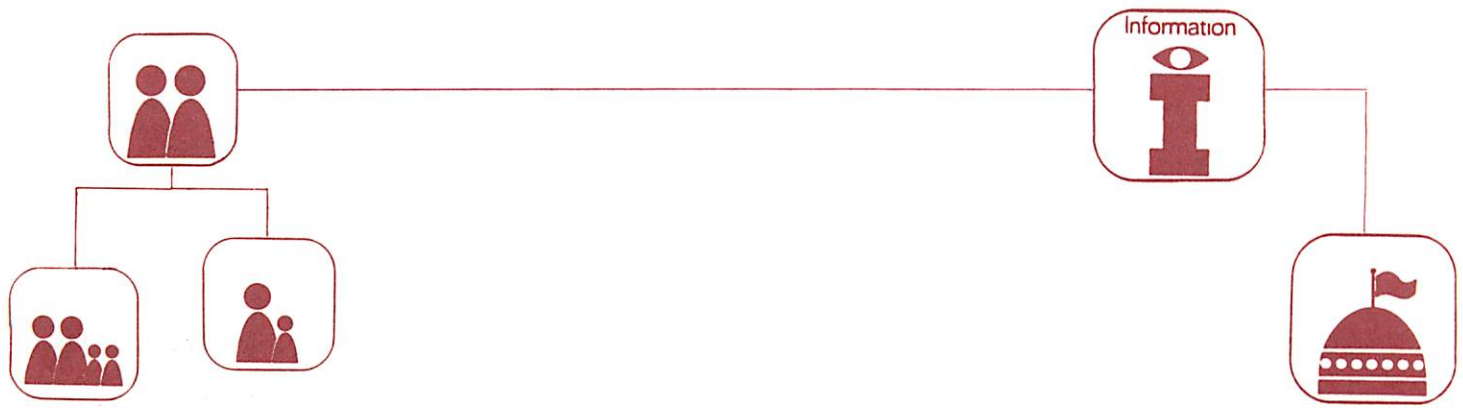


Looking Ahead: The Promise of Head Start as a Comprehensive Family Support Program

The Policy Institute for Family Impact Seminars



Family
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Seminar



Looking Ahead: The Promise of Head Start as a Comprehensive Family Support Program

February 11, 1994, Hart Senate Office Building, Rm. 902

Panelists: **Joan Lombardi**, policy consultant, Office of the Assistant Secretary for Planning and Evaluation, DHHS
Jeff Hoffman, Head Start director, Mid-Iowa Community Action (MICA)
Shirley Hamilton, project director, Family Start CCDP, Baltimore, MD
Steven Carter, male involvement specialist, Project HIM, Mercer County, NJ

Moderator: **Theodora Ooms**, director, Family Impact Seminar

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Looking Ahead: The Promise of Head Start as a Comprehensive Family Support Program

Background Briefing Report

by

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Looking Ahead: The Promise of Head Start as a Comprehensive Family Support Program

Highlights of the seminar meeting held on February 11, 1994, in the Hart Senate Office Building. (A Supplement to the Background Briefing Report.)

Theodora Ooms, director of the Family Impact Seminar, began the meeting by noting that President Clinton's proposed funding increase for Head Start, Secretary Shalala's Advisory Committee on Quality and Expansion report, and last week's reauthorization bill introduced by the Administration made this a very timely topic.

Elena Cohen, moderator, identified two critical reasons for Head Start to strengthen its family support component. First, there is growing recognition that interventions to break the cycle of poverty are not successful unless the whole family unit is targeted. Secondly, the most powerful predictors of outcomes for children are family poverty and parental education.

She added that Head Start has fallen short as a family support program. There has been considerable discussion of Head Start's long-term impacts on children, but there has been little discussion of the impact of Head Start on families and communities. The panelists were chosen to illustrate the potential of Head Start to be a comprehensive family support program.

Joan Lombardi, policy consultant with the Office of the Assistant Secretary for Planning and Evaluation, the Administration for Children and Families, opened with a description of the paradox of Head Start's family support component. On the one hand, Head Start set what is now known as the family support agenda by working with, and in support of, families. Even before the details of the parent involvement component were spelled out, Head Start founders believed in providing services to children and families in an integrated way. As a result, since its inception, Head Start has included health and social services and parent involvement as an integral part of the early education program. Head Start parents have always been involved as decisionmakers in parent education activities and in helping advocate for children. Approximately one-third of Head Start staff are current or former parents of children enrolled in Head Start.

On the other hand, in spite of Head Start's success in parent involvement, most of the major Head Start reports (see DHHS, 1980; NHSA, 1990; and Advisory Committee on Head Start Quality and Expansion, 1993) have recognized that Head Start confronts many challenges in responding to family needs, especially today.

The Advisory Committee report includes the following overall findings on ways Head Start works with families:

- (1) Head Start has been not been able to respond to the changing needs of its families, due in part to large caseloads and the lack of sufficient staff training and support.
- (2) In the past, additional funding has been used to serve more children. There is a need for the same level of commitment to support the family service component.
- (3) Head Start programs must be allowed to respond better to critical family needs. For example, it is estimated that 55 percent of Head Start families are on AFDC, but few Head Start programs are offered full day or operate the whole year.
- (4) Head Start must focus future parent involvement activities on fathers as well as mothers.

Lombardi ended her presentation with a quote from a Head Start parent: "I thought it was a bunch of bull that bureaucrats would let us make the decisions. Low-income people, no way. We've always been herded through the system by their rules, rules made by people we didn't know. After all, they have never lived as I have. Yes Virginia, there is a Santa Claus and Head Start truly works."

The second panelist, **Jeff Hoffman**, is the director of Head Start programs and the Head Start/Public School Transition Project for Mid-Iowa Community Action (MICA) (see p. 26). This project has a strong emphasis on family support and a staff which is specially trained to provide these support services. He began by describing the story of a child enrolled in their Head Start Transition project. The mother and "significant other" in the mother's life were reported for child abuse and they were both arrested for child endangerment. Although this was not a totally atypical situation, the program's response and outcomes were different. The family development specialist on staff was able to mobilize services for the mother and the children and become a support for the whole family. For example, a mental health and a substance abuse evaluation were done very quickly, there was no "passing of the buck" among agencies and as the crisis abated, the family development specialist was able to offer more time for supportive services to help the family.

Hoffman indicated that this case exemplifies several critical issues in the implementation of a comprehensive family support program. The family development specialist is a well-trained professional and former Head Start parent; she has a small caseload that allows her to respond to crisis of this family and still respond to the other families in her caseload. In addition, this case demonstrates that the challenges confronted by Head Start families are not resolved in a typical nine-month period. Being a part of the transition program allowed this family to continue receiving services.

Hoffman described the following principles underlying the competency-based certification and training process for family development specialists:

- (1) The family is conceptualized as a system. That is, all its members are constantly interacting with each other and influencing one another.
- (2) The professionals' interactions should maximize family's growth;
- (3) Family development specialists focus on assessment in ten life areas (shelter, nutrition, health care, alcohol/drug abuse, employment, adult education, parenting, and family relations). Within these areas there is a range of well-being, from at risk to thriving.
- (4) The family development specialist and the family jointly determine the best course of action for the family, strategies and plans to achieve the goals are made, the family is referred to other services, and follow-ups are made to determine effectiveness.

The seven areas for the training of family development specialists are as follows.

- Mapping the terrain, (foundation and background, family structure and dynamics).
- Becoming an ally (structure of the helping process, family relationships).
- Assessing of families (ongoing process, linkages with community and history of family, social environment).
- Naming the pain (toxic issues, triggers of emotions).
- Envisioning, (assisting families in setting behavioral objectives, possibilities for solutions, problem solving).
- Claiming the power (assertiveness and negotiating skills, self-esteem).
- Saying goodbye (terminating the relationship and process).

Hoffman emphasized that Head Start Transition Projects provide an expanded window of opportunity to serve families. The continuity that is available through these projects is crucial to the long-term success of Head Start families. For Head Start to be successful, he recommends that they have smaller caseloads, that they provide competency-based training to the social services staff, and that Head Start views itself as a family program.

The third panelist, **Shirley Hamilton**, is the director of Family Start, a Comprehensive Child Development Program (CCDP) operating under Friends of the Family in Baltimore, Maryland. This project (see p. 13) focuses on 120 families with children 0 to 5 years of age and provides a variety of services, such as home visits and case management interventions.

Hamilton indicated that even though each of the 12 family advocates works with no more than 10 families, they still have large caseloads because they work with every member of the household (there are about 175 children under age 5 in the program). Family advocates visit each family weekly to design an individualized case management plan, which includes services for all members of the family, and review progress in the attainment of the family goals. During these home visits, developmentally appropriate educational experiences are provided for the children that are in the home.

Family Start has several specialists on staff, including a mental health specialist (to work with families with emotional problems); two child development specialists (to conduct screening and assessments with children) who work with other Head Start programs and with agencies that provide services to children with developmental delays; an economic development specialist to assist participants with education, employment, and training; and a health specialist who links families with health care providers.

According to Hamilton, this program assists family members in using existing community resources. Support services such as transportation and child care are provided to family members that are working or in training. In addition, family advocates foster the family involvement in the program, making special efforts to encourage fathers to play a more significant role in their children's development.

Based on the experience of the Family Start program, Hamilton made some recommendations to increase the impact of Head Start programs on the families they serve.

- Make better use of existing community resources by forming partnerships with other programs which work with similar families and child age groups.
- Involve more men and have them work in all components, especially with the children.

- Provide services for younger children.
- Look at staff qualifications to make sure they have specialized training to work with this population and with very young children.
- Work with child care providers to develop wrap-around services.
- Contract with programs already established to serve children birth to three years of age.
- Continue requiring parent involvement.
- Employ more parents.
- Work more with entire family.

The last panelist was **Steven Carter**, a male involvement specialist with Project Head Start 7Involving Males (HIM) in Trenton, New Jersey (see p. 2). He indicated that Head Start programs are predominantly staffed by women and, as a consequence, there is a lack of good male role models for the children attending the program. Project HIM, one of the six Male Involvement Projects funded by the Head Start Bureau, is designed as a comprehensive program focusing on the involvement of males (fathers, grandfathers, uncles, and other significant men in the lives of the children enrolled in Head Start) in the program.

Carter indicated that the interventions of the HIM program are geared to help fathers/males:

- Build self-esteem.
- Understand child development.
- Understand legal rights.
- Plan parenthood.
- Encourage continuing education.
- Provide crisis intervention when needed.
- Respond to health concerns (including mental health and substance abuse).

At first it was difficult to get men to attend meetings, so the staff decided to change the design of the program. They had a meeting and asked both fathers and mothers what would be most helpful. Some of suggestions included: calling meetings "*infoshops*" and not workshops (because this work has negative meanings); informing mothers about the program (so they would not feel men were "invading" their territory); design some infoshops only for men, others for women, and others for couples. Men indicated that they would like to have the opportunities to learn about different issues related to child rearing and to their own professional development and employment.

Carter said that responding to the felt needs of the whole family made the activities more relevant to fathers, gave them a sense of purpose and got them interested in participating classroom activities. Since about half of the men are unemployed, the Center was able to use their skills in many of the operations.

Approximately 119 fathers participated in the different activities in the first year of the program. The number rose to 175 in the second year. Project HIM has also designed some activities to follow up with men who have been participants but whose children have the Head Start program and go to other schools. These activities include periodic calls, a newsletter, and case management for those that are involved in different interventions.

Based on Project HIM's positive impacts on the whole family, Carter recommends that other Head Start programs develop these types of interventions that address the needs of fathers of children enrolled in their programs.

Points made during the discussion period

- A participant from the Office of Child Support Enforcement asked about interventions that effectively encourage child support payments.

Carter stated that HIM has several interventions designed to advocate for fathers and encourage those that are behind on child support to catch up with their payments. For example, they accompany fathers to court for scheduled hearings and they have monthly support groups for those that are way behind in child support. In addition, the child support issue is discussed with the two parents by bringing in the mother and opening the channels of communication between the parents.

- Another participant asked Carter about outreach and identification strategies.

Carter indicated that Head Start gets the information about men in the family (either fathers or any male providing nurturing to the child on a daily basis) during the initial interview.

- A staff person from ACYF asked about continuity of services when children move out of Head Start into other programs.

Hamilton responded that Family Start (like all CCDPs) serves children age birth to five and follows the children as they enter school. Hoffman indicated that as a result of some Transition Projects, elementary schools are beginning to recognize value of providing family support services and are beginning to fund family resource centers linked to the school.

Lombardi described the Head Start Transition Projects that started in 1990 with \$20 million funding to develop strategies to follow Head Start kids the school (see p. 5).

- A staff person from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reiterated the need for continuity of services but asked about funding to maintain services and resources for a longer period of time.

Hamilton, Carter, and Hoffman indicated that Head Start must systematically work with outside sources to be able to provide the range of services required to meet family needs for a longer period of time. The three projects they described are focused on coordinating with existing community services. In addition, the panelists emphasized that there needs to be federal leadership so that coordinated services are institutionalized in every community.

- A member of the Congressional Research Service inquired about different models for Family Development Certification training.

Hoffman responded that the Family Development Specialist training that MICA is implementing is similar in format to the Child Development Associate (CDA) certification project. This training came out of the community action philosophy. Nationwide, over a thousand paraprofessionals have been trained (see p. 22).

- A participant asked how these projects envision the future for families and communities after they are out of the programs. For example, how do these projects conceptualize self-

sufficiency for families and is there a place for families who can function on their own, instead of staying in the support system forever?

Hoffman responded that MICA, with funds from the Annie E. Casey Foundation, is implementing the "Move the Mountain" initiative. This project, which is a five-county collaborative that includes human service and education providers, is creating the structures to have representatives of different agencies planning strategically to design a seamless delivery system with an emphasis on prevention.

Hamilton indicated that families want to be self-sufficient, but they have different levels of need. The purpose of these interventions is to move the families along the continuum with the ultimate goal of self-sufficiency.

A member of the audience indicated that we need to find another word to describe self-sufficiency, because none of us are really self-sufficient.

- Someone in the audience inquired about the current educational legislation and its implications for Head Start.

Lombardi responded that Head Start has to link with the educational reform movement. She indicated that there is specific language in the Head Start and education bills that refers to the need for linkages. The same things will eventually happen in the health and welfare reform bills.

- A participant asked how programs such as MICA and HIM can become the norm instead of the exception.

Lombardi indicated that there is a need to make "every Head Start program like these demonstrations." This means lowering caseloads, training more family support workers, and finding new ways of involving parents. Lombardi believes this to be the thrust of the current administration.

- Another member of the audience asked about measures of success.

Hamilton indicated that CCDPs use very concrete measures of success, for example, adults finishing training, getting a job, or moving to a better house. Carter responded that Project HIM has found that children have higher attendance rates and self-esteem. In addition, in an evaluation of their program, Project HIM found that there is a lower rate of arrest for fathers in the program, compared with other Head Start programs. (Carter indicated that among the fathers currently enrolled, none is in trouble with the law.) In addition, fathers have a better understanding of their rights.

- A participant questioned how to disseminate information from these programs to all Head Start programs.
- A staff person from the Head Start Bureau indicated that there will be opportunities for sharing this information in a meeting of all Head Start family support demonstration to be held in March 1994.

Looking Ahead: The Promise of Head Start as a Family Support Program

Background Briefing Report

INTRODUCTION

Throughout its 28-year history, Head Start's popularity has bounced from positive to negative and back again. In the last few years, it has been praised by Democrats and Republicans as the premier example of an effective and highly popular federal anti-poverty program. Interest in Head Start is at an all-time high; it received a \$550 million funding increase for FY '94 and President Clinton is requesting further increases for FY '95. In addition, it is scheduled for reauthorization this year.

Recently, many criticisms have surfaced about its quality and effectiveness. The truth is that these criticisms were voiced before in a number of studies that, while reaffirming the program's value, identified some management and quality problems. As a result, early last summer, Secretary of Health and Human Services Donna Shalala appointed a bipartisan commission to conduct an in-depth review of the program and advise her on how best to fulfill this Administration's commitment to expand Head Start while strengthening and improving its effectiveness. The Committee's report was released a few weeks ago.

Contrary to the popular image frozen in people's minds---a half-day, center-based, preschool experience---Head Start programs are quite diverse. Although the *typical* Head Start child is four years old and attends a half-day program for one year, many grantees are funded to provide other models, including the home-based Home Start programs, the Parent and Child Centers (from birth to three years), and the Transition Projects (for 5-7 year olds). Some Head Start programs provide full-day child care services and others are funded as Family Services Centers to provide intensive substance abuse prevention, literacy, and employment services to families.

Head Start's original intent was to boost low-income preschool children's learning and social competence in order to increase their school achievement in later years. Indeed, its strong support has largely rested on its reputation for improving child outcomes. What is not well understood is that for over two decades, Head Start has served as a national laboratory for the development and testing of innovative, early childhood programs and, increasingly, family support programs. Thus, its potential for improving broader family, and even community, outcomes has not been widely appreciated.

Head Start is at the forefront of the national agenda because of its potential to contribute to several national policy priorities:

- The goal embraced at the executive, legislative, and state level, as well as by the U.S. business community, that by the year 2000 all children in America must start school ready to learn;
- The national challenge to respond to the needs of contemporary families in communities plagued with problems such as violence, substance abuse, homelessness, and teenage pregnancy;

- The welfare reform efforts included in the Family Support Act (FSA), and its centerpiece the Job Opportunities and Basic Skills (JOBS), and other programs designed to help families attain economic self-sufficiency while providing high-quality child care and parenting education;
- Current national efforts (demonstrated in Vice President Gore's National Performance Review initiative) to develop a less categorical and more consumer-friendly and integrated system of service delivery.

Many national experts agree that to improve its effectiveness, Head Start must: (a) improve the quality of its services; (b) expand and improve its family support focus to respond better to the needs of contemporary families and communities; and (c) coordinate with other early childhood and related federal, state, and local programs to be able to provide a more coordinated and effective system of services to families.

This seminar and briefing report, the first in the series on Head Start, will present a historical overview of Head Start's efforts to provide a comprehensive range of services to low-income families. It will then describe some Head Start programs that exemplify its potential as a family support program. The programs described are not the result of a systematic, evaluative, or comprehensive survey, but an attempt to identify some of the strategies used by local programs to serve families in more effective ways. Part III of this briefing report provides a description of the major concerns and issues Head Start has confronted during the last decade, and the recommendations of Secretary Shalala's Advisory Committee relevant to each of the issues. The final section provides some recommendations that need to be taken into account in the reauthorization of the program and the implementation of the Committee's recommendations.

A second seminar and briefing report are planned to provide an overview of the challenges Head Start faces to provide more integrated services to the families they serve and coordinate more effectively with other programs. This seminar will describe several new Head Start initiatives that focus on achieving better linkages between federal, state, and local programs and some of the barriers to implementing these linkages.

PART I. SETTING THE CONTEXT

(Sources: Advisory Committee, 1994; Bolce, 1991; Collins, 1990; Pande, 1993; Silver Ribbon Panel Report, 1990; Slaughter, *et al.*, 1988; Stewart and Robinson, 1990; Washington, 1985; Zigler and Muenchow, 1992; Zigler and Styfco, 1993)

Background and Description of the Head Start Program

Brief History. Launched in 1965 as part of President Johnson's War on Poverty, Head Start began as an eight-week summer child development program for low-income 4-5 year old children and their families. (By 1982, however, the program had expanded to serve children throughout the school year.) Originally administered out of the Office for Economic Opportunity, Head Start was transferred to the Office of Child Development in the U.S. Department of Health, Education and Welfare in 1969. The program is now administered by the Head Start Bureau within the Administration on Children, Youth and Families, Department of Health and Human Services. The Washington, DC, office is located at 330 C Street SW. The telephone number is (202) 205-8572.

During the 1970s and early 1980s, Head Start experienced alternating periods of favor and disfavor among policymakers, reflected in the levels of appropriations. In the early 1970s, it succeeded in warding off termination threats but barely managed to sustain its funding level. Amendments to the program in 1978 required that all Head Start programs operate in accordance with a set of

comprehensive performance standards. Attempts over the next few years to move its administration to the Department of Education were defeated by advocates who feared the program's comprehensive nature would be compromised by the more narrowly focused education establishment.

By the early 1980s, the program had gained substantially broad popular support and politicians in both political parties were vying with each other to prove who was the best friend of Head Start. Since its benefits were now widely accepted, calls mounted to expand the program so that it could serve a greater proportion of---if not all---eligible children. The first significant expansion since its inception was enacted in the Human Services Reauthorization Act of 1990 (P.L. 101-501). This bill authorized sufficient funds to allow all eligible three and four year olds and 30 percent of five year olds (not in kindergarten) to receive Head Start services by 1994. Authorization was increased by \$1 billion to \$2.38 billion for fiscal year 1991; for 1992 through 1994, the amounts are \$4.27, \$5.92, and \$7.66 billion. However, actual appropriations for 1991, 1992, and 1993 fell far below these amounts. Nevertheless, in 1990 Head Start added nearly 90,000 students, bringing the total up to almost 541,000. Enrollment reached 721,000 in 1993.

The 1990 legislation included funds set aside for quality improvements. Ten percent of the total appropriation in the first year and 25 percent of the increase after inflation in succeeding years was to be used for improving quality. Half of the set-aside was reserved for increased salaries and benefits. Funds were also marked for training, technical assistance, facility improvements, and transportation. The Act also established the Head Start Transition Project, expanded the Parent and Child Center programs, and required each Head Start classroom to have at least one teacher with a Child Development Associate credential by 1994. (These are discussed in more detail below.) It also included authorization for a major longitudinal study of Head Start. This study has yet to be launched. In 1992, additional amending legislation was passed. The Head Start Improvement Act authorized for the first time that the funds could be used by Head Start grantees to purchase facilities.

Head Start is once again scheduled for reauthorization in 1994. Several Republican bills have already been introduced, including S. 670, the Head Start Quality Improvement Act, by Senator Kassebaum and its House companion bill, H.R. 1528 by Representative Goodling. The Administration is expected to introduce a reauthorization bill within the next few months, and it will undoubtedly draw heavily on the recommendations of Secretary Donna Shalala's Advisory Committee on Head Start Expansion and Quality Improvement.

Goals. From its inception, Head Start's primary aim was to boost the children's social competence in order to improve their school achievement in later years. "Social competence means everyday effectiveness in dealing with both the present environment and later responsibilities in school and life" (Advisory Committee Report, 1994: 2). To help break the cycle of poverty, Head Start was also designed to provide preschool children with a wide range of comprehensive services to meet their emotional, social, health, nutritional, and psychological needs. The program also included a strong component of community and parent participation.

Organization. Structurally, Head Start is a federal program of direct grants to community-level entities, known as grantees, who may subcontract with delegate agencies to run the programs. In 1993, Head Start served approximately 721,000 children and their families through a network of more than 2,000 grantees and delegate agencies operating some 36,300 classrooms and nearly 600 home-based programs. Grants are awarded by the U.S. Department of Health and Human Services (HHS) regional offices, except for the American Indian and Migrant programs which are administered from Washington, DC. Initial grant applications are awarded on a competitive basis, but then renewed annually upon submission of a reapplication.

Head Start programs are sponsored by a variety of community-based agencies, which include community action agencies (35.4 percent), private nonprofit organizations (31.5 percent), school systems (18.8 percent), state and local governments (5.5 percent), and Indian Tribes (5.3 percent).

Most programs are center based and operate four to five days a week or less and under six hours per day. However, a variety of other models exist (see below, p. 5).

Eligibility. Current regulations require that 90 percent of the enrolled families' income should be below the federal poverty level---which is currently \$14,800 for a family of four---with the lowest income given preference. In 1993, 68 percent of Head Start families had incomes of less than \$9,000 per year and 84 percent have yearly incomes of less than \$12,000.

Although policies allow ten percent of the Head Start children to come from families above poverty, only five percent of current enrollees do. Ten percent of the slots must be available for the children with disabilities. Once enrolled, the child may continue in the program even if the family's income changes.

Despite expansion in the past few years, Head Start only serves approximately 40 percent of the 1.8 million eligible three and four year olds, (21 percent of eligible three year olds, and 53 percent of the eligible four year olds). However, due to differences in eligibility requirements and duplications counts across surveys, there is no adequate accounting of how many of these Head Start eligible children attend other child development or child care programs, nor how many are cared for in family-based day care homes (Advisory Committee Report, 1994).

Characteristics of the children and families served

In 1993, 13 percent of the children served in Head Start had diagnosed disabilities. Enrollment peaked in 1966 (733,000) and then dropped in half by the late seventies, but since the early eighties has been rising steadily. Currently, the majority of enrolled children are four years old (63 percent), followed by 27 percent who are three years, seven percent who are five, and three percent under three years old. In terms of race and ethnic distribution, 37 percent of the children are black, 33 percent white, 23 percent Hispanic, four percent American Indian, and three percent Asian.

The majority of Head Start children reside in single-parent homes (55 percent), but 41 percent come from two-parent households, one percent reside in foster care, and three percent live in other arrangements. Nearly half of the families receive AFDC, although a growing number are working or in training. Thirty-three percent of children in Head Start have at least one parent who works full time, another fifteen percent have parents who work part-time or seasonally, and five percent of the parents are in school or training. Almost half of the children live in central cities, nearly one-quarter in rural areas.

Funding and costs

Funds for Head Start have increased dramatically over the past few years, although costs per child have remained relatively stable in constant dollars. Federal support for Head Start rose from \$1.235 billion in FY '89 to \$2.756 billion in FY '93, the largest increase in any four-year period in the program's history. The FY '94 budget is more than \$3.3 billion. The average cost per child in terms of federal expenditures is about \$3,800, only slightly higher in terms of constant dollars than those spent per child in 1980.

The Head Start legislation states that the federal grant to operate a local Head Start program shall not exceed 80 percent of the approved costs. The nonfederal share of matching funds may be provided in cash or contributed services.

Program Design and Key Components

Contrary to the popular view, Head Start programs are quite diverse. "Head Start is not, in any simple sense, a uniform treatment. The common denominator of the Head Start programs nationwide is a conformity to a set of regulatory performance standards that reflect comprehensive service requirements in education, parent involvement, social services and health services" (Silver Ribbon Panel Report, 1990, p. 4).

Program Options. Many program variants have evolved from the original Head Start design. While the typical Head Start child is still usually four years old and participates in a half-day program for one year prior to kindergarten, grantees are allowed, and often encouraged, to choose from a variety of program options. These options include both center-based and home-based services ranging from a full-day, full-week schedule to a part-day, part-week schedule or weekly home visit.

The design of an individual program is determined through negotiation with regional office staff during the grant application and review process. These negotiations are the principal vehicles through which any particular federal administration exercises its own policy priorities and preferences in the Head Start program.

The basic program is a **center-based** classroom primarily serving children aged three to five. Most children attend a half-day session for a school year, although some participate for two years. Full-day programs are delivered at some locations. Head Start mandates that every family participating in a center-based program receive at least two home visits per year by a teacher.

For more than two decades, Head Start has served as a national laboratory for the development and testing of innovative early childhood and family support programs. These include the Home-Based programs, Parent and Child Centers, and Comprehensive Child Development Centers.

- **Project Home Start**, now referred to as the Home-Based option, was begun initially as a three-year demonstration project in 1972. The Home-Based option offers the same services and activities, but in a home rather than a center. Visits typically take place twice a month and last about 90 minutes each. In 1993, there were about 612 home-based programs serving approximately 49,442 children. Home-Based programs are especially common in rural areas where families have restricted access to transportation. Some grantees offer both center-based and home-based activities.
- In 1967, just two years after the program began, the first **Parent and Child Centers (PCCs)** were opened to offer supportive services and parent education to families and children from birth to age three. PCCs were developed as preventive (rather than remedial) in focus, aiming to reach disadvantaged families of very young children before the negative effects of poverty and neglect had taken hold. PCCs were the first programs in the nation to combine the elements of child advocacy, community orientation, and family support. There are currently 106 PCCs in operation.
- Head Start also began to test ways to serve older children and sustain the effects of its efforts. **Project Follow Through**, instituted in 1967, was designed to be a large-scale service delivery program which continued comprehensive programming to extend Head Start services into kindergarten through third grade. However, it never became a national program and is currently operational in only about 40 schools where it operates mainly as a program that demonstrates innovative curricula (Pande, 1993; Zigler and Muenchow, 1992).
- **Head Start Transition Projects.** In 1990, the Human Services Reauthorization Act, which included the reauthorization of the Head Start Act, enacted a number of expansions and improvements in the Head Start program, including launching a new demonstration program, the Head Start Transition Project. This project is designed to provide follow-up supportive activities

to Head Start graduates and other low-income children in kindergarten and the early grades in an attempt to sustain the benefits of participation in Head Start. \$20 million is currently awarded to partnerships formed at the county or city level between Head Start grantees and public school systems in 32 states and the Navaho Nation. A national evaluation of this project by Civitan International Research Center, University of Alabama, will examine the nature, extent, and duration of the gains achieved by participating children and families. Its initial report is currently in preparation.

- In addition, four other newly launched demonstration programs focus specifically on providing more comprehensive family support and family development services. They are the **Child and Family Resource Programs, Comprehensive Child Development Programs, Family Service Centers, and Head Start Male Involvement Projects**. These programs will be described in more detail in Part II.

Performance Standards: Comprehensive Services

The regulations and guidance documents require Head Start grantees to provide comprehensive services in the following broad areas, with specific performance standards spelled out in each area. Each grantee and delegate agency must develop a plan to implement these standards. The plans must be reviewed annually by each program's Policy Council.

Health services. These services include medical immunizations, examinations and referrals (including mental health services), dental services and other preventive health services, and parent health education. Programs are encouraged to reach out for other sources of funding for these services, such as the Medicaid program, and to fund nutritious meals through the federal Child Care Food Program.

Education services. These services include providing children with a learning environment and varied experiences to help them develop socially, intellectually, physically, and emotionally in a manner appropriate to their stage of development and to promote their social competence. Parents are provided with education services related to improving their knowledge of child development and improving their parenting skills.

Social services. Social workers conduct outreach activities to recruit eligible children and families to enroll in Head Start, including children with disabilities. They encourage parent participation in the program and work with families to assess their needs for social services and then refer them to appropriate resources to obtain such services.

Parent involvement. The parent involvement component of Head Start is a unique and important feature of the program. It originally aroused some controversy as the planners and activists debated whether parents were to run the program or simply be participants in its parent education services (Zigler and Muenchow, 1992). By 1970, under the leadership of the director of the new Office of Child Development, Dr. Edward Zigler, the concept of parent involvement had been fleshed out in various guidance documents and regulations to include their "maximum feasible participation" in four different types of activities.

- **Parent empowerment activities.** Parents are elected to serve on advisory committees and policy councils. (A minimum of 50 percent of the members of these bodies must be parent representatives.) In this capacity, parents help to establish program priorities, policies, and procedures.

- **Parent education activities.** As indicated, specific education activities offered either in the center or in the home provide parents with information about child development and enhance parenting

skills. In addition, parents are strongly encouraged to participate in the classroom as volunteers. This volunteering not only helps bring additional resources into the classroom, but also helps teach parents a great deal about child development and how to work with, and relate to, preschool children.

- *Training and a career ladder.* Since its inception, several thousand parents have gained paid professional positions working in the programs. Parents are hired as teacher aides and provided with inservice training. Parents of current or former Head Start children comprise about 36 percent of all paid employees. Through acquiring the Child Development Associate training and credential (see p. 9), the program offers parents a career ladder with considerable employment potential in the child care and early childhood field.

- *Parent services.* The program's basic social services component provides direct services to parents through assessment of some of their individual and family problems, such as poor housing or substance abuse. Demonstration programs such as the Family Service Centers and Comprehensive Child Development Centers extend and strengthen this emphasis and provide more intensive and a wider range of services. (See Part II for more detail.)

Monitoring and compliance

Regional Head Start Bureau staff monitor the grantees and delegate agencies for compliance with the performance standards. Regional staff are generalists and have no special health, mental health, or social service expertise. The role of staff in the national office is to provide leadership to the regions through guidance documents and to directly manage the special initiatives and demonstration programs described below.

From the early eighties until quite recently, regional staffing shortages and lack of travel monies seriously constrained regular monitoring of programs. Although regions differ somewhat, when on-site reviews did occur, they generally focused only on the problem grantees. Otherwise, regional staff tended to rely on the self reports sent in by the programs, including the annual Program Information Reports (PIRs) and the occasional use of the Self-Assessment Validation Instruments (SAVI).

In 1990, The Administration on Children, Youth and Families (ACYF) estimated that only about 20 percent of the programs were monitored on site that year. An intensive effort was made to catch up and resume routine on-site visits. By the end of 1993, all grantees in existence before October 1, 1990, had been monitored within the previous three years.

The 1992 Head Start Improvement Act greatly strengthened the monitoring process and procedures. It requires that all programs funded for the first time receive a comprehensive on-site review at the end of the first year and every three years thereafter. The purpose of these monitoring reviews are three-fold:

- To assure that Head Start grantees are in compliance with regulations;
- To provide technical assistance to strengthen program management and service delivery;
- To identify issues that require follow-up technical assistance.

The 1992 law requires that each review be conducted by at least a three-person team led by a federal official, but may include others such as other Head Start program staff and private sector consultants with special expertise who are familiar with Head Start. The on-site reviews are to be conducted over three to four days and must review all components of the program. Members of the team conduct interviews with staff, parents, and others, observe program operations, and review records. They must meet with the grantee's Policy Council (at least 50 percent of which are parents) and the Health Services Advisory Committee, and must share their findings with key program representatives at the end of their visit and then later in a written report.

All team members must conduct the review using the standard On-Site Program Review Instrument (OSPRI) that is based on Head Start regulations.

Under the leadership of the new ACYF Commissioner, Olivia Golden, the Head Start Bureau Associate Commissioner, Helen Taylor, and staff are undertaking a reassessment of their monitoring efforts and resources in light of the Administration's renewed commitment to improve the quality of the Head Start programs. The recommendations of the Advisory Committee on Head Start Quality and Expansion, published in its January 1994 report, are expected to be helpful in this reassessment (see p. 16).

Training and Technical Assistance

The Head Start program's training and technical assistance system is already undergoing a major transition as the program strives to improve quality by assuring that Head Start program managers and staff have the skills and training needed to do their jobs well (*National Head Start Bulletin*, 1993). The existing Training and Technical Assistance Network is being reorganized, expanded, and strengthened in 1993-94 and will comprise four main components.

(i) **Sixteen Technical Assistance Support Centers (TASCs)**, managed on a day-to-day basis by a Regional Office TASC coordinator, will engage in the following tasks and activities:

- Identify and train a pool of 75 locally based consultants through the TASC service area who will have the expertise to assist grantees in each of the four component areas;
- Provide intensive, on-site technical assistance to grantees who have special needs, initiatives, or problems, with a special focus on helping them meet the Program Performance Standards;
- Assist the regional office in planning and implementing two conferences annually for grantees;
- Provide an annual orientation conference for new grantees, directors, and component coordinators;
- Assist grantees in planning and managing their own training/technical assistance (T/TA);
- Provide opportunities for grantees and consultants to learn about the work of the National Training Centers and the guides the centers will produce;
- Provide assistance to grantees in meeting the Child Development Associate requirements.

(ii) **Head Start National Training Contracts.** Five National Training Contracts have been awarded to develop and disseminate high quality, skill-based training guides which fully address the Program Performance Standards. The contracts address the four Head Start components, plus the area of services to children with disabilities. A sixth National Training Contract on management and a seventh on transitional issues was awarded in July 1994.

(iii) **Resource Access Projects (RAPs).** The RAPs are the primary vehicle for providing Head Start grantees with training and technical assistance to enable them to fully include children with disabilities and their families. (American Indian and Migrant grantees, however, receive the T/TA in the area of disabilities from their TASC.)

(iv) **Head Start Teaching Centers.** Fourteen Head Start Teaching Centers have been established to demonstrate an innovative approach for training Head Start staff. They provide on-site training in

an exemplary Head Start program based on the specific needs of each trainee. The training addresses all component areas, and in some cases will include follow-up with the trainee at the site of her/his own program. Most Teaching Centers have installed two-way windows next to the classrooms and their curricula combine teaching, practice, and observation.

The Teaching Centers spent their first year planning and piloting their programs and began full operation in September 1993.

A list of names and addresses for the individual TASCs, RAPs, Teaching Centers, and Training Contracts is available from the Head Start Bureau (see National Head Start Bulletin, 1993).

The Child Development Associate National Credentialing Program

The 1990 Reauthorization Act requires that by September 30, 1994, each Head Start classroom in a center-based program have a qualified teacher who, at a minimum, has a Child Development Associate (CDA) credential to serve children ages three to five. The CDA program is administered by the Council for Early Childhood Professional Recognition (CECPR). The CECPR is based in Washington, DC, and operates under a cooperative agreement with the Administration for Children, Youth and Families (ACYF). The CDA credential is awarded based on the ability of a candidate to meet the standards of good child care practice established by a federal task force of early childhood experts. There are two ways to become a CDA, either through direct assessment on the job, or through a one-year professional preparation program for candidates with little prior early childhood work experience. (CECPR, 1341 G St. NW, Suite 400, Washington, DC 20005. 202-265-9090.)

National Head Start Association (NHSA)

The program emphasis on parent involvement led to parents playing a strong role in the National Head Start Association almost from the beginning. In 1973, the Head Start directors formed a national association and admitted parents and staff as members the following year. By 1976, the NHSA was composed of four groups---parents, directors, staff, and "friends" of Head Start, with parents representing the largest component (Zigler and Muenchow, 1992). The NHSA embodies, according to Zigler and Muenchow, both the parent education and parent empowerment components of "maximum feasible parent participation" and it does so in a manner that is even palatable to conservative politicians such as Senators Orrin Hatch of Utah and Jeremiah Denton of Alabama. Developing increasingly sophisticated lobbying techniques, the NHSA made itself a force to be reckoned with in the U.S. Congress. "Once the most controversial aspect of Head Start, parent involvement became the policy that made the program most politically viable" (p. 122).

NHSA is governed by a 24-member Board of Directors which is composed of equal numbers of representatives of the NHS Parents', Directors', Staff, and Friends' Associations. Its mission is to nurture and advocate for children and families; provide the Head Start community the opportunity to express concerns; define strategies to address pertinent issues affecting Head Start; serve as an advocate for Head Start; provide training and professional development opportunities for the Head Start community; and develop a networking system with other organizations. Major activities of the NHSA include education and advocacy, quarterly publications, regular policy and legislative updates to affiliate organizations, and an annual training conference.

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Results of Head Start

From its earliest days, the Head Start program has been embroiled in controversy about its effectiveness. The accumulation of anecdotal evidence about the program's positive benefits for children and parents led to ever stronger support from parents, community leaders, and politicians. However, the research community has had long debates about the significance of the findings of major studies on Head Start effectiveness and the adequacy of the research measures and methods used in these studies. Dr. Zigler and others have pointed out that the outcomes measured were very narrow and there have been few studies that attempted to assess the program comprehensively.

There is clear research evidence to demonstrate short-term gains in children's cognitive skills, school readiness, and health status from participation in Head Start, but there is a general consensus that the cognitive gains are difficult to sustain in the longer run. And while studies show that involvement in Head Start clearly has had a positive impact on parent training and employment, researchers, essentially, have not studied the other impacts of involvement with Head Start on the parents or on family relationships. This issue is discussed in more detail on page 24.

Part II. HEAD START'S POTENTIAL AS A FAMILY SUPPORT PROGRAM

(Sources: Advisory Committee, 1994; Kennedy, 1993; National Commission on Children, 1991; Schorr, 1988; Smith, 1991; Smith, *et al.*, 1992; U.S. Department of Health and Human Services, 1994; Yoshikawa, undated)

Rationale for a Family Support Focus in Head Start

There is a growing consensus that interventions targeting poor children will not be successful in the long run unless the family unit is also the target of change. The accumulation of research evidence and program experience provides strong support for programs that have been dubbed "two-generation" programs, programs that provide services directed towards meeting the needs of parents and children. Two arguments underpin this conclusion. First, the most powerful predictors of children's poor cognitive and social outcomes are family poverty and low levels of maternal education (U.S. Department of Health and Human Services, 1994). Secondly, poverty is a legacy passed along from one generation to the next. Children generally do not develop well when families are denied basic supports that promote "good health, opportunities to participate in productive work and community life, and, above all, belief in a better future" (Smith, *et al.*, 1992: 5).

One of the principles underlying social programs that are effective in breaking the cycle of poverty is that the programs are comprehensive in scope and go beyond serving the needs of the children to include the family and the community. Research evidence shows that programs combining early intervention with comprehensive family support may represent a particularly powerful intervention strategy "to combat risks and strengthen protective factors for multiple childhood problems, including antisocial behavior and delinquency, child maltreatment, substance abuse, and depression" (Yoshikawa, undated).

Head Start is, and was from its conception, a comprehensive program intended to address all aspects of the children's lives---their physical and emotional health and social and intellectual development. In addition, the involvement of parents has always been emphasized and the program design recognized the importance of the social service component intended to refer families to social agencies to deal with their pressing problems of family and community violence, substance abuse, AIDS, poor housing, and other problems is more evident every day.

In practice, Head Start programs have fallen short of this potential to help meet the families' needs and support their development. Child outcomes have taken precedence over parent and family outcomes. Resources for ensuring high-quality attention to parent and family needs have been uneven and staff contact with family members has been limited to focusing on their parenting role.

Supporters of Head Start readily admit that the family service component of the program is not up to par with the program performance standards, let alone the wide array of new challenges which many Head Start families experience today. Although 95 percent of enrolled families received some type of social services through the program in 1989, the Silver Ribbon Panel warned that this is becoming the most problematic issue for local centers. A recent Office of the Inspector General report confirmed this conclusion (1993 b). More recently, the December 1993 report of the Secretary's Advisory Committee found that "the lack of adequate family service workers and specific training for social service and family support staff appear to be one of the most pressing problems in reaching families within Head Start" (p. 14).

In light of the complex problems facing low-income children, families, and communities, Head Start must build on its philosophy and lessons learned during the last 28 years, including family-centered service strategies developed during the last decade, to become a truly integrated child *and* family development program. Head Start reauthorization, the proposed expansion, and the recommendations of the Advisory Committee on Head Start Quality and Expansion offer an excellent opportunity to do so.

This next section of this report will describe recent family-centered initiatives and demonstration programs within Head Start which aim to explore and test strategies for incorporating a stronger family support focus. We begin, however, with a brief definition of what is meant by "family support."

Family Support, Resource, and Education Programs

(Sources: Allen, *et al.*, 1992; Colloquium, 1990; Kagan, *et al.*, 1987; Staton, *et al.*, 1991; Weiss and Halpern, 1991)

During the last two decades, there has been a proliferation of family resource centers, family support programs, and parent education programs. This movement is rooted in the charitable efforts to help poor families in the mid-to-late nineteenth century through friendly visitor programs and in the settlement house movement. Family support and education resurfaced in the sixties as a result of trends in research and the emergence of ecological theory in psychology, which emphasized the importance of the various nested contexts---families, neighborhoods, and society ---on children's development and well-being.

Because most of these programs have grassroots origins, they differ considerably in the scope of services they provide, the setting, funding, and organizational auspices. Many are free standing and community based. Others have been launched as part of statewide government initiatives and are situated in schools or more formal agencies. Thus, there is no precise definition of what constitutes a family support program. However, all programs which fall broadly under the umbrella of "family support and resource" programs share some core, distinctive principles and characteristics.

- They provide the chief elements of social support (information, guidance, practical assistance, and emotional and peer support) parents of every income level need, but are often unavailable today, especially for the poorest families.
- Services are provided on a voluntary basis and are available to all families in the community. They have no stringent eligibility requirements or elaborate intake procedures.

- They focus not on problems, but on enhancing child development and reinforcing family competence and strengths.
- Programs share a strong orientation towards prevention, rather than remediation or treatment.
- They may provide support to young families over a sustained period of time, or on and off for a number of years.
- They are usually easily available, often on a drop-in basis, and provided in an informal, comfortable setting. Often, program staff go to parents' homes to provide support.
- Programs are community based and tailored to respond to the culture(s) of the families living in that community.
- They involve parents in determining the design of the program and in helping provide some of the services.
- Program's principal methods to help parents are group activities for parents, home visits, and activities involving parents and children together.
- Participation in these programs is voluntary.
- Programs do not relate to the parents from a hierarchical, expert stance, but rather seek to work with parents in partnership.
- For those families who need additional, intensive services not provided by the program, the program serves as a single point of entry helping families find access to these more specialized services through referral.

One of the most important effects nationally of what has become the family support "movement" has been its influence on the design and delivery of public social services. This was highlighted at a colloquium on Public Policy and Family Support held in 1990. "As public agencies carry out mandates in the areas of welfare reform, early childhood education, teen pregnancy prevention and assistance, child health and child welfare, there is more and more willingness to promote local family support and education as key components of new strategies in these new areas" (Colloquium Report, 1990: 2).

While the philosophy of family support is gaining many adherents, there is recognition of a number of new directions in which the family support movement needs to move forward. These include:

- Training program staff to focus on helping parents with their relationships with other adults, such as their own parents or male partner.
- Emphasizing working with male family members.
- Providing support to families with teenagers, not just young children which has been their primary emphasis to date.
- Structuring developmentally appropriate child development components as part of their programs.

Emerging Emphasis on Family Support in Head Start Programs

It is not well known by the public at large that Head Start is gradually shifting its emphasis to pay more attention to meeting the needs of total families. Over the past decade, it has implemented new family-focused demonstrations and launched a variety of initiatives within the framework of its existing

demonstration authority to help local programs provide family support services as well as better address significant problems affecting the families they serve. One of the major challenges for the future is how the lessons learned from these new efforts can be more widely disseminated into the regular programs so that Head Start itself fulfills the promise of family support. Some of these family-centered programs and initiatives include the following.

The Child and Family Resource Program (CFRP) was a demonstration program started in 1973 by ACYF. Eleven programs were funded, with each program serving 80-100 low-income families with a pregnant mother and children from birth to eight years old. As a family-oriented child development program, it provided continuity through the child's early years by offering three components: (i) an infant-toddler component (prenatal to 3); (ii) Head Start (age 3-5); and (iii) a preschool linkage component (for children making the transition into elementary school). In addition, CFRP emphasized comprehensive assessment, individualized planning, and reassessment for identifying families' needs and providing services to meet these needs. CFRP families were provided with developmental services for the children and educational services for the parents. Many CFRPs provided the range of health, counseling, and other social services associated with Head Start programs.

Studies documented several positive effects after only 18 months of participation in CFRP. The results were obtained by comparing CFRP participants and control groups on five outcome domains: family circumstances, parental independence and coping ability, health, parent-child interaction, and child development. They found that:

- (i) CFRP children spent significantly more time interacting with their parents than did the control children.
- (ii) A significantly higher proportion of CFRP mothers received treatment for health problems than did control group mothers.
- (iii) CFRP mothers showed increased knowledge and utilization of community services.
- (iv) Children from families who were actively involved in the CFRP achieved higher scores on the Bayley Scales of Infant Development than children from families who were less involved and than control children.
- (v) More CFRP children had been immunized, however, *not all* CFRP children had received proper immunizations.

Despite these favorable evaluations of the CFRP by both Abt Associates and the General Accounting Office, CFRP programs were terminated in 1983. The passage of legislation enacting the Comprehensive Child Development Program in 1988, embodies certain aspects of the CFRP program.

Comprehensive Child Development Program (CCDP). Authorized by the Comprehensive Child Development Act of 1988, Part E of P.L. 200-297, the CCDP is a large-scale demonstration program designed to enhance the intellectual, social, emotional, and physical development of children from birth to their entrance into elementary school and *to provide support to parents and other family members to enable them to achieve economic and social self-sufficiency*. Supportive services provided are intensive, comprehensive, and continuous. Funding for CCDP is provided under separate legislation, but the program is administered within the Head Start Bureau.

Thirty-four projects have been funded to date (24 in FY '89 and '90 and 10 in FY '92 and '93) to provide specific core services to all members of the family. For infants and young children, these services include: infant care; child health care (including screening, immunization, and treatment); licensed child care; early childhood education that is developmentally appropriate; early intervention services for children at risk of developmental delays; and nutrition services. For parents and other adult members of the household, the CCDP provides prenatal care; parenting education (in child development, health, and nutrition); assistance in securing adequate income support, health care, nutritional assistance, and housing; mental health care; vocational training and adult education; and

substance abuse education and treatment. CCDP projects do not provide all of these services directly; rather, projects help connect families with a variety of community resources that can meet specialized family needs.

An impact evaluation of CCDP is being conducted under contract by Abt Associates. The study examines child outcomes and family outcomes, including the impact of the program on income, parent aspirations and self-esteem, family stability, and welfare dependency.

The CCDP program is intensive. The case manager caseloads are relatively small, only 1:10-12, and many family services are provided on site. Hence, this demonstration model is expensive. The family costs per year are about \$8,200 and \$2,100 per family member* (U.S. Department of Health and Human Services, 1994). (*This figure cannot be compared to Head Start costs because of different calculation formulas.)

Family Service Centers (FSC). The FSC projects have been funded since 1990. Their goal is to demonstrate how Head Start programs can more effectively address the complex problems of illiteracy, substance abuse, and unemployment, which limit the capacity of many Head Start families to work toward self-sufficiency.

Head Start Family Service Centers establish specific collaborative arrangements with community organizations and resources, such as adult literacy programs, alcohol and drug abuse prevention and treatment programs, and employment assistance and training resources. Additionally, in order to develop comprehensive approaches for working with families, FSC projects emphasize a needs assessment process that continuously incorporates new information about families and utilizes case management techniques to integrate Head Start services with services available through other local organizations collaborating in the FSC demonstration.

Substance Abuse Demonstrations. The substance abuse demonstrations address problems among Head Start families and staff. These Head Start programs are using the additional funds to conduct training to increase staff awareness of alcohol and drugs; develop identification, intervention, and referral programs for staff or Head Start family members experiencing problems related to substance abuse; and develop approaches for supporting and working with children from substance abusing families.

Family Support Projects. These twelve, three-year demonstrations (started in 1991) were funded to focus on a priority issue identified by each local community. Some of the issues addressed are: homeless families, family/community violence, and child abuse.

Head Start Family Child Care Homes. These projects provide comprehensive child development services, based on the Head Start Program Performance Standards, in family child care home settings. This demonstration will test whether comprehensive Head Start services can be provided in a family child care setting, assess the program characteristics that are necessary to ensure program effectiveness, and determine the impact on children participating in the Head Start center-based program. A national evaluation of the family child care homes will assess the impact on children participating in this demonstration, in comparison with children participating in center-based programs.

Head Start Male Involvement Demonstration Projects. These six demonstration projects (started in September 1991) are three-year grant awards to Head Start agencies for the purpose of meaningfully involving male family members in the Head Start program and for increasing their participation in the program. The males targeted are usually those who have a significant nurturing role for the child in Head Start, including fathers, grandfathers, uncles, or other men in the household. Local projects' final evaluation of these demonstration projects are due in December 1994.

Special initiatives to better meet family needs

Over the past 10 years, the Head Start Bureau has launched a number of cross-cutting initiatives designed to explore and develop new program emphases, tools, and strategies in response to noted gaps in the program or emerging needs. These initiatives are generally conducted under contract and managed by staff in the national office in Washington, DC. In some cases, a systematic plan exists for linking these initiatives with the regional staff's ongoing monitoring and technical assistance activities so that the findings are more widely incorporated. There is no such plan in other cases.

Parent Involvement Initiative. Established a Commissioner's Task Force on Parent Involvement in Head Start, which submitted a final report in 1987. An expanded conceptual framework for parent involvement, developed in 1993, was the basis for the first national Institute in August 1993.

Social Services Initiative. Established a task force that led to the development of a training manual for social services staff, as well as to the first National Social Services Training Institute which was held in August 1989.

Model Family Needs Assessment Instrument. This instrument contains four main sections (family profile, family needs survey, family goals, and the family assistance plan) and is accompanied by a user's manual. The needs assessment is used by program staff to improve support services to the whole family.

Head Start Health Initiative. Introduced in 1987, this initiative provides for a network of consultants in the areas of medicine, nursing, nutrition, dental health, and mental health. Regional consultants from the Maternal and Child Health Bureau and the U.S. Public Health Service (including the Indian Health Services) select and train professionals who serve as local consultants and visit selected Head Start agencies to assist them with the health component.

Literacy Initiative. In 1991, ACYF and Head Start began the Family Literacy Initiative which focuses on providing families access to literacy materials, supporting parents as teachers, and supporting parents as adult learners.

Substance Abuse Initiative. In 1990, the Head Start Bureau developed an initiative to address the growing needs of Head Start programs to respond to the problem of alcohol and drug abuse. The initiative addresses the needs of families at high risk for involvement in alcohol or drug abuse, or who already are abusing substances, along with the needs of Head Start staff attempting to assist these families.

Head Start/JOBS Initiative. The Administration for Children and Families (ACF) and the Office of Family Assistance have developed a joint Head Start/JOBS initiative which encourages local-level partnerships between these two programs. Goals of the initiative are to provide extended day care to Head Start children whose parents work or are in training and to provide child behavior management that addresses family needs, the child's development, and the parent's successful progress toward employment.

Survey of Head Start Family Self-Sufficiency Initiatives. A survey was initiated in FY '92 by the Head Start Bureau to obtain information on the efforts of Head Start grantees to help the families they serve to address three priority problem areas that threaten families ability to become self-sufficient: illiteracy, unemployment, and substance abuse.

Homeless Children and Their Families. In FY '92, the Head Start Bureau issued a funding guide which encouraged local Head Start programs to consider giving priority to serving homeless children and families in their plans for program expansion and to develop program designs tailored to their special needs. In an *Information Memorandum*, the Bureau provided guidance on how to work with

homeless families and outlined the perceived programmatic barriers to serving this population group. In addition, the *Memorandum* also urged local programs to consider using their "quality improvement" funds to meet any increased cost that may be associated with serving the homeless.

Head Start Family Information System (HSFIS). Head Start has contracted with Ellsworth Associates to design and pilot test a new management information system to collect family and child data. Currently, many grantees are collecting some information (using private software available), but there is no uniformity or consistency so the information cannot be used at other levels. HSFIS will capture demographic and socioeconomic data on families (such as needs assessments, income, employment status, and level of education), as well as data on the children (health histories, developmental assessments, etc.). In addition, it will be possible to gather program data such as social services provided, program attendance, and meals provided by the program. The information will be used for program and case management, research, and monitoring purposes.

The forms to collect the information are currently being developed. On February 6-8, 1994, there will be a National HSFIS Conference to obtain input to develop the HSFIS modules and train staff from 22 randomly selected sites (at least one for each region and representing different types of programs). (Contact David Baker, Ellsworth Associates, (703) 821-3090).

Lessons Learned

Some of the lessons that were learned by implementing these different programs and initiatives include the following.

Program capacity to respond to families' needs is inadequate. The range and intensity of family needs are great and social service staff are not able to respond adequately to these needs due to high caseloads and inadequate training and supervision.

Programs do not place sufficient priority on providing family support and services. The program performance standards do not specify appropriate indicators of meeting family needs. Management of projects that emphasize family services is a much more complex undertaking.

PART III. MAJOR ISSUES AND CONCERNS ABOUT HEAD START

(Chafel, 1992; NHSA, 1993; OIG, 1993 a and b; U.S. Department of Health and Human Services, 1980; Zigler, 1993; Zigler and Styfco, in press)

Note: In Part III we review and discuss concerns about four major issues that thread through all of the recent studies and debates about Head Start: expansion, quality, training, and effectiveness. We highlight those aspects that are especially significant for our report's focus on strengthening Head Start's provision of family support. At the end of each section we excerpt the relevant recommendations of the new Advisory Committee Report. Issues of coordination and collaboration with other programs and organizations will be reviewed and discussed in the second FIS seminar and briefing report planned in our series on Head Start.

While the general public has regarded Head Start to be the premier example of a successful government program, concerns about effectiveness, staff training and support, and the tough trade-offs between the need to improve quality while expanding Head Start to all eligible children have been quietly recognized, discussed, and debated within the greater Head Start community for many years. However, in the summer of 1993 these concerns attracted considerable media attention as a result of a vigorous reaction to the findings of several government and academic reports.

These reports stated that the program suffers from considerable quality problems and it has not produced the results that some of its supporters have long claimed. In addition, the program surprisingly received criticisms from one of its most eminent supporters, Edward Zigler. In a New York Times interview, he stated that in his view only about half the nation's 1,400 Head Start programs are of high quality, while about a quarter are "marginal," and the rest are so poorly run that they are doing virtually nothing to help children.

Amidst all the brouhaha, both critics and supporters of Head Start agree that the advent of a Democratic administration created "a climate to debate this [Head Start] without being accused of being against children" (Hood, 1993).

In response, in August 1993, Secretary of Health and Human Services Donna Shalala appointed a 47-member, bipartisan **Advisory Committee on Head Start Quality and Expansion** to conduct a top-to-bottom review of Head Start and recommend ways to improve quality. This committee was formed to draft recommendations that would ensure that "every Head Start center offers the comprehensive family services and high quality early childhood experience that are the core of the Head Start vision" (U.S. Department of Health and Human Services, 1993: 1).

The Advisory Committee recently released its report, *Creating a 21st Century Head Start*. This report, the result of six months of intensive study, focus groups, and other discussions, reinforced the finding that although Head Start has been successful in improving the lives of many low-income children and their families, the quality of its program is uneven across the country. In addition, the report indicates that Head Start needs to be better equipped to serve the diverse needs of families and that there continues to be a large unmet need for Head Start services. The report includes a set of recommendations to the federal government, Head Start providers, and the nation at large. These recommendations build on three broad principles:

1. "We must ensure that every Head Start program can deliver on Head Start's vision by **striving for excellence** in serving both children and families;
2. We must expand the number of children served and the scope of services provided in a way that is **more responsive to the needs of children and families**;
3. We must encourage Head Start to forge **partnerships** with key community and state institutions and programs in early childhood, family support, health, education, and mental health, and we must ensure that these partnerships are constantly renewed and recrafted to fit changes in families, communities, and state and national policies" (Advisory Committee, 1994: vi).

EXPANSION

(Sources: Advisory Committee, 1994; Besharov, 1994; NHSA, 1993; OIG, 1993 a and b; Zigler, 1993)

Head Start currently serves about 40 percent of the children and families eligible for the program. Given the general consensus about the significant benefits of Head Start for low-income children and their families, and the increase in the number of preschool children living in poverty who do not attend preschool (GAO, 1993), several reports have strongly recommended that additional funding is needed for expansion (NHSA, 1990; National Task Force, 1991; Zigler and Muenchow, 1992). Current debates focus on whether to expand to include more of the eligible children (expanding horizontally

making it an entitlement program for 3-4 year olds), serving younger and older children (expanding vertically), or serving fewer children for a longer period of time (full day, full year).

Since 1988, Republicans and Democrats have been competing to see who can provide the greatest boost for Head Start, and both party platforms have called for extending services to all eligible children. Many advocates have concurred. As a result, there was widespread support for making Head Start an entitlement program as Congress considered the reauthorization of Head Start in 1990. However, criticisms have been raised about the fact that politicians may be playing a "numbers game" at the expense of program quality.

The reauthorization, expansion, and other amendments included in Title I of the Augustus F. Hawkins Human Services Reauthorization Act of 1990 (P.L. 101-501) marked the beginning of the largest funding increase to date to expand the number of Head Start grantees.

This rapid expansion led to a concern that the program was being expanded too quickly. In the fall of 1991, the National Head Start Association (NHSA) surveyed 314 Head Start agencies to collect information on the impact of the new legislation on local programs. The survey was designed to provide insight into how programs used the new funds to expand enrollment, improve salaries, and strengthen quality, and what effect these funds had on local programs and communities. They found that local programs had taken a significant step forward in expanding and strengthening most aspects of the program in the first year of the Act. However, the study found some indication that continued, significant investment in quality was required.

In 1992, the Assistant Secretary for Management and Budget (ASMB) and the Assistant Secretary for Planning and Evaluation (ASPE) requested that the HHS Office of the Inspector General (OIG) review the implementation and status of Head Start expansion. The OIG office conducted two studies using different methodologies. The first report, *Readiness for Head Start Expansion*, was based on program self-assessments (OIG, 1993 a). It indicated that grantees were meeting their expansion goals for FY '90 and generally were positive about their expansion experiences. However, grantees reported problems acquiring facilities in many communities, finding qualified staff and transportation, and responding to increased demands on social services. In addition, this report pointed to the fact that the national and regional Head Start Bureau staff expressed doubts that grantees receiving expansion funds could maintain or improve their program performance over the next several years. Regional office staff also had serious concerns about their own capacity to manage expansion. Nevertheless, grantees indicated that they were still able to meet all Head Start Performance Standards.

The second report was based on telephone interviews with staff and on-site visits in a random sample of 80 grantees and delegate agencies (OIG, 1993 b). Grantee performance was assessed by applying specific performance indicators that were developed with input from the Head Start Bureau, ASPE, Head Start grantees and delegates, program experts, and researchers. The study, which was designed to assess the impact of expansion on Head Start grantee performance, did not find any statistically significant difference in grantee performance as a result of expansion. It did find, however, that the level of grantee performance as measured by the developed indicators, was consistently lower than the level of performance reported by grantees and published by ACF. The specific findings included that:

- ACYF's Program Information Report (PIR) data did not accurately reflect information in children's health records;
- Children were not fully immunized when they left the Head Start program;
- Grantees frequently do not identify or address families' social service needs; and
- Grantees' files and records frequently are incomplete, inconsistent, and difficult to review.

Some of Head Start's critics seized upon these criticisms to oppose President Clinton's proposal to request \$1.4 billion in the Administration's budget as the first installment toward his goal of expanding and improving Head Start. Head Start supporters claimed that the reports overstated the problem.

They acknowledged, however, that expansion had caused some of the problems that were reflected in the uneven quality in delivery of services.

Excerpts From Advisory Committee Recommendations Related to Expansion

#2. Expanding to Better Meet the Needs of Children and Families

The Advisory Committee recommends a more strategic approach to expansion which balances the need to maintain quality and serve additional children, with a greater sense of responsiveness to family needs.

Specific Actions

- Step 1. *Enhancing family services and increasing parent involvement.*
 - Review and expand resources used for family services, parent education, and family support.
 - Increase efforts to involve parents in all aspects of the Head Start Program.
 - Encourage male involvement in Head Start programs.
- Step 2. *Assessing needs and planning strategically.*
 - Encourage programs to reassess their total program during expansion.
 - Strengthen the tools and capacities for conducting community needs assessments and for assessing family resources and needs.
 - Encourage involvement of other early childhood and family support providers in the community needs assessment process.
- Step 3. *Expanding to reach children and families who are currently underserved.*
 - Continue to expand the number of children served.
 - Provide additional support to address the special needs of Indian and Migrant programs.
- Step 4. *Promoting full-day and full-year services.*
 - Allow Head Start programs to use Head Start funds to provide full-year and full-day services.
 - Allow grantees to provide services during the summer as appropriate to respond to the needs of children and families.
 - Continue to maximize other resources to meet the full-day needs of children eligible for Head Start.
 - Encourage Head Start programs to work more closely with the broader child care community.
 - Improve federal child care policies serving low-income children.
- Step 5. *Serving families with young children.*
 - Ensure that the services Head Start currently provides to infants and toddlers and their families are of the highest quality.
 - Develop a new initiative for expanded Head Start supports to families with children under three.

QUALITY

(Sources: Advisory Committee, 1994; Bowman, 1993; Knitzer, 1994; NHSA, 1990; U.S. DHHS, 1980; Zigler and Muenchow, 1992; Zigler and Styfco, 1993)

Quality problems have plagued the Head Start program since its beginnings. The program started with very ambitious goals and it had to be implemented so fast that quality controls were left behind. Program Performance Standards were not implemented until 1975. Regional offices have the primary responsibility for assuring that grantees adhere to the standards, but regional staffing has declined considerably over the years, even as Head Start has grown in size.

Over the years, many early childhood experts, researchers, and policy analysts have identified problems related to quality such as low employee salaries, inadequate training, poor facilities, gaps in health and other services, serious management problems, too many unqualified workers, and frequent staff turnover. Head Start supporters indicate that during the 1970s, Head Start programs suffered through hostile or indifferent administrations and from inflation and funding cutbacks against a backdrop of increasing need. And in spite of strong community support and dedicated staff, many programs found it increasingly difficult to meet the Head Start Performance Standards. These cutbacks threatened the quality of the programs in many ways (Zigler and Muenchow, 1992).

- (i) It made it difficult for programs to recruit and retain trained staff;
- (ii) Many Head Start programs were located in inappropriate, run-down, or potentially unsafe facilities;
- (iii) Many programs were forced to eliminate or combine family support positions; and
- (iv) Funds for training and technical assistance, as a percentage of the Head Start budget, declined from 5.4 percent in 1971 to 2 percent in 1990.

In addition, the federal infrastructure for monitoring the program was depleted. Travel funds for staff were virtually eliminated and many regional offices no longer had even a single child development specialist on staff. Given this reduction in regional staff, on-site monitoring declined significantly. Not only did the regional offices lose staff, but, equally important, they also lost staff with appropriate training and experience.

For the project's 15th anniversary, a major advisory committee was convened in 1979 to chart future directions for the program. The committee's report stressed areas where improvement was needed and made recommendations for corrective action. The report labeled the protection of quality as its highest priority (U.S. DHHS, 1980). However, the decline in quality noted above continued throughout the 1980s.

1990 Silver Ribbon Panel Report (NHSA, 1990). For its 25th anniversary, the Silver Ribbon Panel of the National Head Start Association issued a report which found that many of the same problems affecting quality were still there and had worsened over time. This report indicated that parental involvement and the family support component of Head Start had been the most neglected of all. As a result, the report recommended that Head Start expand its original focus and called for actions and strategies to expand family support services targeted to address such issues as substance abuse, literacy, homelessness, and employability. The report also recommended a more systematic approach to demonstration, research, and dissemination of promising practices.

Task Force on Head Start and Mental Health. Mental health is one of the least discussed components of quality services within the Head Start program. In the fall of 1993, Dr. Edward Zigler, president of the American Orthopsychiatric Association (AOA), asked Jane Knitzer, a nationally known mental health expert, to form a task force to review what is known about the mental health needs of Head Start children, families, and staff, and to assess the adequacy of Head Start's capacity

to address these needs. The AOA Task Force was also asked to develop policy and program recommendations to strengthen the mental health capacity within Head Start.

Some of the Task Force findings are that mental health is not defined as a "stand alone" component, but is part of the health services component. Philosophically, the Head Start program has always been committed to promoting mental health, defined broadly as promoting the healthy emotional development of children, supporting family strengths, identifying early signs of emotional and behavioral difficulty, and assisting families with special needs. There is a set of mental health performance objectives and standards. However, the Task Force report points out that there have been many difficulties with implementing these standards and in many programs efforts have been severely limited or nonexistent.

The draft Task Force report states that "two sets of realities make it imperative that attention to mental health in Head Start increase. The first is obvious. The stresses facing poor families and communities, the large numbers of families with complex and multiple needs, and the long shadow of violence and substance abuse are placing great demands on a model (of mental health services) developed at a time when poverty wore a different face" (Knitzer, 1994).

The Report identified the following major findings:

- **The mental health needs of the Head Start community are complex and varied.** The range and intensity of family needs among Head Start parents is great. The impact of violence (both direct and community-level violence) on Head Start children, families, and staff is a growing concern. Teachers, other staff, and consultants report that they are seeing more and more children who manifest challenging, disruptive, and sometimes frightening behaviors. Relatively few children are being identified as having emotional or behavioral disabilities and for those who are, there are no data on what help the children, families, and teachers receive and with what outcomes. (However, new regulations published in January 1993 may help address this issue.) Given the intensity of need among children and families, Head Start staff are especially vulnerable to stress and burnout.
- **Mental health performance standards and objectives need updating.** Although the existing standards provide a useful framework, in practice, mental health strategies in the programs are often limited and based on a very traditional and narrow medical model which emphasizes child-focused evaluations, occasional out-patient therapy, and occasional consultations with staff. (There is anecdotal evidence that a few programs have created more comprehensive approaches.)
- **Mental health staffing capacity throughout Head Start is inadequate.** Staff with the range of mental health expertise needed in Head Start, both at the national and regional level, is stretched thin or nonexistent and an adequately trained pool of mental health coordinators and consultants does not exist. This gap compounds the extraordinary pressures on social services staff.
- **Organizational and fiscal constraints hinder program options in creating coherent family support/mental health programs.** Information about family support/mental health-related best practices in Head Start or of broader developments in the field are not available to the Head Start community. Mental health is a low priority in training and technical assistance, and directors and mental health coordinators get little help in how to contract with and use mental health consultants.
- **Linkages between Head Start and other federal programs---such as the Part H program, schools, and the child welfare system---are spotty.** (This issue will be discussed in detail in the second FIS seminar and briefing report on Head Start.)

Based on these findings, the AOA Task Force on Head Start makes a number of recommendations to strengthen, reorient, and restructure the mental health component to bring it up to date with new theory and practice approaches, and change value orientations in order to better serve the emerging, urgent needs of Head Start children, their families, and staff. The report's main recommendations are echoed in the Secretary's Advisory Committee Report in its recommendations about updating the Head Start Performance Standards.

Excerpts From Advisory Committee Recommendations Related to Quality

#1. Striving for Excellence

The Advisory Committee believes that all Head Start programs should provide high-quality comprehensive services in order to be effective and to better assure long-term benefits for children and families. Head Start programs must have a clear understanding of policies and expectations and should receive sufficient levels of support and resources to achieve this goal.

Specific Actions

- **Step 2. *Improving the management of local programs.***
 - Emphasize and expand management training.
 - Strengthen financial management policies and practices.
 - Support strategic planning at the local level through a multi-year "phased in expansion" strategy.
 - Update the Head Start Performance Standards.
 - Develop performance measures to support strong outcomes.

- **Step 3. *Reengineering federal oversight to provide for greater accountability.***
 - Reassess and design the Head Start training and technical assistance system to support program quality and expansion.
 - Review and strengthen Head Start monitoring.
 - Ensure prompt action to deal with low-performing grantees.
 - Review Head Start's administrative structure and federal staffing levels.
 - Launch a professional development and training initiative for federal staff at the regional office and central office levels.

TRAINING

(Sources: Brunson Phillips, 1993; Fenichel, 1992; Piotrkowski, *et al.*, 1993; Weikart, undated)

The need for well-trained staff to operate the programs has been fully recognized since the advent of Head Start. However, as Head Start is pushed to improve its quality, the issues of training and support for staff have become much more complex and urgent.

Although staff development and training activities have been ongoing, the overall training system in Head Start has not kept up with the need. "Not enough attention has been given to the infrastructure that should support, evaluate and improve these activities" (Brunson Phillips, 1993: 2). As a result, in too many places, no thoughtful decisions are made to distinguish between the goals of preservice, inservice, staff development, and continuing education. Over time, some agency training schedules proliferate repetitive and fruitless training events. In other places, staff all attend the same events all

the time, regardless of level experience or anything else. At the other extreme, some staff are left at conferences to attend whatever they want, with little opportunity of connecting the new knowledge with their past or future experiences. Further, staff with varied levels of preparation and experience can be found employed in the same role, with the same responsibilities, at the same salary.

As indicated by the National Head Start Association (1992), a thorough review of the present training and technical assistance system was needed, and began to be undertaken within the Head Start Bureau. This review included capacity building for agencies to analyze their own staff development decisions and to sustain goal-driven, competency-based training activities. As a result, the training and technical assistance has been substantially revamped and strengthened, although the new Administration will undertake its own reassessment.

While these staff training difficulties are true for staff throughout Head Start, they are especially acute for the social services and parent involvement staff. There is no explicit indication of the qualifications needed for working with families in Head Start. Furthermore, as in other family-centered programs, the content, skills, and actual strategies needed to successfully work with the family unit are not yet commonly taught in the preservice and inservice training for most human service professions.

The National Social Services Training Institute was held in August 1989 and attended by social service coordinators from around the country. The possibility of developing a certification process equivalent to the Child Development Associate for family service coordinators was discussed at the institute. Unfortunately, the suggestion has not yet been followed up, although it is included in the Advisory Committee's recommendations.

The National Resource Center on Family Based Services has developed a certification process for Family Development Specialists, which they consider equivalent to the CDA. Some Head Start programs have successfully used this certification process for their case managers. More recently, the Institute for Family Support and Development was formed to advance and disseminate new family support and family development knowledge. This Institute offers an eight-day course in family support and development to persons who work with families in family-centered programs. (See description of MICA Head Start Program, p. 26.)

Excerpts From Advisory Committee Recommendations Related to Training

#1. Striving for Excellence

Specific Actions

•**Step 1. *Focusing on staffing and career development.*** In order to assure quality and sustain excellence in Head Start, the Advisory Committee recommends launching a Head Start staff support and improvement initiative. Action steps include:

- Provide national leadership in developing and implementing staffing plans in every Head Start program.
- Develop a new initiative to encourage "qualified mentor teachers" to support classroom staff.
- Establish competency-based training for staff who work directly with families.
- Ensure sufficient staffing levels to serve children and families effectively.
- Continue to increase the compensation of Head Start staff.
- Strengthen the availability of training and career development opportunities at the local level.

EFFECTIVENESS

(Sources: Besharov, 1992; Collins, 1990; Consortium For Longitudinal Studies, 1983; Copple, 1987; Haskins, 1989; Hood, 1992; Leik and Chalkley, 1988; McGroder, 1990; McKey, *et al.*, 1985; Parker, *et al.*, 1987; Schweinhart and Weikart, 1987; Zigler and Styfco, in press)

Head Start's complexity and uniqueness has made evaluation of its effectiveness difficult from the start. The burst of research that was conducted in the program's first decade illuminated the challenges involved in evaluating such a complex intervention. For example, despite the many goals of Head Start, initial studies focused almost exclusively on how much the program could raise children's intelligence scores. These early studies showed that children's I.Q. scores increased by at least 10 points and their achievement levels rose after just a few weeks of participation in Head Start. Then the Westinghouse Learning Corporation delivered the news that the achievement gains faded away shortly after children entered school. Although the Westinghouse study's methodology was severely criticized, subsequent studies of Head Start's impact (and almost every other early intervention program) reached the same conclusion: graduates of preschool intervention programs generally do not continue to do better on cognitive tests or school quizzes in the long run.

Nevertheless, other studies document that there are other positive effects of early (preschool) intervention. The Consortium for Longitudinal Studies examined the long-term effects of twelve preschool programs (two of them Head Start) and found that their graduates, after six to thirteen years, were significantly less likely to have failed a grade in school or to have been assigned to special education classes than children who did not attend a preschool. The Consortium also confirmed that children who attend quality preschool programs evidence an initial boost in I.Q. and achievement scores that lasts for some years but eventually fades.

The most complete overview of Head Start research, conducted for the U.S. Department of Health and Human Services in 1985, yielded similar results. This Head Start Synthesis Project, a meta-analysis of over 200 studies, found the loss of initial cognitive gains but reported that Head Start children had better health, immunization rates, nutrition, and socioemotional characteristics. A small subset of these studies found former Head Start children were more likely to be promoted to the next grade and less likely to be assigned to special education classes. Family life was also found to be strengthened through the involvement of parents in the program (McKey, *et al.*, 1985).

A later study (Copple, 1987) of thousands of children who attended Head Start showed that they had better school adjustment than peers who had no preschool experience.

Zigler and Muenchow (1992) indicate that although much of this research has technical problems that make the findings tentative, the results all point in the same direction: "Head Start prepares children for school" (p. 13). They lament, however, that by focusing on the the loss of initial cognitive benefits, many critics have overlooked Head Start's success on other indicators.

One of the major elements in the continuing debate about the research evidence on Head Start's is the misuse of the findings from the longitudinal study of the Perry Preschool Program in Ypsilanti, Michigan. The striking, positive long-term results of this study and its evidence of cost effectiveness have been used both by critics and supporters of Head Start, even though the researchers themselves have cautioned against generalizing from the findings of their study to Head Start.

Supporters have used the Perry Preschool findings as evidence of the effectiveness of preschool interventions and to argue for more generous appropriations for Head Start. Critics have pointed out that the study's very small sample and much more intensive and expensive intervention make it inappropriate to compare the findings with Head Start.

Ronald Haskins (1989) conducted a balanced review of the research literature and draws four summary conclusions about the effectiveness of Head Start and other preschool programs.

- (i) Both the model programs and Head Start produce significant and meaningful gains in intellectual performance and socioeconomic development by the end of a year of intervention.
- (ii) For both types of programs, gains on standardized I.Q. and achievement tests, as well as on tests of socioemotional development, decline within a few years (somewhat sooner in the case of Head Start).
- (iii) On certain indicators of school performance, such as special education placement and grade retention, there is very strong evidence of positive effects for the model programs and modest evidence of effects in Head Start programs.
- (iv) On measures of life success, such as teen pregnancy, delinquency, welfare participation, and employment, there is modest evidence of positive impacts for model programs but virtually no evidence for Head Start.

The results of these findings are interpreted in different ways by supporters and critics of the Head Start program. For example, Haskins argues that "there is ample reason to continue its funding and to focus serious attention and additional resources on improving its performance" (Haskins, 1989: 281). On the opposite side, John Hood, research director of the John Locke Foundation, a North Carolina think tank, considers that the \$2.2 billion appropriated for Head Start would be better spent if converted to vouchers or tax relief to allow parents to send their children to private or parochial schools in their communities (Hood, 1992: 30).

Importantly, many point out that Head Start, or any other time-limited, early childhood intervention, should not be viewed as a solution to the multiple problems associated with growing up in poverty. It is totally unrealistic to expect that one year of preschool education can be a means to end, or even significantly reduce, rates of crime and welfare dependency.

However, these somewhat discouraging findings about child outcomes have led many to highlight the need to improve program leverage by targeting more attention and services to the family context. Participating in a quality, family-focused and comprehensive program can improve the functioning of low-income families and sustain and amplify gains for their children.

Evaluation of Head Start as a Comprehensive, Family-Centered Program

What is known about the effects of early intervention programs on the family unit? Most Head Start evaluations have focused on the preschool educational component and its effects on I.Q. and achievement. Possible benefits to social interactions, parents' child-rearing abilities, family stability and functioning, parental empowerment, and community responsiveness have been undervaluation and undervalued. Although there is abundant anecdotal evidence about the positive impact of Head Start on parents' lives, no systematic study has been conducted of the effects of Head Start on parental employment, educational status, income, aspirations, or other measures of economic mobility---a striking omission given the comprehensive goals of the program to reduce poverty.

Zigler and Muenchow report that despite these success stories, studies are only just beginning to attempt to quantify the impact of Head Start parent involvement activities on families and they are being conducted on a very small scale. One recent study found that mothers who participated in the program reported fewer psychological symptoms, greater feelings of mastery and self-confidence, and greater life satisfaction at the end of the program (Parker, *et al.*, 1987). Another study, the Head Start Family Impact project, found that parent involvement in a Minnesota Head Start program increased the sense of family cohesion and adaptability (two well-tested measures of strong family functioning), which is expected in the long run to improve children's school performance (Leik and Chalkley, 1988). Clearly, more research needs to be conducted to assess other measures of family impact, and on a

broader scale. More data is also needed to document the extent and type of parent involvement, including parent employment, in Head Start.

Excerpts From Advisory Committee Recommendations Related to Effectiveness

#1. Striving for Excellence

Specific Actions

Head Start is entering a historic period of reexamination, improvement in quality, and expansion of services. The size of its program, its comprehensive services, the diversity of the population it serves, and the fact that it is federally funded suggest a role for Head Start as a national laboratory for best practices in early childhood and family support services in low-income communities. There is a concomitant and compelling need for a new, expanded, and formal role for Head Start research.

•Step 5. *Strengthening the role of research.*

- Build a strong and enduring infrastructure for Head Start research to ensure that Head Start is able to carry out its leadership role on an ongoing basis.
- Conduct new Head Start research focusing on quality and other policy issues.
- Conduct longitudinal research on children and families served in Head Start programs.
- Expand the partnership between research and practitioners by encouraging better communication and better utilization of data.
- Develop a long-term research plan for Head Start which: places Head Start in the broader context of research on young children, families, and communities; ensures a commitment to ongoing themes; and yet has the flexibility to respond to new and emerging issues.

PART IV. VIGNETTES OF PROMISING FAMILY-ORIENTED PROGRAMS AND PRACTICES

It is the basic premise of this report that improving quality and effectiveness in Head Start today entails strengthening the capacity of the entire Head Start system to become a comprehensive family support program. Family support was always intended to be a major goal of the program by its founders, but families' needs and circumstances today have changed dramatically and the program needs to refocus and restructure to fulfill this goal. In addition, a lot has been learned during the last two decades about the importance of providing family support to attain and maintain child development outcomes.

As described in the previous section, several family-centered demonstration programs and initiatives within Head Start are being funded and pilot-tested. The Head Start community needs to build on these lessons and find ways of integrating family support principles and practices into the system comprehensively **so that every Head Start program becomes a true family support program**. This will require leadership from the Administration and Congress and some changes and modifications of major components of the program. It will also involve more effective coordination with other federal and state programs---the subject of the next Family Impact Seminar. We describe in this section a few examples of Head Start programs providing a wide range of supportive services to families.

MID-IOWA COMMUNITY ACTION, INC. (MICA)

MICA's goal is to increase the capacity of families to rise out of poverty. To achieve this mission in all its programs, MICA is committed to its Family Development Program which offers comprehensive,

home-based family services that promote learning, growth, and development in individual family members. MICA's Head Start program serves 228 children in a five-county area in central Iowa (in center, home-based and combination options). MICA also manages a Comprehensive Child Development Program (CCDP), Head Start Teaching Center, Transition project, and Family Development Self-Sufficiency project (for AFDC families at risk of long-term dependence).

Staff providing services to families enrolled in Head Start and the other programs are trained and certified in the Family Development Model. This training model is based on family systems theories and views all members of a family as working together---both in helpful and nonhelpful ways---to perform the vital functions of the family (meeting the family's physical, social, cognitive, psychological, and spiritual needs). Using this framework, the family development specialists are trained to become aware of the positive and negative behaviors they observe in the families with whom they work and to explore alternative, more effective behaviors.

The family development process consists of assessment, planning, and supporting and joining/linking with the family. The **assessment** helps family members identify systemic needs and strengths through use of a comprehensive set of descriptive and analytical tools. The **joining** process aids the family in establishing community ties, support networks, and avenues to enriching activities. **Goal setting** facilitates vision building and the development and implementation of incremental plans of action which translate that vision into reality. **Support** provides the family with information, encouragement, referrals, and celebration of successes through regular, ongoing contact.

Family development staff in the Head Start program perform the dual role of social services and parent involvement staff. Their family assessment and change processes address outcomes in several domains of family life (work, family relationships, income, shelter, parenting education, etc.).

For more information on the family development certification process contact: National Resource Center on Family Based Services, School of Social Work, University of Iowa, 112 North Hall, Iowa City, IA 52242. (319) 335-2200.

For more information on the family development associate certification program contact: Arlene McAtee and Wendy Deutelbaum, Co-Directors, The Institute for Family Support and Development. For more information on MICA's Head Start programs contact: Jeff Hoffman, Head Start Director. The Institute and MICA are located at 212 West Ingeldue, Marshalltown, IA 50158. (515) 752-7162.

HEAD START INVOLVING MALES (HIM)

For years, the parent participation in Mercer County, New Jersey's five Head Start Child Development Centers (as in most other Head Start programs) was distinctly female. Realizing that many low-income households lack stable male role models, these Head Start programs began the task of getting men more involved in the lives of the children who attend the program. They later became one of the six federally funded demonstration projects for programs geared toward getting males involved in Head Start. The HIM program is one of the six models developed for similar programs in cities in Massachusetts, Pennsylvania, Kentucky, Texas, and Nebraska.

The main goal of the program is to send a message to fathers and other men in the family that they have an important role to play in their children's lives. To do this, the project director and the male involvement specialist (both men) conduct one-to-one needs assessments with a male member of the family/household. Among the 200 families enrolled in Mercer County in 1993, there are about 185 males involved in some way in the program. This includes fathers, grandfathers, boyfriends, and other male family members.

HIM seeks to increase male involvement by providing information about child development, parental legal rights and responsibilities, career enhancement, planned parenthood, and self-esteem. Staff organize a variety of information and recreation activities to bring kids, parents, and males together.

Project HIM collaborates with First Steps, a local program for teen fathers, by providing employment training to enhance career development.

Contact: Steven Carter, Male Involvement Specialist, (609) 586-5894.

ROBERT WOOD JOHNSON FOUNDATION'S FREE TO GROW INITIATIVE

This initiative will assist a number of Head Start programs to develop and implement model substance abuse prevention projects that will strengthen both the families and neighborhoods. The main targets for intervention in this initiative are the family and other significant adults and the neighborhood, *not the child*. The initiative has several expectations: (i) families will better be able to nurture and protect their young children if parents and caregivers are free of addiction and have a wide range of supports, such as health, housing, and employment; (ii) strengthened and supported families will be more likely to resist abuse of alcohol and illegal substances; and (iii) a more stable, protective living environment—including the basic necessities and caring relationships—will be more likely to occur; and a safer, less chaotic neighborhood will help reduce the young child's later vulnerability to substance abuse and other problems.

The overall program strategies are to (1) link the child and the family with community supports that will continue after the Head Start experience ends; and (2) act as a catalyst for neighborhood action. The national program office is headquartered at the National Center for Children in Poverty, Columbia University School of Public Health. This office will be responsible for the design and implementation of the grantee selection process, and for the provision of technical assistance and project monitoring.

Contact: Judith E. Jones, National Center for Children in Poverty (212) 927-8793.

TEXAS MIGRANT COUNCIL SIBLINGS IMMUNIZATION PROJECT

The Texas Migrant Council Head Start program ensures that younger siblings of the children enrolled in the Head Start program receive on a timely basis all the immunizations recommended for younger children by the Texas Department of Health. The project is conducted in high poverty areas along the Texas-Mexico border that demonstrate very low rates of immunization in preschool-aged children. Siblings of Head Start children are identified and immunization histories are taken at the time of Head Start enrollment. Staff and parents are provided with training and each Head Start center is provided with vaccines. A tickler system is established to track the children and reminders are sent to parents in advance of immunization due dates. Parents are asked about migration patterns and plans and copies of the immunization records are forwarded to the health department in the area to which they move. Information on immunizations received in the new area is sent back to the Texas Migrant Council and the tracking system is constantly updated.

Contact: Oscar Villareal, Texas Migrant Council, Inc., (512) 722-5174.

HEAD START PUBLIC AND INDIAN HOUSING CHILD CARE DEMONSTRATION PROJECT

The Carteret Community Action Head Start in Beaufort, North Carolina, provides full-year, full-day Head Start services for children birth to 5 years of age and to 16 school-aged children (ages 5 to 12) in

an extended day program and a full day summer child development program. Priority for the participation is given to residents of this housing development run by the local housing authority who are working, single mothers, mothers who are receiving Aid to Families with Dependent Children (AFDC) and are in school, in a training program, or working, and families in a crisis environment or in great need. Volunteer opportunities and employment opportunities as substitute teacher assistants and part-time drivers are offered to residents of the housing development. Training and technical assistance is provided through the Head Start associate degree program. On-site training for the JOBS program, GED training, and other programs are available to families. Senior citizens who are housing complex residents are involved in the classrooms.

Contact: Leon Mann, Jr., (919) 728-4528.

SAINT PAUL HEAD START FAMILY SERVICE CENTER

The Ounce of Prevention Fund expanded the social services component of a Head Start program in Chicago, by establishing a Family Service Center, one of the 66 federally funded demonstrations. The project goals include enhancing Head Start families' ability to take advantage of Head Start services through volunteerism and participation, increasing positive interaction between parents and their children, and supporting the families' progress toward self-sufficiency.

A team that includes a licensed social worker and a paraprofessional family advocate provide in-depth family needs assessments, bimonthly home visits, periodic staffings (case reviews), referrals, and follow-up to families. Program resources include on-site literacy programs which feature computer-assisted, small group, and individual instruction; Project Match, a program supporting long-term welfare recipients in their efforts to achieve self-sufficiency; and close relationships with the Illinois Department of Alcohol and Substance Abuse for the development of linkages with alcohol and drug treatment programs.

Contact: Harriet Meyer, (312) 853-6080.

HEAD START AAMFT VOLUNTEER INITIATIVE

Recognizing the need for new and creative strategies to work with Head Start families, the Head Start Bureau and the American Association of Marriage and Family Therapy (AAMFT) established a collaborative partnership. The purpose of the project is to develop ways to recruit marriage and family therapists to work as volunteers in Head Start programs. The major goal of the pilot phase of the project was to identify the most appropriate volunteer roles and activities for different types of Head Start programs in a variety of geographical locations.

In addition to special training in marriage and family therapy and experience working with families, many marriage and family therapists (MFTs) have trained in a variety of mental health professions, including clinical social work, psychology, counseling, and psychiatric nursing. (As qualified and licensed or certified mental health professionals, MFTs already serve as mental health consultants for local Head Start programs nationwide.)

Head Start programs have sought MFT volunteers to: (i) consult on family issues; (ii) provide staff training in areas such as family dynamics and family needs assessment; (iii) lead family support groups; (iv) offer crisis consultation services; and (v) help establish programs which refer families to local mental health clinics.

Contact: Jana Staton, Research and Education Director, (202) 467-5127.

HEAD START FAMILY INFORMATION SYSTEM (HSFIS)

The Head Start Bureau has contracted with Ellsworth Associates to develop a new management information system to collect family-level data for all the children and families that Head Start serves. The previously developed Program Information Reports (PIRs) are geared primarily to monitoring compliance with performance standards. Because of the aggregate nature of this information, the PIRs cannot be used to track families and children and is of limited use in addressing policy issues.

HSFIS will be designed to capture demographic and socioeconomic data about Head Start families, as well as data that identify family service needs coupled with the actual services received through Head Start. The smallest unit of analysis will be the Head Start child, his or her parents or other significant adults, and any younger siblings. The system will have the capability to produce detailed cross-tabulations of the data and of aggregating it to program, grantee, state, regional, and national levels.

Forms, reporting requirements, and data elements for HSFIS are being pilot-tested in 12 randomly selected sites. Contact: Bill Wilson, Head Start Bureau, (202) 205-8913.

PART V. LOOKING AHEAD: PROGRAM AND POLICY RECOMMENDATIONS FOR ACHIEVING THE PROMISE OF FAMILY SUPPORT

We highlight below a number of recommendations for the Administration and Congress to consider as they draft legislation for reauthorization or implement current legislation. These recommendations are a synthesis drawn from a number of the studies and reports already cited as well as discussions with experts.

◆ *Provide leadership to define/clarify Head Start as a family support program.*

Congress and the Administration must set forth clear expectations in law, regulations, and program guidance that every Head Start program must strive to meet the needs of families as well as their children.

- The Head Start Act should be amended in several sections. For example,
 - The *Statement of Purpose and Policy* could indicate that in recognition of the pivotal role of families for children's healthy development, it is the purpose of the Act to extend the authority for the appropriation of funds for services to meet the needs of families.
 - Earmark funds to hire additional staff to provide direct or case management services to the families of the children enrolled in the program.
 - Earmark funds to provide training and technical assistance to all levels of staff to improve their capacity to serve low-income families.
 - To select an eligible Head Start agency, the national office should require that potential grantees demonstrate how they will provide services directly and/or link with community-based services to meet the needs of families.
- Head Start Performance Standards (HSPS) must be updated to reflect the changing role of Head Start and to incorporate a broader definition of mental health and family support services.

- The guidance for the implementation of the HSPS must be improved by developing measurable definitions of the standards that refer to the provision of family services.
- The Administration should develop regulations establishing family-level outcome measures for Head Start agencies. For example, the number of needs assessments conducted, number of comprehensive family assistance plans, provision of assistance to support families to reach the goals in the plan, and the effectiveness of services in achieving stated family goals.

♦ *Make the family component a priority principle for expansion.*

Head Start must adjust to a society where the entrance of parents with infants and toddlers into the workforce is the norm; in which at least half of Head Start families receive AFDC and are being required to participate in employment and training; and in which staff is increasingly faced with problems of substance abuse, violence, and teenage pregnancy, among others. The major priority for newly available funds should be to increase Head Start's responsiveness to the families they serve by providing full-day, full-week, and full-year services; to serve families with children under three; and/or to demonstrate the capacity to work with fragile families.

Head Start will have to use these funds strategically and establish partnerships with other community-based agencies serving low-income families. The coordination of family-oriented policies is emphasized in a number of other policy areas, including welfare reform, family preservation and family support, and Part H.

♦ *Improve the quality of family services in Head Start.*

Improvement of the quality of family services across all components is critical to the realization of the full potential of Head Start. To obtain additional funds, grantees should be able to demonstrate best practices and the competency of the staff that work with families across all components.

- Shift the emphasis in mental health services from labelling the child to assessing the emotional and support needs of the whole family.
- Expand the number of staff who have family support/mental health expertise at the central office and regional and program levels. Provide assistance for local programs to link with family support/mental health specialists for training, supervision, consultation, and treatment referral.
- Revise the training and technical assistance system to prepare all staff to work better with families. This would include developing competency-based training and certification (modeled after the CDA process) for staff who work directly with families, as well providing training across components for staff in the health, social services, and parent involvement components.
- Redefine the traditional parent involvement component (which offers an array of activities that reach few parents) to the concept of building Head Start-family partnerships with every family. In these partnerships, families are included as decisionmakers on the most appropriate and meaningful supports they need. The parents and program staff communicate regularly and work collaboratively to best meet each child's needs. In addition, parents can choose their own type and level of involvement. Individual families are not penalized or displayed as "star parents." Families are also asked to participate in the evaluation of policies and services.
- Establish a networking system to identify and disseminate the exemplary family support and service strategies and "lessons learned"---whether they are part of special initiatives and

demonstrations (and therefore monitored from the national office) or part of innovative practice in local Head Start programs (and monitored from the regional offices)---to implement these practices.

- Hire additional staff to reduce caseloads of staff working with families to 1:35.

♦ ***Revise Head Start's standards, monitoring, and quality control system.***

Head Start relies on its HSPS to achieve quality and to monitor programs. These valuable and necessary performance standards (ratios, group size, parent involvement, and staff training) are minimum requirements, but are not sufficient to assure that each Head Start program achieves quality.

- Head Start should establish clear, high *content* standards that set forth the knowledge, behaviors, and skills that children and family members must acquire or demonstrate and *delivery* standards that assure that both children and families have meaningful opportunities to meet the standards.
- Revise the system and monitoring tools to assess progress towards standards.
- Design an accountability system that emphasizes outcomes instead of accounting for dollars or procedures. Special attention must be paid to identifying **family-level outcomes**.
- In order to shift toward outcome-based accountability, it is critical to develop better automated systems and the capacity to analyze the information gathered. For example, to understand the changes in outcomes in relation to contextual factors; to select appropriate comparisons against which to measure the outcomes (i.e., the use of comparisons over time or the use comparisons among various racial and income groups); and to make realistic judgements regarding expected results.

REFERENCES

- Administration on Children Youth and Families, *Accomplishments: FY 1989 to FY 1993*. Memorandum from Wade F. Horn, January 13, 1993.
- Administration on Children, Youth and Families, *Project Head Start*. Statistical Fact Sheet, January 1993.
- Advisory Committee on Head Start Quality and Expansion (ACHSQE), *Creating a 21st Century Head Start*. Final Report, Washington, DC: 1994.
- Advisory Panel for the Head Start Evaluation Design Project, *Head Start and Evaluation: A Blueprint for the Future*. Vienna, VA: Collins Management Consulting, 1989.
- Allen, M., Brown, P., and Finlay, B., *Helping Children by Strengthening Families*. Washington, DC: Children's Defense Fund, 1992.
- Besharov, D., "New Start for Head Start," *The World and I*. January 1992.
- Besharov, D., *Statement of Testimony Before the Senate Committee on Labor and Human Resources*. January 12, 1994.
- Bolce, D., "Head Start Reauthorization," *NHSA Journal*. Vol. IX, No. 3, Winter 1991. pp. 23-25.
- Bowman, B., *Head Start: Then and Now*. manuscript. June 26, 1993.
- Brunson Phillips, C., *Staff Development: Preparing the Head Start Workforce for Success*. unpublished manuscript. June 22, 1993.
- Chafel, J., "Funding Head Start: What are the issues?" *American Journal of Orthopsychiatry*. 62, 1992.
- Collins, R., *Head Start Salaries: 1989-90*. Alexandria, VA: National Head Start Association, 1990.
- Colloquium on Public Policy and Family Support, *Helping Families Grow Strong: New Directions for Public Policy*. Washington, DC: Center for the Study of Social Policy, 1990.
- Consortium for Longitudinal Studies, *As the Twig is Bent...Lasting Effects of Preschool Programs*. Hillsdale, NJ: Lawrence Erlbaum Associates, 1983.
- Copple, C., *Path to the Future: Long-Term Effects of Head Start*. Washington, DC: DHHS, 1987.
- CSR, Incorporated, *Report on ACYF Efforts to Help Head Start Programs Address the Self-Sufficiency Needs of Their Families*. Prepared for the Head Start Bureau under Contract No. 1-05-92-1538, 1992.
- Family Resource Coalition, *Report: 10 Years*. Anniversary issue. Vol. 10, No. 1, 1991.
- Fenichel, E., *Learning Through Supervision and Mentorship*. Arlington, VA: Zero to Three/National Center for Clinical Infant Programs, 1992.
- Haskins, R., "Beyond Metaphor: The Efficacy of Early Childhood Education," *American Psychologist*. February 1989.

Hood, J., "Caveat Emptor: The Head Start Scam," *Policy Analysis*. No. 187, December 18, 1992.

Kagan, S., Powell, D., Weissbourd, B., and Zigler, E., Eds., *America's Family Support Programs*. New Haven, CT: Yale University Press, 1987.

Kamerman, S., and Kahn, A., *Head Start, Child Care, Family Support, and Family Policy*. manuscript, undated.

Kennedy, E., "The Head Start Transition Project: Head Start Goes to Elementary School," in *Head Start and Beyond: A National Plan for Extended Childhood Intervention*. Edited by Zigler and Styfco. New Haven, CT: Yale University Press, 1993.

Knitzer, J., *Memorandum to the members of the Ortho Head Start Task Force*. January 5, 1994.

Leik, R., and Chalkley, M., *Head Start Family Impact Project*. Final Report. University of Minnesota-Minneapolis, 1988.

McGroder, S., *Head Start: What Do We Know About What Works?* prepared for the U.S. Office of Management and Budget, 1990.

McKey, R., Condelli, L., Ganson, H., Barret, B., and McConkey, C., *The Impact of Head Start on Children, Families and Communities: Final Report of the Head Start Evaluation, Synthesis and Utilization Project*. Washington, DC: Government Printing Office, 1985.

Mottola, J., *Testimony. Hearing on New Challenges for Head Start*. Senate Subcommittee on Children, Family, Drugs, and Alcoholism, July 22, 1993.

National Commission on Children, *Beyond Rhetoric: A New American Agenda for Children and Families*. Washington, DC: Author, 1991.

National Head Start Association (NHSA), *The Impact of Head Start Expansion and Improvement Act of 1990 In Its First Year of Implementation*. Alexandria, VA: Author, 1993.

National Head Start Bulletin, No. 46, July/August 1993. Available from the Head Start Bureau.

National Task Force on School Readiness, *Caring Communities: Supporting Young Children and Families*. Alexandria, VA: National Association of State Boards of Education. 1991.

Office of the Inspector General (OIG), *Head Start Expansion. Grantees Experiences*. Washington, DC: author, 1993 a.

Office of the Inspector General (OIG), *Evaluating Head Start Expansion Through Performance Indicators*. Washington, DC: U.S. Department of Health and Human Services, 1993 b.

Pande, N., *A Head Start-Public School Transition Model: Making Schools Ready*. Senior Thesis, Princeton University, April 1993.

Parker, F., Piotrkowski, C., and Peay, L., "Head Start as a Social Support for Mothers: The Psychological Benefits of Involvement," *American Journal of Orthopsychiatry*. 57: 220-233. 1987.

Piotrkowski, C., Robinson, R., Collins, R., and Knitzer, J., *Strengthening Mental Health Services in Head Start: A Challenge for the 90s*. manuscript, revised 10/04/93.

Schorr, L., *Testimony. Hearing on New Challenges for Head Start*. Senate Subcommittee on Children, Family, Drugs, and Alcoholism, July 22, 1993.

Schorr, L., *Within Our Reach: Breaking the Cycle of Disadvantage*. New York: Anchor Books, 1988.

Schweinhart, L., and Weikart, D., *Young Children Grow Up: The Effects of the Perry Preschool Program on Youths Through Age 15*. Ypsilanti, MI: High Scope Press, 1980.

Schweinhart, L., Barnes, H., and Weikart, D., *Significant Benefits: The High/Scope Perry Preschool Study Through Age 27*. Conference sponsored by the Committee for Economic Development, 1993.

Silver Ribbon Panel, *Head Start: The Nation's Pride, A Nation's Challenge*. Recommendations for Head Start in the 1990s. Alexandria, VA: National Head Start Association, 1990.

Slaughter, D., Oyemade, U., Washington, V., and Lindsey, R., "Head Start: A Backward and Forward Look," in *Social Policy Report*. Vol. III, No. 2, Summer 1988. A publication of the Society for Research in Child Development, Committee on Child Development and Public Policy.

Slavin, R., *Primary Options: Federal Policies for Young Children*. Center for Research of Effective Schools for Disadvantaged Students, Johns Hopkins University, June 1993.

Smith, S., "Two-Generation Program Models: A New Intervention Strategy." *Social Policy Report*. V:1-15, Spring 1991.

Smith, S., Blank, S., and Collins, R., *Pathways for Self-Sufficiency for Two Generations*. New York: Foundation for Child Development, 1992.

Staton, J., Ooms, T., and Owen, T., *Family Resource, Support, and Parent Education Programs: The Power of a Preventive Approach*. Washington, DC: Family Impact Seminar, 1991.

Stewart, A., and Robinson, D., *The Head Start Program: Background Information and Issues*. CRS Report for Congress. Washington, DC: Congressional Research Service, 1990.

U.S. Department of Health and Human Services (DHHS), *Head Start in the 1980s. Review and Recommendations*. Washington, DC: Author, 1980.

U.S. Department of Health and Human Services, *A Guide for Providing Social Services in Head Start*. Washington, DC: Author, 1991.

U.S. Department of Health and Human Services, *HHS NEWS*. June 16, 1993.

U.S. Department of Health and Human Services, *Comprehensive Child Development Program—A National Family Support Demonstration*. Interim Report to Congress. Washington, DC: Author, 1994.

U.S. General Accounting Office (GAO), *Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families*. Washington, DC: Author, 1979.

U.S. Senate, *Human Services Reauthorization Act of 1990*. Report to accompany H.R. 4151. Report 101-421. Washington, DC. August 3, 1990.

Washington, V., "Head Start: How Appropriate for Minority Families in the 1980s?" in *American Journal of Orthopsychiatry*. Vol. 55, No. 4, October 1985. pp. 577-590.

Washington, V., and Oyemade, J., *Project Head Start: Past, Present and Future Trends in the Contexts of Family Needs*. New York: Garland, 1987.

Weikart, D., *Inservice Training and High-Quality Head Start Programs*. manuscript, undated.

Weiss, H., and Jacobs, F., Eds., *Evaluating Family Programs*. New York: Aldine de Gruyter, 1988.

Westinghouse Learning Corporation, *The Impact of Head Start: An Evaluation of the Effects of Head Start on Children's Cognitive and Affective Development--Executive Summary*. Ohio University Report for the Office of Economic Opportunity, 1969.

Yoshikawa, H., *Head Start's Potential to Provide Cumulative Protection Against Multiple Childhood Mental Health Problems*. manuscript, undated.

Zigler, E., *Testimony. Hearing on New Challenges for Head Start*. Senate Subcommittee on Children, Family, Drugs, and Alcoholism, July 22, 1993.

Zigler, E., and Muenchow, S., *Head Start: The Inside Story of America's Most Successful Educational Experiment*. New York: Basic Books, 1992.

Zigler, E., and Styfco, S., *Head Start and Beyond: A National Plan for Extended Childhood Intervention*. New Haven, CT: Yale University Press, 1993.

Zigler, E., and Styfco, S., "Using Research and Theory to Justify and Inform Head Start Expansion," *Social Policy Report*. (in press).

Zigler, E., Piotrkowski, C., and Collins, R., "Health Services in Head Start," *Annual Review of Public Health*. (in press).