MIC), the Migrant Head Start program, and the Oregon Preschool Program (OPP); and
- Oregon Human Development Corporation, which is a JTPA 402 program.

Woodburn is a community of about 13,000 people in Marion County, Oregon. It is located approximately 35 miles southeast of Portland and 12 miles northeast of Salem, the state capitol. Woodburn has the highest agricultural work per capita in the state of Oregon. While it is a primarily agricultural region, the nature of the agricultural work varies widely. The industry includes nursery work, tree planting and harvesting, row crops and processing, and fishing.

Woodburn has a large migrant and seasonal farmworker population, consisting mainly of individuals of both Hispanic (70 percent) and Russian (18 percent) ethnicity. Approximately 1 percent of migrants are black or Southeast Asian and the remainder are of Anglo heritage. Many of the migrants come from Texas, California, or Mexico, but the numbers from southern Mexico and Central America have been increasing dramatically. Many arrive in very poor health due to conditions existing in their native countries.

In addition to the migrant population, Woodburn has a significant number of seasonal farmworkers who have settled out of the migrant stream and live year-round in Woodburn. Many may go to Mexico for a short period of time in the winter, but not to do farmwork. In addition to the settled out farmworkers, Woodburn also serves as a homebase to an increasing number of migrants. These two factors, in addition to the nature of the agricultural work available, have added to the numbers of migrants and seasonal farmworkers living in the area year-round. The busiest time, especially for crop farmworkers, is May to October, but many nursery workers, tree planters/harvesters, and processors work nearly year-round.

EXEMPLARY EFFORTS

There are many models of coordination of services and exemplary use of resources in the Woodburn area involving programs serving the migrant population and their families. Formal agreements exist between agencies. There are also informal networks that have developed in the community, as well as an entrepreneurial spirit in seeking out resources to enable agencies to provide comprehensive services to migrant families.

There are a number of formal consortia such as the Great Start program, La Familia Sana (operated by a regional consortia of three migrant health centers), and the Healthy Child Clinic (funded by the United Way).

- The migrant education technical assistance center run by the Marion Education Service Center employs a health coordinator who assists in procuring health resources for the education programs. A two-day health fair was organized for the Migrant Even Start program, which employed volunteers for medical screenings and tapped additional resources in the medical community by using medical students from the medical school in Portland.

- Training of lay health educators through the La Familia Sana program has expanded available resources to the community with very little expenditure of funds. It has also been an effective way to reach community members who may not otherwise be as responsive to outsiders.

- The Great Start program has provided resources to multiple agencies to enable them to take a case management approach to providing comprehensive services to families.

- Even Start is co-located at a local elementary school and the migrant preschool program is co-located with the Migrant Head Start program. This enables sharing of resources and enhances referrals among programs.

- The Farmworker Housing Development Corporation, currently being developed, will provide 90 units of rental housing, with on-site daycare, laundry rooms, play areas for children, and community gardens. The land was given to the corporation by the city of Woodburn and the funding comes from several sources, including grants and low-interest loans.

- Staff and administrators sit on boards of other agencies, promoting information sharing and coordination. The personal relationships thus developed also widen the referral network among agencies, which is critical to successful coordination.

- A number of informal interagency groups in Marion County meet weekly or biweekly to discuss service needs of the farmworker population. The primary group, HOPE (Helping Other People Energize), operates like a local farmworker task force, sharing information on the needs of the population and available services. There is a strong referral network among agencies developed in part through personal relationships.

SERVICE NEEDS

Space is a problem for several migrant programs. Staff at one elementary school believed that more services could be provided, and other services such as preschool services could be expanded if space were made available. The space at Salud Medical Center is so limited that storage space and closets are being transformed into offices to accommodate increases in staff and patient load.

Another dominant service need is for translators or bilingual support staff such as receptionists, particularly for mental health and health services. If a farmworker cannot communicate at the point of entry for services, it does little good if medical staff is bilingual.

There is also a tremendous need for housing. Often more than a dozen children and their families are found in a single wide trailer. In extreme cases, families have been found living in their cars. Poor quality housing and surrounding environments ultimately lead to poor health, resulting in the need for additional services within both the health and education systems.

There are only two mental health workers in the Woodburn area who are bilingual and provide culturally appropriate services to meet the mental health needs of the farmworker population. With an increase in the incidence of domestic violence and alcohol and drug abuse, this is an insufficient number to provide an adequate level of service to the community.

Transportation to services, particularly to health center appointments, is a problem. Often Migrant Education and Migrant Head Start staff must transport children to and from clinic appointments, taking them away from their job and the needs of the other children.

SUMMARY

The successful delivery and coordination of services in the Marion County area are largely due to the hard work and commitment of individuals involved in service delivery to migrant and seasonal farmworkers and their families. In recent years, there has been a shift in the demographic profile of the population, and the area has become a homebase for many farmworkers. Because this area has found itself with a growing population with an increasing need for services, coordination for efficient and effective service delivery has become necessary for survival.

WOODBURN EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
Marion County ESD	Migrant Education, Chapter 1, and Migrant Even Start	Migrant Education program specific to needs of student at each school; Preschool and adult education components of Migrant Even Start.	Full-time health coordinator, co-location of Even Start at Elementary school, health fair for Even Start kids.
Migrant and Indian Coalition (MIC)	Migrant Head Start and the Oregon Preschool Program (OPP)	Health screening, early childhood education, referral to social services.	Co-location of Oregon Preschool Program and Head Start, involvement in Great Start program with Salud Medical Center and other agencies.
Salud Medical Center	Migrant Health (330, 329, PHS)	Dental services, health screening, and immunizations on site and at schools and Head Start centers, referrals to specialists and non-health services.	Executive director involved in farmworker housing project, involved in Great Start program, and training of lay health educators through La Familia Sana.
Oregon Human Development Corporation	JTPA, Title IV, Section 402	Employment and training and supportive services, Farmworker Resource Referral Program, energy assistance, weatherization.	Support group for Hispanic women who are victims of domestic violence.

WOODBURN EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	Migrant Head Start OPP	Migrant Even Start	Migrant Health	Early Intervention Services	Social Services
Services	Early childhood ed, health screening, referral to social services.	Early childhood ed, adult education, referral to social services.	Health screening, immunizations, clinic services.	Serves children with special needs.	WIC, food stamps, emergency food and shelter.

Elementary and Middle School Child

Program	Migrant Education	Migrant Health	Early Intervention Services	Social Services
Services	Services designed to meet particular needs of students at each school.	Clinic services, immunizations, health screening, referral to specialists.	Serves children with special needs.	Food stamps, emergency food and shelter.

High School Student/Young Adult

Program	Migrant Education	Migrant Health	Oregon Human Development Corporation	Social Services
Services	Services designed to meet particular needs of students at each school.	Clinic services.	Vocational and on the job training, migrant program, high school equivalency program.	Food stamps, emergency food and shelter.

SITE VISIT SUMMARY: HIDALGO COUNTY, TEXAS

(McAllen, Mercedes, Weslaco, and Pharr)

BACKGROUND

This site visit focused on programs and services for migrant children and families in Hidalgo County, Texas. The site visit included interviews with a large number of community agencies and programs serving migrant families in McAllen, Mercedes, Weslaco, and Pharr in the lower Rio Grande Valley.

Interviews included representatives of the following programs and agencies:

- Texas Migrant Council (TMC);
- Texas Migrant Interstate Program (TMIP);
- Migrant Education Program, Pharr-San Juan-Alamo Independent School District;
- Hidalgo County Health Care Corporation (HCHC);
- A dentist and family physician in private practice;
- Motivation Education & Training (MET);
- Department of Community Affairs (DCA);
- Migrant Even Start Family Literacy Project;
- Planned Parenthood;
- Hidalgo County Housing Authority (HCHA);
- Texas Rural Legal Aid (TRLA);
- Salvation Army;
- Special Supplemental Food Program for Women Infants and Children (WIC);
- Expanded Nutrition Program;
- Community Service Agency (CSA).

The Lower Rio Grande Valley is located in the southernmost tip of Texas and shares a border with Mexico. The "Valley," comprised of Cameron, Hidalgo, and Willacy counties, is one of the poorest regions in the United States. Hidalgo County is a large, rural county of nearly 1,600 square miles. The Texas Employment Commission estimates that 39 percent of Hidalgo County residents have incomes below the poverty level. The unemployment rate in the county is over 15 percent. Only 14 percent of the total county population is covered by Medicaid, and an additional 73 percent are uninsured. Approximately 85 percent of county residents are Hispanic, almost exclusively Mexican-American, and many speak only Spanish. The county also has a relatively young population (the average age is 22), and a high birth rate.

Hidalgo County is home to over 208,000 farmworkers (117,000 migrant; 91,000 seasonal). This represents slightly over 40 percent of all migrants and seasonal farmworkers in Texas. Many of these farmworkers live in *colonias*. *Colonias* are unincorporated rural subdivisions characterized by substandard housing and inadequate water, sewer, and plumbing systems. Hidalgo County contains an estimated 366 *colonias* populated by almost 52,000 people. Lack of potable water and adequate sewage places residents of *colonias* at high risk for cholera and other infectious

diseases. Death rates from infectious and parasitic diseases and dysentery are two to four times that of the rest of Texas. Unemployment and school dropout rates exceed 50 percent in some of the *colonias*.

The county's temperate climate and irrigation system allow for year-round agricultural production. The major crops include cotton, citrus, grain, vegetables, and sugar cane. Large-scale processing plants have developed around these agricultural products. The proximity to Mexico supports retail trade in Hidalgo County, but also exacerbates housing and employment problems in the area.

EXEMPLARY EFFORTS

Effective practices that have developed for serving migrant farmworker families reflect the unique aspects of both the setting and the service delivery network in Hidalgo County. For example:

- Interstate coordination is exemplary. The staff of programs serving migrants, particularly Migrant Head Start, Migrant Education, and Rural Legal Aid are familiar with programs and resources in upstream states and have developed relationships with staff of programs in these receiving states.

- Many staff of the programs serving migrants are former migrants themselves, and share the ethnic and cultural heritage of the families they serve. Perhaps because of this common understanding, the programs serving migrants in this community have a particularly strong family focus.

- Programs serving migrants have developed a wide range of mutually beneficial relationships with university programs. These affiliations provide much needed resources and expertise in medicine, dentistry, nutrition, and early childhood education, while providing unique training and teaching opportunities for the participating educational institutions. Examples include the HCHC/University of Texas Health Sciences Center collaboration, and the TMIP/Texas A&I Coordinating Center for migrant education.

- The model of migrant coordinator in school and housing programs seems well-suited to an area with a large concentration of migrant families and a large number of organizations with which to negotiate services, and is important in addressing the needs of the migrant family as a unit. The migrant coordinator is familiar with community resources and is identified as a key contact for referrals of migrants from other community agencies.

- The Texas Migrant Interstate Program (TMIP) recognizes that a key to increasing high school graduation rates among migrant children is interstate communication. This includes timely and complete records, credit transfer agreements, awareness of differences in curricula, and the development of alternative means of meeting

graduation requirements. The model of a regional center that provides training and technical assistance to local schools and takes the lead in negotiating arrangements for testing, credit transfer, and dissemination of information is worthy of consideration by other states or regions within states.

- The Texas Migrant Council (TMC) is also moving toward a regionalized model of interstate coordination. While interstate continuity of services was excellent when TMIP staff moved upstream in the summers, the current model, which funds delegate agencies upstream, will enable TMC to focus more on its role of building resources in receiving communities and assuring that systems are developed to facilitate timely transfer of information.

- The *promotores* model, providing training to residents of the colonias who then serve as lay educators and organizers in their communities, has been implemented successfully in Hidalgo County by both Planned Parenthood and the Expanded Food and Nutrition Program. The lay educators are well-received in their communities, thus providing an effective means of educating residents. The programs also serve as a means for individual residents to gain confidence and skills in order to better themselves and their communities. The *colonias* project of the Texas Department of Human Services (Partnership for Self Sufficiency) is a more recent initiative with broad support by community agencies. This project holds promise for mobilizing private support and for coordinating the many efforts that are underway or in the planning stages to serve *colonias* residents.

SERVICE NEEDS

Inadequate resources were noted repeatedly by almost all those interviewed during this site visit. While there are many exemplary programs serving migrants and other indigent families, this region is so poor and underserved that these programs only begin to fill the need. Access to specialty medical care, mental health providers, and substance abuse treatment is also very limited.

More preventive services including immunizations are needed, and there is a need for culturally specific research on health behaviors. For example, why aren't Hispanic women seeking early prenatal care?

The needs go well beyond health care. The economic status of migrants, which needs to be addressed nationally, is a much more pressing issue in this region, which has such a high concentration of migrant families. There is a need to try to approach growers, local governments, and industry to get involved in issues such as housing, jobs, education, and employment benefits.

Migrants are affected by the overall economic conditions in the Valley. There is a shortage of jobs, affordable housing, and emergency housing. Yet there is continued population growth,

with new immigrants arriving from Mexico every day.

In education, a number of needs were identified. There is a shortage of teachers for migrant education, and more resources are needed for planning the transition of preschool children to public schools. More migrant parents need to be reached by literacy programs. Illiteracy of migrant farmworker parents affects their children and parents' ability to serve as educators of their children. Head Start staff note that ESL and other literacy programs are available, but that not enough migrant farmworkers are taking advantage of them.

Transportation and infrastructure such as roads and sewage continue to be areas of great need.

Many agencies noted that limited funding and changes in regulations of the various assistance programs they administer require some agencies to change their focus every year. Often their annual funds for such basic needs as utility payments or emergency housing are depleted within months of authorization.

SUMMARY

The unique employment, housing, education, health, and legal problems faced by a border community, coupled with the large and ever growing indigent population to be served, evades simple solutions. A large number of community organizations exist to serve this population and new programs are opening, but all have limited resources and there is no single coalition or organization that encompasses all of them. Providing integrated services across such a dispersed service network is difficult. However, many respondents noted that the time is now riper for coordination. Any national or state policies or evaluations must consider issues of scale in this large and populous county.

HIDALGO COUNTY EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
Texas Migrant Council (TMC)	Migrant Head Start	Early childhood education, health screening, referral to health and social services.	Close working relationships with upstream states; coordination with private dental and medical providers and migrant health center.
Texas Migrant Interstate Program (TMIP)	Migrant Education Chapter 1	Credit accrual and credit exchange programs, dropout prevention, self-esteem and skills training.	Regional center provides training and technical assistance to local schools and takes the lead in interstate coordination.
Pharr-San Juan-Alamo School District	Migrant Education Chapter 1; Migrant Even Start	Teacher aides, tutoring, counselors, supplemental services, home-based program for three-year olds, Even Start family literacy centers.	Migrant service coordinator in each school; evening hours for Even Start centers to provide vocational classes for parents.
Hidalgo County Health Care Corporation (HCHC)	Migrant/Community Health (329, 330 PHS)	Comprehensive primary health care.	Physicals, immunizations, dental screening, dental care for Migrant Head Start children; dental screening at elementary schools.
Texas Rural Legal Aid	Legal Service Corporation	Civil legal assistance: government benefits, civil rights, housing, employment, farmworker health and safety.	Work with Texas Department of Human Resources on farmworker safety and health education.
Expanded Nutrition Program	Texas Agricultural Extension Service/USDA	Training and education for adults and children in the *colonias* and other rural areas.	Classes at Head Start parent meetings, training in nutrition and meal planning for Head Start teachers.

HIDALGO COUNTY EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	Migrant Head Start	Migrant Even Start	Migrant Education	Health Center and Private Health Providers	Social Service Programs
Services	Early childhood education, health screening, referral to social services. Disabilities specialist coordinates assessments, refers children to early intervention program.	Early childhood education 3-5 year olds; child care for infants; parenting classes.	Home-based education program for 3-year olds; half-day preschool for 4-6 year olds.	Health screening, immunization, dental screening, primary health and dental care.	WIC, Food Stamps; emergency food, clothing, transportation via Community Service Agency.

Elementary and Middle School Child

Program	Migrant Education	Health Center and Private Health Providers	Texas Rural Legal Aid	Social Services
Services	Teacher aides, tutoring, counselors, supplemental services. Migrant counselors and migrant service coordinators.	Dental screening at schools; immunizations; primary health and dental care.	Challenges school rules that adversely affect migrant students.	Emergency food, clothing, and shelter. Referrals by migrant education, housing authority, and others.

High School Student/Young Adult

Program	Migrant Education	Health Center and Health Providers	JTPA	Texas Rural Legal Aid	Social Services
Services	Teacher aides, tutoring, counselors, credit transfer, dropout prevention, self-esteem programs.	Primary health and dental services. Planned parenthood provides education programs.	Youth employment and training programs.	Defends student rights; holds career days at high schools.	Emergency food, shelter, and transportation.

SITE VISIT SUMMARY: BELLE GLADE, FLORIDA

(Hendry and Palm Beach Counties)

BACKGROUND

The purpose of this site visit was to learn about the delivery of services to migrant children and their families in Belle Glade, Florida and the neighboring communities of South Bay and Clewiston. One reason for selection of this site was the existence of some unique relationships which have facilitated service integration. This site visit also provided an opportunity to talk with a grower representative and with Migrant Head Start parents.

The following programs and agencies were visited:

- East Coast Migrant Head Start Program (Shannon Migrant Head Start Center);
- West Technical Vocational School;
- Brumback Health Center (Palm Beach County Health Department);
- Clewiston Health Center;
- HIV Prevention Center;
- Adult Migrant and Seasonal Farmworker Program;
- Duda and Sons, family-owned grower (DUDA).

Belle Glade and South Bay, neighboring towns about 10 miles apart, are located in west Palm Beach County, 45 miles inland from West Palm Beach, Florida. Belle Glade, the largest city in the Everglades, has a permanent population of approximately 4,000. In the winter harvest season the peak population is about 20,000. Clewiston, further inland, is located in Hendry County. Western Palm Beach County is more like Hendry County than the urbanized and more affluent coastal areas of Palm Beach County. Agriculture is the leading industry in this area. The main crops are sugar cane and vegetables including celery, lettuce, sweet corn, and radishes. The peak growing season is from November through May.

According to the Florida Bureau of Agricultural Programs, the South Florida region reported a total of over 35,800 seasonal farmworkers in 1989. Approximately 68 percent of the workers were local, 17 percent were interstate migrants, and 15 percent were intrastate migrants. Approximately 72 percent of South Florida seasonal workers were Hispanic, 13 percent were nonwhite Hispanic, 12 percent were black, and 11 percent were Haitian. According to those interviewed during the site visit, the demographics of the migrant farmworker population in the Belle Glade area has changed. Many black families that had been migrants have settled out and are now employed in seasonal farmwork. The migrant population is increasingly Hispanic and Haitian Creole.

Poverty levels and unemployment levels are high in Hendry County relative to the state of Florida. Hendry County has a high birth rate, 21.9 in 1990, compared to 16.3 for the United

States as a whole. The infant mortality rate of 20.8 is more than twice as high as the infant mortality rate for the United States as a whole.

EXEMPLARY EFFORTS

- The Glades Interagency Network (GIN), mandated by a Florida state law requiring interagency councils for early childhood in every county, facilitates cooperation between service agencies. The GIN meets monthly, and most service agencies participate.

- The area's small size and focus on agriculture create a strong community spirit in the Belle Glade/Clewiston area. Collaborative efforts and an interest in providing integrated services for migrants have increased in recent years. The Brumback Health Center has initiated new outreach efforts and improvements in service delivery. The East Coast Migrant Head Start Project (ECMHSP) has expanded its services to adults as well as children with its Family Literacy Project. DUDA and West Tech have excellent working relationships with ECMHSP and have broadened the range of activities they sponsor with ECMHSP.

- The HIV Prevention Center and its wide acceptance as a community resource are also exemplary. The center works with many other community agencies and is called upon for education and outreach by a range of programs far beyond traditional public health and social service programs. The center's work is respected by both public and private employers in the community.

- The key role that growers play in facilitating integrated services for migrant farmworkers in the Belle Glade/Clewiston area demonstrates an enlightened approach. For example, DUDA managers regularly travel to Texas and Mexico to visit their Florida migrant employees in order to better understand their needs and to encourage them to return to Florida for the next growing season. There appears to be a real "meeting of the minds" among growers and ECMHSP, and Migrant Education concerning the desirability of co-locating work, housing, and child development programs for migrant families. In addition, there is a willingness on the part of growers to contribute substantial resources for this purpose.

- The Shannon Migrant Head Start Center, located on DUDA property, is an excellent model of how co-location and grower support have facilitated the provision of integrated services for migrant farmworker families. The co-location of work with housing and Head Start facilities has been beneficial to growers and migrant families and has encouraged further integration of services. For example, DUDA is working with Palm Beach County Migrant Education to establish an after-school tutoring program at the migrant camp, and DUDA provides space for

the Brumback Health Center's mobile van so that health screenings can be conducted on site.

- Another example of productive collaboration is the West Tech/East Coast Migrant Head Start/Adult Migrant and Seasonal Farmworker Program relationship. The initial agreement began when ECMHSP needed space for a new Migrant Head Start center. West Tech saw this as a training opportunity for students preparing for child care careers. This relationship developed well beyond the Child Care Assistant program when students from other programs at West Tech repaired the Head Start trailer and built them a storage shed. The relationship between West Tech and the Adult Migrant and Seasonal Farmworker Program includes numerous vocational and technical programs that West Tech offers.

- The overall support for integrated services provided by ECMHSP is worthy of special note. This umbrella organization enables sites to go about the business of serving families and teaching children because its central offices take on the burden of the administrative tasks. ECMHSP also facilitates continuity as families migrate. The Family Literacy Project is an excellent example of an innovative program that is operated by ECMHSP. The facility is a single van equipped with up-to-date computer workstations and audio equipment, and a full complement of software for learning basic literacy skills, English language, and GED requirements.

SERVICE NEEDS

The number of migrant and seasonal farmworkers in Florida is tremendous, and many service providers feel that they only scratch the surface in serving eligible families. However, many service providers felt that needed services are available, one just has to search them out. Problems often relate more to access and sensitivity to the population, rather than to availability of services.

The health needs of the migrant population in Florida are great, due to a higher than average rate of HIV and TB infection. The current health care system is simply not sufficient to deal with the tremendous need. Here again, access appears to be a problem, as is tracking clients who use several sources of health care and who migrate.

The limited number of child care and pre-K programs is a problem, as is limited school capacity, which particularly affects migrant students who arrive after the start of the school year.

Other gaps in services include housing, transportation, and difficulty in recruiting providers, especially bilingual and bicultural staff.

SUMMARY

State initiatives such as the Glades Interagency Network can be very helpful in facilitating the integration of services. On the other hand, efforts to integrate services are sometimes hindered by bureaucratic decisions beyond the control of service providers. Collaboration between growers and service providers works well in this community in promoting service integration. Finally, the increasing number of migrant parents that have themselves been served by migrant programs has resulted in stronger advocacy for migrant children.

BELLE GLADE EXHIBIT 1: MAJOR PROGRAMS INCLUDED IN THE SITE VISIT

Local Agency Name	Program/Funding	Services	Unique Arrangements
East Coast Migrant Head Start	Migrant Head Start	Early childhood education, outreach, adult literacy, transition to elementary school.	Co-location on grower's property, adult literacy traveling van.
Migrant Education	Migrant Education, Chapter 1	Full-year program, both in-class and pull-out, pre-K, outreach, parent advisory council.	Co-location of pre-K program on grower's property.
Brumback Health Center, Clewiston Health Center, and HIV Prevention Center	Migrant Health (Sections 329, 330, PHS); CDC	Comprehensive health and medical services, referrals to specialists.	Involvement of HIV Prevention Center provides research and community education.
Adult Migrant and Seasonal Farmworker Program and the Agricultural and Labor Program, Inc. (ALPI)	JTPA, Title IV, Section 402	Counseling and evaluation, basic skills training, ESL, GED, job readiness, job skills training, financial aid, energy assistance, health and nutrition education, information and referral to social services.	ALPI was founded by migrant farmworkers and supported by Coca-Cola. Agreement with local community college for education and ECMHSP for practical training placement.

BELLE GLADE EXHIBIT 2: CONFIGURATION OF SERVICES AVAILABLE TO MIGRANT CHILDREN

Preschool Child

Program	East Coast Migrant Head Start	Migrant Education, Pre-K Program	Migrant Health	Social Services
Services	Early childhood education, outreach, referrals to social services, adult literacy, transition to elementary school.	Early childhood education, outreach, referral to social services, transition to elementary school.	Clinic services, physicals, lead and dental screening, immunizations.	WIC, Food Stamps.

Elementary and Middle School Child

Program	Migrant Education	Migrant Health	Social Service
Services	Full-year program, both in-class and pull-out, outreach, parent advisory council.	Clinic services, physicals, lead and dental screening, immunizations.	Food Stamps.

High School Student/Young Adult

Program	Migrant Education	Adult Migrant and Seasonal Farmworker Program and Agricultural and Labor Program, Inc. (ALPI)	Migrant Health/ HIV Prevention Center	Social Services
Services	Full year program, GED, ESL, parent advisory council.	Counseling and evaluation, basic and job skills training, GED, ESL, financial aid, job readiness.	Clinic services, HIV testing and education, family planning services.	Food stamps, energy assistance.

APPENDIX F
BIBLIOGRAPHY

Appendix F

BIBLIOGRAPHY

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