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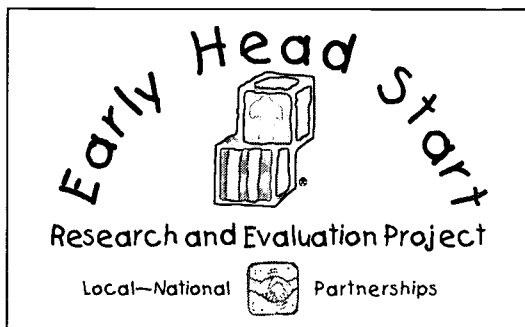
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ABSTRACT

Early Head Start (EHS) is a comprehensive, two-generation program providing intensive services from before birth to age 3 to promote improved outcomes in children's development, family development, staff development, and community development. The second of a 3-volume series designed to share the experiences of the 17 EHS programs participating in the Early Head Start National Research and Evaluation Project, this report describes the Early Head Start program and its national evaluation, and presents in-depth profiles of each of the participating research programs. Information for the profiles was obtained through two rounds of site visits conducted in Fall 1996 and Fall 1997. The programs participating in the national evaluation represent diversity in location, rural-urban setting, client population, and service delivery approach. There are 4 center-based programs, 8 home-based programs, and 5 mixed-approach programs profiled in this report. The profiles describe each programs' enrollment, recruitment procedures, the context in which the program operates, the services offered in each program area (child development, family development, community building), continuous program improvement efforts, and local research

studies. Contact information for the program directors and local researchers is also provided. The profiles are grouped according to program approach as of Fall 1997 and presented in alphabetical order by state within each group.
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Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs

Volume II: Program Profiles

December 1999

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Early Head Start Implementation Study Reports and Primary Research Questions

Leading the Way Report: *What were the characteristics and implementation levels of 17 EHS programs in fall 1997, soon after they began serving families?*

Executive Summary: *Summarizes Volumes I, II and III.*

Volume I: *Cross-Site Features--What were the characteristics of EHS research programs in fall 1997, across 17 sites?*

Chapter I: What was the historical and national context of the first years of Early Head Start?

Chapter II: What were the programmatic approaches, community contexts, and expected outcomes of the new programs? What were the characteristics of the families enrolling in the new Early Head Start programs?

Chapter III: What program activities and services were the new programs delivering within the first year of serving families?

Chapter IV: What challenges and successes did the new programs experience?

Volume II: *Program Profiles--What were the stories of each of the EHS research programs?*

Volume III: *Program Implementation--To what extent were the programs fully implemented, as specified in the revised Head Start Program Performance Standards, by fall 1997?*

Pathways to Quality and Full Implementation Report: *What were the characteristics, levels of implementation, and levels of quality of the 17 EHS programs in fall 1999, three years into serving families? What pathways did programs take to achieve full implementation and high quality? This report will be released in early 2000.*

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INTRODUCTION

Seventeen grantees are leading the way in developing Early Head Start programs. They are not only tackling the challenges of implementing comprehensive services for diverse families, they are also working with researchers to improve our knowledge about effective program strategies to promote healthy child development and family well-being in low-income families. As part of the first group of EHS programs funded, they are on the forefront in designing and implementing programs that meet the general Early Head Start program guidelines.¹ As participants in the Early Head Start National Research and Evaluation Project, they are demonstrating what Early Head Start programs can accomplish and sharing their experiences and the lessons they have learned in creating Early Head Start programs and developing high-quality services for infants and toddlers and their families.

This volume and its companion volumes are the first of two reports designed to share the experiences of the 17 Early Head Start research programs with others. The first report focuses on the programs early in their implementation (fall 1997), approximately two years after they were funded and one year after they began serving families. Volume I examines the characteristics and experiences of the 17 research programs from a cross-site perspective, focusing on the similarities and differences among the programs in fall 1997. Volume III analyzes the levels of program implementation achieved by the programs across program areas in fall 1997. Following a brief description of Early Head Start and the national evaluation, this volume presents in-depth profiles of each of the research programs in fall 1997.

¹The Administration on Children, Youth and Families has funded new Early Head Start programs in waves, with the first wave funded in September 1995 and subsequent waves of programs funded approximately annually thereafter.

EARLY HEAD START

Early Head Start was created just as the “quiet crisis” facing families with infants and toddlers in the United States, as identified in the Carnegie Corporation of New York’s *Starting Points* report, began receiving national attention. The Administration on Children, Youth and Families (ACYF) designed the Early Head Start program in response to (1) the growing awareness of this “quiet crisis;” (2) recommendations of the Advisory Committee on Head Start Quality and Expansion; (3) growing community needs for services for infants and toddlers; and (4) the 1994 Head Start reauthorization, which established a special initiative setting aside 3 percent of 1995 Head Start funding for services to families with infants and toddlers (and 4 percent of 1996 and 1997 funding and 5 percent of 1998 Head Start funds).² Secretary Shalala’s Advisory Committee on Services for Families with Infants and Toddlers then set forth a vision and blueprint for Early Head Start programs.

Early Head Start is a comprehensive, two-generation program that provides intensive services beginning before the child is born and concentrated on enhancing children’s development and supporting families during the critical first three years of the child’s life. Early Head Start programs offer services designed to promote improved outcomes in four domains:

1. **Children’s development** (including health, resiliency, secure attachments, social competence, and cognitive and language development)
2. **Family development** (including parenting and relationships with children, the home environment and family functioning, family health, parent involvement, and economic self-sufficiency)
3. **Staff development** (including professional development and relationships with parents and children)

²The 1998 Coats Human Services Reauthorization Act increased Early Head Start funding to 7.5 percent for fiscal year 1999, 8 percent for fiscal year 2000, 9 percent for 2001, and 10 percent for 2002 and 2003.

4. **Community development** (including enhanced child care quality, community collaboration, and integration of services to support families with young children)

Early Head Start programs are guided by the Revised Head Start Performance Standards, which were published in November 1996 and became effective January 1, 1998. Using these standards, the Head Start Bureau monitors Early Head Start program services and performance in three main areas: (1) early childhood development and health services, (2) family and community partnerships, and (3) program design and management. In fall 1997, the programs were still seeking clarification of some aspects of the revised standards, and they had not yet received monitoring visits by Head Start Bureau staff.

Early Head Start has been growing steadily. Sixty-eight local programs, serving about 75 families each, were funded in September 1995. Another 75 were added in September 1996, followed by more programs in subsequent years, so that today more than 500 programs are serving infants, toddlers, and their families.

THE EARLY HEAD START NATIONAL RESEARCH AND EVALUATION PROJECT

A comprehensive national evaluation conducted in tandem with a cluster of local research and evaluation studies is addressing a broad range of issues. This research and evaluation is going beyond assessing program impacts to encourage a new generation of research for understanding the role of program and contextual variations and creating a foundation for a series of longitudinal research studies.

The Early Head Start Research and Evaluation Project encompasses five major components:

1. ***An implementation study*** to examine service needs and use for low-income families with infants and toddlers, assess program implementation, illuminate pathways to

achieving quality, examine program contributions to community change, and identify and explore variations across sites

2. ***An impact evaluation*** to analyze the effects of Early Head Start programs on children, parents, and families in depth, using an experimental design and state-of-the-art analytic methods; descriptive analyses to assess outcomes for program staff and communities
3. ***Local research studies*** to learn more about the pathways to desired outcomes for infants and toddlers, parents and families, staff, and communities
4. ***Policy studies*** to respond to information needs in areas of emerging policy-relevant issues, including welfare reform, fathers, child care, infant-toddler health, and children with disabilities
5. ***Continuous program improvement*** activities to guide all EHS programs in formative evaluation

The Early Head Start Research and Evaluation Project was designed as a dynamic research project, and its multiple reports on program processes and outcomes will inform the program's early development. Lessons from early implementation identified by the research will help fledgling Early Head Start programs improve their practices.

THE EARLY HEAD START RESEARCH PROGRAMS

ACYF selected 17 Early Head Start programs from the first two waves of programs to participate in the national evaluation (see map). Sixteen of these are also participating in site-specific research studies. The programs and their local research partners are:

- Child Development Inc. Early Head Start in Russellville, Arkansas, working with the University of Arkansas, Little Rock
- Venice Family Clinic Children First Early Head Start in Venice, California, working with the University of California, Los Angeles
- Clayton/Mile High Family Futures, Inc., Early Head Start in Denver, Colorado, working with the University of Colorado Health Sciences Center

Early Head Start Research Programs



- Family Star Early Head Start in Denver, Colorado, working with the University of Colorado Health Sciences Center
- Mid-Iowa Community Action, Inc., Early Head Start in Marshalltown, Iowa, working with Iowa State University
- Project EAGLE Early Head Start in Kansas City, Kansas, working with the University of Kansas
- Region II Community Action Agency Early Head Start in Jackson, Michigan, working with Michigan State University
- KCMC Early Head Start in Kansas City, Missouri, working with the University of Missouri, Columbia
- Educational Alliance Early Head Start in New York, New York, working with New York University
- Family Foundations Early Head Start in Pittsburgh, Pennsylvania, working with the University of Pittsburgh

- School District 17 Early Head Start in Sumter, South Carolina, working with the Medical University of South Carolina
- Northwest Tennessee Head Start in McKenzie, Tennessee
- Bear River Early Head Start in Logan, Utah, working with Utah State University
- United Cerebral Palsy Early Head Start in Fairfax County, Virginia, working with Catholic University of America
- Early Education Services Early Head Start in Brattleboro, Vermont, working with Harvard University
- The Children's Home Society of Washington--Families First Early Head Start in South King County, Washington, working with the University of Washington, School of Nursing
- Washington State Migrant Council Early Head Start in Yakima Valley, Washington, working with the University of Washington, College of Education

As the list indicates, the programs participating in the national evaluation represent a wide diversity of locations and urban-rural settings. The programs also serve diverse populations. Some are new programs, while others build on the sponsoring agency's previous experiences as a Comprehensive Child Development Program or another program serving infants and toddlers.

The programs are taking diverse approaches to serving children and families. Some provide child and family development services primarily in regular, frequent home visits. Others offer center-based child development services and provide family development services in less-frequent meetings with parents, either at the center or in families' homes. Still others combine these approaches, providing services to some families in centers and to other families in home visits. The programs that provide services in home visits take a variety of approaches to ensuring that children receive high quality child care, ranging from making referrals to local child care resource and referral agencies to establishing collaborative agreements with child care providers and providing training

and technical assistance to them. The programs also involve parents in group activities, ranging from monthly parent meetings to intensive weekly play groups for parents and children.

Early Head Start program guidelines specify that Early Head Start programs may serve pregnant women and families with children under age 3 who meet the Head Start income criteria. Although most families must have incomes at or below the federal poverty line or be eligible for public assistance, up to 10 percent of children may be from families with higher incomes. Programs are also required to make at least 10 percent of program spaces available to children with disabilities. Early Head Start programs that are participating in the national evaluation were expected to recruit 150 to 200 families with pregnant women or children under age 1 to participate in the evaluation research (half were randomly selected to participate in the program and half were randomly assigned to the control group). Thus, many of the research programs focused on recruiting and enrolling families with children under age 1 (or younger, in some cases).

THE PROGRAM PROFILES

The profiles of the 17 research programs presented in this volume provide a detailed overview of each of the Early Head Start research programs in fall 1997. They describe the programs' enrollment, the services they offer in each program area, and their continuous program improvement efforts and local research studies. The profiles are designed to provide basic information about each program in a common format, to facilitate their use as a reference. At the same time, the content and focus of the profiles vary, reflecting the diversity and unique characteristics of each program and community.

The program profiles are based on information gathered in two rounds of site visits conducted by researchers from Mathematica Policy Research, Inc., and Columbia University's Center for Young Children and Families. The first round of site visits was conducted in the summer and early

fall of 1996, around the time each program began serving families. The second round of site visits was conducted in fall 1997.

The Early Head Start programs are dynamic, and they operate in a changing world. The profiles represent each program as it was at the time of the fall 1997 site visit. Where programs were making changes or experiencing changed circumstances at that time, the profiles describe the changes that were under way.

At the time of the site visits, local Early Intervention Programs for Infants and Toddlers with Disabilities were authorized under Part H of the Individuals with Disabilities Education Act (IDEA) and were often referred to as Part H programs. As of July 1998, Part H was renamed Part C. To avoid future confusion, the profiles use the Part C designation when referring to the Part H programs with which the Early Head Start programs were working.

Another change that took place soon after the site visits in fall 1997 was a change in the Head Start Bureau's training and technical assistance system. At the time of the site visits, two regional networks provided training and technical assistance to Early Head Start programs--a network of 16 regional Technical Assistance and Support Centers (TASCs) and a network of 12 regional Resource Access Projects (RAPs). The program profiles describe the programs' use of their TASCs and RAPs. Shortly after the site visits were completed, however, the system was reorganized, and training and technical assistance is now provided by regional Head Start Quality Improvement Centers and Disabilities Services Quality Improvement Centers.

Welfare reform has also created a backdrop of change for the Early Head Start programs. At the time of the site visits, new policies and programs were being implemented, families and staff members in community programs were learning about the new requirements and learning to operate in new ways, and community service providers were collaborating and working harder than ever to

address the needs of families facing the new welfare requirements. Many of the Early Head Start research programs were considering changes in services to respond to the changing concerns and needs of enrolled families.

The remainder of this volume presents the profiles of the 17 Early Head Start research programs. The profiles are grouped according to program approach as of fall 1997 and presented in alphabetical order by state within each group.

PART 1:
CENTER-BASED PROGRAMS*

*At the time of the site visits in 1997, the revised Head Start Program Performance Standards had not officially gone into effect and the programs had not yet been monitored. Following these two events, some programs instituted changes that are not reflected in these profiles.

EARLY HEAD START PROGRAM PROFILE

**Child Development Inc. Early Head Start
Russellville, Arkansas
October 27-30, 1997**

Child Development, Inc., a community-based organization that operates both center-based and home-based child development programs, operates an Early Head Start program for 45 families in centers located in three rural Arkansas counties. The program serves mostly white, working-poor families, many of whom are headed by two parents. The program provides full-time child development services in its centers and offers parent training and case management in group sessions and during home visits. When they enroll in the program, parents must agree to spend two hours per week on self-improvement activities, including one hour per week of developmental activity with their child. Child development services are based on the premise that children should lead by expressing their needs and interests, and the staff should be there to support them.

OVERVIEW

Child Development, Inc. (CDI) is a multi-funded agency headquartered in Russellville, Arkansas, that operates an Early Head Start (EHS) program in three rural Arkansas locations: Morrilton (Conway County), Dardanelle (Yell County), and Clarksville (Johnson County). In addition, the agency operates a Head Start program for 1,004 3-to-5-year-olds in 26 centers and 14 home-based programs in 12 counties, a migrant Head Start program for 75 families in another county, developmental child care for children ages 6 weeks to 12 years, and state-funded Arkansas Better Chance programs. CDI also serves families through vouchers and block grants from the state Department of Human Services. CDI is currently the largest provider of comprehensive developmental services to children and families in Arkansas.

The EHS program evolved from Parent Child Centers (PCCs) that CDI had operated

since 1991. As a long-time Head Start grantee, CDI has extensive experience operating both center-based and home-based child development programs. Throughout its 32-year history, CDI has participated in six major national research projects.

Community Context. Although these communities have large percentages of children living in poverty, unemployment is low, and many jobs are available in the manufacturing and poultry processing industries. Employment opportunities have attracted a large number of Spanish-speaking families to the area. CDI's target population has traditionally been working families.

Program Model. CDI operates a center-based EHS program. At each site, children attend an EHS classroom at the center from 8 a.m. to 3 p.m. Families who need child care during additional hours can obtain up to three additional hours of care before and after EHS program hours in developmental child care rooms also located

at the centers. Families pay for this additional care directly or obtain child care vouchers from the state. Program staff members work individually with parents to provide parent training and case management services during monthly one-on-one training sessions. The program also requires parents to complete two hours of self-improvement activities each week, including one hour of developmental activity with their child and one hour of self-focused activity.

Families. The CDI EHS program serves mostly white families, but nearly one-quarter of the families belong to minority racial/ethnic groups. More than half of the families are single-parent families. About 20 percent of mothers were pregnant when they enrolled in the program. A relatively small proportion of families were receiving welfare cash assistance when they enrolled.

Staffing. At the time of the site visit, program staff members included a director, three family support assistants, and 11 teachers. The program director provides overall supervision and direction for the program. She visits the centers frequently to observe classrooms and provide feedback and training. A family support assistant at each center provides backup support and supervision for teachers, works with parents on family development issues, and organizes monthly parent meetings. Teachers at each center serve as the primary caregiver for a group of children. Teachers also provide case management and family development services to parents and other family members of the children in their groups. At a minimum, teachers hold at least one individual parent training session with the parents in their caseloads each month. Other CDI specialists are available to provide services, training, and other support for the EHS program when needed.

RECRUITMENT AND ENROLLMENT

Program Eligibility. To be eligible for the program, families must have incomes at or below the poverty level, have a child younger than 1 year old, and live in Conway, Johnson, Pope, or Yell County. The target population includes white, African American, Hispanic, and Asian American families. Parents who are not working or attending school or training also must agree to work towards self-sufficiency with assistance from the program.

Recruiting Strategies. Staff members used multiple strategies to recruit the initial group of families, including going door-to-door (with an interpreter when visiting the Hispanic community); talking to local health department personnel, school counselors, and other service providers; setting up a table in the lobby at Wal-Mart; visiting area employers; putting up posters and distributing flyers at support program offices, clinics, laundromats, and grocery stores; and arranging for public service announcements in local newspapers, on the radio, and on the local university's cable television station. At the time of the site visit, the program was receiving referrals from other service providers on a regular basis and had waiting lists at two of its three centers.

Enrollment. CDI's EHS program was originally funded to serve 45 children and their families. CDI's EHS program reached full enrollment in September 1996 and at the time of the site visit, had enrolled 52 families in the program, six of whom subsequently dropped out. All of these families are participating in the EHS research.

The Head Start Bureau recently awarded CDI's EHS program additional funds for quality enhancement and expansion. The program will use these

COMMUNITY PROFILE

CDI's EHS centers are located in Clarksville, Dardanelle, and Morrilton, which serve as the county seats of Johnson, Yell, and Conway counties. The Dardanelle program also serves families from nearby Russellville, the county seat of Pope County. All of these communities are rural and have large percentages of children living in poverty.

Unemployment in the area is low, and many jobs are available in the manufacturing industry. For example, parents are employed in manufacturing plants operated by Levi Strauss (clothing) and Sarah Lee (hosiery). Jobs are also available in poultry processing plants and in the restaurant industry. Although jobs are plentiful, most pay low wages, and many employers do not offer benefits such as sick leave and vacation time. Consequently, parents with young children face significant challenges managing work and family responsibilities.

During the past three years, these communities have experienced a large influx of Spanish-speaking families from Mexico, El Salvador, Guatemala, and south Texas. Families have been drawn to the area by employment opportunities in the poultry processing plants operated by Tyson Foods and other companies.

Although staff members report that they can obtain most services that families need, gaps exist in several areas, including affordable dental and vision care for adults, affordable housing and shelters for victims of domestic violence and homeless families, pediatricians in the Morrilton area, and pediatric specialists in all communities.

CDI staff members report a high level of collaboration among community service providers. Because the area is rural, service providers must work together to make the most of available resources.

At the time of the site visit, not many services were available for families who speak Spanish. CDI and other service providers were struggling to hire more Spanish-speaking staff, translate program materials into Spanish, and design services to meet the needs of this population. When CDI hires additional staff for its planned expansion of the EHS program, the agency will try to add at least one Spanish-speaking teacher to each EHS center.

funds to increase the number of program slots to 68 and to enroll an additional 23 families. The additional funds will add at least 46 families to the research sample (23 program families and 23 comparison group families). At the time of the site visit, the program director had not yet decided whether to add slots to existing centers or to open a fourth center.

Families participating in the program possess several important strengths. Many are two-parent families with fathers who are involved with their children. CDI has traditionally served the working poor population, and almost all EHS parents work or attend school. At the time of the site visit, only five families were receiving cash assistance. Parents are motivated to learn

more about their children's development and to improve their economic situations through education and employment.

Enrolled families also face significant challenges. Many parents lack self-esteem, and virtually all parents need better job opportunities. Although CDI's EHS provides seven hours of child care per day, many families need vouchers to cover the cost of additional child care. For some parents, lack of reliable transportation is a significant barrier to working and bringing their children to the EHS centers. Some parents also lack access to health, dental, and vision care.

CHILD DEVELOPMENT CORNERSTONE

Center-Based Child Development Services. CDI's EHS program provides child development services primarily through center-based child care in three locations. The program cares for 16 children in Clarksville, 16 children in Dardanelle, and 13 children in Morrilton. Each EHS center provides child care for seven hours per day (from 8 a.m. to 3 p.m.), five days per week throughout the year.

The program strives to provide high-quality child care in its centers. Child-staff ratios in the EHS rooms are 4 to 1, and the program has obtained National Association for the Education of Young Children (NAEYC) accreditation in its Dardanelle and Morrilton centers. CDI expected to obtain NAEYC accreditation for its Clarksville EHS program by the end of 1997. The staff also strives to adhere to the EHS performance standards, NAEYC's developmentally appropriate practices, and Arkansas' Environmental Scales. At the time of the site visit, all teachers had a child development associate (CDA) credential, an equivalent or higher degree, or were actively

working toward a CDA. Each teacher is assigned four families whose children are close in age to promote continuity in caregivers and within groups of children. CDI's EHS program covers the full cost of the child care centers and provides infant formula and food for the children.

The program's approach to providing developmentally appropriate child care is based on the premise that children should lead and the staff should be there to support them. By providing a responsive and stimulating child care environment, program staff members strive to promote confidence, curiosity, intentionality, self-control, capacity to communicate, and cooperativeness in children.

All centers participate in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program, and staff members are trained in nutrition and food preparation for infants and toddlers. Parents must provide diapers, bottles, and infant formula if the family uses a formula not covered by the USDA program.

Although the program does not use a specific curriculum in its centers, WestEd's *Program for Infant/Toddler Caregivers*, a comprehensive training system for caregivers, provides the foundation for the program's approach to providing responsive care. In addition, teachers draw on a broad range of curricula and other resources--including the work of Stanley Greenspan, Thelma Harms, and T. Berry Brazelton--to promote the intellectual, social, emotional, and physical development of infants and toddlers.

COMMUNITY CHILD CARE

Although the quantity of child care in the area is sufficient to meet current demand and some area centers provide good-quality care, there are not enough good-quality slots or slots for infants available. For example, in Clarksville, CDI's center provides the only licensed infant care in the area.

With the increased availability of child care vouchers for families leaving welfare for work, many for-profit centers have opened. These centers compete for business by offering low rates. This is a self-defeating practice, because state reimbursement rates are set based on the current rates in the community. Competition by family child care homes and for-profit centers is pushing state reimbursement rates down, resulting in a lower level of quality in all centers. The unregulated child care market has also grown, further driving down the cost through competition. Finally, churches, public schools, and family child care homes with fewer than five children are exempt from licensing and are able to operate at a lower cost. All of these factors contribute to the lack of quality child care available in the community.

Working parents face difficulties in trying to obtain state child care vouchers. Like many other states, Arkansas has focused more of its child care resources on families leaving welfare than on working-poor families. For example, families not on welfare must work for a full week before they are eligible for a voucher, so arranging and paying for child care during the first week of work is a challenge. Moreover, there are not enough vouchers for all families who need them, so many families must wait several months and reapply several times before obtaining a voucher.

Other Child Care Services. Most parents enrolled in the EHS program work or attend school, and many families need more than seven hours of child care per day for their infants and toddlers. Because the EHS program is housed in centers that provide a range of developmental child care and Head Start services, the agency is able to provide up to three hours of additional child care services per day before and after the EHS program for families who need it. Parents must pay \$27.50 per week for the additional hours or obtain a child care voucher from the state to cover the cost of care. At the time of the site visit, 17 families were using these wraparound child care services, and most of these families had vouchers to cover the cost of care.

Children who arrive before the EHS program begins receive care in a developmental child care room staffed by CDI child care workers. The child-staff ratio in these rooms is 6 to 1 for infants and 8 to 1 for toddlers (these are the state-mandated ratios). The group size is 6 for infants and 8 for toddlers. At 8:00 a.m., EHS teachers bring the children to the EHS room where they remain until 3:00 p.m. Children who stay at the center after that time are taken by the EHS teachers back to the developmental child care rooms, where they remain until their parents arrive. Child care workers in CDI's developmental child care rooms must have a high school degree and participate in 10 hours of in-service training per year. These caregivers also

receive informal mentoring from EHS teachers. At the time of the site visit, the EHS program director was exploring the possibility of using a quality enhancement grant from the Head Start Bureau to provide wraparound care for EHS children in the EHS rooms and to maintain the child-staff ratio of 4 to 1 before 8:00 a.m. and after 3:00 p.m.

Other Child Development Services.

The CDI EHS program works with parents to increase their knowledge and understanding of the educational and developmental needs of their children by providing information in newsletters, weekly parent-child activities for parents to do at home, home visits by teachers and family support assistants, one-on-one training sessions at the EHS centers, monthly parent meetings at each center, and daily contacts as children arrive and leave. Each EHS center also maintains a resource library for parents and the staff that includes materials on child development.

Child Development Assessments.

Teachers conduct an initial developmental assessment of each child within 45 days of enrollment and at least every 90 days after the initial assessment. To assess children's development, the program uses the Early Learning Accomplishment Profile (ELAP). Based on the results of this assessment, teachers and parents develop individual child activity plans. The plans include the results of the ELAP, a summary of the child's strengths and weaknesses in six developmental areas, goals, and a plan for helping the child work on weak areas and achieve missed items from the ELAP. A target date is set for achieving each goal. Next, the teacher meets with the parent to review the results of the ELAP, review the child activity plan, and provide parent-child activities for the parent to carry out at home. Both the teacher and parent monitor the child's progress, and the teacher records the

date that the child achieves each item in the plan.

Health Services. At the time of the site visit, virtually all children enrolled in CDI's EHS had a medical home and were up-to-date on immunizations and well-child examinations. Most children had health coverage through Medicaid or private health insurance, and a new program called AR Kids First extends Medicaid coverage to uninsured children whose families have moderate incomes. EHS assists all families in finding a physician for their child and tracks immunizations and well-child examinations to ensure that services are provided on schedule. Children are not permitted to attend the centers unless their immunizations are current. Family support assistants will arrange transportation to and from health care providers when necessary and will follow up to make sure that children receive needed services.

CDI operates a Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) clinic and works with the local county health departments to provide services for EHS children and well-child examinations according to the EPSDT schedule. A nurse on staff at the Clarksville site conducts well-child examinations for EHS children at that center, and a nurse from the CDI central office travels to Morrilton and Dardanelle to conduct well-child examinations at those centers. Staff members make referrals to the health department and private physicians for any needed follow-up services.

Services for Children with Disabilities. If a teacher identifies potential developmental delays through the ELAP, the teacher refers the child for early intervention services, and the program director reviews the results of the ELAP. The teacher and the family support assistant at the center work with the early intervention provider to

conduct additional assessments and to provide early intervention services as necessary.

Once the assessments have been completed, the CDI disabilities coordinator, the teacher, and the family support assistant meet with the parent(s) and the early intervention coordinator to develop an Individual Family Service Plan (IFSP) and to discuss coordination of services. Service providers such as speech therapists and physical therapists typically come to the center to work with the children in the classroom. In some cases, these specialists also provide training to EHS staff members so that they can do additional work with children on a daily basis. At the time of the site visit, 25 percent of children enrolled in the program had suspected or diagnosed disabilities or delays.

Transitions. The program expects to begin working with families on transition plans six months before they leave EHS. Parents and teachers will meet with the CDI transition coordinator to work out transition plans. Transition activities will include application to Head Start, visiting the new Head Start teacher, orienting the parents to Head Start, and making sure all assessments have been completed. If the child receives early intervention services, the teacher will also work with the child's case coordinator to develop a transition plan from Part C to Part B services. If families are not eligible for Head Start, the program will help them arrange ongoing child care with CDI, if possible, or in another center or preschool program if CDI has no spaces available. Staff members will also help them plan for paying for child care and apply for vouchers.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Family development services begin when staff members hold an enrollment conference with new families and begin completing the program's Family Service Journal. The program developed the Family Service Journal to serve as the program's family partnership agreement. The journal is intended to guide each family towards self-sufficiency and was developed for use during one-on-one interactions between parents and staff.

To assess needs and plan services, teachers work with families to conduct an initial needs assessment. They develop a child description for each child in the family, a family information summary about the family's strengths and needs, and a family priority sheet. Staff members use the journal to track and follow up on all referrals made. Teachers and family support assistants also complete meeting planning sheets to document monthly parent training sessions. Families will take their completed journals with them when they leave the program.

Parent Training. An important component of the CDI EHS program's approach to the family development cornerstone is parent training, which encompasses education, skill building, and parent involvement in activities with children. Teachers and family support assistants each conduct individual parent training sessions with parents on a monthly basis. The training sessions typically last for 60 to 90 minutes and are conducted at the center or during home visits. Staff members work with parents to plan training sessions on topics of interest to parents. Teachers usually focus on topics related to child development and parenting, while family support assistants focus on topics related to self-sufficiency and self-improvement. Staff

members also use these meetings to discuss needs, make referrals, identify resources, follow up on services received, assess progress towards goals, and set new goals.

The CDI EHS program's family development services are based on the belief that the parent is the child's first and primary teacher. Staff members also believe that it is important to serve the whole family. In the family development area, the program works to empower pregnant women and parents with both the personal skills and parenting skills needed to assure optimum family growth.

To participate in EHS, parents must agree to complete two hours of self-improvement activities per week, including one hour of developmental activity with their child and one hour of self-focused activity. To meet this requirement, parents can participate in parent meetings and individual parent training sessions, do parent-child activities at home, read materials about child development, attend school, read, exercise, or do other self-improvement activities.

Education and Employment Services.

Each site has a parent learning center equipped with a computer and printer and a TV/VCR with a satellite linkup. Staff members are available to assist parents in becoming computer literate, and parents may use word processing, General Educational Development (GED), and literacy/employability software at any time. CDI's media specialist assists staff members and parents in participating in distance learning programs, including GED programs and

other personal and parenting training opportunities provided via satellite.

To arrange adult education and employment services, staff members refer families to family literacy groups and other programs located in each county. Each community has an adult education center that parents can use. Many parents prefer to begin with home study through public television and then progress to adult education classes when they feel ready. Through the adult learning centers and the parent learning centers at each CDI site, parents can work towards a GED, study for college entrance tests, participate in precollege programs, get job training in computer programs, develop resumes, and work on job readiness skills.

Several programs are available to assist parents in preparing for employment. A program for displaced homemakers conducts workshops for parents and provides support services such as transportation, child care assistance, and resume development. In Morrilton, the public schools work with adults and older teenagers in the area of job readiness. Through this program, parents can obtain information about career choices, take aptitude tests, and develop education and training plans. Finally, the Job Training Partnership Act (JTPA) program at Arkansas Tech University in Russellville provides retraining services to unemployed parents.

Health Services. The CDI EHS program works closely with a diverse group of community partners to arrange services for EHS families. When families are also involved with early intervention services, counseling, or programs operated by the Department of Human Services, staff members conduct joint planning to ensure that services are not duplicated. In addition, all families are referred to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

program, and many use the health department when they need immunizations and physicals.

The program also collaborates with several mental health service providers that work with low-income families. One of these agencies is available to provide on-site counseling services at one of the EHS centers. A licensed counselor at CDI provides initial assessment and precounseling services to children and families and makes referrals for ongoing counseling. Staff members can arrange for families to meet with this counselor, or families can contact this individual directly.

When families enroll during pregnancy, teachers and family support assistants meet with parents monthly and conduct parent training in the areas of prenatal health, birth, and newborn care. The program refers all pregnant women to area physicians and clinics and provides transportation to prenatal appointments if necessary. In addition, the program also refers these parents to birth preparation classes at local hospitals, and staff members are available to attend classes with expectant mothers if requested.

Other Services. Several civic organizations provide material assistance to EHS families. For example, last year the Junior Auxiliary in Clarksville worked with a teen parent for a year. In addition to paying medical bills, this group provided emotional support, tutoring, clothing, and other material goods. Other groups, such as the United Way and area churches and clubs, have paid for eyeglasses and dental services for parents in the EHS program.

Father Involvement. Although the program has not organized special events for EHS fathers, many EHS families are two-parent families with fathers who participate

in the program. Some fathers attend parent meetings, and several have volunteered in the EHS classrooms. Fathers also make repairs in centers, participate in fund-raisers, and attend parent group outings and social activities.

Parent Involvement in the Program.

Each center has an EHS parent group that elects a representative to interact with CDI's advisory boards and to participate in CDI's policy council. Parent groups meet monthly, usually at the centers. Sometimes, however, the program makes arrangements for other activities, such as outings to restaurants, recreation areas, bowling, hayrides, and plays.

Parent groups also organize fund-raisers for the centers. This year parents have used the funds raised to purchase a new washing machine for one center, purchase toys for the centers, and make other center improvements.

Many parents do volunteer work in the centers. Shortly after enrollment, parents submit references and undergo a background check so that they can volunteer in the classrooms with the other children. Parents provide backup support to teachers, read to children, answer phones, and do office work and cleaning. Parents who cannot come to the centers during working hours make materials for the centers, make repairs at the centers, put up bulletin boards, make bibs and cot sheets, and staff booths at community fairs.

STAFF DEVELOPMENT CORNERSTONE

The CDI EHS program is committed to providing staff with ongoing training, supervision, and mentoring and providing adequate salaries, benefits, and a pleasant

work environment to maintain high morale and minimize turnover. CDI has a career development policy giving first priority to current staff members when new positions become available.

Training. CDI provides EHS staff with extensive training in a variety of topics. EHS staff received more than 80 hours of preservice orientation covering the EHS cornerstones and principles, case management, family-centered services, effective listening and communication, effective home visiting, building relationships, development and implementation of child activity plans, services and support for families with disabilities, cardiopulmonary resuscitation (CPR) and first aid, and continuous and responsive caregiving.

EHS staff members also participate in annual preservice training conducted by CDI for all Head Start staff members prior to the beginning of fall Head Start enrollment. This training includes cross-training in all Head Start components, developmentally appropriate practices, and family-centered services.

All of the pre- and in-service training conducted by CDI provides continuing education credits (CEUs) through Arkansas Tech University. CDI has also developed training videotapes and owns an extensive collection of other training videotapes developed by early childhood experts. The videotapes rotate from center to center on a monthly basis for use by staff members on-site.

EHS teachers also receive regular individual and small-group training on-site from the EHS director, their center's family support assistant, CDI specialists, and mentors. In addition to on-site training, teachers participate in regular in-service

training sessions conducted by CDI's executive director, specialists, and other CDI staff members, as well as consultants from the Technical Assistance Support Center (TASC), Resource Access Project (RAP), and other community and state agencies.

Family support assistants receive monthly training at CDI's central office on advocacy, empowering parents to meet their own and their family's needs, and obtaining resources and making referrals. The training focuses on a wide range of topics, including child abuse, substance abuse, child development, domestic violence, social service needs, and cultural issues. During the past year, EHS staff members participated in an in-depth training series based on WestEd's *Program for Infant/Toddler Caregivers* that was conducted by the program's TASC consultant.

At CDI's request, Arkansas Tech University developed an early childhood associate of science degree requiring 21 credit hours of courses. CDI will pay all tuition and fees and provide release time for staff members to complete the 12 credit hours needed to prepare for the child development associate (CDA) credential and will work with staff to facilitate completion of the associate's degree. CDI can also arrange for staff members to participate in an alternative CDA program for those who do not wish to take college courses.

Supervision and Support. Teachers work in the classroom for seven hours per day (8 a.m. to 3 p.m.) and spend one hour per day in training, working with parents, or doing paperwork. Staff members also use this time to talk about issues, share ideas, and plan activities. This planning hour provides the staff with an important opportunity for peer support. New teachers are also assigned mentors, who help them learn to do home visits, help them learn

WELFARE REFORM

Arkansas implemented its welfare reform program in July 1997, so the community had not yet felt the full impact of the new program. Approximately 13 percent of EHS families were receiving cash assistance when they enrolled in the program. Under the new policies, TANF recipients are required to work within one month of receiving benefits. Parents of infants under 12 weeks are exempt from the work requirement, and other parents of infants under 12 months are exempt if child care is not available. Families may receive TANF cash assistance for a maximum of two years.

Because there is a 12-month time limit, communities expected to feel the program's impact in 1998. CDI staff members think that there are enough jobs in the community to employ everyone who leaves welfare for work, and they report that many families have gone to work before reaching the end of their time limit. For example, according to the center director in Clarksville, at the time of the site visit only 33 families in Johnson County received cash assistance. In addition, the state now provides more support services for families leaving welfare for work, such as transportation and child care subsidies for up to three years after parents begin working. CDI staff members believe that these support services, especially child care, will enable parents who leave welfare for work to stay employed.

CDI's target population has traditionally been working-poor families, so not many families enrolled in EHS receive welfare. At the time of the site visit, only five families in the program received cash assistance. Consequently, program staff members do not expect welfare reform to have a significant impact on the program.

how to complete paperwork, and serve as a training resource.

The EHS program director visits each center on a weekly basis to provide supervision, training, and support. Family support assistants at each center provide daily supervision and support for teachers and convene a staff meeting with teachers each week. In addition, family support assistants provide backup assistance in the classroom to provide release time for teachers to meet with parents.

The program is staffed by teachers and family support assistants who were laterally

transferred from the PCC program and CDI's Teen Parenting Program, which ended in May 1995. Initially, caregivers in the EHS classrooms were hired as teachers and assistant teachers, and the salary scale was lower than the scale for Head Start teachers. However, in October 1997 the agency upgraded all assistant teachers to teacher positions and placed all EHS teachers on the same salary scale as the agency's Head Start teachers.

Staff Turnover. Three of 14 staff members left the program during the year prior to the site visit. The family support assistant at one site was promoted to center

director. One teacher left the program to move out of state, and another teacher left the program for personal reasons.

COMMUNITY BUILDING CORNERSTONE

Staff members believe that CDI and the EHS program must become part of the total community--by building a reputation as a team player, collaborating with other community service providers, creating linkages with the business community, including community representatives on its advisory boards, and building community among EHS families.

Program Collaborations. The CDI EHS program benefits from the many collaborations CDI has already established. In 1997, CDI had written partnership agreements with 24 state and local agencies and informal verbal agreements with 31 agencies.

Interagency Collaboration. CDI and EHS staff members also participate in many state, regional, and local interagency coordinating groups, such as Children and Adolescent Service System Providers (CASSP) teams, Child Protection Teams, Welfare Reform Committees, and Child Sexual Abuse Teams. EHS staff members have also worked on forming relationships with local industries and making arrangements with them to visit parents during their lunch break at their workplace.

The CDI EHS program also benefits from CDI's two advisory committees: the Education, Social Services, and Parent Involvement Committee and the Health, Mental Health, Nutrition, and Disabilities Committee. There are no separate advisory committees for EHS, but each EHS parent committee has a representative who can

work with the advisory committees. In 1997, these advisory committees involved more than 20 community representatives. In 1998, this structure will be modified to create an advisory committee for each county. These county committees will be divided into subcommittees according to subject areas.

Community Building Among Parents.

In addition to building community among local agencies and businesses, staff members feel that building community among EHS parents is important, because many of the families have the same needs and can help each other by sharing baby-sitting and transportation. Moreover, they believe that peer interaction can be an effective way to influence behavior. The program encourages families to participate in community activities by planning field trips, posting notices of community activities on bulletin boards in each center, and helping parents become involved in the public schools. Staff members have also worked to build community among EHS parents by forming parent groups at each EHS center. Monthly parent meetings are held in the evening during hours when most parents are not working.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. CDI's EHS staff have received training and technical assistance from several sources. Staff from Zero to Three worked closely with the EHS program director to develop the program's continuous improvement plan. CDI's TASC consultant visited the program monthly from January through June 1997 to train seven staff members on WestEd's *Program for Infant/Toddler Caregivers*. CDI's RAP consultant provided or arranged for staff

training on family relationships, cultural issues, and home visiting. Others who have provided training to EHS staff include local Part C providers, local community service providers for non-English-speaking populations, substance abuse treatment specialists, domestic violence counselors, child abuse specialists, and mental health specialists.

Continuous Program Improvement.

Continuous improvement is primarily the responsibility of CDI's EHS program director. She has used the agency self-assessment, the family need assessments, and staff self-assessments to develop a continuous improvement plan. She also has involved staff from all levels, parents, and community members in developing the plan. During the past year, she has updated the plan on a quarterly basis by revising the staff training plan and documenting training completed.

Local Research. A team of researchers at the University Affiliated Program/Department of Pediatrics at the University of Arkansas, who specialize in research on early childhood development and children from low-income families, are serving as the CDI EHS program's local research partner. They are studying adult relationships in EHS and investigating the role these relationships play in moderating the effectiveness of the program.

During the past year, the team has been working on an assessment of EHS mothers and their relationships with their own mother figures, usually the focus child's grandmother. For those young mothers who receive substantial support from the focus child's grandmother or another mother figure, the local research team is conducting a videotaping protocol during a local research data collection visit. During the videotaping session, a researcher asks the mother or grandmother to initiate a

discussion about an unresolved problem and then talk about how to resolve it. After this discussion has ended, the researcher asks the mother and grandmother to switch roles and repeat the process with a second unresolved issue. Out of 50 local research data collection visits completed at the time of the site visit, approximately 45 percent had a suitable grandmother figure for conducting the videotaping. The videotapes will be coded by the protocol's developer at the University of Chicago.

The local research team is also gathering additional data about the parents and their own characteristics and behavior. The team is attempting to learn about their behaviors, especially in the areas of independence, productivity, and relationships. At six months after enrollment, the local research team is collecting data on the parents' level of physical activity, nutritional status, nutrition behavior, and drug use. In addition, at that time local researchers assess the parents' involvement with the child and the parents' attachment to the child using an adult attachment scale. At 15 months after enrollment, the local research team will gather data about the history of infant feeding, maternal activities such as exercise and television usage, household nutrition patterns, the household food environment, and food frequency. A nutritionist on the university's faculty helped the team design its nutrition component.

PROGRAM SUMMARY

The CDI Early Head Start program provides much-needed center-based child development and child care services to working-poor families in four rural Arkansas counties. CDI provides wraparound child care to accommodate the schedules of working parents. The program emphasizes

parent training and requires that parents spend two hours per week on self-improvement activities. At the time of the site visit, the program had just received quality improvement funds and planned to increase enrollment. Staff members were also considering using some of these funds to provide higher-quality wraparound child care as part of the EHS program.

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EARLY HEAD START PROGRAM PROFILE

Family Star Early Head Start Denver, Colorado November 3 - 5, 1997

Family Star, which operates a Montessori school for infants and toddlers, operates a new Early Head Start program for 75 families at two centers in northeast and northwest Denver, Colorado. Many families served by the program are Spanish-speaking Latino families. The program provides full-time child development and care in Family Star's Montessori school while parents are working or in school and offers monthly parent education meetings. Program services are child-centered, and staff members speak both Spanish and English with the children.

OVERVIEW

Family Star operates an Early Head Start (EHS) program in Denver, Colorado. Family Star began in 1989, when a group of citizens took over an abandoned building being used as a crack house across from the Maria Mitchell Elementary School (a Montessori school) in northeast Denver. They turned the building into a Montessori school for children ages 0 to 6. Family Star expanded in 1997 and opened a school in northwest Denver, where most of the EHS children are served.

Community Context. Family Star serves families living in the poorest areas of Denver. Northwest Denver has problems common to many urban areas, including high levels of poverty, crime, and substance abuse, as well as a lack of services (most notably child care, affordable housing, and public transportation). Community leaders are committed to improvement and have formed collaborations to address these problems.

Program Model. Family Star is a center-based child development program providing services in two centers. Children receive full-time care in Family Star's Montessori school while their parents are working or in school. The family services advocate works with families to develop family goals, and she reviews their progress toward those goals. Families receive home visits from their child's directress/director (the lead teacher) before families enter the program and again when children make a transition to a new classroom (usually when they are 14 months old).

Families. Family Star serves diverse families. Two-thirds are Hispanic, and one-third belong to other racial/ethnic groups. The majority of families are single-parent families, but about one-third of families include two parents. Approximately one-fifth of the mothers were pregnant when they enrolled in the program. About one-third of the families were receiving welfare cash assistance when they enrolled.

Staffing. The Family Star staff members who care for children include 5 directresses, 1 director, and 12 assistants. Family Star also employs three part-time assistants who provide coverage when staff members are absent or must leave early. The Montessori mentor observes staff as they work with children and provides individual and group feedback, which is also used to plan staff training sessions. The health coordinator and infant/mental health specialist work directly with families as needed and also provide staff training and consultation. The family services advocate is responsible for all recruitment and enrollment activities, and she works with families to link them to needed community resources. The child services coordinator schedules the child development center staff, plans and conducts staff training, and oversees the program's adherence to the Montessori approach. The program coordinator oversees all aspects of the program, facilitates the program's health services advisory council and policy council, and serves as a key link to the Head Start community. The executive director is a community leader who creates and maintains collaboration among community agencies and programs serving children.

RECRUITMENT AND ENROLLMENT

Program Eligibility. Family Star serves families who live in northwest Denver, between Interstate 70 and Alameda Boulevard from north to south, and from Sheridan Avenue to Broadway from west to east. Families must meet the EHS income guidelines, be working or in school, and have a child between the ages of 7 and 12 months. (The age requirement was designed to facilitate enrollment in the research.) For its infant/parent classroom, Family Star recruited 10 expectant mothers. The program also targets Spanish-speaking

families, homeless families, and families with children who have special needs.

Since its beginnings in northeast Denver, Family Star's approach has been to develop a program that serves families at all income levels, with a sliding-fee scale. The executive director plans to expand the northwest program to include families from all income levels, because she believes that a mixed-income model is the best way to support a high-quality child development center and enrich the lives of all families in the community.

Recruiting Strategies. Family Star staff members use many strategies to recruit families. Those strategies include sending flyers out from the city's Department of Social Services and from local high schools, canvassing door-to-door, advertising on the radio, conducting over 50 community presentations, and providing an orientation to the program for community members. To overcome strong cultural beliefs against having strangers care for very young children, the program has worked intensively to introduce itself to the community. Referrals from other community service providers have been the best source of families to target for recruitment.

Enrollment. Family Star's Early Head Start program is funded to serve 75 families, all of whom will participate in the EHS evaluation. At the time of the site visit, Family Star was serving 52 children at the northwest center, 38 of whom were participating in EHS and the national research (the children who were not in EHS were older or were from families who did not meet the EHS income guidelines). The northeast center was serving seven EHS nonresearch children. Since Family Star began providing EHS services, five families have left the program because they moved,

COMMUNITY PROFILE

Family Star serves families living in four neighborhoods in northwest Denver, Colorado. Denver is a booming city that has grown substantially in the past 10 years. The housing and job markets are very tight, and the cost of living has increased. The vacancy rate in Denver is three percent, and affordable housing is lacking. Northwest Denver is home to a diverse community that includes approximately 70 percent Latino families. Part of the area Family Star serves is located in an Enterprise Zone.

Northwest Denver has problems common to many urban areas, including crime, drug use, a high teenage pregnancy rate, low high-school completion rates, and heavy traffic. Approximately 40 percent of families in the area are at or below the federal poverty level, and half are headed by single parents. The high school dropout rate ranges from 6 to 65 percent across the four neighborhoods.

Few low-skilled jobs are available in the area. Parents reported that most jobs that pay well require technical training. Parents believe that transportation is a barrier to finding better positions, because many large employers are located in the suburbs, and there is no fast, reliable public transportation system. At the time of the site visit, Denver citizens voted down a proposal to build a light rail system to link the growing city to its sprawling metropolitan area. Community leaders hope to address the transportation issue over the next few years.

Local service providers and EHS staff reported that many services are available in the community, but they are often insufficient, and families do not know how to access them. In particular, the supply of affordable, quality child care is insufficient, and affordable housing is lacking.

Funders have encouraged service providers in Denver to coordinate services for low-income families. The network of community health clinics is strong and provides high-quality health care for low-income families. Many other successful collaborations have been developed. Community collaborators reported, however, that Head Start and the public health community have not cooperated with each other in the past. The Family Star staff members have worked with community partners to improve collaboration; in the past year, they have brought in a dentist to conduct dental screenings for all of the children, arranged for staff members to receive donated vaccines, and held a community-wide disabilities screening at the school.

A significant strength of the community is its commitment to programs that serve young children. Colorado has had a state-run preschool program since 1992. It serves approximately 1,500 at-risk three- and four-year-old children in Denver. The governor and the mayor have commissioned a variety of panels to study such topics as the availability of child care and the effects of new welfare reform requirements on children. A new initiative, called Educare, brings together the business, education, and child care communities concerned with early child care and education. The Family Star executive director is a community leader who is often invited to participate on panels that recommend strategies to develop programs to serve children in Denver.

lost custody of their child, or did not actually live in the program's service area.

The families the program serves are culturally diverse; about two-thirds are Latino, 10 percent are African American, 10 percent are white, and the rest are from mixed ethnic backgrounds. The program's focus is on serving Latino families; therefore, most of the staff are bilingual. Both Spanish and English are spoken with the children throughout the day. Fifteen percent of the mothers enrolled in the program are teenagers. The majority of families are single-parent families.

Enrolled families bring a variety of strengths to the program. Many are highly motivated to succeed and meet their education and employment goals, and they are responsive to the help and input they receive from the program. Families also have a range of needs, including transportation, child care, better employment opportunities, and affordable, safe housing.

CHILD DEVELOPMENT CORNERSTONE

Center-Based Child Development Services. Family Star provides full-time child care services Monday through Friday from 7:30 a.m. to 5:30 p.m. Children who are 2 to 14 months old are cared for in the Nido (an Italian word for nest). At the time of the site visit, the maximum group size in the Nido was 10, and the child-adult ratio was 3 to 1. When children are about 14 months old, they move to the Infant Community. In the Infant Community, the maximum group size is 10, and the child-adult ratio is 5 to 1. Each classroom is led by a Montessori directress or director, who must hold an Association Montessori

Family Star staff members believe that their Montessori curriculum and approach (which requires a well-trained, aware adult, a prepared physical environment, and children who are given the structure and materials they need) will improve child development outcomes by supporting child exploration, communication, development of trust, and independence.

Internationale (AMI) diploma. Each directress/director is supported by assistants, who are trained by the program on the Montessori approach and other aspects of caring for children in the school.

Everything Family Star staff members do in the classrooms is child-centered. Staff members provide direction, while the classroom environment and routine give a sense of order, helping to establish appropriate sleeping and nutritional habits for the children. Because Family Star emphasizes a respectful, multi-cultural approach, staff speak both Spanish and English with the children. Because the classrooms were designed to "fit" children and meet their needs, everything is child-sized. Parents are indirectly affected by these practices, and many parents begin to institute these patterns at home.

In February 1997, the program conducted an infant/parent classroom (I/PC) for 10 expectant first-time mothers and their male partners. Four of the mothers were teenagers. For eight weeks, the I/PC met in the school three times a week for three hours a day. Expectant parents participated in the prenatal curriculum, which introduced them to the Montessori approach and what it was

COMMUNITY CHILD CARE

The Family Star EHS program provides full-time child care, and at the time of the site visit, none of the children were receiving care in other child care arrangements.

In the four neighborhoods Family Star serves, six child care centers serve children under age 3. Community leaders believe that child care availability and quality will become larger issues as more families in the community reach the welfare reform time limits during the next two years. Community partners and parents noted that many members of the Latino community have strong reservations about leaving their children in the care of paid child care providers, because their preference is to have parents or other close relatives care for their children. Parents reported that after getting to know the Family Star staff members and seeing how well their children are cared for, their concerns have decreased. Staff members believe that community attitudes toward center care and using child care in general will change as more parents and community leaders share their experiences working with Family Star.

like to become a parent. The I/PC also provided an opportunity for additional social support and sharing. The directress who conducted the class visited each family at home after the baby was born to help it set up the best environment for its newborn. Seven of the 10 families who participated in the I/PC enrolled their children in the school. Staff reported that those parents seem more sure of themselves and have had fewer problems adjusting to the demands of the program than other parents who did not participate in the I/PC. The program plans to conduct the I/PC again.

Family Star requires parents to prepare and bring nutritious food for their children that is consistent with the Montessori approach. Children under six months old receive ground solid foods that consist of protein, grains, vegetables, and fruits. Older children eat solid food. Staff members discourage parents from sending sweets or “junk foods.” All children over six months old drink from glasses, use “real” plates and utensils, and sit on child-sized chairs at

small tables for all meals and snacks. Children help with preparing meals and with cleaning up, and they eat at their own pace. Everything is done at the children’s pace. The Montessori curriculum also prescribes the approach to toilet learning and to the structure of the classroom’s physical environment, which parents learn about when they enroll their child in the school.

Group Child Development Activities.

The program provides parent education through informal teaching and modeling when parents drop off and pick up their children, discussions at monthly parent meetings, and special program activities. Parent meetings are held one evening a month in the program’s large staff room/kitchen. The staff conducted a parent interest survey to determine which parent education topics would be of interest. At the time of the site visit, the infant/mental health specialist was preparing to discuss guidance and discipline at the next parent meeting. Parent meetings are well attended, with approximately 40 parents participating.

Family Star's community includes some grandparents who are primary caretakers for children in the program. Staff members are working to support these grandparents and their unique needs. One grandparent organized a support group that provides a forum for grandparents to discuss their concerns and share them with each other.

Child Development Assessments.

Family Star directresses/directors conduct formal assessments of progress toward early childhood education and parenting goals three times per year using the *Ages and Stages Questionnaires*. They conduct informal assessments and observations in the classrooms more frequently. Classroom staff use the results of the assessments as they develop each child's individual lesson plan. They complete the assessments with parents at parent conferences held at the school three times a year. At the parent conferences, they also discuss the assessments, set goals, and plan how to meet those goals.

Health Services. At the time of the site visit, the program had recently hired a part-time health coordinator to monitor the children's physical health, oversee staff training and parent education in the health area, and monitor child and family health services. The health coordinator will also work with the program's infant/mental health specialist to meet child and family needs for mental health services. The infant/mental health specialist works directly with families and serves as a resource for staff who have concerns about particular children and families. In the past six months, the program has arranged for on-site dental screening for every child over 12 months old, and the community's Part C (formerly Part H) provider has used space at the school for a community-wide bilingual screening for children suspected of having developmental delays.

Services for Children with Disabilities. If staff members suspect that a child has a disability or delay, they refer the family to the Part C provider for further evaluation. For one child, who came to the program with severe medical complications, staff have worked with the parent and other community service providers to accommodate the child's needs in the classroom environment. At the time of the site visit, 6 percent of enrolled children had a suspected or diagnosed disability.

Transitions. Within six months of each child's third birthday, the child's directress/director and members of the family services team will work with the family to create a summary of the child's skills in seven areas and begin planning for the child's transition out of the program. The group will review the child's development status, discuss the child's readiness to make the transition, and discuss program options that are available in the community.

If the child will move into a Family Star program for 3- to 5-year-olds, one month before the child's third birthday, the parent will meet with the releasing and the receiving directress/directors to develop a phase-in plan. If the child is moving to a program outside of Family Star, staff will develop a phase-out plan, which will include visits from the receiving teacher to Family Star and visits from Family Star staff and the family to the new program.

The program coordinator hopes that each child can be accepted into Head Start, and at the time of the site visit, the program's executive director and the program coordinator were working to develop a Montessori Head Start program that would be administered by Family Star.

FAMILY DEVELOPMENT CORNERSTONE

To be eligible for the program, parents must be in school or working full-time. Even during the summer months, teenage mothers are required to bring their children to the center. If a parent loses a job or quits school, the program works with them to revise their family development goals. Program staff members see themselves as resources for families, and the family services advocate maintains a community resource guide. Her office, near the school entrance, serves as a resource center. At the time of the site visit, the program administrators planned to have the newly hired male involvement coordinator and health coordinator also serve as members of the family services team.

Staff members believe that the high-quality child development program they provide gives families the confidence to pursue their educational and employment goals.

Needs Assessment and Service Planning. The family services team and the directresses/director work with families to conduct a needs assessment and develop three family goals. The family services team and the program coordinator support families as they choose their goals and work toward them. The family services team provides referrals to community service providers and formally updates goals every six months. Staff informally monitor progress toward reaching goals during

conversations with families when they drop off or pick up their children.

Education and Employment Services. Family Star refers many families to MiCasa, a program that helps families develop long-term education, training, and employment goals and provides additional referrals and coordination of services to meet those goals. In the coming year, the staff plans to offer GED, English as a Second Language, and computer classes at the Family Star school.

Father Involvement. At the time of the site visit, the program was in the process of hiring a male involvement coordinator who would serve as a role model for the fathers in the program and run a father support and discussion group.

Fathers are very active in the program. Staff members reported that fathers drop off or pick up their children about half of the time. Fathers also attend parent meetings and policy council meetings.

Parent Involvement in the Program. Parent meetings, the policy council, and the program's newsletter are key parent involvement activities. In response to the results of the parent interest survey, parent meetings in the coming year will include discussions of family development topics. The program coordinator facilitates the work of the policy council, which includes three parents of children in Nido, three parents from the Infant Community, and two parents from the northeast Family Star program. The program's newsletter is distributed quarterly to all families and contains articles by parents and staff members about Family Star activities, child development topics, and parent education topics.

STAFF DEVELOPMENT CORNERSTONE

Family Star's Montessori approach guides its staff development activities. Staff receive support for becoming accomplished Montessori teachers and assistants. The program administrators believe that it is their responsibility to help staff prepare professional development plans that include staff agreements about how they plan to do their jobs and commitments to specific attendance goals. The professional development plans will include goals in areas such as English and Spanish literacy, GED attainment, and computer proficiency. Professional development plans will be reviewed formally once a year and updated informally every six months.

Training. Because it is very difficult to find Montessori teachers who are certified to work with children from birth to age 3, Family Star hired eight candidates to be trained as Montessori directresses/directors. This group signed a contract to work for Family Star for three years in exchange for 10 months of intensive Montessori training and the 350 hours of observation required to attain an Association Montessori Internationale diploma. Staff members were hired based on their affinity for children and experience working with them, rather than on their professional degrees. The program also sought bilingual employees.

All assistants received six weeks of training before the school opened, and they received Montessori assistant certification. Many of the assistants are EHS parents. Their children receive care in the center but not in the same room in which they work. Other Family Star staff members can enroll their children in the school at a reduced tuition. All new assistants receive on-the-job training and mentoring.

The program hired a part-time Montessori mentor to work with staff and provide training and support at the individual, classroom, and school levels. Using the Montessori approach, she observes staff and individual children. She often asks classroom staff members to spend time observing the children they work with and discuss their observations with her. The Montessori mentor provides hands-on modeling and immediate feedback to staff. The Montessori mentor and the child services coordinator identify staff training needs by observing staff and by discussing their needs with them.

The executive director, program coordinator, and Montessori mentor plan to evaluate the Montessori training requirements that staff members have met already and compare them to the requirements for the child development associate (CDA) credential. To meet the education credential requirements in the EHS performance standards, they will identify parallels between the Montessori training and the CDA requirements.

In addition to their Montessori training, staff receive training on the basic health and safety issues necessary to meet the school's licensing requirements. Staff members are also trained to work effectively with parents, so they can foster strong relationships with parents. Staff believe that by building strong relationships with parents, they are able to communicate even very sensitive information to parents (such as concerns about suspected developmental delays).

Supervision and Support. The Nido and Infant Community directresses/directors meet once a week with the child services coordinator for group supervision that covers all aspects of their work, from classroom staffing to how individual children are doing. At the time of the site

visit, staff informally received individual supervision of their work during conversations with the child services coordinator, the Montessori mentor, and the program coordinator.

It is Family Star's policy to hire staff members from the immediate neighborhoods they serve. Family Star's director grew up in northeast Denver.

Program administrators have found that staff at their northeast school are highly committed to their work. Family Star staff members receive competitive wages and generous fringe benefits.

Staff Turnover. Since the northwest school opened in February 1997, three of the assistants have left the program and been replaced. Two of the assistants who left moved from the area, and the other decided that child care was not her desired profession. None of the directresses or the director have left the program.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. Family Star staff have worked hard to introduce the EHS program to their new community. Before the school opened, staff met with over 50 community leaders and other community service providers to introduce themselves and begin forging collaborative relationships. Staff members also used these meetings to learn about the resources available to families in their community.

Because of the difficult experiences the Latino community has had with research studies in the past, community leaders were concerned about the implications of randomly assigning families to the program. To address this concern, staff helped the

community understand the importance of the EHS national evaluation.

Community service providers have responded to Family Star's dedication to improving the experiences of children and families in their community by contributing their own time and the time and resources of their organizations to help Family Star meet the needs of EHS families. Members of the health services advisory council reported that their personal interactions with Family Star staff, who follow up immediately with them when they promise to help the program, make Family Star stand out from other similar organizations. Family Star staff take full advantage of opportunities to collaborate and receive services and training for family and staff. Community collaborators appreciate the persistence of Family Star's staff members and their dedication to their mission.

Family Star grew out of the Montessori elementary school program that was located in northeast Denver and planned to provide Montessori education for children from birth through sixth grade. The Denver Public Schools moved the Montessori elementary program to another area of the city. Family Star has been collaborating with one of the new Head Start grantees, Rocky Mountain Ser, to administer a Montessori Head Start program in northwest Denver, so that the EHS children in northwest Denver can receive a Montessori education from birth to age 5 and then have the opportunity to apply to the Montessori elementary school. At the time of the site visit, Family Star was negotiating with Rocky Mountain Ser and its landlord to determine whether additional classrooms could be added to the northwest facility for Head Start.

Interagency Collaboration. Family Star staff believe that they have improved the quality of care available in their

WELFARE REFORM

Colorado's new welfare policies limit the amount of time individuals can receive TANF cash assistance to five years over their lifetime. After two years, recipients must work. Counties may choose to exempt families with very young children from the work requirement. Approximately one-third of Family Star families were receiving cash assistance when they enrolled in the program. Child care subsidies are available to parents with incomes below 130 percent of the poverty level (or up to 185 percent of the poverty level, at county option).

At the time of the site visit, welfare reform had not had a large impact on the program, because all of the families who participate must be involved in education or employment activities. The program coordinator reported that many parents are referred to MiCasa, a cooperating service organization that provides education and employment services for families. She believes that families will access more of Family Star's family development services in the coming year because of the welfare reform requirements.

community and that they serve as a model for the community of what a high-quality program for infants and toddlers can be. Community service providers are welcome to observe at the school and speak to administrators about what it takes to develop and implement a high-quality program for young children. Family Star's executive director plans to work with other community leaders to help parents and grassroots community organizations build similar child development programs in other parts of Denver.

Family Star staff members serve on many community collaboration committees, including the mayor's Head Start commission, an alternative school's advisory council, the voting district's interagency council, a local Part C interagency council task force, and northwest's teen pregnancy prevention council. The program coordinator leads the area's neighborhood nutrition collaboration.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. Family Star received extensive support from its TASC consultant during the early stages of program implementation. It also received key support from its RAP and Zero to Three consultants and from its federal project officer. This group of professionals guided Family Star's development of comprehensive services, including assistance with service plans, designing training sessions, developing systems for program governance, and ensuring that quality services for children, families, staff, and communities would be in place.

Continuous Program Improvement. Two faculty members from the Center for Human Investment Policy at the Graduate School of Public Affairs, University of Colorado at Denver, serve as Family Star's continuous program improvement (CPI) consultants. Family Star's local research partner recommended them to the program.

The CPI team worked with staff members to explore their theories of change and developed an outcomes matrix listing the outcomes that the staff expects to affect under the four cornerstones. The CPI team also talked with the staff about how they will measure their progress, and it will develop ways to measure the program's chosen outcomes.

Local Research. A team of researchers from the University of Colorado's Health Sciences Center is serving as Family Star's local research partner. The University of Colorado researchers, whose backgrounds are in psychiatry, psychology, human development, and anthropology, are experts on the socioemotional development of infants and toddlers, interventions targeting families in poverty, and risk research, and they have extensive experience conducting large-scale, longitudinal research projects.

The local research team is focusing on understanding which parts of the program work best for whom, with an emphasis on understanding individual differences in each child's development and caregiving context. They are assessing the building of positive relationships, the development of socioemotional competence (including early moral strengths), and the intentional and self-directed activities of the child as they relate to readiness for learning. They are supplementing the national data collection with observations of the families, process observations, and ethnographic observations and interviews. The researchers have also developed a form that staff use weekly for each child to document the child's experiences in the classroom. The researchers will use this information to describe the intensity and type of services each child received.

PROGRAM SUMMARY

Family Star provides full-time center-based child development services to working-poor families, many of whom are Latino, single-parent families. The center provides culturally-sensitive, child-centered services using the Montessori curriculum. At the time of the site visit, the program was in the process of adding staff to strengthen services in several areas, including health and father involvement. The program had just hired a health coordinator to coordinate and oversee health-related services and was planning to hire a male involvement coordinator to support fathers' involvement in the program.

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EARLY HEAD START PROGRAM PROFILE

Educational Alliance Early Head Start New York, New York October 15-20, 1997

The Educational Alliance, a community-based organization that began as a settlement house and now provides many services, including Head Start, in New York City, operates an Early Head Start program for 75 families in 3 centers. One center is located at the Educational Alliance headquarters, one is located in a school for pregnant and parenting teenagers, and one is located at a residential program for pregnant and parenting substance-abusing women. The families served by the program are ethnically diverse, predominantly single-parent families, about one-third of whom receive welfare cash assistance. The program emphasizes the development of supportive relationships and mental health, and in addition to center-based child development services, provides families with psychotherapy services.

OVERVIEW

The Educational Alliance is a large, century-old social service agency that began as a settlement house and Jewish community center in lower Manhattan. It currently provides a wide range of services, including Head Start and child care services. It operates an Early Head Start (EHS) program with three sites in New York City: (1) the Educational Alliance headquarters on the Lower East Side of Manhattan; (2) Teen Aid, a Brooklyn school that is part of the New York Board of Education's Program for Pregnant and Parenting Services; and (3) Veritas, a residential drug rehabilitation program for pregnant and parenting substance abusing women in the Manhattan Valley area of Manhattan. The Veritas site was added in July, 1997; it replaced a planned site in another New York City public high school that did not work out.¹

Community Context. The Lower East Side of Manhattan, where the Education Alliance headquarters are located, has a history of being home to recent immigrants and is the most racially diverse area of the city. Housing projects and old tenements are the dominant types of housing. Poverty, unemployment, drug trafficking, and a lack of affordable child care--especially for infants--are problems in the area. The Teen Aid and Veritas sites serve mothers who come from all over New York City. Nearly all of these young mothers are members of racial/ethnic minorities; most are Hispanic or African American.

Program Model. The Educational Alliance EHS program is a center-based child development program with state-of-the-art classrooms in each of the three sites. This EHS program emphasizes the development of supportive relationships--

¹Since the site visit, Veritas and Educational Alliance Early Head Start discontinued their affiliation.

among family members, between staff and families, and among staff members themselves--and mental health. It also stresses infant mental health. In keeping with these emphases, the program provides families with psychotherapy services, including individual counseling, parent-infant therapy, group therapy, and marital/couple counseling.

Families. Slightly more than one-third of the families served by the Educational Alliance EHS program are African American, about one-third are Hispanic, and the remainder belong to other racial and ethnic groups. Most of the families are single-parent families. Nearly one-fourth of the mothers were pregnant when they enrolled in the program. More than one-third of the families were receiving welfare cash assistance when they enrolled.

Staffing. The staff of the Educational Alliance EHS program consists of a program director, a social worker, three clinical case managers (one for each site), a father involvement/adult educator, three educational supervisors (these are head teachers--one for each site), and four to eight paraprofessionals for the classrooms. The program director has extensive experience in infant mental health and serves as the co-president of the New York City Zero to Three Network.

RECRUITMENT AND ENROLLMENT

Program Eligibility. To be eligible for the Educational Alliance EHS program, families must have incomes at or below the poverty level and have a child younger than 12 months. In addition, at the Teen Aid site, EHS participants must be pregnant and

parenting teenage mothers who are enrolled in that high school. At the Veritas site, participants must be homeless (this includes those recently released from other institutions, especially prison), substance-abusing, pregnant or parenting women.

Recruiting Strategies. Educational Alliance staff members use a variety of strategies to recruit families. Staff members distribute pamphlets, go door-to-door in housing projects, and stop mothers and children on the street. They also conduct community outreach by making presentations at hospitals, obstetrician-gynecologist offices, and community service agencies. The program director identified these community outreach activities as the most fruitful recruiting method.

Recruitment for the EHS Teen Aid site is conducted through the public school system and through the "Babygram" program within the Board of Education's Pregnant and Parenting Services division. The Babygram program identifies and recruits teenage mothers in the hospital immediately after they have given birth. A special effort is made to recruit young mothers who have dropped out of school, especially those who have dropped out in anticipation of not having child care for their children.

Recruitment for the Veritas site is conducted at the Rikers Island Correctional Facility by an EHS staff member who previously worked at the prison and has maintained contact with Rikers staff working with substance-abusing women.

Enrollment. The Educational Alliance EHS program has contracted to serve 75 families. At the time of the site visit, 28

COMMUNITY PROFILE

The Educational Alliance EHS program serves families from all over New York City. The program site at Educational Alliance's headquarters is located on Manhattan's Lower East Side. The Teen Aid site is located in Brooklyn, and the Veritas site is located in the Manhattan Valley area of Manhattan, but both of these sites enroll families from all over the city.

In 1990, the population of New York City's District 3 (the Lower East Side of Manhattan), where the Education Alliance headquarters is located, was approximately 163,000, although this number does not reflect the many illegal immigrants. It also does not reflect the many illegally housed (two and three times as many people in a household than is legally permitted, which is perceived to be the case in at least 20 percent of Lower East Side households). District 3 is the most racially diverse district in Manhattan, with a history of being home to recent immigrants. At the turn of the century, this population consisted principally of former Eastern Europeans. Today, most of the Lower East Side's recent immigrants are Hispanic (mostly Dominican) or Asian (Chinese and Vietnamese). Approximately 32 percent of Lower East Side residents are European American, 32 percent are Hispanic (mostly Puerto Rican and Dominican), 30 percent are Asian American, and 8 percent are African American.

On the Lower East Side, 16 percent of the households are headed by a female, and 62 percent of these include children. About half of the residents of the southern portion of the Lower East Side (the area served by the Educational Alliance) are unemployed, and the median household income is approximately \$19,000. Approximately half of the residents have high school diplomas, and about half of the children belong to families living below the poverty level.

Although it has many problems, the Lower East Side also has a tradition of strong community service organizations. The Educational Alliance, in particular, has played a pivotal role in the community for more than 100 years. The Educational Alliance is a major social service provider for the Lower East Side and provides physical education, ESL, and GED classes; computer literacy training; substance abuse treatment; services for older adults; and child care. It also provides adult and child mental health services; recreational camps for children and senior citizens; home care services; and cultural activities such as art classes, a lecture series, and Jewish holiday festivals. Another major health provider in the area is Gouverneur Hospital. Two other Early Head Start programs also operate on the Lower East Side. Except for a dire shortage of full-time child care for infants and toddlers, services to meet families' needs are generally available.

families were enrolled at the Educational Alliance, 18 were enrolled at Teen Aid, and 36 were enrolled at Veritas.

Since the Educational Alliance program began, 14 families who enrolled in the program have been removed from the rolls

for one or more of the following reasons: (1) they needed full-time child care, which the program was attempting to create but did not provide at the time of the site visit; (2) they were interested in attending a more conveniently located program (for example, one of two EHS programs that have recently opened on the Lower East Side); (3) they were moving out of the area; and/or (4) they were experiencing an overwhelming degree of life stress and chaos that interfered with their ability to take advantage of program services.

The families served by the program are racially/ethnically diverse. African American, Hispanic, and Asian American families attend the Educational Alliance site. African American and Hispanic mothers predominate at Teen Aid. The Veritas site serves mostly African American families but also serves a few white families. According to program staff members, participants' principal strengths are their love for their children and their motivation to better their lives. Families' principal needs include education (including English as a Second Language [ESL] classes), child care, and mental health treatment.

CHILD DEVELOPMENT CORNERSTONE

Clinical Case Management. The program begins with the assignment of a regular clinical case manager to each infant and parent. The clinical case manager is the family's primary therapist, who serves as the family's first point of contact and continuing liaison with the program. The clinical case manager also coordinates all of the child's and family's services. Clinical case managers are required to have at least a bachelor's degree.

The program assigns clinical case managers to families based on race/ethnicity, gender (if the child's primary caregiver is his or her father, the father will be assigned to the single male staff member, the father involvement/adult educator), the apparent needs of the child and family, and the skills of the staff member.

At the Educational Alliance, cases are shared among the clinical case manager, the social worker, and the father involvement/adult educator, with the clinical case manager responsible for at least 20 of the 28 families. At the Teen Aid site, a single case manager is assigned to all 18 mothers. This clinical case manager also tries to keep track of Teen Aid mothers who have left the Teen Aid school but are still part of the research sample. At Veritas, the 30 cases are split between the EHS clinical case manager and the parent educator, who is supervised by the EHS social worker.

The Educational Alliance EHS program emphasizes relationships as engines of and pathways to change. According to program staff, it is within supportive relationships with program staff members that parents will grow and develop as adults and as parents. Similarly, it is within supportive relationships with their parents and with program staff members that children's socioemotional and cognitive development will best be fostered.

Home Visits. Direct child development services are delivered principally in high-quality child care centers and secondarily in

home visits. In the Educational Alliance and Teen Aid sites, child development services begin with a home visit by the family's clinical case manager. Home visits, which generally last one hour, are conducted every two weeks during the mother's pregnancy and until the child begins attending the child care center.

The home visit activities are planned in staff conferences and vary depending on the stage of the mother's pregnancy and age of the child. If the mother is pregnant, the clinical case manager may counsel the mother on prenatal health care or discuss her fantasies about the pregnancy and the child. As soon as the child is born, the clinical case manager monitors the child's general well-being, begins to educate the primary caregiver about infant development, and supports the infant-caregiver relationship by identifying and praising supportive parenting activities. If the clinical case manager identifies other problems, she will provide additional services either directly or by referral. The program director and/or program social worker may participate in a home visit to assess or treat more severe problems.

Center-Based Child Development Services. The Educational Alliance EHS provides part-time child care in centers at each program site. At the time of the site visit, all children enrolled in the program were attending one of the three centers. The Educational Alliance EHS program does not refer families to other child care providers. If an eligible child is too old to fit into the research window or requires full-time care, however, the family will be referred to one of the other New York City EHS programs. The program applied for Head Start Quality Improvement grant funds to enable it to offer full-time care, but its application was not successful.

The child care center at the Educational Alliance site consists of two connecting infant-toddler classrooms that combined can accommodate up to 17 children at a time, with child-staff ratios of up to 3 to 1. Classroom caregivers consist of a head teacher, an assistant teacher, a teacher's aide, and up to five caregiving interns. (These interns are Head Start parents who have been competitively selected to serve as caregiving assistants and, at the same time, to enhance their own parenting skills and caregiving training and development.) There are two classroom sessions per day (2.75 hours each), with a 30-minute lunch break between the sessions. Depending on their parents' schedules, children attend between 5 and 10 sessions per week. Some children stay through lunch.

Consistent with the program's emphasis on supportive relationships, each child is assigned a primary classroom caregiver, matched in part on race/ethnicity. Infants and toddlers attend the same classroom so that the children can remain with their primary caregivers over time.

Within the classroom, another guiding philosophy is that children need to learn but adults do not necessarily need to teach them. The teachers and paraprofessionals are viewed as active models and facilitators of children's development and learning. There is no formal curriculum, although some guidelines have been adapted from the *Hawaii Early Learning Profile*, the *Infant/Toddler Environmental Rating Scale*, and Magda Gerber's *Resources for Infant Educators* program. Individualized activities are designed to match each child's needs, temperament, and activity level. They focus on caretaking routines and self-care activities; free play and exploration in a safe, rich, inviting and responsive environment; socialization with loving

caregivers; and physical contact between adults and children, with adults holding the children and rocking them while making eye contact.

The child care center at the Teen Aid site consists of two infant-toddler classrooms that combined can accommodate up to 18 children at a time, with a child-staff ratio of up to 4 to 1. Classroom caregivers consist of a head teacher and four paraprofessional caregivers hired by the New York City Board of Education. There is one full-day session that all children attend five days per week. During this time, the teen mothers are attending classes in the building. They frequently come into the classroom to have lunch with their children and, if necessary, to administer medication (New York state law prohibits anyone except parents from administering medication in child care settings).

The Teen Aid classroom operates according to the principles that apply throughout the New York City school district's Living for the Young Family Through Education (LYFE) program for student parents, which closely parallel those underlying the operation of the Educational Alliance EHS classroom. As in the Educational Alliance classroom, each child is assigned a primary classroom caregiver, and infants and toddlers attend the same classroom so that the children can remain with their primary caregivers over time. There is no formal curriculum, although, again, some guidelines have been adapted from the *Hawaii Early Learning Profile*, Gerber's *Resources for Infant Educators* program, and the National Association for the Education of Young Children (NAEYC) guidelines for developmentally appropriate practices. As in the Educational Alliance classroom, Teen Aid classroom activities are designed to match each child's needs.

Holding infants while making eye contact is a clear priority for the youngest infants.

Veritas has three child care classrooms. Classroom caregivers consist of an educational supervisor (head teacher) and eight rotating paraprofessional caregivers. At the time of the site visit, EHS and Veritas staff were planning to combine two of the classrooms into one mixed-age setting, while leaving one classroom for newborn infants up to the age of four months. The mixed-age classroom will be able to accommodate 16 to 20 infants with a child-staff ratio of 3 or 4 to 1. At least one-third of the Veritas infants exhibit symptoms of in utero substance exposure and are very small and sensorially fragile. The separate newborn room allows for the special care of these young infants. The newborn room accommodates 8 to 10 infants with a child-staff ratio of 3 to 1.

The Veritas classrooms operate according to the same principles as those underlying the operation of the Educational Alliance EHS classroom. As in the Educational Alliance classroom, each child is assigned a primary classroom caregiver, and infants and toddlers will soon attend the same classroom so that the children can remain with their primary caregivers over time. Again, although there is no formal curriculum, some guidelines have been adapted from the *Hawaii Early Learning Profile*, Gerber's *Resources for Infant Educators* program, and the NAEYC guidelines for developmentally appropriate practices. As in the Educational Alliance classroom, the Veritas classroom activities are designed to match each child's needs, especially special needs resulting from in utero substance exposure.

All of the Educational Alliance classrooms also carry out the following

COMMUNITY CHILD CARE

Across all of New York City, the demand for high-quality, affordable child care--especially for infants and toddlers--has long exceeded the supply. Child care for children under age 13 is guaranteed to families receiving Family Assistance when the parent(s) are working (including working in community service jobs and participating in approved vocational education and training). Families who meet these criteria receive child care vouchers (in New York City, \$76 per week). There are no criteria governing the type or quality of child care to which these vouchers can be applied. There is a fixed number of child care vouchers available; therefore, long waiting lists have developed.

The New York City Administration for Children's Services (ACS) operates child care centers that charge fees on a sliding scale basis and subsidizes child care slots in private-sector centers for poor families. The New York City ACS also provides training for welfare recipients interested in becoming family child care providers. This training can count toward a WEP placement. The training, however, is limited to 15 hours, and future monitoring of quality is limited to one drop-in visit.

The EHS leaders view the use of Head Start parents as classroom caregiver interns as making a special contribution to the community. The caregiver interns are receiving specialized training and hands-on experience in caring for infants and toddlers. After working in the Educational Alliance EHS program, they should have the skills to get a salaried job as a child care provider or to offer high-quality home-based care; in either instance, the quantity and quality of child care in the community are likely to improve. The program director described this system as a cottage industry and noted that last year's caregiver interns are now in "real" jobs in the community.

mandates: (1) pay special attention to health and safety (no street shoes are permitted in the classroom, and all toys and equipment are cleaned and disinfected several times a day); (2) provide a child-centered environment, with child-sized furniture, activities, and materials set up at a child's level; (3) have adult-sized furniture (including a rocking chair and a couch) to create a homelike atmosphere; (4) pay attention to the race/ethnicity and culture of the child's family, and its rules for childrearing; and (5) have caregivers create

daily reports to share with parents at the end of each session or day.

Other Child Development Services.

Parent education and support services consist of "Mommy and Me" play groups, dyadic therapy sessions for infants and their parents, individual therapy sessions, group therapy sessions, and parenting education groups for parents. The Mommy and Me play groups are part of the Teen Aid EHS program and are unique to this LYFE program. Each Wednesday afternoon,

mothers and their infants sit together on the floor and play, simply to have unstructured, one-on-one time together, to build the infant-mother relationship. During these afternoons, the EHS program director and social worker are available to conduct dyadic therapy sessions with the infants and their mothers. In these sessions, which are also conducted with Educational Alliance parents, the therapists focus on identifying and praising supportive parenting behaviors (including those viewed together on videotapes made at early home and center visits) and on helping parents read their infants' behavioral and emotional cues.

In addition, Educational Alliance parents receive weekly individual psychotherapy with the EHS social worker and clinical case manager and may attend group therapy sessions led by their clinical case manager. Parents from all three sites come together for biweekly parent education meetings covering such topics as developmental milestones and appropriate disciplinary practices. Child care is provided during the meetings. At Teen Aid, the young mothers attend weekly support group/parenting education sessions led by the Teen Aid clinical case manager. These sessions cover a range of topics and activities, from developmental milestones, to the young mothers' romantic relationships, to mothers' questions and concerns about the EHS-LYFE classroom activities, to the planning of a baby fashion show. At Veritas, all mothers receive classroom-based parenting education as well as individual counseling and group therapy.

Child Development Assessments.

During the initial home visits and meetings at the center, the clinical case manager administers a bio-psycho-social assessment

developed by the Educational Alliance EHS director. This assessment gathers a wide range of information on demographics, the mother's family of origin, the mother's mental health history, the history of the pregnancy, and the parents' perceptions of the child's temperament. This assessment helps the clinical case manager and parents get to know each other.

During all home visits in the infant's first two months, the clinical case manager videotapes infant-parent interactions. Together, the bio-psycho-social assessment and the videotapes are used as diagnostic tools. The clinical case manager and parent share relevant information with the child's future child care provider(s) and with the program director and program social worker.

Health Services. Clinical case managers monitor families' health care and work to ensure that all families have a medical home. At the Educational Alliance and Teen Aid sites, many of the mothers and their infants receive medical care covered by their own or their parents' Medicaid benefits, with an increasing number of families participating in Medicaid-funded managed care.

Veritas has an on-site medical clinic run by Saint Claire's Hospital. At the Educational Alliance site, Bellevue Hospital has been contracted to provide 15 hours a week of on-site medical care to participants in the Educational Alliance program. A pediatrician and obstetrician-gynecologist are part of the Bellevue team. Any EHS family not participating in Medicaid managed care or in some way receiving regular health care services is encouraged to take advantage of the on-site services provided by Bellevue at no charge to

families. Periodic dental clinics are also offered at the three sites by New York University pediatric dental students.

Services for Children with Disabilities. The Educational Alliance EHS program coordinates services for children with disabilities with the New York City Department of Mental Health's (DMH) Early Intervention Program, which is the local agency for Part C. If an EHS infant is suspected of having a disability, the family will choose a facility where their child can receive a formal evaluation. Subsequently, a city caseworker from the DMH Early Intervention Program must take responsibility for coordinating the child's service plan. To make it as easy as possible for families, these coordinated services frequently will be provided at the Educational Alliance or Teen Aid sites. For example, a sign language teacher will come to the EHS classroom to instruct a toddler in signing. Veritas has an on-site Part C provider. At the time of the site visit, 13 EHS children across all three sites (16 percent) had disabilities and were receiving Part C services.

Transitions. When children are within six months of their third birthday, the program will invite their parents to a series of workshops designed to help them with their transition out of EHS. Children who are eligible will be given priority for enrollment in the Educational Alliance's Head Start program, and the EHS social worker will visit the Head Start classroom with parents and facilitate a meeting with the Head Start social services coordinator. Children who are not eligible for Head Start will be referred to the Educational Alliance's fee-for-service nursery school.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Clinical case managers assess family needs, develop individualized family plans, and make referrals for necessary social services, many of which are available at the Educational Alliance. At the Educational Alliance, family members have access to physical education classes, ESL and General Educational Development (GED) classes, computer training, substance abuse treatment, and adult and child mental health services. Clinical case managers also work with parents individually on job searches and help parents integrate their computer training with training in writing a resume. At Teen Aid, mothers receive referrals for needed services. At Veritas, mothers spend much of the day in substance abuse treatment, but they also attend parenting classes and counseling with the clinical case manager and parent educator.

The Educational Alliance EHS program's approach to family development centers on the relationship between the clinical case manager and the parent developed in therapeutic sessions. The program aims to foster parents' self-esteem and self-sufficiency so they can do things for themselves, both socioeconomically and as supportive parents. Education is seen as a key to this goal.

Clinical case managers avoid doing things for parents, and they encourage self-

assertion and self-motivation, especially in accessing other types of services. Clinical case managers work with parents to break down barriers of mistrust and suspicion of others and to build parents' abilities to seek help. Frequently, linking parents to mental health services takes the form of increasing awareness of infant mental health and working to lift the stigma of receiving mental health services. This stigma is especially evident in the Asian American community. In the Hispanic community, acceptance of the value of mental health services has increased noticeably.

Father Involvement. In the past year, the Educational Alliance EHS program has expanded its efforts to include fathers. The full-time father involvement/adult educator conducts a weekly fathers' group, leads a relationship group with the Teen Aid clinical case manager, and publishes a newsletter, *"For Men Only,"* that has fathers on the editorial board. At the time of the site visit, this staff member was also organizing an EHS fathers' basketball team with fathers from all three sites. Staff members have found fathers less accessible and more difficult to engage than mothers.

Parent Involvement in the Program. The Educational Alliance EHS program also views parent involvement in EHS as a stepping-stone to increased self-esteem and self-sufficiency. The Educational Alliance EHS program has formed a parent policy committee. At the time of the site visit, the parent policy committee was holding its first meetings and conducting elections. Parent policy committees were forming at Veritas and Teen Aid. Parents on the committees will be integrated into the Educational Alliance Head Start Parent Policy Council.

STAFF DEVELOPMENT CORNERSTONE

Training. Before beginning to work with families, all EHS staff caregivers participate in a comprehensive training program in infant and toddler care and development that was created by the LYFE program. The EHS program has contracted with LYFE to provide this training. The program has submitted a request to the Head Start Bureau asking that this curriculum be considered an infant-toddler equivalent of the child development associate (CDA) credential.

Ongoing training takes place in weekly all-staff meetings and monthly study groups that explore a current topic in the child development literature. At the Teen Aid site, the head teacher conducts ongoing training for caregivers in the classroom. In addition, each LYFE staff member is granted two days per year for professional development activities. Other EHS staff members also receive time for professional activities such as attending CDA training, conferences, and workshops.

Support and Supervision. The Educational Alliance EHS program's approach to staff development is consistent with its emphasis on supportive relationships--the program provides a considerable amount of ongoing, one-on-one debriefing and reflective supervision sessions with staff members.

The EHS program director meets weekly with the program social worker and the head teachers to give them individual supervision. The program director is also in

WELFARE REFORM

The New York State Temporary Assistance for Needy Families (TANF) program, called Family Assistance, was initiated in December 1996. The Family Assistance program specifies that, after two years of welfare receipt, recipients must go to work. Families also may not receive benefits for more than five years, total, over their lifetime. Pregnant women are exempt after the eighth month of pregnancy, and new parents personally caring for a child under age 1 are exempt for 3 months (although the state Department of Social Services can extend this exemption up to 12 months). Minors age 19 or younger are exempt from work requirements if they are in school. To receive full benefits, however, mothers age 19 or younger must either work or attend school as soon as their child is three months old. The Work Experience Program (WEP) provides job placements when private-sector jobs are not available.

The percentage of parents receiving cash assistance varies across the centers. Approximately 90 percent of parents at Veritas and 60 percent of parents at the Educational Alliance center receive cash assistance. At the Teen Aid site, 20 percent of parents receive cash assistance, but all parents receive Medicaid and Food Stamps. Since the advent of welfare reform, EHS staff members have witnessed families' increasing need for child care. Staff members reported that EHS mothers are ambivalent about leaving their young children in the care of others while they work.

The assistant principal for LYFE reported that, before welfare reform, poor families relied on Head Start for child care, whereas working poor and middle-class families used ACS-subsidized full-time child care. Now, welfare reform requirements are driving more poor families into ACS-funded child care slots. This change, in turn, has made it harder for working- and middle-class families to find affordable child care. The assistant principal for LYFE expressed concern that the struggle for these working- and middle-class families to find affordable child care would force them to leave work for welfare or to accept low-quality child care arrangements.

The Educational Alliance EHS program director has made an agreement with the New York City Office of Employment Services for EHS caregiver interns (drawn from Head Start parents) who are welfare recipients to have their work at EHS count as a WEP placement. The Educational Alliance staff members expressed concern that the welfare reform requirements are too demanding and that, by forcing poor young parents into dead-end, low-skill jobs, they will prevent these parents from becoming fully self-sufficient.

EHS parents expressed more mixed feelings about welfare reform. Some parents approved of welfare reform, because it would force able-bodied people to make more of an effort to take care of themselves. One mother currently receiving welfare described it as a temporary crutch and expressed concern that welfare recipients were viewed as universally lazy and self-serving. Many of the parents agreed that welfare caseworkers treat their clients disrespectfully. Many parents also agreed that, before welfare reform, the public assistance system allowed some people to abuse the system at the expense of those who more legitimately needed help.

regular contact with the assistant principal of Pregnant and Parenting Services (director of Teen Aid) and the director of Veritas. The program social worker meets weekly with each clinical case manager for individual supervision, and the head teacher meets weekly with the assistant teacher and each caregiver for individual supervision. In addition, the classroom staff holds weekly group meetings.

At the Teen Aid site, the head teacher and the assistant principal of Pregnant and Parenting Services, who oversees the entire LYFE program, meet regularly in person and hold frequent phone meetings. In addition, the head teacher, the Teen Aid clinical case manager, and the EHS social worker meet weekly to discuss individual Teen Aid cases.

At Veritas, the clinical case manager and educational supervisor work closely together. The educational supervisor holds regular meetings with the child caregivers, and the clinical case manager attends these meetings. The clinical case manager and educational supervisor also meet weekly with the EHS social worker to discuss Veritas cases. The educational supervisor conducts biweekly individual meetings with caregivers.

Staff morale was generally high at the time of the site visit. Most staff members perceived their pay as low but comparable to other human service positions.

Staff Turnover. During the year prior to the site visit, the program experienced a fair amount of staff turnover, particularly at the Educational Alliance site. The assistant to the educational supervisor at the Educational Alliance site left to pursue a different career path. In addition, the Educational Alliance head teacher resigned, and the father involvement/adult educator

left to pursue a different type of work. All of these vacancies have been filled by people that the program director views as equally or more qualified than their predecessors.

COMMUNITY BUILDING CORNERSTONE

The Educational Alliance EHS program's approach to community development stems from an ecological view of the program community as the outermost circle of a set of nested circles. According to this scheme, the family is nested in the program, which is nested in the agency, which is nested in the community. The program aims to address child and family development by increasing families' ability to use their community. It also aims to address community development by raising community awareness of the importance of the first years of a person's life, of providing needed services for infants, and of nurturing and strengthening its youngest citizens.

The EHS staff anticipates that it will enhance the development of this community's children and families; this development eventually should enhance the quality of the community as a whole. As EHS services increase parents' education and self-sufficiency, these parents should also become more productive citizens, role models, advocates (for example, in the public school system), and community leaders. In addition, the parent policy council links EHS parents in new ways. The program also anticipates that staff members' development will enhance their contributions to the community as a whole.

Program Collaborations. Although the Lower East Side houses many other service agencies, collaboration and coordination across agencies has been

lacking. The Educational Alliance EHS program is trying to address the problem through formal agreements with the Board of Education and Bellevue Hospital. The agreement with the Board of Education stipulates that the Teen Aid school will provide the physical space and access to the teen mothers in return for enhanced (EHS) services in the LYFE classroom there. The Educational Alliance's agreement with Bellevue stipulates that, in return for on-site services, Bellevue may bill these services to Medicaid. In addition to having these formal agreements, the Educational Alliance is a member of the United Neighborhood Houses, a group that represents 35 New York City settlements.

The EHS program also has many informal relationships with other community service providers and organizations (for example, local hospitals, early intervention [Part C] providers, and the New York City Head Start Bureau) with whom they trade information and referrals. In addition, the program has special agreements with several residential substance abuse programs to enroll pregnant or parenting women who are eligible for Veritas services but get randomly assigned to the comparison group. Finally, the EHS program director has been invited to participate in a newly formed group of the seven New York City EHS directors.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The program has received training and technical assistance from its Resource Access Project (RAP) consultant on working with children with developmental delays. The technical assistance focused on identifying specific developmental delays and adapting the child

care environment and materials for sensorially fragile infants. The program has also received support from its federal project officer.

Continuous Program Improvement. The Educational Alliance EHS program is working on continuous program improvement with data analyzed and interpreted by its local research partner, a team of researchers from New York University's School of Social Work and Applied Development Psychology department. The team includes researchers with expertise in program development and evaluation, prevention and treatment of violent/aggressive youth, post-traumatic stress disorder (especially in youths exposed to violence), and early child language and cognitive development (especially within the context of child-mother interaction).

Continuous improvement efforts focus on families' use of, perceptions of, and satisfaction with EHS services. Data for continuous program improvement and local research are collected in child and mother assessments conducted when the child is between 5 and 6 months old, and again at 14, 24, and 36 months of age. The local research team also has developed a survey to assess the effectiveness of staff training for paraprofessional child care staff. In addition, qualitative data collection methods are being used to gather data on cultural values about childrearing and satisfaction with EHS services.

Local Research. The local research focuses on examining the effects of the Educational Alliance EHS program on a wide range of outcomes across each of the four cornerstones. Substantive focuses of the local research include the impact of culture on childrearing, and family and community violence and their effects on

childrearing and child development. The local researchers will assess child cognitive and social competencies, propensity for aggressive and violent behavior, and coping skills; parental health, mental health, and self-sufficiency (school and/or work performance, use of social and career-development services); staff members' skills in working with infants and their families, and staff burnout; and availability of community service providers and collaboration across community-based service organizations.

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PROGRAM SUMMARY

The Educational Alliance EHS program provides part-time center-based child development services and parenting education to diverse families, including parents from diverse ethnic backgrounds, teenage parents, and substance-abusing parents, in three settings. The program emphasizes mental health and provides psychotherapy services.

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EARLY HEAD START PROGRAM PROFILE

Northwest Tennessee Head Start McKenzie, Tennessee October 21-24, 1997

Northwest Tennessee Head Start operates an Early Head Start program for 75 families in child development centers located in five rural Tennessee counties and in the town of Jackson, Tennessee. The program serves mostly African American, single-parent families who are receiving welfare cash assistance. Many parents are teenagers who live at home with their own mothers. The Early Head Start centers provide full-day, full-year child care and parent training activities. Program staff also provide family development services and referrals designed to assist families in achieving self-sufficiency. The program focuses on providing developmentally appropriate and responsive care in a nurturing environment.

OVERVIEW

Northwest Tennessee Head Start (NWTHS) is a program of the Northwest Tennessee Economic Development Council, a community action agency. The agency has operated a Head Start (HS) program since 1965, and at the time of the site visit, it was serving more than 1,300 children and their families in 13 counties. NWTHS operates the Early Head Start (EHS) program in six counties: Carroll, Fayette, Lauderdale, Madison, Obion, and Tipton.

Community Context. With the exception of Madison County, all of these communities are rural and have large proportions of families living in poverty. Families in the EHS program face problems that many rural communities face, including lack of transportation to jobs and services, lack of affordable housing, lack of jobs, and an inadequate supply of medical care providers and specialists located near where families live. Although the supply of child

care varies by county, in general there are not enough good-quality slots available. Many families cannot access child care centers because they lack transportation.

Program Model. NWTHS operates a center-based program that offers child care from 6 a.m. to 6 p.m. year-round while parents work or attend school. Each child is assigned a primary caregiver who provides basic caregiving, conducts regular developmental assessments, conducts four home visits each year, and maintains communication with parents about each child's developmental progress and needs. Case managers at each center provide family development and case management services.

Families. NWTHS serves mostly African-American families, but about 10 percent of families are white. At the time of the site visit, one family was Hispanic and spoke Spanish as a first language. Although some families are two-parent families, most

COMMUNITY PROFILE

NWTHS operates the EHS program in Carroll, Fayette, Lauderdale, Madison, Obion, and Tipton counties. With the exception of Madison County, all of these communities are rural and have large proportions of families living in poverty. Madison County contains the area's largest town, Jackson, which has a population of just under 50,000 residents. According to the agency's most recent community needs assessment, more than 23 percent of children under 18 in the agency's service area live in poverty. The majority of these children are younger than 6 years old and live in single-parent families. In addition, although the level of crime has risen in Jackson, other areas served by the program boast relatively low crime rates.

Most EHS families live in rural areas that lack jobs that pay more than minimum wage and the public transportation services necessary for getting to work. However, some EHS parents work in manufacturing jobs in the garment industry or for shoe or furniture companies. Others work in nursing homes or in other service jobs. Almost all of these jobs pay low-wages and do not offer benefits.

families are headed by a single parent. A significant proportion of families are headed by teenage mothers, many of whom live at home with their own mothers.

Approximately 10 percent of mothers were pregnant when they enrolled in the program. About 80 percent of families were receiving welfare cash assistance when they enrolled, and all of these families are participating in Families First, Tennessee's welfare reform program.

Staffing. The program is staffed by a director who provides leadership to the EHS staff and is responsible for oversight of the program. Three specialists--an early childhood development specialist, an early childhood health services specialist, and a family and community partnerships specialist--participate with the director in a senior management team responsible for managing and supervising the program. Center managers at each of the six centers are responsible for staff supervision and

operations at each site. The program employs 23 teachers who work directly with infants and toddlers. One case manager at each center is responsible for working with families to assess needs, set goals, plan services, and track progress and services received.

RECRUITMENT AND ENROLLMENT

Program Eligibility. To be eligible for the program, families must have incomes at or below the poverty level, have an eligible child under 3, and live in one of the six counties in which EHS operates.

Recruiting Strategies. NWTHS recruited the initial group of EHS families in a variety of ways. The agency received a list of income-eligible families with infants and toddlers from the Tennessee Department of Human Services and sent letters to these families. The local health departments and the Special Supplemental Nutrition Program for

Women, Infants, and Children (WIC) programs referred several families to the program, and current Head Start families encouraged their friends, relatives, and neighbors to apply. Particularly in Madison County, the staff recruited many families by going door-to-door in low-income neighborhoods. As community awareness about the program increases, staff members anticipate that many more families will express interest in the program. In fact, at the time of the site visit, centers in five of the six participating counties already had waiting lists for the EHS program.

Enrollment. NWTSH EHS has the capacity to serve 75 children and their families. The program reached full enrollment in July 1997 and has enrolled 75 families (43 of whom are participating in the EHS evaluation research). The nonresearch families have children who were too old to participate in the research (more than 12 months old) when they enrolled in the program. As children age out of the program and transition into Head Start, the program planned to enroll additional research families. NWTSH was planning to enroll at least 75 research families by June 30, 1998.

The program enrolled the initial group of eligible families on a first-come, first-served basis. However, in the future the program will consider prioritizing families according to need and may give priority to teen parents and families who have children with disabilities.

Enrolled families bring many strengths to the program. Families take responsibility for bringing their children to the EHS centers daily, and program attendance has been high. Most parents are enthusiastic about their children's participation in the program and are eager to learn about their children's development. Many parents have volunteered in the EHS infant and toddler rooms. In addition, most parents are

participating in Families First, Tennessee's welfare reform initiative, and are attempting to enter the work force and achieve self-sufficiency. All teen parents enrolled in the program are still in high school.

At the same time, EHS families face considerable challenges. Almost all families have incomes below the poverty level, and many lack the education necessary to obtain jobs that can provide adequate income to support their families. With the exception of the families in Madison County, EHS families live in rural areas where public transportation is not available. Lack of reliable transportation is a significant barrier to self-sufficiency for many families. Some parents work in second- or third-shift jobs and need child care during evening or overnight hours. Few spaces are available in regulated child care settings during these hours.

CHILD DEVELOPMENT CORNERSTONE

Center-Based Child Development Services. NWTSH EHS plans to provide child development services to all families through full-year center-based programs. At the time of the site visit, the program was operating center-based programs in five of the six participating counties. The program delayed opening its EHS center in Lauderdale County because of problems with the facility's roof. However, renovations were close to completion, and NWTSH planned to open the center in early 1998.

The EHS centers are open year-round for up to 12 hours per day (from 6 a.m. to 6 p.m.) so that parents can work or attend school. At the time of the site visit, most children attended the centers from 8 a.m. to 2 p.m., although some children arrived earlier and left later. Each center operates separate rooms for infants and toddlers.

Although staff members draw on a variety of resources, all centers use *The Creative Curriculum for Infants and Toddlers*, developed by Teaching Strategies, as their primary infant/toddler curriculum.

By providing developmentally appropriate and responsive care in a nurturing environment, program staff members believe that they will positively influence child outcomes. The program's goals for child development include ensuring that health problems are identified and addressed and that children with disabilities or delays are identified and connected with early intervention services as early as possible; increasing self-esteem and independence; and enhancing cognitive abilities, social skills, and children's willingness to share. Staff expect that children who transition out of EHS will be ready to learn.

Other resources used by teachers include *Games to Play with 2-Year-Olds*, *Games to Play with Babies*, *Playtime Learning Games for Young Children*, and *Talking to Your Baby*.

NWTHS is in the process of obtaining National Association for the Education of Young Children (NAEYC) accreditation for all of its Head Start and EHS centers. During the time of the site visit, validators from NAEYC were visiting the centers and observing HS classrooms and EHS infant and toddlers rooms as part of the accreditation process.

Child-staff ratios are four to one in all centers except the Washington Douglas Center in Madison County, where the ratio for infants is three to one. The Washington

Douglas Center is the largest of the EHS centers and has two infant rooms in which the group size is six.

As part of their pre-service training, all EHS staff members attended a two-week course on infant and toddler caregiving sponsored by the University of Tennessee at Martin. All EHS teachers, assistant teachers, and center managers have a child development associate (CDA) credential or are actively working toward obtaining the credential. All staff members expected to complete course work for the CDA by the end of 1997.

NWTHS covers the full cost of the child care centers and provides all diapers, infant formula, and food for the children. All centers participate in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program, and staff members are trained in nutrition and food preparation for infants and toddlers. Staff members conducted an initial nutritional assessment for each child by talking with parents about each child's eating habits, ability to eat solid foods, likes and dislikes, and allergies. In collaboration with parents, the program introduces soft foods and finger foods as soon as infants are ready for them. In addition to providing meals at the centers, the program conducts workshops for parents about nutrition and food preparation for infants and toddlers.

Other Child Care Services. Some parents work second- and third-shift jobs and need child care outside of EHS program hours (6 a.m. to 6 p.m.). NWTHS refers these families to the child care brokerage service in the county in which the family lives. In some counties, this service is provided by NWTHS's grantee agency, Northwest Tennessee Economic Development Council. Although some counties have 24-hour child care centers, the staff feels that good-quality child care for those who work second and third shifts is in short supply.

Group Child Development Activities.

In addition, each center has monthly parent meetings that are usually held during the evening. During these meetings, parent training on a variety of topics is provided by center managers, case managers, and outside speakers. NWTHS also holds a series of agency-wide parenting workshops and provides transportation, meals, and child care for parents who attend them. Each year parents complete a parent training needs survey in which they suggest and rank training topics, and staff members use the results of this survey to plan training sessions.

Home Visits. In addition to providing center-based care on a daily basis, EHS teachers make four home visits per year. The purpose of these visits is to discuss with parents each child's progress at the center, review results of developmental screenings or other testing, suggest parent-child activities that parents can do at home, and discuss any issues or problems that parents want to raise. At the time of the site visit, teachers had completed at least one home visit with each family.

Because the EHS center in Lauderdale County had not yet opened, EHS teachers were conducting two 90-minute home visits per week with each family. During the visits, teachers bring toys and activities for the children and child development information to share with parents. Teachers model developmentally appropriate interaction with the children and encourage parents to participate in the visits as much as possible. In addition, the case manager in Lauderdale has worked with the local child care brokerage agency, Delta Human Resources, to obtain state child care vouchers and to arrange child care for EHS children. NWTHS expected to open the Lauderdale EHS center in January 1998.

Other Child Development Services.

NWTHS EHS provides parent education and child development information in a variety of ways. Teachers provide information to parents on a daily basis during dropoff and pickup. Teachers keep detailed records of children's eating and sleeping patterns, daily activities, and achievements. These records are reviewed with parents each day, and teachers suggest developmentally appropriate activities for parents to carry out with their children at home that complement the center's curriculum. Teachers also answer parents' questions about a variety of child development issues. Almost all parents have spent some time volunteering in the EHS rooms, and many volunteer on a regular basis. Thus, teachers have an opportunity to model developmentally appropriate care for them.

Child Development Assessments. The program uses the *Ages and Stages Questionnaires (ASQ)* developed by the University of Oregon to conduct periodic developmental screenings. The questionnaire is designed for use by parents, and teachers encourage parents to complete as much of the questionnaire as possible either at home or at the center with the teacher's assistance. Teachers then score the assessment and meet with parents to discuss the results and suggest parent-child activities to build skills in weak areas. If a toddler receives a low score on the *ASQ*, the teacher will conduct an *Early Learning Accomplishment Profile* assessment before discussing the results with the parents or referring the child for early intervention services.

Health Services. NWTHS conducts comprehensive on-site health screenings two times each year and encourages parents to participate in the screening process. In September 1997, vision, hearing, and dental screenings were conducted at each EHS center. At the time of the site visit, the staff was in the process of following up on all

COMMUNITY CHILD CARE

The program provides center-based child care services for all families in the program (or will soon, once the sixth center has opened). Some families need child care during nonstandard hours however, and the program refers them to the county resource and referral agency for help in arranging care.

The availability of child care varies by county. In some areas, the supply is adequate, while in other counties, few child care slots are available. In all counties, the supply of family child care homes is greater than the supply of child care centers, and many families cannot access the centers that are available because of lack of transportation.

The state is encouraging mothers on welfare to establish family child care homes as a means of achieving self-sufficiency. However, even with small start-up grants from the state, state child care subsidies, and funds from the USDA dependent care food program, family child care providers earn very little income.

The quality of child care in the state also varies, but in general, few good-quality slots are available. Most area child care facilities are not comparable to EHS in terms of child-staff ratios, facilities and equipment, or level of staff training and commitment.

potential problems identified by referring families to appropriate specialists for more in-depth assessments and treatment as necessary.

Once all screenings are completed, case managers assigned to each family are responsible for ensuring that children receive appropriate follow-up assessments and treatment. Case managers also track health services to ensure that children receive all necessary immunizations and well-child examinations. About 85 percent of all EHS families are covered by TennCare, Tennessee's Medicaid managed care program. For these families, case managers must often help parents identify their child's primary care physician, advocate for children to receive all needed services, help families arrange transportation to medical appointments, and work with primary care physicians to obtain records of well-child examinations and immunizations. Children

without health insurance receive services directly from local health departments in each county, and EHS covers the cost of this care.

Services for Children with Disabilities.

When health or developmental screenings identify potential disabilities or delays, program personnel will work with the Tennessee Early Intervention System sponsored by University of Tennessee at Martin to conduct further assessments and provide early intervention services as necessary. The disabilities coordinator, the child's teacher, and other EHS staff members will hold a coordinating meeting with the early intervention specialists, representatives of the school system, and the parents to develop a service plan for the child. In addition, the program will provide any special equipment or food that the child needs. At the time of the site visit, one child had a diagnosed disability, and staff were in the process of compiling the results of

developmental, hearing, vision, and other screening conducted on all children and making referrals to Part C.

Transitions. NWTSH will begin planning for each child's transition EHS into its Head Start classrooms when the child reaches 3 and will complete the transition by age 3-1/2, depending on the maturity of the child and the availability of Head Start slots. At the time of the site visit, the program was also considering developing a transition room for children who are too old for EHS but not quite ready for Head Start.

To plan the transition, staff will hold a transition meeting that includes EHS staff, Head Start staff, parents, and health care providers if the child has special needs. During this meeting the transition team will develop a written transition plan and a timeline. Children will transition into Head Start classrooms located in the same building as the EHS rooms, so children will have many opportunities to visit their Head Start classroom, meet teachers and peers, and become familiar with their new environment during the transition period.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. During their first visit with families, case managers work with the families to complete a family needs assessment questionnaire. To elicit information about families' needs, case managers review with families the needs identified in the original Head Start Family Information System (HSFIS) application and ask about any changes or problems that have occurred since the intake visit. Next, case managers ask families to identify goals and activities they would like to complete during the coming year. These goals are recorded in the family's Family Partnership Agreement booklet. Case managers and families also use

the booklets to develop and document a plan of action for achieving families' goals and for tracking services and referrals.

Case Management. The agency's social service specialist coordinates family development services provided to EHS families. Services are implemented by six case managers (one at each EHS center) who work under the supervision of center managers. Except for the case manager in Madison County, case managers provide services to both Head Start and EHS families. The average caseload per case manager is approximately 60 families, including 10 to 12 EHS families. In Madison County, one case manager works exclusively with 18 EHS families.

All case managers have a social service competency-based training (SSCBT) certificate or are working towards obtaining this credential. Tennessee State University provides the SSCBT training program, which includes one year of course work, a period of field observation by an advisor (including observation of a home visit), and an oral review.

Case managers provide a minimum of two home visits per year and make additional visits as necessary, depending on family need. Case managers make a minimum of one additional visit to each family midway through the year. During this visit, case managers and families discuss progress towards goals, discuss any new issues that have arisen since the first visit, and revise the Family Partnership Agreement as necessary. Additional visits are made throughout the year to discuss problems with regular attendance at the EHS center or other problems or issues that arise during the year. Case managers talk almost daily with parents when they come to the centers to pick up and drop off their children and use these regular interactions to discuss new issues, make referrals, plan services, and update goals.

The program's primary family development goal is to assist families in achieving self-sufficiency. Program staff members provide family development services and referrals with the aim of helping parents improve the skills necessary to obtain employment and increasing parents' understanding of basic work requirements. By providing child care, program staff members believe that they are enabling parents to attend work, school, or other activities associated with Tennessee's welfare reform program.

As noted earlier, more than 80 percent of EHS families are also enrolled in Families First, Tennessee's welfare reform program. This program requires families to develop goals and a plan of action, called a Personal Responsibility Agreement. Case managers have participated in two training sessions provided by Families First staff about the Personal Responsibility Agreement and are trying to coordinate goals and services identified in the EHS Family Partnership Agreement with plans developed for Families First. In the coming year, the program's social services specialist plans to work with the Families First program to develop a system for conducting joint planning for families enrolled in both EHS and Families First.

In addition to the Families First program, NWTTHS works with many community partners to provide or arrange services for EHS families. For example, the program regularly refers families to West Tennessee Legal Services and coordinates with counties and school systems to provide Adult Basic Education for parents. The University of Tennessee at Martin, Jackson State

University, and Union State University all provide General Educational Development (GED) testing for parents. The local Job Training Partnership Act (JTPA) agency provides job training and employment search services to EHS families. NWTTHS also collaborates closely with county health departments and WIC programs to arrange health services for families.

Other Services. NWTTHS provides emergency assistance to families through a variety of sources. The agency has a small emergency fund that can be used to provide grants to Head Start and EHS families who need emergency assistance. In addition, civic organizations such as United Way, Salvation Army, and Kiwanis provide small grants when families need vision and dental care. Organizations such as McKenzie United Neighbors and local churches also provide in-kind assistance, including furniture, household goods, clothing, and toys for needy families.

Father Involvement. During the year prior to the site visit, NWTTHS worked hard to involve fathers and other male family members in its Head Start and EHS programs. The agency has developed a Male Initiative program in collaboration with the Alpha Phi Alpha Fraternity at Lane College. In April 1997, the agency held a planning conference for the Male Initiative that was attended by agency staff members, parents, members of Alpha Phi Alpha, and representatives of several community organizations. The agency later held a leadership conference for Head Start and EHS parents and community members and planned a Family Focus Conference about male involvement in early 1998. The agency planned to hold an entrepreneurial workshop for Head Start and EHS men in the spring of 1998.

In addition to conferences, a men's group has been meeting monthly and has participated in the Lane College

Homecoming Parade, participated in a local talk radio program, and held basketball games. The agency also holds a monthly "Meet and Greet Our Men" event in each center, in which volunteers provide a special welcome to male parents and other family members who come to the centers with their children. Finally, the agency included a session in its pre-service training on how to make men feel comfortable in the centers and how to increase male involvement in the program.

Parent Involvement in the Program.

EHS parents are actively involved in many aspects of the NWTES EHS program. For example, four EHS parents are members of the agency's policy council. At the center level, EHS parents participate in combined Head Start and EHS center committees. Each committee elects officers and sets its own schedule of monthly meetings. During these meetings, parents discuss fund-raisers, plan field trips and social activities, provide input to lesson plans, and discuss any issues or concerns they have about the center. In addition, center managers and case managers are responsible for providing program information and parent training during these meetings.

In addition to participating in parent committees, parents are directly involved in day-to-day program operations. For example, many parents volunteer in the EHS centers assisting teachers in the classroom, helping with office work, helping in the kitchen, and serving as bus monitors. NWTES also provides employment opportunities for Head Start and EHS parents interested in pursuing a career with the agency. In fact, more than 75 percent of the agency's 240 employees, including several EHS case managers, are former Head Start parents.

STAFF DEVELOPMENT CORNERSTONE

NWTES's primary goal in the area of staff development is to provide opportunities for career advancement and for personal and professional development to all employees. The agency's staff development coordinator is responsible for planning and organizing all staff development activities.

Training. During its annual pre-service training, all Head Start and EHS staff complete a self-assessment and training needs survey in which they identify and prioritize training needs and set staff development goals and objectives. The staff development coordinator compiles the results of the survey and with input from supervisors develops a staff training plan each year.

The agency requires all staff members to participate in annual pre-service training, annual cardiopulmonary resuscitation (CPR) training, and biannual first-aid training. In addition, all teachers, assistant teachers, and center managers must complete CDA training provided by Tennessee State University, and case managers must obtain the SSCBT certificate.

The agency also provides monthly training for staff members and parents on such topics as sudden infant death syndrome (SIDS), lead poisoning, behavior management, family violence, and substance abuse. However, because most of these trainings are offered during the day when EHS rooms are open, EHS staff members often cannot attend these training sessions.

Prior to opening the EHS centers, all EHS teachers, assistant teachers, case managers, and center managers participated in a two-week summer institute on infant and toddler caregiving provided by the University of Tennessee at Martin. The university donated all housing, meals, and training for

WELFARE REFORM

Tennessee's welfare reform program, called Families First, began in September 1996 when the state received a waiver from the federal government, and the design of the program did not change with the implementation of federal welfare reform. The program's design includes a requirement to work after 18 months of cash assistance and a 60-month lifetime limit for receiving cash assistance. Parents of infants under 4 months old are exempt from the work requirement. Participants must develop a Personal Responsibility Plan that maps out the mix of education, job training, job readiness, and support services the state will provide and the steps the participant will take to achieve self-sufficiency within the 18-month time limit.

NWTHS works closely with the area's Job Training Partnership Act (JTPA) program, which contracts with Families First to provide case management, training, and other services to program participants. For example, one component of the Families First program is a four-week life skills course called Fresh Start, and JTPA provides this course on-site at several of the Head Start and EHS centers. In addition, several Head Start and EHS centers serve as community service work sites for Families First participants who lack work experience and have not been able to obtain unsubsidized employment.

At the time of the site visit, more than 80 percent of NWTHS's EHS families were enrolled in the Families First program and were required to participate in education, training, or work activities during the day. The child care provided by NWTHS EHS enables these parents to participate in required activities and move towards self-sufficiency, although a few families who work nonstandard hours face difficulties locating good-quality child care. Despite the child care provided by EHS, parents face several difficulties associated with their participation in Families First. Because the supply of jobs is inadequate, many parents cannot find employment and must participate in community service work. Because of the rural nature of the community, many parents lack transportation to get to the jobs that are available. Some parents are required to participate in adult basic education classes to continue receiving benefits, and some have become discouraged about obtaining their GED certificate. Staff members report that some parents in the program who have become discouraged about locating employment or obtaining their GED certificate have dropped out of Families First and have lost their benefits.

the institute. Topics included stages of development, room arrangement, and other aspects of infant and toddler caregiving. The training format was interactive and included opportunities for practice and role-playing.

In addition to training needed to fulfill job responsibilities, NWTTHS provides opportunities for employees to further their professional development. The agency provides release time and funds for staff members to attend a wide variety of local, state, and national training conferences and workshops. In 1997, the agency paid for eight staff members to participate in the Success Program developed by Bethel College. The program enables participants to earn a B.S. degree in early childhood education in 18 months and is designed for adult learners. To earn the degree, participants must complete 60 credit hours of courses in early childhood education and sociology or complete 30 credit hours and submit a portfolio of written work.

Supervision and Support. Center managers are the primary staff members responsible for providing day-to-day supervision and support to EHS teachers, assistant teachers, and case managers. Center managers hold weekly staff meetings with teachers and case managers, observe staff members in the classroom on a regular basis, provide regular feedback on performance, and conduct annual evaluations. The agency director and three component specialists provide supervision and support to center managers.

To help the staff sustain motivation, the agency provides release time and funding for staff members to attend outside conferences and workshops, celebrates staff birthdays, and holds an end-of-year party for all staff members.

According to the program director, staff salaries are generally competitive with those of local school districts and businesses.

Staff Turnover. Out of 39 staff members who work with EHS children and families, only 3 teachers and 1 case manager left the program during the year prior to the site visit.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. The Northwest Tennessee Economic Development Council, the grantee agency for NWTTHS, operates 14 programs for low-income families in nine of the counties served by the Head Start and EHS programs. Its 51-member board of directors is made up of local elected officials, community representatives, and low-income community residents. As an organization deeply rooted in the community, the grantee agency provides the EHS program with critical linkages to a wide array of community partners.

NWTTHS has established written collaborative agreements with numerous service providers, including all primary care physicians and dentists who provide care for Head Start and EHS families, all child care brokerage agencies that serve the counties in which the agency operates, child care centers, the state Department of Human Services, the state Department of Education, local health departments, local school districts, local WIC programs, and many other providers. A number of health professionals participate in the agency's two health screening days each year. In addition, South Central Telephone participates in the screening days by collecting fingerprints and photographs of each child who attends the health screenings. The agency is also a member of the Chamber of Commerce in each community in which Head Start and EHS operate.

Interagency Collaboration. NWTTHS participates in several interagency collaborative organizations. The case

manager at each center participates in a monthly interagency collaborative group meeting of all service providers in that county. The agency participates in the Tennessee Commission on Children and Youth, and all case managers are members of the commission. In addition, NWTTHS participates in the Tennessee Conference on Social Welfare, and the education specialist serves on the conference's policy committee. Each year, the agency arranges for several parents to attend this organization's annual conference.

CONTINUOUS PROGRAM IMPROVEMENT

Early Program Support. In addition to the pre- and in-service training described above, NWTTHS has received ongoing technical assistance from its Technical Assistance Support Center (TASC) and Resource Access Project (RAP) consultants. They have provided training about EHS, parenting issues, coordination between the grantee board and policy council, the revised HS performance standards, and agency policies for resolving staff differences and conflicts. The agency's RAP consultant works out of the NWTTHS office and regularly attends staff meetings. The agency considers her to be part of the staff. The TASC consultant also spends a large portion of her time working out of office space at the NWTTHS center office. The program has also received support from its federal project officer and Zero to Three consultant.

Continuous Program Improvement. NWTTHS has assembled a continuous improvement team that meets approximately once every two months to discuss program

issues and staff training needs. The continuous improvement team includes the program director, all specialists and coordinators, and the EHS committee of the policy council. The EHS committee, initially a planning committee formed to advise the agency on preparing the EHS grant application, includes parents and community representatives and advises the agency on EHS program issues. As the agency gains more experience in operating the program, the continuous improvement committee may begin to meet less frequently. Because the program began operating only a few months before the site visit, the continuous improvement team was still focused on gathering information rather than planning activities.

PROGRAM SUMMARY

The NWTTHS EHS program serves primarily African American, single-parent families receiving welfare cash assistance and provides much-needed high-quality child care services. The EHS centers provide developmentally appropriate child care for up to 12 hours per day throughout the year. Program staff members, working closely with welfare agency staff members, assist families in working toward self-sufficiency and link them with services they need.

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PART 2:
HOME-BASED PROGRAMS¹

¹At the time of the site visits in 1997, the revised Head Start Program Performance Standards had not officially gone into effect and the programs had not yet been monitored. Following these two events, some programs instituted changes that are not reflected in these profiles.

EARLY HEAD START PROGRAM PROFILE

Venice Family Clinic Children First Early Head Start Venice, California November 11-13, 1997

The Venice Family Clinic, a private community health clinic that has provided health care to low-income families for many years, operates the Children First Early Head Start program for 100 families in the Venice, California area. The program, which serves primarily Hispanic families, provides child and family development services in weekly home visits, as well as in parent education and other group activities. The program refers families who need child care to a state-funded resource and referral agency that screens providers, makes referrals, and monitors quality. The child development services focus on strengthening parents' and caregivers' relationships with children through instruction and modeling.

OVERVIEW

Venice Family Clinic Children First Early Head Start (CFEHS) in Venice, California, is operated by the Venice Family Clinic (VFC), a private community health clinic serving Venice and parts of Santa Monica and neighboring communities. VFC has provided free primary health care to low-income and homeless families in the Venice community for 27 years, with support from foundations, corporations, individuals, and some state, county, and city funds. The largest free clinic in the United States, VFC currently serves 17,000 patients a year. In 1989 the clinic began operating a Comprehensive Child Development Program (CCDP), one of the clinic's few nonmedical programs. Receiving funding to provide Early Head Start services allowed VFC to continue providing child and family services after the CCDP program was phased out.

Community Context. The program's service area encompasses an urban area of about 16 square miles on the western edge of Los Angeles County. It includes the communities of Venice, Mar Vista, Santa Monica, West Los Angeles, and Culver City. The area is characterized by cultural and socioeconomic diversity and high levels of community violence. Child care, employment and job training, housing, and the prevention and resolution of gang violence and substance abuse have been identified as foremost needs in the community. Community leaders and service providers are committed to providing quality social services and fostering collaboration among service providers to address these community needs.

Program Model. Home visits are the cornerstone of the CFEHS program model. Home visitors try to complete weekly visits that focus on strengthening relationships between children and caregivers through instruction and modeling of appropriate

interactions. Home visitors construct an individualized curriculum for each family and encourage families to participate in a number of other services designed to promote children's healthy development, such as community child care, parent education meetings, counseling, a men's group, and family outings. The program also tracks child health screenings and immunizations and provides health services to children whose medical home is VFC.

When it was funded, the CFEHS program was a mixed model. In addition to home visits, it provided center-based child development services by funding child care slots at Westside Children's Center. The program discontinued funding these child care slots because they were too expensive and the therapeutic nursery model for providing care was not appropriate.

Families. The CFEHS program serves mostly Hispanic families, but nearly one-fifth of families belong to other racial/ethnic groups. Approximately three-fourths of enrolled families do not speak English as their primary language. Approximately half of the families include two parents. One-fourth of the mothers were pregnant when they enrolled. One-third of families were receiving welfare cash assistance when they enrolled.

Staffing. The CFEHS staff includes the program director, home visitor supervisor, 10 home visitors, resource specialist, mental health specialist, male program coordinator/driver, pediatrician, data manager, office manager, data entry clerk, and receptionist. The staffing structure is designed to support home visitors' focus on the parent-child relationship by having other staff members play a greater role in addressing social service needs. The home visitor supervisor provides training and

supervision to home visitors. The resource specialist oversees recruitment and transition activities and acts as a liaison between the CFEHS staff and community agencies and resources. The mental health specialist coordinates in-house counseling services for families that would like to address issues related to family relationships, depression, eating disorders, grief, and substance abuse. The program director oversees all program operations, provides leadership to the staff, and serves as a liaison between CFEHS and leaders of collaborating community agencies. At the time of the site visit, the program was attempting to fill positions for a health and nutrition specialist, a parent involvement specialist, and an early childhood family day care homes coordinator.

RECRUITMENT AND ENROLLMENT

Program Eligibility. Eligible families reside in the service area and meet Head Start income guidelines. In addition, the national evaluation requires that families not have been in CCDP within the last five years, and the local program-research agreement requires that children be under 8 months of age at the time of enrollment.

Recruitment Strategies. The program has used multiple strategies for recruiting families. Program staff members have recruited pregnant women and families with infants through the VFC (including its prenatal clinic), the University of California at Los Angeles (UCLA) hospital and pediatric clinic, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Westside Regional Center. Adolescent parents have been recruited at Santa Monica High School. In addition, staff members have contacted other

COMMUNITY PROFILE

The CFEHS target area consists of the low-income subcommunities within five contiguous Westside Los Angeles communities: Mar Vista, Venice, Santa Monica, West Los Angeles, and Culver City. These communities are culturally and socioeconomically diverse. Several public housing projects are located in Mar Vista, an area with a growing Middle Eastern population and both poor and affluent families. Venice is a historic artists' community where African American and Latino groups have coexisted in a relatively small geographic space. Recent gentrification of this beach town has resulted in older, modestly priced homes being replaced by newer, more expensive ones. Oakwood, a predominantly African American section of Venice, has recently experienced outbreaks of gang violence. Bordering Venice is Santa Monica, which is known for its liberal, progressive city government and the coexistence of poverty and affluence among its neighborhoods.

Most of the jobs that are available in the CFEHS target area are service jobs in hotels and restaurants, domestic service, and landscaping. Jobs in industry are located far away, and good transportation is necessary to get to them.

The area served by CFEHS has many service needs. In September 1997 the VFC published a report outlining the results of its extensive community needs assessment. The greatest needs were child care, employment and job training, and housing. The report also identified other needs, including access to general adult health care, specialty care, health education, dental care, and mental health services. Health-related needs included treatment for tuberculosis and prenatal care.

CFEHS staff members identified prevention and resolution of gang violence and substance abuse prevention and treatment as important needs in the service area. Staff members noted that gang wars over turf in the crack cocaine trade pose a significant threat to community safety, and that few substance abuse rehabilitation centers exist in the area because most funding for such centers has been funneled to South Central and East Los Angeles (areas with greater perceived needs).

The communities in the CFEHS service area are committed to providing quality social services and to fostering collaboration among service providers to meet the communities' needs. Community service providers noted that the Westside area is relatively rich in resources compared with other communities in and around Los Angeles. The city of Santa Monica is especially recognized for its intensive efforts to address community problems through the provision of high-quality, integrated social services.

agencies and attended community meetings to recruit families.

Enrollment. Staff reported during the site visit that recruitment had been a difficult process. CFEHS is funded to serve 100 families, 75 of whom will participate in the

national EHS evaluation. At the time of the site visit, 88 families were enrolled, 56 of whom were participating in the research (due to a previous commitment, the program was serving 32 families who were not eligible for the research because their children were older than 12 months; these families will age out of the program over the next year and be replaced with research families). The staff attributed enrollment difficulties at least in part to the reluctance of Westside Regional Center (the program's Part C provider) to refer families due to the random assignment process. The center reportedly did not want to subject comparison group families (who would not receive services) to an intensive application process. Another barrier to recruitment has been parents' need for child care, which the program is not funded to provide. In addition, the eligibility requirements for the national and local research somewhat reduced the pool of eligible families.

The program had experienced relatively low turnover (less than 9 percent). Eight families left the program because they were not willing or able to accept program requirements and responsibilities, or because they were seeking child care and were disappointed to find that it was not provided by the program.

Enrolled families have several strengths. Most families exhibit resourcefulness, persistence, interest in their children's development, and a desire to improve their circumstances. Families make a substantial effort to participate in program activities, and a core group of about nine men (out of 58 fathers in the program) are involved in these activities. Almost all families are participating in home visits. Families often need employment, child care, housing, transportation, and help overcoming social isolation. Undocumented

families face special challenges with respect to finding stable employment and accessing needed services. In the wake of several local outbreaks of gang violence, program staff members and parents named violence prevention as a primary need in the community.

CHILD DEVELOPMENT CORNERSTONE

The program provides child development services mainly in home visits. Additionally, families are encouraged to take advantage of other services designed to promote children's healthy development, including parent education meetings, a men's group, counseling, child care referrals, and family outings. The program tracks child health screenings and immunizations, and health services are provided to children whose medical home is VFC. The program also has sponsored a few group socialization sessions designed to enhance parent and child interactions and to network families socially, but it temporarily discontinued these sessions due to poor attendance and in November 1997 was in the process of redesigning these activities.

Home Visits. Home visits are conducted by the program's staff of 10 home visitors, each of whom has a caseload of 8 to 10 families. Home visitors are required to have at least an associate's degree (with a bachelor's degree in child development or social work preferred), to be bilingual, and to have experience in home visiting in either a Head Start or an infant/toddler program. Their responsibilities include doing weekly home visits, conducting all EHS-required assessments for children and adult family members, assisting families in establishing a medical home, referring families to EHS

CFEHS services are designed to facilitate child development by strengthening parental and family functioning. Through its interventions with parents, the program expects to have primary impacts on parenting and parent-child relationships and secondary impacts on children's physical health and emotional development.

support staff and/or community agencies, advocating for families with local agencies, encouraging families to participate in program activities, and providing transportation for families when needed.

Home visits, which typically last 60 to 90 minutes, are based on the CELEBRATE model, which focuses on strengthening relationships between children and caregivers through instruction and modeling of appropriate interactions. Using the CELEBRATE model as a guide, home visitors attend to and address with parents the importance of cues, eye contact/expression, love, environment, parental beliefs, rhythmicity/reciprocity, ages and stages, touching and holding, and empathy. Home visitors observe and praise positive parenting behaviors and attempt to build on family strengths.

Home visitors construct an individualized curriculum for each family, drawing from published curricula such as *Portage*, *Small Wonder*, and various other resources. Following recommendations presented in Technical Assistance Support Center (TASC) training, home visitors plan weekly visits that (1) include followup on the previous week, (2) cover a preplanned topic and activity facilitated by the home visitor, (3) include an evaluation of what

happened, and (4) end with planning for the next visit. Home visitors are increasingly referring parental social service needs to the resource specialist so that they can focus on facilitating positive parent-child interaction and promoting parents' knowledge of child development. Furthermore, the program has developed a new planning form to ensure that child development activities occur during every home visit.

At the time of the site visit, home visitors were having some difficulty meeting the program's goal of visiting families weekly. They typically completed visits with 8 of their 10 families each week, and some visits were brief. Some families reportedly cancel up to half of the scheduled visits. The program director suggested that parents who are coping with difficult circumstances may be unable to participate in weekly home visits, group socializations, policy council meetings, and other program activities.

Group Child Development Activities.

For a brief period, CFEHS staff members brought parents and children together for group socializations to interact and to help families build social networks. Initially, home visitors invited their families to the CFEHS center two evenings a month for parent-child play and group activities and discussion. The sessions were very informal and did not address specific topics. The socialization sessions were followed immediately by parent education sessions; each session lasted an hour and a half.

Low participation rates led the staff to conclude that this strategy was not effective. Staff members are currently seeking strategies for improving the format, content, and setting of socializations. Technical Assistance Support Center (TASC) and Resource Access Project (RAP)

representatives have advised the program staff to set up a space in the CFEHS center that would be more child friendly and conducive to group interaction. The group socializations have been discontinued while the staff develops new plans for them.

Child Care Services. CFEHS does not provide child care directly but refers parents to Connections for Children. This state-funded resource and referral agency screens providers, makes referrals, and monitors quality. At the time of the site visit, 36 percent of program children were in child care arrangements, and the 25 families who were receiving TANF were eligible for child care subsidies.

The program's approach to child care was changing at the time of the site visit. CFEHS previously funded 22 half-day slots at Westside Children's Center, but it discontinued this funding for two reasons: (1) Westside Children's Center serves mostly abused children, and technical assistance providers deemed its therapeutic nursery model inappropriate for Early Head Start, and (2) its services were too expensive. After discontinuing care arrangements at Westside, CFEHS was able to place all except one of the displaced children in other child care settings. Program staff members arranged child care funding for at least 10 families, through a state program administered by Connections for Children that provides funding for "respite care" for children at risk of abuse or neglect, and the program is currently paying for family child care for one family. Staff members are making plans to pay for family child care for 10 program families.

The program has created a new staff position to monitor quality among family child care providers. One home visitor has been assigned to 10 families with children in family child care, and this individual will

conduct half of her home visits with these families in the family child care home.

Child Development Assessments. Home visitors conduct developmental assessments of children within 45 days of enrollment and at least every 6 months after that using the Denver Developmental Screening Test II or the Hawaii Early Learning Profile. They refer children who exhibit signs of possible difficulties to the VFC pediatrician, who conducts a more complete assessment and refers the family to the local Part C provider if warranted.

Health Services. Staff members work with families to identify primary health care providers. At the time of the site visit, 89 percent of the children had a medical home. About half of these children have their medical home at VFC. The data manager is continually refining computerized record-keeping methods designed to help the staff track immunizations, well-child checkups, health status, and insurance information. Based on these records, the program sends reminder letters to families that miss immunizations and examinations.

The VFC medical staff provides a number of services to program children and families who are VFC patients. Within their first three months in the program, children who are VFC patients receive a thorough entry examination that includes screening for anemia and lead levels. Children with elevated lead levels are referred to WIC. The clinic staff also provides "anticipatory guidance" to program families on such topics as dental health, nutrition, weaning, fever management, MediCal, and safety and violence issues.

Most parent education on health-related and other topics occurs during home visits.

In addition, the program has sponsored two parent education meetings focusing on policy council issues and HIV/AIDS education. Parents also learn about their children and their own influence on their

children's well-being during counseling sessions. The mental health specialist leads a staff of VFC social workers in providing individual, family, and group therapy to families in the program. This specialist also

COMMUNITY CHILD CARE

The supply of child care in the CFEHS service area is inadequate, especially for infants, toddlers, and special-needs children. Changes in welfare policy have increased the demand for subsidized child care services, and some CFEHS families waiting for subsidized child care have been displaced by lower-income families who receive priority when subsidized child care spaces become available. Program staff members were aware of only two local infant-toddler centers to which they could refer families. Throughout the state, only four percent of slots in licensed child care centers can be filled by infants under 2 years of age. Family child care slots are more abundant but still fall short of the need. Quality across providers is uneven.

consults with families about child mental health issues such as tantrums, bed-wetting, and discipline strategies.

Services for Children with Disabilities.

At the time of the site visit, three of the children enrolled in CFEHS were diagnosed with disabilities and had been referred to Westside Regional Center, the local Part C service provider. These children were either diagnosed prior to their recruitment into the program or were identified by CFEHS staff. When the Westside Regional Center staff members develop an individualized family service plan with a family, a CFEHS staff member is involved in the process.

Transitions. Depending on each family's needs, CFEHS staff members coordinate with schools and other agencies to facilitate children's transition into Head Start or other preschool programs. Beginning about six months before a child turns 3, the home visitor and parents together develop a transition plan that is then reviewed by the home visitor supervisor and

resource specialist. Its purpose is to ensure that services continue uninterrupted. The parent and home visitor then review the plan throughout the remaining home visits.

FAMILY DEVELOPMENT CORNERSTONE

The CFEHS program provides home visiting, case management, mental health, health, group socialization, emergency assistance, and transportation services to promote positive family functioning and self-sufficiency. It refers families to outside agencies for services that address employment, educational, and substance abuse needs. Home visitors help families target specific goals based on their individual needs and interests.

Needs Assessments and Service Planning. Within the first 90 days after families enroll, home visitors assess the families' needs and strengths. The program previously used a needs assessment survey

based on Head Start Family Information System (HSFIS) categories but, in accordance with the recommendations of TASC consultants, has revised the survey to be more strengths focused. Home visitors work with families to develop and document specific goals in an Individualized Family Partnership Agreement (IFPA). The IFPA is updated every six months.

Family development is interwoven with child development in the implementation of program services. The program aims to help parents decrease stress in their lives and the increase their child development knowledge, self-esteem, employability, and economic security.

Case Management. During home visits, home visitors work directly with parents to address their goals or refer them to other service providers. Home visitors also follow up with families on their progress toward achieving their goals.

Home visitors reported that addressing urgent family crises and social service needs can take up a substantial amount of time during their home visits, especially when families first enter the program. The program is attempting to enhance home visitors' ability to focus on the parent-child relationship by asking other specialists to play a greater role in addressing families' social service needs. The resource specialist helps home visitors link families to agencies that provide employment, child care, education, housing, and emergency assistance services. The mental health specialist coordinates in-house counseling services for families that want to address issues related to family relationships,

depression, eating disorders, grief, and substance abuse. When warranted, this specialist refers families to other programs, such as substance abuse treatment programs and domestic violence programs.

Health Services. Parents who are VFC patients (those who lack health insurance and those with MediCal who have chosen the clinic as their primary care provider) receive prenatal, postnatal, and health education services from the VFC. Prenatal and postnatal services consist of checkups and education about pregnancy, nutrition, childbirth, and newborn care. Home visitors ensure that pregnant women who are not VFC patients receive high-quality prenatal services at another facility, and they provide emotional support and health and nutrition information to pregnant women and new mothers. Home visitors refer qualified families to the local WIC office, which provides nutrition education and food coupons for pregnant and breast-feeding women and for children up to 5 years of age. The VFC also offers health education on HIV risk and prevention.

Father Involvement. The CFEHS staff recognizes the importance of actively encouraging male involvement in the program. The male program coordinator leads a monthly men's meeting, which has been carried over from the previous CCDP program. This meeting functions as an educational forum as well as a support group. Every other month a representative from the Los Angeles Child Guidance Center speaks on a variety of family and parenting topics, leads a group discussion, and shares reading materials with participants. Nine program fathers participate regularly and are committed to this group. The male program coordinator also organizes recreational activities, such as participating in sporting events and attending Lakers games. The coordinator

noted that men are more likely to attend recreational activities, but interest in the men's group has been increasing.

Parent Involvement in the Program.

Beyond participating in home visits, parents have several opportunities to be involved in the CFEHS program. A major goal of group socializations has been to help parents form social networks that will outlast their participation in the program. As mentioned previously, staff members are currently planning changes to the socializations to increase their effectiveness in meeting this goal. The program's policy council is now in place and involves parents in program activities and decision making. Policy council parents give input into the scheduling of home visits and socializations and participate in hiring decisions. Three parent committees--personnel, finance, and refunding--have been formed. Six to eight parents participate regularly in policy council and parent committee activities. In addition, parents volunteer to assist with program events and parties.

STAFF DEVELOPMENT CORNERSTONE

Training. The CFEHS program assesses training needs by conducting periodic staff surveys and reviewing annual staff evaluations. Ten times between July and October 1997, home visitors participated in 90-minute training sessions conducted by staff from St. John's Child and Family Development Center. These sessions covered topics related to infant and toddler care, child development, and home visiting. At the time of the site visit, the program was planning to switch training providers (to Cedars-Sinai Hospital).

receiving varied amounts and types of training. In addition to the training provided by St. John's, staff members have received some training through Development Associates, the program's new TASC provider. One home visitor attended a seminar on infant development, and the mental health specialist attended training in infant mental health and mental health services for home visiting programs. Some staff members received training in breastfeeding and child abuse and neglect through VFC, as well as parent education training through the Los Angeles Unified School District. Several staff members stated that they expected the hiring of a new home visitor supervisor to result in more consistent staff training.

CFEHS also encourages staff members to attend Head Start conferences--as well as workshops or conferences sponsored by local community agencies--and pays for them to attend. Staff members reported attending seminars on the role of fathers, immigration rights, and welfare reform.

Supervision and Support. At the time of the site visit, the home visitors did not meet regularly with other program staff, but they met to discuss issues as they arose. In addition, the program sponsors annual staff retreats and monthly lunches with the program director. Home visitors also have informal opportunities to talk with each other about their work.

Home visitors meet with coordinators for case reviews. Recently, case reviews have become more consistent and thorough; they now occur at least monthly and have evolved from a quick analysis of 10 families in an hour and a half to more intensive reviews.

Overall, staff members reported

WELFARE REFORM

California's welfare-to-work plan, CalWORKS, was implemented January 1, 1998. The plan includes a five-year cumulative lifetime limit on aid, with new applicants and existing recipients limited to receiving cash assistance for 18 and 24 months, respectively. Adult recipients are required to participate in an initial four-week period of job search, followed by work. Counties may choose to exempt parents with children up to 1 year old from the work requirement. When recipients do not meet work participation requirements, grants are reduced by the adult's portion. Children of adults who reach the lifetime limit fall within the Safety Net and receive continued aid in the form of vouchers or cash. Families are eligible for child care subsidies for 24 months after termination from aid or until their wages exceed 75 percent of the state median income, and eligibility for transitional MediCal coverage extends for 12 months after termination from aid. At the time of the site visit, one-third of EHS families were receiving cash assistance.

Under the new welfare regulations, undocumented persons in California are ineligible to receive aid and several types of social services, including prenatal care and food stamps. At the time of the site visit, these restrictive measures had not yet been implemented. Program staff members and local service providers expressed apprehension that these changes would greatly hamper their ability to help undocumented families. The VFC was particularly concerned about how it will continue to provide prenatal care to low-income families if state funding for undocumented families is discontinued. Along with the welfare changes, the program has also seen greatly increased interest in job training programs and "incredible increases" in use of local food banks.

Staff receive performance reviews annually. The program was in the process of redesigning supervisory practices at the time of the site visit.

Staff Turnover. At the time of the site visit, several staff changes had occurred recently. First, a new home visitor supervisor was hired three weeks before the visit. The staff was excited about this individual's hiring and saw her as a good fit with the program in terms of cultural background, expertise, and experience. She is bilingual and brings to the position experience in infant/toddler programs and special education. In addition, the recruiting specialist was promoted to resource specialist (a newly created position). In addition to recruitment, this specialist

oversees transition activities and acts as a liaison between the CFEHS staff and community agencies and resources. Finally, four new home visitors were hired, including two with Head Start home visiting experience. Thus, the home visiting staff has grown, despite the resignations of two home visitors who left during the past year for better-paying jobs.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. CFEHS has worked to maintain, build on, and improve VFC relationships with other community agencies. The program has informal agreements with nine other service

providers. CFEHS collaborates closely with the Westside Regional Center, WIC, Connections for Children, and Santa Monica-Malibu Infant/Family Outreach. CFEHS exchanges referrals with these agencies and also engages in cross-training of staff with WIC and Santa Monica-Malibu Infant/Family Outreach. The local school district sponsors the Santa Monica-Malibu Infant/Family Outreach program, which operates preschool, after-school, and teenage parent programs. It is currently launching a “wellness model” infant/toddler program for expectant families in certain school attendance areas.

CFEHS collaborates less intensively with other service providers. It exchanges referrals with St. Joseph Center, Venice Skills Center, Vera Davis Family Resource Center, Venice Dental Center, Chrystalis, and Westside Children’s Center. St. Joseph Center provides an array of social services (parenting, counseling, preschool, senior outreach, homeless, and job training programs) to 12,000 people annually in Westside Los Angeles. Venice Skills Center provides adult education services (computer, literacy, and child care training) through the public schools, and Vera Davis Family Resource Center is a newly established non-profit provider of youth and family services. CFEHS families receive dental services through Venice Dental Center. Chrystalis provides employment services for homeless adults. Westside Children’s Center provides child abuse prevention and treatment services for children up to age 5 (foster care, substance abuse treatment, parent education, child care, and family reunification services). CFEHS refers families who receive state child care subsidies to the center, but it is no longer contracting with Westside to provide child care for non-subsidized families. Westside also makes referrals to CFEHS, and both agencies have engaged in some cross-training of staff.

Interagency Collaboration. CFEHS staff members participate in interagency collaborations, including the Westside Cities Collaborative (providers of special needs services), Venice-Westchester and La Ballona Healthy Start Collaboratives, Oakwood United group (social service agencies serving Oakwood), Pacific Division of Police (police and community issues), School District Outreach Collaborative, and Community Clinics Association of Los Angeles County. CFEHS also participates in the Westside Hunger and Shelter Coalition, which encompasses all of these groups.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. At the time of the site visit, the program had not yet conducted its self-assessment, but its TASC and RAP consultants had visited recently to assess technical assistance needs. The program had also received key support from its Federal project officer and from Zero to Three consultants.

Continuous Program Improvement. A team of researchers from the University of California at Los Angeles (UCLA) serves as the program’s continuous improvement partner and local research partner. An ethnographer on this team, an anthropologist trained in participant observation methods (who is also bilingual) provides most of the continuous improvement feedback to the program. This individual has helped program staff members document theories of change and has provided feedback on home visiting patterns and program implementation. The local research team has also provided staff with general information on engaging difficult-to-reach families.

Local Research. The local research team, which is led by a researcher with expertise in infant/toddler social and emotional development, with emphasis on children with child care experience, is conducting a study designed to examine (1) the efficacy of the CFEHS program's two-generational service model, which uses home visitors to provide child and family services, for this sample of low-income, immigrant, Latino families; and (2) the pathways mediating program effects. The researchers' main hypothesis is that the success of the program rests on its ability to support and enhance strong, caring, continuous relationships that nurture children, parents, family, and caregiving staff.

The study focuses on child, family, and staff outcomes. Child outcomes include social competence and secure attachments with parents or other caregivers. Responsive and sensitive maternal caregiving is being investigated as a family outcome and as a process explaining child outcomes. The researchers are also examining attachment relationships between children and child care providers and relationships between mothers and program staff members as outcomes and as process variables explaining child and family outcomes. Changes in staff member relationships with families, in their perceptions of children, and in their child guidance beliefs following training are also being analyzed as staff development outcomes.

The research will examine processes and changes over time based on multiple assessments of children, family, and staff development. These include in-home observations, maternal interviews, observations in child care, provider interviews, parent interviews, and staff questionnaires conducted over the three-

year period in which children are enrolled in the program.

PROGRAM SUMMARY

In a culturally and socioeconomically diverse community in Los Angeles County, the CFEHS program provides child development services primarily through home visits. Most of the families served by the program are Hispanic. Home visitors work with families on strengthening child-caregiver relationships through instruction and modeling. Family development services are woven into the home visits and group activities, and the program actively encourages male involvement. At the time of the site visit, the program was redesigning several elements of the program, including group socialization activities and staff supervision and support practices.

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EARLY HEAD START PROGRAM PROFILE

**Mid-Iowa Community Action, Inc. Early Head Start
Marshalltown, Iowa
October 28 - 30, 1997**

Mid-Iowa Community Action, Inc., a 24-year-old community-based organization that provides services to low-income families, operates an Early Head Start program for 75 families in five rural counties in central Iowa. The program serves primarily white families, many of whom are two-parent families. The program provides child development services in weekly home visits and family development services in biweekly home visits. The program also holds monthly parent meetings in each county. The child development services focus on strengthening parents' skills and abilities as their children's first teachers.

OVERVIEW

Mid-Iowa Community Action, Inc. (MICA) operates an Early Head Start (EHS) program in five rural counties in central Iowa. MICA is a community-based organization and Head Start grantee that has been serving low-income community members since 1974. The EHS program builds on MICA's experiences operating a Comprehensive Child Development Program (CCDP). The EHS program benefits from the resource sharing and collaboration among MICA staff members who serve families through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Head Start, and many other programs that MICA administers.

MICA serves families in Hardin, Marshall, Poweshiek, Story, and Tama counties. MICA's main office is in Marshall County. Staff members work out of satellite offices in each of the counties.

Community Context. Although each of the five counties has distinguishing features that make working with families and community service providers unique, they are all rural and share many similar needs and resources. One of the biggest challenges faced by the community is the isolation families may experience because they often live quite far from one another. Reliable transportation is necessary in this rural area, but often families cannot afford to maintain their automobiles. Despite the physical isolation that may occur, however, many people are active in their public schools, churches, and community organizations, and have a strong sense of community and support.

Program Model. MICA's EHS is a home-based program. Each family receives weekly home visits from a child development specialist, who provides child development services and parent education in many areas, including nutrition. Twice a month a family development specialist visits each family to provide family development

services. In its CCDP program, MICA also provided family and child development services. Its focus in EHS during the past year has been on enhancing the child development services for infants and toddlers. MICA has also been working with local child care resource and referral agencies to locate child care for EHS families and to build infant care networks.

Families. The MICA EHS program serves mostly white families, but one-fifth belong to other racial/ethnic groups. Nearly half of the families include two parents. Approximately one-fourth of mothers were pregnant when they enrolled in the program. About one-third of the families were receiving welfare cash assistance when they enrolled.

Staffing. MICA has a strong staff structure to support the work of six child development specialists, six family development specialists, and five county team leaders. All MICA EHS staff members also provide Head Start services. Each county team leader supervises staff members and serves as a key link to the MICA central office staff. Team leaders in the two smaller counties also deliver family development services for the families in their caseloads.

These staff members receive support from nine coordinators and specialists who work directly with families as needed and work with other staff members to plan and coordinate family services. Those staff members include the family health services and disabilities coordinator, the nutrition coordinator, the parent involvement coordinator, the family practice coordinator, the home-based specialist, and the adult education/employment coordinator. The program's information systems coordinator maintains the program's management information system. The family services grants management coordinator and the

accountant monitor the program's fiscal activities. The early childhood education coordinator oversees the delivery of child development and parent education services by providing support and feedback to the staff, reviewing lesson plans, and planning staff training. The program director provides overall leadership to the staff and, together with the early childhood education coordinator, creates and maintains a strong network of community collaborations.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The MICA EHS program serves families that live in the five counties and meet the eligibility requirements for EHS (have income below the poverty level and have a child under 3).

Recruiting Strategies. Staff members use multiple strategies to recruit families, including making announcements on the local radio stations in each community, distributing flyers, canvassing door-to-door, contacting potential participants from lists of WIC participants, talking to family members who visit county offices to apply for MICA's Low Income Heating and Energy Assistance Program, and seeking referrals from maternal and child health clinics in each county. In collaboration with the maternal and child health clinics, MICA conducts a yearly Head Start roundup, where Head Start families meet staff members and obtain physical examinations and wellness checks for their children. At the roundup, staff members speak with expectant mothers about participating in EHS. Staff members reported that using the WIC participant lists is the most effective way to recruit families into EHS.

Enrollment. The MICA EHS program is funded to serve 75 families, all of whom

COMMUNITY PROFILE

MICA serves families living in Hardin, Marshall, Poweshiek, Story, and Tama counties in central Iowa. MICA's service area is approximately 3,000 square miles, and the population of the five counties ranges from about 18,000 in Tama to 75,000 in Story. Each county has different characteristics; however, they share many features.

Central Iowa's economy is based in agriculture, with thousands of farms that produce corn, soybeans, and other crops. The five counties also have many hog farms and dairies and two meat processing plants. Many people in the five counties, however, no longer have occupations directly related to agricultural production. One of the major employers, a firm that manufactures heating and cooling systems, is located in Marshalltown. Many low-skilled adults work in the growing retail sales market, which does not pay well. Iowa State University at Ames, in Story County, and Grinnell College, in Poweshiek County, provide additional employment opportunities and cultural diversity for a community that is mostly white. Since the meat packaging plants opened a few years ago, many Spanish-speaking families have moved to the area from Mexico.

The unemployment rate in the area is about four percent. The cost of living is low, with the average income approximately \$20,000. More than 75 percent of the adults who live in the five counties are high school graduates, and more than 11 percent completed college degrees. Parents emphasized that, although there are many jobs available, without more education they would not be able to compete for positions that require technical skills.

The communities have some problems that urban areas tend to have. Community leaders and parents are concerned about increases in gang activity, teen pregnancy, and drug use in the community.

Local service providers reported that, although many services are available, the medical care available does not begin to meet families' needs, and child care and transportation services are limited.

Community service providers are coming together to address these needs, which are growing in importance as families approach time limits for receiving Temporary Assistance for Needy Families (TANF) cash assistance. Because of MICA's long history of service to the community and its administration of many of the programs that serve low-income families, staff members participate in and lead many of the community collaboration groups in the five counties. Collaboration takes place at many levels, from sharing referrals and networking to coordinate services for individual families, to joint service planning for improving the quality of child care available in the community.

participate in the EHS evaluation research. The program reached full enrollment in October 1996. At the time of the site visit, 64 families were enrolled, and the program was continuing to recruit families to fill openings. Twenty-nine families had left the program because they moved, their child died, or they refused to participate in program activities.

The families served by the program are primarily white, but in some counties families are more diverse. For example, a few families in Story County, whose members are attending Iowa State University in Ames, are from other countries. In some of the counties the number of Hispanic families in the community is increasing. Overall, about 10 percent of families include parents who are graduate students at Iowa State University. Enrolled families bring a variety of strengths to the program. Many of the parents are highly motivated to succeed in their jobs, most have supportive extended families nearby, and most want to learn more about how to help their children develop. Families have a range of needs, including transportation, jobs with good wages, education and training, and affordable child care.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. The MICA EHS program provides child development services to families in weekly home visits by child development specialists, who have caseloads of up to 13 families. The typical home visit lasts about 90 minutes. Visits are scheduled at times when both parents can be present. The child development specialist may also be accompanied by the family development specialist if the family wants to work on family issues that involve the child. During

each visit, the child development specialist guides the parent, as the parent engages the child in an activity that may involve other family members. Child development specialists are required to have a bachelor's degree in child development or early childhood education.

Child development specialists develop activity plans using the *Ages and Stages Questionnaires* assessments and activity guides, as well as other curricula, such as WestEd's *Program for Infant/Toddler Caregivers*. Often, the child development specialist brings along simple toys or household materials that he or she can use during the parent-child activities. The child development specialist also teaches the parents to use common things in the home, such as plastic containers, as toys, and he or she teaches them ways to enrich the child's home environment. The child development specialist talks to the parents about child development issues that are relevant to the activity and addresses the parents'

MICA EHS staff members believe that their program will improve child development outcomes by strengthening parents' skills and abilities as their children's first teachers. The program's approach to child development services is to work with parents on improving parenting skills, conduct activities that will allow parents to see the different skills and abilities their children have, improve children's prenatal environment by helping pregnant mothers meet their health needs and goals, work with families to improve child health and nutrition, and refer families to high-quality child care.

COMMUNITY CHILD CARE

At the time of the site visit, more than 40 percent of EHS families needed child care. Most of them were relying on family child care providers or relatives to care for their children.

The availability and quality of infant and toddler child care have been identified as concerns in central Iowa, and new collaborative groups have formed to address these issues. Very few child care centers exist, and the number of spaces in family child care homes is insufficient to meet all child care needs. Community norms may be a barrier to developing additional child care services, because many people feel that parents or close relatives should care for very young children. Concerns about child care quality focus on the low standards required by Iowa's family child care registration procedures for child-adult ratios and the low reimbursement rates available for centers and child care homes.

Community collaborations with the two child care resource and referral agencies have resulted in agreements to support an infant care network of family child care providers in Story County and plans to develop similar networks in the other four counties. The first one, in Story County, supports family child care providers as they begin their child care businesses and provides consultation and assistance in meeting quality standards. MICA's early childhood education coordinator is working with the collaborative partners on developing the infant care networks.

To facilitate collaboration, the early childhood education coordinator serves on the board of directors for one of the two child care resource and referral agencies that serve MICA's five-county area.

questions. Each visit ends with a discussion of plans for the next visit. The child development specialist sometimes leaves a ball or a simple toy with the family to use during the week. Child development specialists encourage parents to jot down the questions that come up between visits. If the child development specialist does not have the answer, he or she will research the question and find appropriate materials to share with the parents.

Child Care Services. Because central Iowa is so rural, families who need child care face unique challenges. Very few child

care centers operate in the five-county area. Program staff reported that there are not enough registered, high-quality family child care providers to meet the increasing demand for those services.

MICA has made arrangements with two local child care resource and referral agencies to help EHS families find registered family child care providers who have received an eight-week training, called Child Net. All family child care providers must have child-staff ratios of four to one and must care for no more than eight children. If an EHS family wants to use a

family child care provider who has not received the Child Net training, the child care resource and referral agency enrolls the provider in the training. The program does not pay for child care for EHS families. The child care resource and referral agencies help families obtain child care subsidies. Approximately 42 percent of program families were using child care services, and most of those were using full-time care. The majority of EHS families that need child care use family child care providers or their children are cared for by a relative.

Story County's child care resource and referral agency has developed an infant care network of family child care providers. If providers choose to participate, they receive child care equipment, training, referrals, and consultation services from the resource and referral agency. The EHS program is collaborating with Story's child care resource and referral agency to use the infant care network as a source of referrals for EHS families. Staff members plan to have EHS child development specialists conduct monthly consultations at the homes of child care providers in the infant care network who are serving EHS children, to reduce the duplication of services for the child care resource and referral agency staff. The early childhood education coordinator hopes to work with the child care resource and referral agencies to create similar programs in the other four counties.

Child Development Assessments. The child development specialists conduct formal assessments of families' progress towards early childhood education and parenting goals at 4, 6, 8, 12, 16, 18, 20, 24, 30, and 36 months, using the *Ages and Stages Questionnaires*. The assessments involve a combination of asking the parents what they have seen the child do and directly observing the child doing something in each

activity area. The results of the assessments serve as the anchor for planning home visits and alert staff and family members to any areas of concern.

Health Services. MICA's health and family services/disabilities coordinator conducts an initial visit with each family to obtain a detailed health history of the focus child and other family members participating in the program, to determine whether the family has a medical home, and to set health goals for the child and the parents. If family members do not have a medical home, the coordinator refers them to the local Maternal Child Health (MCH) clinic, which offers health care on a sliding-fee-scale basis. Each county has several MCH clinics that serve children and young adults through age 21, as well as adults, who use vouchers to pay for services.

At the time of the site visit, the program had just hired an additional part-time nurse, who will track children's receipt of immunizations and conduct one or two home visits per year with each family. She will also conduct initial health visits with all new EHS families. The health staff and the WIC nutrition coordinator provide health-related training for the child and family development staff and serve as a resource for staff and family members.

The MICA service area has few health professionals, and often they do not accept new Medicaid clients. Dental screenings are available at the MCH clinics, but there are no dentists who serve Medicaid clients in the area. The health services advisory council hopes to attract more health professionals to the five-county area by actively recruiting.

Services for Children with Disabilities. If EHS staff members discover

child health problems or disabilities, they refer families to their Area Education Agency (AEA; the local Part C provider) for further evaluation. A 25 percent delay in one functional area is required to qualify for early intervention services. The program collaborates closely with the Part C providers (a staff member from one of the AEAs serves on MICA's health services advisory council, and they also meet monthly with MICA staff members outside of the council meeting). At the time of the site visit, eight children had suspected or diagnosed disabilities, all had been referred for evaluation, and two qualified to receive AEA services.

Transitions. At the time of the site visit, the program was in the process of developing plans for how it will work with families when their children turn 3 years old and transition out of EHS.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Following a comprehensive assessment of needs in 12 life areas--such as shelter, employment, adult education, and transportation--family development specialists visit families at home every two weeks for 90 minutes to support them as they work toward their goals and help them access available community resources. (Visits may be more frequent for teen parents or for families experiencing a crisis.) Family development specialists work with families to complete monthly status reports on the goals each family chooses to work on. From these reports, the family development specialists work with families to develop plans for meeting their objectives. At the time of the site visit, the staff was piloting a family development partnership agreement

that, if successful, would be used with all families by early 1998.

Home Visits. The MICA EHS program provides family development services in biweekly home visits. Family development specialists, who are required to have a bachelor's degree in a human resources or family development field or equivalent experience, have caseloads of 18 families. They are knowledgeable about the family development services available to parents in all life areas, from adult education and employment to emergency assistance, and help families obtain needed services.

MICA's approach to family development is to build rapport with families and to work with them on assessing and improving their status in 12 major life areas. The MICA staff provides support for families that want to work on moving beyond safety to health and well-being in all life areas. Staff members serve as resources for families. The families are asked to do as much as they can for themselves using the skills MICA staff members cultivate, such as accessing community resources, developing and using families' social networks, and meeting education and training goals.

Education and Employment Services. MICA's adult education/employment coordinator works with EHS staff members and families to help families meet their education and employment goals. MICA views families as lifetime learners, and staff members foster this belief in their families. The adult education/employment coordinator has conducted staff in-service training on job search strategies, the latest

technology available to conduct job searches, and adult education.

MICA has close ties to the local community college, and staff members have been working with local businesses to offer adult education and General Educational Development (GED) classes for families at their work site. The adult education/employment coordinator is certified to conduct the preassessments for the GED. GED services are free for adults, and public funding for community college tuition is available to low-income adults.

The adult education/employment coordinator has arranged computer classes for parents in the MICA county offices. At the time of the site visit, 13 parents were enrolled in these computer classes.

MICA also helps families access the services available at their local work force development center and adult education center. Staff members have developed close relationships with the agencies that work with EHS families participating in Iowa's welfare reform initiative, Promise Jobs, which allows for six months of training and covers child care costs for participants. MICA is funded to serve as a training site for Promise Jobs participants, and it offers training in carpentry, electrical wiring, and other trades. In the past year, the adult education/employment coordinator worked closely with community leaders to improve economic development opportunities and to create jobs in the region.

At the time of the site visit, 46 percent of EHS families were employed. In addition to increasing the number of parents who are employed, the program aims to help families prepare for jobs with higher wages and opportunities for career growth.

Health Services. MICA has pooled EHS and Head Start funds for mental health services and has contracted with another agency to conduct two parent meetings on mental health issues in each county annually, to conduct home visits with families as needed, and to conduct monthly meetings with staff members from each county to provide support and answer questions about individual family issues. At the time of the site visit, however, the mental health group did not have a person on staff with expertise in infant mental health. The program has plans to locate an infant mental health consultant in the coming year.

Other Services. Family development staff members help families access emergency services, such as food, emergency funds, and homeless shelters. Available emergency services vary, but each county offers some support for families in extreme need.

Families in rural Iowa need reliable transportation. In most of the counties, families do not have access to convenient public transportation. Most EHS families have cars, but they are often unreliable. Family development staff members work with families to arrange transportation and create a backup plan for transportation when cars break down.

Father Involvement. The program includes fathers in all aspects of the program. Home visits are scheduled at times when fathers can participate, and they are invited to all program meetings and events. Fathers in the program are very vocal about wanting to be seen as full participants in the lives of their children. Staff members reported that it takes extra effort on their part to speak to fathers directly and to include them, but they enjoy working with fathers. At the time of the site

visit, the family involvement coordinator (a man) was helping staff members work with fathers.

Parent Involvement in the Program.

Parents have opportunities for developing their social networks and leadership skills by serving on the EHS policy council. The parent involvement coordinator is responsible for facilitating the policy council, which is a joint EHS and Head Start council. The policy council includes one parent representative and one alternate from each county (Marshall County has two representatives and two alternates). The EHS parents in each county elect their policy council representatives and alternates. At the council meetings, parents and staff members share information about county activities, review staff hiring decisions, discuss any concerns about program services, and provide input into program plans.

STAFF DEVELOPMENT CORNERSTONE

Training. MICA views itself as a learning organization and requires staff members to grow and develop in their positions. All staff members receive intensive EHS orientation and training. Family and child development specialists at MICA are required to complete a nine-day certification program, which covers topics such as needs assessment, strengths-based planning, and supporting families. In addition, EHS staff members attend monthly in-service training sessions and case conferences, and they periodically have opportunities to participate in national conferences and training. Staff members have also received training in cultural awareness to help them work with the

increasing number of Spanish-speaking families in the area.

The program director reported that staff training needs for the coming year are diverse, and include such topics as the implications of welfare reform, teaching strategies, and mental health issues. The program director has encouraged staff members to invite county-level welfare officials to provide briefings and updates on recent changes. Child development specialists require new strategies for teaching children and parents. Staff members are enthusiastic about incorporating new knowledge about early brain development into how they work with the EHS children. The family development specialists find that some families have very severe mental health needs, and staff members require more training in this area.

In the past year, MICA's Head Start Staff Development Center, which used to coordinate training efforts, was closed. The program director plans to hire a career development coordinator to interview all staff members and develop two-year training plans for each staff member. The career development coordinator will plan in-service training, conduct individual training as needed, and represent EHS on MICA's in-service planning committee.

Support and Supervision. County team leaders, the home-based specialist, and the family practice coordinator provide support and supervision for the child and family development specialists. In addition to being available for consultation as needed, the coordinators meet with specialists for family staffings, which are conducted between 2 and 12 times per year for each family (the frequency depends on the number of families in the county--smaller counties review more frequently

than larger counties). The team leaders and coordinators also review monthly status reports and lesson plans and follow up to address any issues identified. Each coordinator accompanies each specialist on a home visit at least four times a year to observe and provide feedback.

Staff members complete personal development plans quarterly. During this process, which takes considerable time, staff members identify their goals, determine how much time they want to spend working toward each goal, and negotiate with their supervisor for time to work on their goals. Each staff member's quarterly personal development plans and the progress made on them feed into his or her annual evaluation.

Staff Turnover. Fewer than 10 percent of MICA staff members leave the organization each year. In the past year MICA moved to having one team leader for each county. Four new county team leaders were named, two of whom were new to the organization, and two of whom were family development specialists. Three child development specialists left MICA in the past year because they moved or took other positions. At the time of the site visit all had been replaced, and the program was fully staffed.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. Through its long history of operating programs for low-income families in the five-county area, MICA has developed close relationships with most of the other local community service providers and with government agency staff members. These relationships facilitate service coordination. However,

barriers to seamless service delivery still exist, and MICA is working to overcome them. MICA has entered into five formal and two informal collaborative agreements with other community service providers to ensure that EHS families will have quality services available to them in all areas.

MICA staff members highlighted a number of their collaborations as being particularly important for them and for the EHS families. The mental health consultants have provided outstanding services to families and to the staff. The two Part C providers are key community collaborators, facilitating a strong, seamless web of services for children with disabilities. Collaborations between employment and training community service providers and MICA staff members ensure that families have access to high-quality skills assessment, training, and employment services.

Program staff members and the health services advisory council members were concerned that medical professionals may not be identifying children with disabilities early enough. Therefore, they developed a presentation for medical professionals about early intervention. The health services and disabilities coordinator worked with the health services advisory council to create useful materials and an engaging presentation, which has been conducted in a number of doctors' offices.

Interagency Collaboration. In addition to these program collaborations, MICA staff members participate in community collaborative groups, such as the interagency coordinating council for children with disabilities.

WELFARE REFORM

Welfare reform is generally viewed as a positive change by service providers, the MICA staff, and many families. In Iowa, welfare reform began when the federal government approved a welfare reform waiver in 1996. Since then, Iowans who need assistance have participated in the Family Investment Program, which requires unmarried parents under 18 to live with a parent or guardian, requires all participants to name the other parent of their child and arrange child support, and requires all families to complete a family investment agreement and to participate in the work and training program called Promise Jobs. Only parents of children under 12 weeks of age are exempt from Promise Jobs. Promise Jobs provides training and job search assistance, child care assistance, and other services for a period of six months. Iowa families are limited to receiving welfare for five years over their lifetime, and after two years of welfare receipt they are required to work. Transitional child care assistance is available for 24 months. Approximately one-third of EHS families were receiving cash assistance when then enrolled in the program.

MICA staff members reported that the new work requirements and welfare time limits have provided strong motivation for families to take advantage of the EHS program's support. Families find the work they do with their family development specialists indispensable as they attempt to meet the welfare reform requirements. MICA staff members also reported that they often visit parents in the evening and on weekends because so many families are working or participating in training or education activities. Staff members are concerned that the welfare reform requirements and an average of six home visits per month from the MICA staff may be too much of a burden on families. Over the next year, staff members will assess whether they should reduce the number of family development specialist visits.

Community Building Among Parents.

The small size of school districts and the strong participation in local churches in central Iowa foster a sense of community among families. The MICA EHS program strives to build on this overall sense of community and encourages the development of relationships among EHS program families so that they will have a network of support available in times of crisis. Family development specialists assist families in social networking and building relationships with their own and other families, their schools, child care providers, church groups, and other resource providers.

To encourage socialization, the program convenes monthly parent meetings in local community centers or church basements in each county. The meetings include a meal or snack and a group activity. In some counties, EHS parents meet jointly with Head Start parents or parents participating in other MICA programs. Approximately one-third of the families attend parent meetings regularly. Staff members reported that the family and child development specialists set the agenda for the parent meetings based on input from parents during home visits.

MICA's parent involvement coordinator works with the rest of the staff to promote parent participation in these meetings and in other community activities that MICA sponsors, such as outings to local orchards, picnics, and pool parties. Staff members use the parent meetings as an opportunity to introduce families to other MICA staff members they may work with in the future, such as the home-based specialist or the family health services and disabilities coordinator.

Each county also has a newsletter, which advertises county-level activities, includes articles by parents and staff members, and presents educational materials for parents. Family and staff members look forward to each county's annual family celebration, which last year was a carnival that included games for the children and parents who dressed up as cartoon characters.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. In the past year, the EHS staff used the regional Head Start staff development center operated by MICA as their main source of training and technical assistance. Because they had access to this facility, they did not require consultation from their Technical Assistance Support Center or their Regional Access Project. The program also received support from its federal project officer and Zero to Three consultants.

Continuous Program Improvement. The MICA EHS director's approach to continuous program improvement is to collect information from all available sources, including the program's local research partner (a team of researchers from

Iowa State University's Department of Human Development and Family Studies), staff members from Grinnell College who conducted an ethnographic study of MICA's organizational structure and procedures, a MICA staff member who serves as a continuous improvement resource, the EHS staff, and the EHS/Head Start policy council. Staff members meet quarterly to work on continuous improvement and to collaborate with their local research partners.

Local Research. The local researchers, who have developed and used instruments for evaluating home visiting services, are focusing their research on identifying the specific home-based intervention strategies that are related to positive child development and parent well-being. The local researchers regularly observe the family and child development specialists on home visits to document the content and quality of the services families have received during home visits. The local researchers have worked with program staff members to modify a home visit observation coding system the researchers used in other studies. Depending on family preference, the visits are either coded live or videotaped for subsequent coding. Approximately two visits per month are observed or videotaped as part of the local research project.

PROGRAM SUMMARY

The MICA EHS program provides child and family development services to families primarily in home visits. At the time of the site visit, staff members had been working to enhance the program's child development services. They had been working with a child care resource and referral agency in one county to develop an infant care network of family child care providers, and hoped to work with child care resource and

referral agencies in the other counties to develop similar networks. At the time of the site visit, EHS child development specialists were planning to conduct monthly consultations at the homes of child care providers in the infant care network. In addition, at the time of the site visit, the program had just hired a nurse to meet with families when they enroll, track children's receipt of immunizations, and visit families at home once or twice per year.

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EARLY HEAD START PROGRAM PROFILE

Project EAGLE Early Head Start Kansas City, Kansas September 29 - October 1, 1996

The University of Kansas Medical Center's Child Development Unit operates an Early Head Start Program, called Project EAGLE, for 120 families in Kansas City, Kansas. The program serves ethnically diverse families, half of whom were receiving welfare cash assistance when they enrolled. Program staff members provide child and family development services primarily in weekly or biweekly home visits. The program has established collaborative agreements with several child care centers and family child care providers in the area to provide care for Project EAGLE children, and program staff provide ongoing training and technical assistance to center staff members and the family child care providers to ensure that Project EAGLE children receive high-quality child care. The child development services are designed to increase parents' responsiveness to their children, engage them in their children's development, and empower them to access the formal and social supports they need to create a better environment for their child.

OVERVIEW

The University of Kansas Medical Center's Child Development Unit operates Project EAGLE (Early Action and Guidance Leading to Empowerment) in Kansas City, Kansas. Project EAGLE began in 1989 as a Comprehensive Child Development Program (CCDP). As part of a university medical center, Project EAGLE benefits from support services the university provides and can gain access for families to a wide range of health services provided by the medical center when no other health care options are available.

Community Context. Project EAGLE serves families living in the poorest areas in Kansas City, Kansas. The community has problems that many urban areas have--including high levels of poverty, crime, and substance abuse--as well as a lack of needed services, most notably public transportation,

child care, and housing. Community leaders are committed to improvement, and service providers and other community agencies have developed strong collaborations to address these problems.

Program Model. Project EAGLE is a home-based program. Each family receives weekly or biweekly home visits from a family support advocate, who provides child development and case management services. The program has continued providing the services it provided as a CCDP program, but its focus has shifted from serving families until the child is 5 years old to serving families only until the child is 3 years old, and it has begun to work more closely with Head Start to facilitate the child's transition into preschool.

Families. The families served by Project EAGLE are diverse. About half are African American, one-fifth are Hispanic,

and the remainder are white or belong to other racial or ethnic groups. About one-third of the parents are teenagers, and only about one-fourth are married. One-third of the mothers were pregnant when they enrolled in the program. Nearly half were receiving welfare cash assistance when they enrolled.

Staffing. Project EAGLE has created a strong staff structure to support the work of the 11 family support advocates who work with families. Coordinators and specialists in the areas of early childhood education, family support services, self-sufficiency, and health care accompany family support advocates on home visits, conduct group and individual training and supervision, and build community partnerships. The program's associate director plans and oversees staff training, provides technical assistance to other community programs, and is also involved in building community partnerships. The program employs a coordinator and data control technician to maintain the program's management information system. The program director provides overall leadership to the staff and is a community leader who has played a key role in creating and maintaining collaboration among community agencies and programs.

RECRUITMENT AND ENROLLMENT

Program Eligibility. Project EAGLE serves families who live east of 78th Street in Kansas City (Wyandotte County), Kansas, have incomes at or below the federal poverty level, and include a pregnant woman or a child under 12 months old.

Recruiting Strategies. Project EAGLE staff members use multiple strategies to recruit families, including contacting

relevant community agencies to encourage referrals, approaching families in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and health department offices, making presentations to participants in school-based teenage parent programs, and knocking on the doors of families with young children living in housing projects. Many families were recruited at the WIC and health department offices.

Enrollment. Project EAGLE is funded to serve 120 families, 100 of whom will participate in the Early Head Start (EHS) evaluation research. (Some families are not eligible for the research because they participated in the CCDP program.) At the time of the site visit, 101 families were enrolled and actively participating in the program. Since Project EAGLE began providing Early Head Start services, 18 families who enrolled in the program have been removed from the rolls because they moved away, could not be located, or were not participating in program services.

When enrolling families in the program, staff members encourage fathers to be present. They explain fathers' roles and participation in the program and include them in the service profile. Staff members believe this has helped promote active participation by a large number of fathers.

Enrolled families bring a variety of strengths to the program--many have supportive extended families, are motivated to improve their situations, and love and want the best for their children. Fathers are present in more than one-third of families. Families also bring a range of needs, including transportation, housing, and family mental health services.

COMMUNITY PROFILE

Project EAGLE serves families living in the eastern half of Wyandotte County, which encompasses the poorest areas in Kansas City, Kansas. Part of the area is located inside the boundaries of the Bi-State Empowerment Zone.

Kansas City, Kansas, is a community with a declining economic base and declining population. It has the problems that many urban areas have--including high levels of poverty, crime, and substance abuse. Few low-skilled jobs are available; most jobs have some technical skill requirements. The main employers in the area are telecommunications companies, the hotel industry, and some factories and service providers. Jobs are available in Johnson County or Kansas City, Missouri, but public transportation to get to those jobs is very limited.

The community lacks some needed services, most notably public transportation, child care, and housing. Local service providers reported that many services are available, but they indicated that the mental health care available does not begin to meet families' needs, and transportation services are limited. They also cited a number of barriers to accessing available services, including eligibility criteria that exclude the working poor, lack of knowledge of available services and how to get them, fear of the "system" (because they have been punished by the system before), and unwillingness to provide the required information. Parents emphasized transportation as a barrier to getting services and becoming employed.

A significant strength of the area is its sense of community and community pride among service providers. Many want to make Kansas City, Kansas, a better place. Community members are coming together around concerns about teenage pregnancy, violence, child care, and other community issues. Momentum is building around the question of "what can we do as a community for children, youth, and families"?

The community's commitment to improvement has facilitated the development of strong collaboration among service providers and other community agencies. Service providers now have a history of collaborating and do so routinely. Local service providers and other organizations have formed different collaborative groups to address particular problems, such as teenage pregnancy, maternal and child health, and violence. Collaboration takes place at many levels, ranging from sharing referrals and networking to coordinating services for individual families to developing strategies and seeking funding together for new programs. For example, members of the Maternal and Child Health Coalition of Greater Kansas City recently joined in writing a successful proposal for a Healthy Start grant that will fund staff positions in several member organizations. Project EAGLE staff members reported that collaboration to help families get needed mental health services has been especially challenging, because mental health services are less readily available and families are more reluctant to seek or accept these services.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. Project EAGLE provides services to families primarily through home visits by family support advocates either weekly, if the focus child is not in a child care center, or biweekly, if the focus child receives developmentally appropriate child care. Family support advocates provide child development services during home visits, which last about 90 minutes. Family support advocates, who must have a college degree plus two years of experience in early childhood education or case management, have caseloads of 12 families. At the time of the site visit, family support advocates were finding it difficult to complete all planned home visits because some families were breaking appointments. In some cases, families were busy with efforts to meet the requirements of welfare reform and did not have time to meet weekly with their family support advocate. On average, families were receiving two home visits per month.

Child development and parenting education services during home visits are based on the *Parents as Teachers (PAT)* curriculum supplemented by lessons and activities developed by the early childhood education coordinator. Using the *PAT* curriculum, parent educators help parents understand what can be expected for their child at each stage of development and work with parents and children on appropriate learning activities. Family support advocates develop weekly lesson plans for home visits, which are reviewed by the early childhood specialist to ensure that they address goals or needs identified in the family's Individual Family Service Plan and follow through on issues that arose in previous home visits. The family support services coordinator and family support specialist also review the documentation of weekly home visits.

Project EAGLE staff members believe that their program will improve child development outcomes by increasing parents' responsivity to their children and engaging them in their children's development. They also expect to improve child development by empowering parents to access formal and social supports, including comprehensive health and mental health services; to choose high-quality child care; to become more employable; and to create better home environments for their children. Project EAGLE staff members place a strong emphasis on helping parents understand how powerful they can be in influencing their children's development.

Child Care. To promote the use of high-quality child care, Project EAGLE encourages families who need child care to enroll their children in a child care center or family child care home that provides developmentally appropriate care. Project EAGLE has established collaborative agreements with several of the best child care centers in the area to provide developmentally appropriate child care for Project EAGLE children. The centers are required to meet state ratio and group size standards--a maximum of 9 infants in a group, with a ratio of 3 children per adult, and a maximum of 10 toddlers in a group, with a ratio of 5 children per adult. Project EAGLE has also established contracts with several family child care providers to provide developmentally appropriate child care for Project EAGLE children.

Whenever possible, Project EAGLE helps families obtain state child care

COMMUNITY CHILD CARE

Project EAGLE families who need child care rely on child care arrangements they find in the community and pay for them using state child care subsidies, whenever possible, or with help from Project EAGLE when necessary. At the time of the site visit, one-fourth of the families were using child care.

Both the availability and quality of infant and toddler care have been identified as concerns in Kansas City, Kansas, and new collaborative groups have formed to address these issues. Project EAGLE staff members noted that there are only 17 infant and toddler slots in child care for every 25 that are needed. Concerns about child care quality center on the high rates of staff turnover (about 50 percent per year) and lack of strong educational backgrounds among many staff members (only slightly more than half of children are cared for in settings where the director or another staff member has an associate's or bachelor's degree in early childhood education). Several agencies have funding to provide resource and referral services, but they rely primarily on licensing lists or list of providers who have participated in training and do not assess the quality of care provided before making referrals.

Project EAGLE staff members are involved in efforts to improve the quality of child care available in the community. Project EAGLE is working with Heart of America Family Services, Part C, and the Kansas Department of Social and Rehabilitation Services to implement a grant from the State of Kansas to recruit 20 new family child care providers and offer training and incentives to them and 20 existing family child care providers--along with eight hours of in-home technical assistance and monitoring. The grant pays for travel expenses, incentives, and substitute care while providers are in training.

In late 1996, the Project EAGLE staff convened a group of early childhood professionals in Wyandotte county to discuss the growing need for child care for infants and toddlers. Following that meeting, committees met to develop goals, formulate action plans, and set timelines for addressing each goal. In May 1997, more than 75 federal, state, and community leaders gathered to review the availability and quality of child care for infants and toddlers in Wyandotte county and to engage in intensive dialogue about the issues, the role and responsibilities of community agencies and action steps for addressing the issues.

subsidies to pay for the care, but Project EAGLE will pay for child care when families are not eligible for subsidies, such as during gaps in employment. At the time of the site visit, approximately one-fourth of EHS-eligible children were in child care.

Project EAGLE provides training and technical assistance to the child care providers with whom it has contracts or collaborative agreements. The training and technical assistance is based on providers' self-assessments using the *Infant/Toddler Environment Rating Scale*.

At the time of the site visit, the program was also developing plans to provide funds to assist the child care centers with which it has collaborative agreements in working toward National Association for the Education of Young Children (NAEYC) accreditation and to enable the center directors to participate in monthly support groups offered through the Child Care Improvement Network of Greater Kansas City.

Child Development Assessments.

Project EAGLE staff members conduct formal assessments of progress towards early childhood education and parenting goals every six months using the *Denver Developmental Screening Test II*. They conduct informal assessments and observations in child care centers more frequently. The results of the assessments are considered by family support advocates when they are developing home visit lesson plans.

Health Services. When families enroll in Project EAGLE, the health care coordinator assesses whether they have a medical home. If not, she works with family support advocates to teach families that seeking health care from a consistent provider is important and to help them identify a way to access health care. Most children (95 percent) are eligible for Medicaid coverage. Children whose parents' employers do not offer health insurance that they can afford and whose parents' earnings are too high to qualify for Medicaid may be eligible for the Caring program sponsored by Blue Cross and Blue Shield. When necessary, Project EAGLE arranges for health care through collaborative agreements with community health care providers who have agreed to accept a capitated or reduced rate. If no other options are available, Project EAGLE

arranges for health care through agreements with University of Kansas Medical Center health care providers who have agreed to accept referrals from Project EAGLE and write off the costs of the care.

Family support advocates track children's receipt of immunizations, well-child examinations, and treatment for health problems with the help of the health care coordinator and the program's management information system. Family support advocates record information about immunizations and health care in their home visit documentation, which is reviewed for accuracy by the health care coordinator before information is entered into the management information system. The health care coordinator also reviews reports on receipt of immunizations and health care produced by the management information system. Based on these reviews, the health care coordinator follows up with family support advocates to make sure that they are working with families to obtain needed immunizations or health care for children.

Health education is integrated into the early childhood education lesson plans for home visits. Family support advocates teach parents about preventive care for their children, help them understand any conditions their child has and how these conditions affect child development, teach them how they can help alleviate these conditions, and teach them about infection control, hygiene, and safety. Before children are born, family support advocates urge mothers to get consistent prenatal care, track their receipt of this care, and use materials the program has developed to teach parents about pregnancy, prenatal care, nutrition, and breast-feeding.

Rotating groups of nursing students are placed at Project EAGLE for their

community nursing clinical experience. They accompany family support advocates on home visits to conduct height and weight measurements, conduct nursing assessments, and identify health needs.

Services for Children with Disabilities. Project EAGLE has established a collaborative agreement with Part C to assign a teacher, a speech/language pathologist, an occupational therapist, and a physical therapist as needed to assist children with special needs in infant/toddler classrooms of Project EAGLE children. In their collaborative agreements with Project EAGLE, child care centers agree to accept help from these staff members in classrooms with EHS children with special needs. At the time of the site visit, Project EAGLE, Part C, and one of the child care centers had initiated a plan for including infants and toddlers with disabilities in a child care setting with typically developing children. Project EAGLE family support advocates and Part C service coordinators serve as co-case managers for families with children with special needs, and when the child is in child care, the family support advocate works with the center personnel to enable the child to receive support services at the center. At the time of the site visit, three children had diagnosed disabilities and were receiving Part C services. Program staff members expect that as the children get older, more of them will have diagnosed disabilities and will become eligible for Part C services.

Transitions. Six months prior to families' graduation from Project EAGLE, staff members will work with families to develop an Individual Family Transition Plan. The plan will cover early childhood education, health, family systems, and self-sufficiency. It will include goals for transitions in these areas, as well as plans for

meeting the goals.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Family support advocates work with families to develop an Individual Family Service Plan (IFSP) within 10 weeks after enrolling in the program. The IFSPs guide the development of weekly home visit lesson plans. IFSPs are reviewed and revised every three months.

Case Management. Family support advocates provide family development services during the 90-minute home visits. They develop caring relationships with families, motivate them to develop goals and work toward them, teach problem-solving skills, and model appropriate behavior. Family development services include case management, transportation assistance, career counseling, literacy services during home visits, a support group for teenage mothers and their mothers, emergency

Project EAGLE places primary emphasis on strengthening individual and family functioning and on supporting families in making competent decisions that are driven by the wants of the families. The Project EAGLE staff works to strengthen families to enable family members to exercise power and control over their own lives as they work in interdependent relationships with service providers and other community systems.

assistance, and referrals to other community agencies for education and employment services, physical and mental health care, and other social support services.

Education and Employment Services. Project EAGLE places a strong emphasis on helping families become economically self-sufficient, and the self-sufficiency coordinator offers in-house skills testing and career counseling, referrals to employment opportunities, followup with employers to learn how contacts went, and feedback to families about their contacts with employers. The program also offers job readiness training, with funding from a Street to Work grant. Staff members noted that family members often have to work in two or three jobs before finding one that will support their family. Project EAGLE has collaborative agreements with several education and employment training providers and several employment services providers.

Transportation. Project EAGLE provides transportation assistance--including bus passes, gasoline vouchers, and taxi rides--to families who need it to obtain services, attend school, or seek employment. In addition, family support advocates sometimes take families to obtain needed services. The program refers families to the Kansas Department of Social and Rehabilitative Services for transportation assistance and has collaborative agreements with several community transportation providers to give transportation assistance directly when necessary. Transportation remains a serious challenge for many families, however.

Health Services. Although most children are covered by Medicaid, fewer adults qualify for Medicaid coverage under the new welfare policies in Kansas. When

adults are not covered by Medicaid, family support advocates work with them toward the goal of obtaining catastrophic health care coverage and/or preparing for a job that will provide them with health insurance that they can afford. While families are in Project EAGLE, the program helps uninsured adult family members obtain needed physical and mental health care by making referrals to providers with whom they have collaborative agreements. These providers have agreed to accept Project EAGLE parents and write off the cost of the care.

Project EAGLE places a strong emphasis on helping families postpone additional births. Staff members make referrals to health care providers for family planning services and follow up to help families achieve their family planning goals.

Other Services. At the time of the site visit, Project EAGLE had recently initiated a monthly group activity for teenage mothers and their mothers to provide information and peer support. The group--which was formed in collaboration with Parents as Teachers, the school district, and a local youth services collaborative group--was designed to help the grandmothers continue to parent their children, who are teenage mothers, but let these teenage mothers parent their own children. Recent meetings have focused on safety, family identity, baby massage, and shopping at thrift stores. At the time of the site visit, about half of the teenage mothers in Project EAGLE had participated in at least one group meeting.

Project EAGLE recently received a Reading Is Fundamental grant. At the time of the site visit, staff members were planning to distribute four books per year to parents and to include activities during home visits for helping parents read to their children.

Family support advocates bring laptop computers along on home visits when they judge that it is safe and useful to do so. They use the laptop computers during home visits to expose families to technology and to enable them to consult a computerized information resources library while they are with families. At the time of the site visit, the information resources library included information on nutrition, prenatal care, preventive health care, and community resources. Having the information immediately available on the computer helps family support advocates build on families' motivation to work toward goals that are being discussed during the home visit. Portable printers are available so that family support advocates can leave copies of IFSPs with families when they are completed.

Project EAGLE helps families obtain emergency assistance from other community agencies and provides emergency financial assistance when necessary. When families request emergency assistance from the program, they are required to draw up a budget, and program staff members work with them to improve their financial planning and self-sufficiency skills.

Father Involvement. In addition to mothers (or primary caregivers), family support advocates have other family members, such as fathers or male partners, participate in home visits whenever mothers agree to include them. Family support advocates emphasize the importance of fathers in children's lives and encourage mothers to involve fathers. At the time of the site visit, 41 program families included fathers or father figures, and the majority of them were participating in home visits.

Parent Involvement in the Program. Each family support advocate works with parents in her caseload to elect a

representative to the EHS Parent Policy Council. The EHS Parent Policy Council includes 20 Project EAGLE parents (one primary representative and one backup representative from each family support advocate's caseload) and two community representatives. About half of the parents attend each meeting. The parents identify areas that they would like to hear about during council meetings, and program staff members assist them in identifying speakers to make presentations during council meetings. Because the Parent Policy Council has hiring and firing authority, the University of Kansas has formed a board of directors to resolve any conflicts that develop between the Parent Policy Council and the program staff. In addition to Parent Policy Council meetings, Project EAGLE organizes two major social events for parents per year.

STAFF DEVELOPMENT CORNERSTONE

Project EAGLE's approach to staff development is guided by several principles: (1) cross-training staff members in child and family development is critical; (2) training must be ongoing; (3) training should begin with concrete explanation, include by active experimentation, and conclude with critical reflection; (4) training must allow for practice and feedback; (5) family support advocates need support from other staff members with expertise in child development and family support; and (6) trainers need to be on staff to continue reinforcing lessons learned in training.

Training. The staff receives pre-service and ongoing training designed to address training needs. The associate director works with all staff members to identify their training needs and arranges for

needed training. Working with other staff representatives, he develops a six-month training calendar so that all staff members are aware of planned meetings and training sessions.

Most of the staff training is conducted by Project EAGLE staff members, who are required to submit written training plans that include learner involvement, practicing/doing experiences, and critical reflection. Staff members have developed a formal curriculum for the initial six-week orientation training that staff receives.

For training in some areas, coordinators have guided family support advocates in defining the topic, identifying resources, suggesting strategies, implementing the strategies, and reflecting on how the strategies worked.

Each staff member may also receive up to \$500 per year for continuing professional development activities, including attending professional conferences, taking college courses, and buying books. In addition, each staff member may use up to 10 days per year for professional activities.

WELFARE REFORM

Welfare reform is generally viewed as a positive change by service providers, Project EAGLE, and many families. Nearly half of Project EAGLE families were receiving cash assistance when they enrolled in the program. In Kansas, families are now limited to receiving welfare for five years over their lifetime, and after two years of welfare receipt they are required to work. Mothers of children under age 1 are exempt from the work requirement. Child care subsidies are available to families with incomes at or below 185 percent of the poverty level, on a sliding fee scale based on income and family size. As of April 1997, the Kansas Department of Social and Rehabilitation Services, which administers the subsidies, reported that there was no waiting list for subsidies.

Project EAGLE staff members noted that the new work requirements and welfare time limits are requiring families to adapt and think differently about education and early childbearing. They are requiring program administrators to adapt (for example, by being flexible in the hours they provide services) and think creatively about ways to help families affected by the new rules. Project EAGLE staff members are finding that welfare reform is causing families to give priority to finding jobs--it is a strong motivating factor and a useful case management tool for helping families work toward self-sufficiency. They are also finding, however, that families have less time for weekly or biweekly meetings with their family support advocate, monthly parent-child group activities, and Parent Policy Council.

Support and Supervision. Project EAGLE coordinators and specialists provide support and supervision for family support advocates. The program employs an early

childhood education coordinator, a family support services coordinator, a self-sufficiency coordinator and a part-time health care coordinator, as well as three

specialists who assist them. In addition to being available for consultation as needed, the coordinators meet with family support advocates for case conferences, which are conducted quarterly for each family. They also conduct family staffings (which focus on selected families) with each family support advocate twice year. The coordinators review home visit contact notes and follow up to address any issues identified. Each coordinator also accompanies each family support advocate on a home visit at least twice a year to observe and provide feedback. Family support advocates receive formal performance appraisals semiannually and meet with each coordinator to discuss their appraisal.

Project EAGLE staff members are University of Kansas employees and receive salaries that are similar to those paid by other areas programs, as well as generous fringe benefits. Staff members may receive merit raises annually.

Staff Turnover. At the time of the site visit, Project EAGLE had experienced relatively little staff turnover. Since it became an Early Head Start program, three family support advocates had left the program and had been replaced.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. As a CCDP program, Project EAGLE developed numerous formal interagency agreements with other community agencies and University of Kansas Medical Center departments to provide core services and emergency assistance to Project EAGLE families. The program has renewed many of these agreements and developed new ones

for Early Head Start. At the time of the site visit, Project EAGLE had written collaborative agreements with 38 service providers and had informal agreements to collaborate with an additional 265 providers.

Based on their experience in the CCDP program, staff members have become more proactive in demanding high-quality services as part of the collaborative agreements. For example, the collaborative agreements the program has with three child care centers and five family child care providers require center staff members and family child care providers to assess the quality of care they provide using the *Infant Toddler Environment Rating Scale*, identify training needs, and work with the Project EAGLE staff to get the training they need. Project EAGLE conducts training for these and other child care providers quarterly. Project EAGLE also has enrolled the family child care providers caring for Project EAGLE children in NAEYC to underscore that they are respected professionals.

Interagency Collaboration. Project EAGLE staff members serve on boards of directors of other community service providers, and they participate and provide leadership in local planning and coordinating groups. Every staff member serves on at least one committee of a local coordinating or collaborative group and following each meeting, must prepare a report of the committee's activities. Program staff members also provide training and technical assistance to other community agencies.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. During its first year as an Early Head Start program,

Project EAGLE staff requested and received help from consultants through its Technical Assistance Support Center (TASC) and Resource Access Project (RAP). By the time of the site visit, the program had received three visits from its TASC consultant and two visits from its RAP consultant. The program also received key support from its federal project officer, its Zero to Three consultant and Region VII federal staff.

Continuous Program Improvement.

A team of researchers at Juniper Gardens Children's Project of the University of Kansas, who have a long-established relationship with the program, is serving as Project EAGLE's local research partner for the national evaluation and for continuous program improvement.

The local research team, which includes experts in early intervention, families with special needs, qualitative research, and data management and analysis, is engaging Project EAGLE staff in a critical thinking process to identify intervention strategies to achieve desired program outcomes, review issues that family advocates encounter in working with families, and discuss ways to resolve those issues. Together the team members have examined the process of providing services and empowering families at a detailed level and discussed the difficulties of implementing the program model as it was designed.

Based on the results of that process, the local research team has prepared a report documenting the program's current theories of change, suggesting steps for developing the theories of change more fully, and suggesting steps for considering possible modifications of basic program strategies for different types of families and family issues. Program staff members have selected

training topics based on some of the critical thinking sessions, without waiting for formal feedback from the local researchers.

Local Research. The local research team also plans to conduct integrated quantitative and qualitative studies to assess local program impacts and to investigate the factors that mediate the relationships between the program intervention and children's and families' outcomes. In particular, the local research is focusing on resilience and the growth over time in child and family outcomes. Local research team members are conducting case studies with 20 families to explore differences in risk and protective factors. They are also supplementing data collected for the national evaluation by collecting data on child and family outcomes at intermediate points, and they plan to examine program impacts and to investigate the role of risk and protective factors in mediating program impacts.

PROGRAM SUMMARY

Project EAGLE, building on its experience as a CCDP, provides child and family development services to diverse families in home visits and by linking families to good-quality child care arrangements. Program staff provide ongoing training and technical assistance to child care providers to improve the quality of care they provide. They are also mobilizing community leaders to address issues of availability and quality of child care for infants and toddlers. The program devotes considerable resources to providing training, supervision, and support to staff members. Program staff members are leaders in the community and have played a key role in developing collaborations among service providers.

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EARLY HEAD START PROGRAM PROFILE

Region II Community Action Agency Early Head Start Jackson, Michigan October 28-30, 1997

The Region II Community Action Agency, a community-based organization with more than 30 years of experience serving low-income families, operates an Early Head Start program for 75 families in Jackson County, Michigan. The Early Head Start program builds on the agency's Infant Mental Health program. The families served by the program are mostly white, single-parent families. The program provides child and family development services in weekly home visits by registered social workers and monthly play groups for parents and children. In the home visits, EHS specialists work extensively with parents on their problems in order to enable them to be better parents.

OVERVIEW

Region II Community Action Agency (CAA) operates an Early Head Start (EHS) program in Jackson County, Michigan. Region II CAA is a community-based organization and Head Start grantee that has been serving low-income community members for more than 30 years. The agency, which has total annual funding of about \$11 million, serves approximately 20,000 low-income individuals from three Michigan counties--Hillsdale, Jackson, and Lenawee. The EHS program, which builds on Region II CAA's Infant Mental Health (IMH) program, provides home visits by trained social workers to at-risk families who have children ages 0 to 3. LifeWays, the community mental health agency, funds the IMH program.

Community Context. Jackson is a sizable community an hour west of Detroit. A large state prison is located in Jackson, and the community includes families of inmates. The employment rate is high in the

area, but many residents work in low-paying jobs. Many poor families live in substandard housing, in community shelters, or with other families. Region II CAA has been very involved in community collaboratives that are working to improve the delivery of services to families.

Program Model. Region II CAA's EHS program is a home-based program. EHS specialists, who provide child development and case management services, schedule weekly home visits with each family. Region II CAA is building a program for children ages 0 to 5 by connecting its EHS and IMH programs with the existing Region II CAA Head Start program.

Families. The Region II CAA EHS program serves a diverse group of families. Approximately three-fourths are white, and one-fourth belong to other racial and ethnic groups. Approximately one-third are two-parent families. Approximately 40 percent of mothers were pregnant when they

enrolled in the program. Nearly half of the families were receiving welfare cash assistance when they enrolled.

Staffing. The EHS program relies on its 10 EHS specialists to provide services to families. As registered social workers, the specialists have the expertise to work with families on both child development and family development issues. A family service worker supports the specialists by coordinating families' transportation needs and connecting families to needed community services, and a child care worker manages the infant-toddler center. The EHS coordinator provides daily supervision and support to the staff, and the EHS project director, who is also Region II CAA's deputy director for family and children's services, provides general oversight of the program.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The Region II CAA EHS program serves families who meet the eligibility requirements for EHS, include a pregnant woman or an infant under 1 year old, and have two or more issues (such as domestic violence, substance abuse, or limited cognitive abilities) identified on a psychosocial assessment. Most families live in Jackson County.

Recruiting Strategies. EHS relies on referrals from the medical community to identify and recruit families. Originally, the program intended to accept referrals only from the Center for Family Health (CFH), a local health clinic, but changes at the clinic, mainly the loss of the clinic's obstetrician-gynecologist, required the program to seek referrals from other sources. At the time of the site visit, most families had been referred to EHS by CFH, but some referrals,

especially for children with disabilities in the Early On system, had come from other agencies in the community. The program has developed brochures and flyers to help these referral sources publicize and explain the program.

Enrollment. The Region II CAA EHS program is funded to serve 75 families, and an additional 40 families participate in the IMH program. The program has been at full enrollment but, at the time of the visit, was serving 66 EHS families, 58 of whom are in the research sample. Nonresearch families either have children too old to be included in the research or have participated previously in the IMH program. Most families that have left the program moved out of the county or state. About three-quarters of the enrolled families are white, and the remainder are African American, biracial, or Mexican immigrants.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. The Region II CAA EHS program provides child development services to families in home visits by EHS specialists. Specialists have caseloads of 12 families, including 9 to 10 EHS families and 2 to 3 IMH families. The specialists, all of whom are registered social workers in the state of Michigan and most of whom have a master's degree in school work or counseling, focus on the bonding between parents and their children and provide support using the Infant Mental Health Model.

Specialists try to spend about half of the home visit on child development issues and half on family development issues. Often, however, specialists spend a large part of the visit providing therapy to the parent and

COMMUNITY PROFILE

Jackson is a sizable town with a small-town feel. Community providers tend to know each other and are able to collaborate to provide services. Residents also tend to know each other or to know people in common.

The employment rate is high, but many residents are in low-paying jobs in the service and retail industries. Beyond some critical need areas, such as housing and child care, families can find most of the resources they need within the community.

One of Jackson, Michigan's prominent characteristics is the large state prison within its borders. According to some informants, the prison has profound effects on the community. Families have moved to the community to be near incarcerated loved ones. This situation has the potential to bring in families with high incidence or risk of domestic violence, drug abuse, and other problems. Also, Department of Correction workers are in high-stress jobs that might result in unstable domestic situations.

The level of crime in Jackson depends on where one lives. Parents participating in the group discussion said that the south and east sides of the town are more drug- and crime-ridden than the other parts of town.

The greatest need of poor families is for affordable and decent housing. Region II CAA conducts an annual survey of its clients, and, for the fourth year, respondents listed affordable housing as the greatest community need. Families continue to live in substandard housing because they have no other options, and many families are homeless, either living with other families or in community shelters. Additional community needs cited by community residents include child care for infants and special needs children, dental care for children and adults, and better job opportunities for poor families.

Various community agencies and human service providers collaborate in many formal and informal ways to meet these needs. According to a list compiled by the Human Services Coordinating Alliance (HSCA), there are 34 collaborative efforts in the community.

HSCA, which is mandated by the state to disburse funds from the state's Strong Families/Safe Children initiative, is charged "to promote, facilitate, evaluate, and coordinate collaborative interagency planning and delivery of human services to enhance community health." The membership of the group includes the welfare department, community mental and public health agencies, intermediate and public school districts, and other agencies. The executive director of Region II CAA has served as chairperson of this alliance. The HSCA goals for 1997 included a community-wide needs assessment, integration and expansion of programming for children ages 0 to 3, and a focus on school-aged children. Currently, the group is working on a plan for disbursing its remaining funds. The group does not want to fund programs that will end when the funding runs out; instead, its members are working with local foundations to develop programs that will receive long-term support.

EHS staff members believe that their program improves child development outcomes by first working with parents on their own self-esteem and behavior. Helping parents deal with their own self-esteem issues enables them to be better parents. Staff members work extensively with parents on their problems in order to improve the lives of their children. In the past, the program tended to focus on the family, but at the time of the site visit, staff members had begun shifting their focus to consider families' problems from the children's perspective.

family. Many families are often in crisis, so the specialist spends time helping the family to navigate the social services system, overcome a violent relationship, or deal with physicians. When not dealing with crises, specialists observe parents and children, encourage parental observation of children, suggest interactions to parents, encourage games and play, model appropriate interactions, and videotape parent-child interactions. Some specialists reported that they begin their sessions by focusing on child development issues so that the adult therapy session does not consume the entire visit.

Specialists attempt weekly visits but often either exceed or do not meet this goal. Specialists may see some families in crisis several times during the week, and other families may not keep their weekly appointments. On average, families receive two home visits per month. Typically, home visits last 60 to 90 minutes.

Group Child Development Activities.
The program invites EHS families to

participate in monthly play groups for parents and children. These groups, which are planned and conducted by staff members, include parent-child interactions and age-appropriate play for infants and toddlers. The main focus of the activities is to teach parents to have positive interactions with their children. Play group activities during the last year included a community service day, a day in the park, a zoo trip and picnic, and sessions on making costumes and cooking turkeys. About 20 families participate in each monthly activity.

Child Care Services. In the last year, the EHS program opened its Infant-Toddler drop-off child care program. Families call their EHS specialists to gain access to this care. The care is used when parents are busy with program-related activities, such as doctor appointments, meetings with Family Independence Agency (FIA) caseworkers, and program group meetings. Occasionally, a specialist invites a family to the facility to play using the center's age-appropriate children's toys. The center is staffed by a child care specialist. The person holding this position must have a child development associate (CDA) credential or equivalent degree.

Low-income families in Jackson have few affordable, high-quality child care options. Many EHS families use relatives to care for their children. When parents need other care for their children, EHS specialists can refer families to a local child care network, Community Coordinated Child Care (CCCC), which provides families with lists of licensed child care providers. The CCCC worker helps parents identify criteria for the child care that will meet their needs. The parent is responsible for visiting the listed child care providers to determine which ones meet the family's needs. On occasion, at the request of the parents, the EHS specialist will accompany the parents

COMMUNITY CHILD CARE

Many EHS families need child care. At the time of the site visit, most parents were relying on their families for child care, and few children were enrolled in child care centers or family child care homes.

A key collaboration, the Child Care Coalition, is focusing on the community's child care needs, and its mission is to plan strategically around the issue. The coalition, which is sponsored by the Kellogg Foundation and run by CCCC, assessed the needs of the community and developed a strategic plan for child care in Jackson. Coalition members identified three goals and began addressing the needs. First, they focused on the need for infant child care. The coalition devised an incentive package which included equipment for infant care and provided training in cardiopulmonary resuscitation and first aid. Through this program, the coalition created new spaces for infants in 15 child care settings. The second need identified was for emergency care. The coalition has worked with a home health agency to train workers to go into private homes to provide child care or to work as substitutes in child care centers. The ultimate goal is to make this service affordable. To date, eight people have been trained. The third need is respite care for families with special needs children.

In general, Jackson County has sufficient child care capacity. CCCC's child care statistics for the county show that there is adequate infant, weekend, and evening care capacity. Parents are choosing not to place their children in some of the child care spaces, however, because of the poor quality. For example, in Michigan, family child care providers are not required to have any training; only 45 percent of providers have training.

to check the quality of the listed child care providers. Specialists do not routinely check the quality of the child care being provided to EHS children. If a specialist has concerns about a particular child care arrangement, however, the specialist tries to visit the provider. If the specialist feels that concerns are warranted, she will counsel the parents to find alternative care for the child.

Region II CAA has a contract with CCCC to conduct training for EHS parents who want to become family child care providers. Staff members believe that this training will be useful whether or not the

families provide child care for other children. This program component has not been used much by families, in part because the training location is not accessible to many families. Also, EHS families often have too many personal problems, such as poor housing conditions and abusive relationships, to provide child care for other families' children.

Child Development Assessments.

EHS specialists assess children's development using the *HELP Strands Child Assessment* tool every six months. Parents tend to enjoy this instrument, because it

enables them to see their children's progress. Specialists also administer an *Infant Assessment* that provides additional information about the children from the parents' perspective. The assessment is completed within 45 days of the family's enrollment into the program.

Health Services. Most families enrolling in the Region II CAA EHS program have a medical home at the Center for Family Health (CFH). Originally, the program expected all families to be using CFH medical services, but the center lost its obstetrician-gynecologist. Now, some families receive medical care from other health care providers. According to parents' reports, most EHS children are up-to-date with immunizations and well-child visits. Parents sign releases so that the program can access their medical records from providers, but the program has not been following up regularly on children's doctor visits.

Services for Children with Disabilities. The EHS program has a close relationship with Early On, the community's Part C provider. Early On trained EHS specialists on administering the *HELP Strands Assessments*. EHS also adapted Early On's individual family service plan (IFSP) for use with EHS families. Early On and EHS staff members work together to develop the IFSP for jointly enrolled families. Currently, about nine EHS children have disabilities.

Transitions. When the family is in its third year of EHS, the EHS specialist will start helping the family transition out of program services. The specialist will hold a team meeting with the family service worker, the disability coordinator (if necessary), and any other appropriate service providers to work with the family on making the transition to other programs. Region II

CAA plans to provide a smooth transition to Head Start for eligible EHS children.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. The EHS specialists work with parents to identify their goals and strengths and to develop IFSPs, which are updated every six months.

Case Management. A family service worker (FSW) assists EHS specialists by connecting families to needed services, such as child care and emergency assistance. The FSW also coordinates various group activities, including the monthly play group; a weekly, parent-led support group; and a monthly group for fathers. EHS specialists rely on the FSW as a resource to learn about other community programs and providers.

Father Involvement. Staff members encourage fathers' participation in the program. EHS specialists try to include fathers in the weekly home visits, but fathers are not always at home, or they may feel that the program is for mothers. The monthly Dads group is led by a male social worker in the community. Because EHS staff members are all women, the program looked outside to find a qualified individual to lead the group and attract fathers. The group, which is conducted in collaboration with the community's Child and Parent Center, is also open to fathers of Head Start children and other community fathers. A core group of fathers has been participating in the monthly meetings, in which fathers discuss their personal growth and participate in father-child activities.

Parent Involvement in the Program. Parents are involved in the program

Region II CAA's approach to the family development cornerstone rests on the belief that parents are the primary nurturers and advocates for their children. Through a model of building relationships between the staff and families and between parents and children, the program strives to enhance family functioning by building on individual family strengths and ensuring that parents have the resources available to them to be good parents.

primarily by participating in the Head Start Policy Council, which has input into Head Start and EHS staff hiring decisions. Region II CAA added five membership slots to the Head Start Policy Council for EHS parents. Recently, three EHS parents joined the council, and one other parent has filled out her membership forms. Few other avenues exist for parental involvement, because the EHS home-based model creates few volunteer opportunities for parents.

STAFF DEVELOPMENT CORNERSTONE

Training. Region II CAA is committed to providing the necessary support to staff members so that they can work effectively with families. Region II CAA contracts with the Merrill-Palmer Institute of Wayne State University to provide training and clinical consultation for EHS specialists. Initially, the Merrill-Palmer Institute provided six days of training to all EHS specialists. The training focused on the Infant Mental Health model. All EHS specialists participate in biweekly three-hour clinical consultations with the Merrill-Palmer consultant. Other

EHS staff members, including the child care worker, the FSW, and the EHS supervisor, attend the consultations when they can.

All EHS specialists also have received training from other sources. They attended the Michigan Association for Infant and Mental Health conference training, a three-day conference for providers of infant mental health services. In addition, the local Part C program provided training to all specialists on writing IFSPs and working with children with special needs, and a local health care provider offered training on mental health issues. The regional technical assistance coordinator from Early On provided two training sessions on using the *HELP Strands Child Assessment Tool*, along with follow-up training meetings.

The EHS program also provides support for individual professional activities. Staff members may take leave for educational activities during the week, and Region II CAA will pay for one course per semester toward a staff member's continuing education.

Supervision and Support. The EHS coordinator provides weekly individual reflective supervision to all staff members. During the one-hour supervision session, the coordinator reviews the specialists' cases and discusses other staff members' work activity. These supervision meetings often provide support and advice to specialists on conducting their next visit to their families. As part of the supervision, the coordinator occasionally accompanies EHS specialists on their home visits.

To improve their understanding of the other agencies with whom the EHS program is collaborating, EHS staff members meet monthly with Center for Family Health staff members and monthly with LifeWays staff

members. These meetings provide an opportunity for staff members to raise questions and further coordinate their activities.

At the time of the site visit, staff morale was good, and most staff members were satisfied with their salaries. The project director reported that staff salaries were at good levels for the community.

Staff Turnover. The program has experienced little staff turnover. In the year prior to the site visit, only one person left her position; she moved from the community for personal reasons.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. As part of its EHS program, Region II CAA has formal contracts with several agencies. LifeWays provides training for EHS specialists and also contracts with Region II CAA to run the IMH program. LifeWays has provided psychiatric services for 10 EHS families and open psychiatric consultations for medical service providers accessed by EHS families. Region II CAA does not have a formal agreement with the CFH, but staff members of both agencies work closely together on behalf of their families. Region II CAA contracted with the Early On program to have Part C children and their families join EHS play groups in summer 1997. EHS also has a contract with Community Coordinated Child Care to provide training in child care to EHS parents.

EHS has less formal relationships with other agencies, including the Family Independence Agency, the state's welfare department; the Child and Parent Center, which provides drop-in child care and other

services; the AWARE shelter, for victims of domestic violence and abuse; the Jackson Housing Commission; and Region II CAA's own community services office. In most cases, the EHS program refers families to these agencies.

Interagency Collaboration. The goal of the Region II CAA EHS program's community building activities is to increase families' access to high-quality services and to create a seamless system of service delivery. Region II CAA has links with most service providers in the county and is working on improving the service delivery system. Region II CAA and the EHS program have a good relationship with many community agencies, including the Family Independence Agency, LifeWays, the local Part C agency, the Literacy Council, the library, and the Center for Family Health. EHS also works with Community Coordinated Child Care to improve the availability and quality of child care in the community.

Region II CAA, and indirectly EHS, is involved in many community collaboratives. The Region II CAA executive director chairs one community collaboration, the Human Services Coordinating Alliance. The Alliance, whose membership is mandated by the state, has responsibility for administering Strong Families/Safe Children, the state's implementation of the federal Family Preservation and Support Services Act of 1993. In addition to its leadership role on the council, Region II CAA is the lead agency or is involved in many Alliance collaborative programs. Region II CAA also is involved in the Child Care Coalition, formed by the Kellogg Foundation to develop a strategic plan for community child care.

WELFARE REFORM

Michigan welfare reform began in October 1996. Families now face a five-year lifetime limit on cash assistance, and welfare recipients must comply with the new work program, Work First. Recipients must work at least 20 hours per week. New mothers must start work when the child is 3 months old. There are few exemptions to participation in Work First. An FIA administrator estimated that 90 percent of the caseload is working. Approximately half of EHS families were receiving cash assistance when they enrolled in the program.

Welfare reform has already affected families and programs. The EHS program is finding it harder to complete weekly home visits because of parents' work schedules, and parents are clamoring for a child care program similar to Head Start. Parents face many difficulties and choices when trying to comply with the welfare changes. In terms of child care, problems arise when the FIA child care reimbursements come after the parent starts working, leaving parents without the means to pay for the first weeks of child care. This situation also is difficult for the providers. Furthermore, the 20-hour work requirement means that families often need part-time care, which requires finding a provider willing to fill only half a slot. Adults who were in school prior to welfare reform find that the new rules make it difficult for them to continue their studies. If the parent works for 20 hours to comply with Work First and takes classes at school, then he or she will have little time to spend with the children. As a result, parents are choosing to drop out of school. Finally, the jobs that are available to welfare recipients do not pay well and often do not provide any health benefits. These jobs do not pay enough to support a family.

EHS staff members and clients hoped the program would be able to create a child care center for the EHS program to better serve families' needs under welfare reform. However, at the time of the site visit, the program had not succeeded in obtaining funding for a center. In the meantime, the EHS specialists are accommodating families' changing schedules and helping families cope with the changing welfare rules.

EHS staff members also participate in various organizations and activities. For example, one specialist is a member of the Jackson County Association for Infant Mental Health, an informal network of providers serving children ages 0 to 3.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. At the time of the site visit, the EHS program staff had

not received much technical assistance or feedback from its Technical Assistance Support Center or Resource Access Project. It had, however, received support from its federal project officer and consultants from Zero to Three.

Continuous Program Improvement. Region II CAA uses several tools to evaluate and improve EHS. It uses the on-site program review instrument (OSPRI) provided by the Head Start Bureau to evaluate both the Head Start and EHS

programs. Region II CAA uses the results of its annual community needs assessment, feedback from the policy council, and information from the local research team to make changes to the program. The agency also incorporates information from the research and the clinical supervision sessions conducted by the Merrill-Palmer Institute of Wayne State University to improve the services provided to families.

Local Research. A team of researchers from the Michigan State University (MSU) Colleges of Nursing, Social Science, and Human Ecology, with expertise in family health, child psychology, and community-based studies, is serving as the Region II CAA EHS program's local research partner. Although located in East Lansing, about 40 miles from Jackson, the local research team is in regular contact with the program.

The local research focuses on family health. The local research team will define family health status using bio-psycho-social components of family health, explore family health as an outcome of EHS participation, and assess family health as a predictor of service use. Data for the research come from observations and surveys, parent interviews, and reviews of medical and service records. As part of the initial program application, MSU was slated to conduct research on EHS fathers. This work is continuing in tandem with the national research consortium's work on fathers.

EHS, Head Start, and Michigan State University worked together to design a welfare reform survey. Program staff members distributed the survey to all EHS, Head Start, and IMH families in fall 1997.

PROGRAM SUMMARY

The Region II CAA EHS program provides child and family development services primarily in home visits focusing on enhancing parent-child relationships and providing support using the Infant Mental Health Model. At the time of the site visit, the program was beginning to shift the focus of services to emphasize child development and address family problems from the children's perspective.

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EARLY HEAD START PROGRAM PROFILE

KCMC Early Head Start Kansas City, Missouri October 29-31, 1997

KCMC Child Development Corporation, a community-based organization that provides child care and Head Start services to low-income families, operates an Early Head Start program for 75 families in the poorest neighborhoods of Kansas City, Missouri. The Early Head Start program serves primarily African American, single, teenage parents, two-fifths of whom were receiving welfare cash assistance when they enrolled. In collaboration with the Kansas City, Missouri, School District's Parents as Teachers program, it provides child and family development services primarily in regular home visits and parent group meetings. At the time of the site visit, KCMC had recently opened a new child development center and expected many Early Head Start children to enroll in it. Child development services focus on establishing and supporting parent-child relationships and working with parents to support their children's development.

OVERVIEW

The KCMC (Karing for Children is our Main Concern) Child Development Corporation operates an Early Head Start (EHS) program in Kansas City, Missouri. KCMC has provided child development services since 1970 and became a Head Start grantee in 1979. In 1990, it also began operating the Full Start program, which provides full-day year-round child care for preschool children and extends care to families who are not eligible for Head Start. KCMC recently opened the Thomas-Roque Family and Child Development Center, which houses one of KCMC's Head Start centers, as well as the EHS program offices. The center also includes several infant and toddler classrooms with spaces available for EHS children.

Community Context. The KCMC EHS program serves families living in some

of the poorest neighborhoods in Kansas City, Missouri. These neighborhoods have problems that most urban areas have, including high levels of crime and substance abuse, as well as a lack of needed services, most notably public transportation, child care, and housing. The greater Kansas City area benefits from strong collaboration among service providers and other community agencies. Service providers now have a history of collaborating and do so routinely. In 1992, the Local Investment Commission (LINC) was formed to foster collaboration and connect public, private, and community resources to create an integrated service delivery system in Kansas City, Missouri.

Program Model. The KCMC EHS program is a home-based program. It has a formal agreement with the Kansas City, Missouri, School District's Parents as Teachers program to work together to

provide child development services to EHS families. Each EHS family receives regular home visits from a Parents as Teachers parent educator and an EHS family development specialist who works with the parent to develop goals in key life domains, shares information on resources, helps parents address barriers to achieving their goals, and works with the parent and child on child development activities.

Families. Most of the families served by the KCMC EHS program are African American; a small proportion are white or belong to other racial or ethnic groups. The majority of the parents are single, teenage parents. About one-third of the parents are 20 or older, and only about 6 percent are married. One-third of the mothers were pregnant when they enrolled in the program. Approximately 40 percent were receiving welfare cash assistance when they enrolled.

Staffing. The KCMC EHS director and the family development coordinator provide support and supervision for five family development specialists. An administrative assistant/data manager provides clerical support and maintains the program's management information system. A supervisor from the Parents as Teachers program occupies an office at the KCMC EHS program and oversees the Parents as Teachers parent educators who work collaboratively with the family development specialists. The KCMC EHS staff members also receive support from other KCMC Head Start coordinators.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The KCMC EHS program is recruiting first-time mothers who are pregnant or have an infant under 12 months of age, have incomes below the federal poverty guidelines, and reside in its target area (the neighborhoods served by

Swope Parkway Health Center). KCMC originally planned to enroll only pregnant women, but it extended eligibility to parents of infants under 12 months of age in order to meet the schedule for full enrollment. Since submitting its grant proposal, KCMC has added several other zip code areas with high poverty rates to its target area, and at the time of the site visit, it was serving families living in 15 zip code areas.

Recruiting Strategies. The KCMC EHS program has used a wide range of strategies to recruit participants, including airing public service announcements on the radio, establishing relationships with and making presentations at community agencies that are potential referral sources, setting up tables at mall events, distributing flyers describing the program, publishing newspaper announcements, and encouraging word-of-mouth referrals. The public service announcements were not as effective as the program had hoped, but referrals from other community agencies have been important for identifying and enrolling eligible families. The program has received many referrals from Swope Parkway Health Center and Truman Hospital.

Enrollment. KCMC EHS is funded to serve 75 families, all of whom will participate in the research. The program reached full enrollment in early 1997; however, at the time of the site visit, approximately 54 families were actively participating in the program. Staff members were working on reestablishing contact with the remaining families following a period of staff turnover and loss of regular contact with families. Several families who have moved or are no longer interested in participating in the program have been placed on a "waiting list" of inactive families and will be replaced.

Most of the families enrolled in the program are African American, and

COMMUNITY PROFILE

The KCMC EHS program serves families living in an area comprising 15 zip codes in Kansas City, Missouri. High concentrations of low-income families live in these neighborhoods, which have problems that most urban areas have, including high levels of crime and substance abuse, as well as a lack of needed services, most notably public transportation, child care, and housing. The family development coordinator reported that jobs are available, but most pay under \$8.00 per hour. Community service providers noted that the neighborhoods served by the KCMC EHS program lack needed businesses, such as gas stations, but include businesses that are not conducive to positive growth, such as liquor stores.

Local service providers reported that many services are available, but public transportation and housing assistance are not adequate to meet families' needs. In addition, more high-quality child care is needed. They also cited a number of barriers to accessing available services, including mistrust of the "system" (because people feel that they have been treated poorly by the system before) and a mismatch between the hours that services are available and the hours that families are available.

The greater Kansas City area benefits from strong collaboration among service providers and other community agencies. Local service providers and other organizations have formed different collaborative groups to address particular problems, such as teenage pregnancy, maternal and child health, and violence. Collaboration takes place at many levels, ranging from sharing referrals and networking to coordinate services for individual families to developing strategies and seeking funding together for new programs. For example, members of the Maternal and Child Health Coalition of Greater Kansas City recently joined in writing a successful proposal for a Healthy Start grant that will fund staff positions in several member organizations.

In Kansas City, Missouri, LINC, which was established in 1992, became the vehicle for reforming the social services delivery system. LINC has worked to foster collaboration and connect public, private, and community resources to create an integrated service delivery system. It administers the welfare-to-work program (FUTURES), has developed school-linked services at 16 school sites, coordinates the Educare program described above, and offers professional development training.

approximately two-thirds of the primary parents are under 20 years old. Approximately one-third of the parents are attending school or training, one-third are employed, and one-third are participating in other work-related activities required by the

Temporary Assistance for Needy Families (TANF) program. Approximately half have received their high school diploma or a General Educational Development (GED) certificate. Many of the families have good family support and came to the program

with an openness to receiving EHS services. Among the families' greatest needs are better housing, transportation, and information about services for which they are eligible.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. The KCMC EHS program has a formal agreement with the Kansas City, Missouri, School District's Parents as Teachers (PAT) program to work together to provide child development services to KCMC EHS families. Each family enrolled in the program is assigned to a PAT parent educator employed by the Kansas City, Missouri, School District and a family development specialist employed by the EHS program. PAT parent educators and EHS family development specialists are paired in a buddy system so that they share caseloads.¹

Parent educators plan a home visit with each EHS family in their caseload for an hour once a month (early in the month) and follow the PAT curriculum. Using the PAT curriculum, parent educators help parents understand what can be expected for their child at each stage of development and work with parents and children on appropriate learning activities. The EHS family development specialist who is responsible for each family is informed about what the

¹ At the time of the site visit, the program's focus was shifting to place more emphasis on child development. Program officials were reconsidering the collaboration with the PAT program, because staff members believed that the PAT services are not intensive enough to meet EHS families' needs. The program was considering relying on family development specialists to provide child development services, with support from a child development coordinator who would be hired to provide child development training and supervision.

parent educator did in his or her visit and plans at least two home visits during the rest

The KCMC EHS program sees the parent as the primary caregiver and focuses its child development services on establishing and supporting the bond between the parent and the child. The program aims to increase parents' knowledge of child development and their confidence in parenting so that they will engage in activities that promote their children's development and work proactively to improve their children's environments. The program also aims to help parents understand the importance of high-quality child care, help them make informed choices, and empower them to have relationships with their children's caregivers.

of the month to enhance what the parent educator did, discuss a specific area of child development, and share materials related to that topic. These home visits, which also include family development activities, typically last between one and two hours (visits are longer when families first enroll in the program and are still developing a relationship with their family development specialist). The PAT parent educator and the family development specialist occasionally make home visits together. Families who are active in the program receive an average of three home visits per month.

The PAT parent educators have caseloads of 19 families, and the EHS family development specialists have caseloads of 15 families. Family development specialists

are required to have a college degree in a family/human services, education, or child development field plus three years of experience working with low-income families.

Group Child Development Activities.

The EHS family development coordinator and the PAT liaison plan a group meeting for parents and children at the Thomas-Roque Family and Child Development Center for two hours after school on one Thursday each month. The children are cared for in the child care area while the parents meet, except during child development activities. The parent meetings have addressed such topics as spanking and male-female relationships. The program provides dinner and gifts (child development information and donated items, such as books) for the parents and children who attend the meetings. Typically, 20 to 30 parents attend each meeting.

PAT parent educators also encourage parents to participate in other PAT activities in the community, including Jumping--Jogging--Jingling sessions to help infants' motor, social, and language skills, Learning Labs, and the First Books program that helps parents collect books for their children. Parents as Teachers maintains a parent and child activity center with a toy lending library at the Thomas-Roque Child and Family Development Center.

Child Care. When children must be in child care so that their parents can participate in school, training, or work, the KCMC EHS family development specialists teach parents how to select a high-quality child care arrangement. The program has several checklists that they can offer to parents to help them make their selection. The family development specialists encourage parents to use center-based care (especially the Thomas-Roque Family and Child Development Center, now that it has

opened) but support parents' choices of other types of arrangements. Parents often prefer care by relatives when their baby is very young, and staff members encourage these relative caregivers to attend parent activities with the parents and to read the program's monthly newsletter. If parents are interested in center-based care, staff members make referrals to several local child care centers that have been rated as providing high quality child care. Staff members also use Heart of America Child Care Resource and Referral services to identify potential child care providers.

At the time of the site visit, most children were in some type of nonmaternal child care. Approximately 12 children were enrolled in the Thomas-Roque Child and Family Development Center. Staff members estimated that approximately 20 children were being cared for by relative caregivers, and the remaining children were enrolled in State-licensed child care centers or family child care homes. The program does not monitor the quality of these child care arrangements. In early 1998, however, staff members were conducting a survey of program families to learn systematically about their child care arrangements, and they planned to work on improving the quality of families' child care arrangements if necessary.

The Thomas-Roque center, which opened in September 1997, planned to give first priority to EHS children for 24 infant slots and 24 toddler slots. These slots will be funded by a combination of EHS funds and state child care subsidies, as well as small co-payments from parents. At the time of the site visit, 29 families had expressed interest in enrolling their children in the Thomas-Roque center. The state has guaranteed subsidies for EHS parents participating in the FUTURES program (Missouri's welfare-to-work program).

COMMUNITY CHILD CARE

All of the EHS families need child care in order to participate in school, work, or other work-related activities. At the time of the site visit, most children were in child care arrangements made by their parents without the program's help. About one-fifth of the children had recently enrolled in KCMC's newly opened Thomas-Roque Child Development Center.

Both the availability and the quality of infant and toddler child care have been identified as concerns in Kansas City, Missouri. Concerns about child care quality center on the high rates of staff turnover (about 50 percent per year) and lack of strong educational backgrounds among many staff members (only slightly more than half of the children are cared for in settings where the director or another staff member has an associate's or bachelor's degree in early childhood). Child care wages are low, and local casinos, which pay more, draw child care staff persons out of the field. Several agencies have funding to provide resource and referral services, but they rely primarily on licensing lists or list of providers who have participated in training and do not assess the quality of care provided before making referrals. The Governor's Commission on Early Care and Education is working to find ways to address child care issues in Missouri.

KCMC plans to help promote higher-quality family child care by participating as a partner in Missouri's Educare program, which offers training, educational resources, and home visits to family child care providers in the EHS target area. KCMC also hosts an annual child care conference.

Child Development Assessments. The PAT parent educators conduct developmental and health screenings with the children at least once a year. They use the *Denver Developmental Screening Test II* and the *Preschool Learning Scale*. The EHS family development specialists also conduct developmental screening tests with children if they enroll in the Thomas-Roque Child and Family Development Center.

Health Services. The EHS family development specialists will educate parents about their children's health care needs and ensure that they receive the preventive and treatment services they need. The family development specialists and the Head Start

health coordinator at the Thomas-Roque center review the immunization status of EHS children and monitor well-baby examinations. When parents do not get needed immunizations or examinations for their children, the program brings a health care provider to the center to provide the needed immunizations or examinations, or staff members take the children to a health care provider for the needed immunizations or examinations.

Initially, the program formed a partnership with Swope Parkway Health Center, located next to the Thomas-Roque center, to provide a medical home for children who did not have one somewhere else. However, the implementation of Medicaid managed care in Kansas City, Missouri, interfered with these plans. Swope Parkway Health Center now participates as one of four Medicaid managed care organizations in the community. Because families enrolled in EHS are enrolled in all four Medicaid

managed care plans, however, Swope Parkway Health Center cannot provide health services to all families who need them, as had been planned originally. At the time of the site visit, the program was gathering information on families' choices of Medicaid providers and assessing whether they had medical homes. KCMC EHS staff members were also talking with staff members from Swope Parkway Health Center about new ways of working together to help meet the needs of EHS parents.

Services for Children with Disabilities. The KCMC EHS program coordinates with First Steps, the Part C program operated by LINC to provide services to children with disabilities. State regulations specify that the First Steps program has primary responsibility for families' Individual Family Service Plans (IFSPs). However, EHS and PAT staff members have input into the contents of the IFSPs, and they reported that the IFSPs are useful for guiding EHS family development specialists in working with families. The EHS family development coordinator serves on the Local Interagency Coordinating Council. In addition to working with First Steps, EHS staff members refer parents of children with disabilities to the Missouri Parent Advocacy Center Training (IMPACT), a support group for parents of children with special needs. At the time of the site visit, eight children enrolled in the program had diagnosed disabilities.

Transitions. At the time of the site visit, the program was planning to develop case management procedures for developing family transition plans. KCMC operates a Head Start program, so the EHS staff expects the transition to be easy for some children and families. The KCMC Head Start transition coordinator facilitates information sharing, involves parents, and makes sure that the Head Start development specialist receives children's assessments.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. EHS family development specialists work with each family to assess their strengths, goals, and needs and develop a Personal Early Head Start Plan within 90 days after enrollment. Family development specialists plan to conduct strengths assessments and review and update individual plans continuously as families achieve goals and make transitions.

Case Management. During their regular home visits, family development specialists provide case management using the Strengths-Based Model of Case Management. They make referrals to community programs for a wide range of needed family support services, including housing, transportation, physical and mental health care, education, and employment-related services. The program focuses on serving the parent and the focus child, but family development specialists include other family members and/or the child's father if the parent wants them to.

The KCMC EHS program's approach to providing family development services grows out of two basic beliefs. First, in order to improve child development, the program must improve parenting. Second, it is important not only to provide services to families but also to teach parents how to obtain services they need so that they do not become dependent on the program and can advocate and obtain services on behalf of their children.

The program employs a full-time family development coordinator to help the family development specialists identify and arrange support services for families. Family development specialists refer families to a wide range of community programs and organizations for needed services. To assist the family development specialists, the program has purchased software from the Mid-America Assistance Coalition listing specific information about available community resources. The software is updated quarterly.

If a parent is participating in FUTURES, the welfare-to-work program operated by LINC, the EHS family development specialist communicates with his or her FUTURES case manager to support the parent's participation in education or employment-related activities. When parents are sanctioned for not meeting participation requirements, FUTURES case managers notify EHS staff members, who follow up with the parents. LINC is one of the EHS program's key partners.

Father Involvement. Fathers of children in EHS are encouraged to participate in home visits and to attend parent meetings. Approximately 10 different fathers have attended parent meetings on at least one occasion. Three fathers attend regularly.

Program staff members may refer fathers in EHS families to several programs designed to encourage male involvement in children's lives. LINC operates the FUTURES Connection, a program for noncustodial parents of children who receive welfare benefits. This program provides employment assistance, education, and other self-sufficiency-oriented services and pays child support for fathers participating in the

program until they become employed. Another program operated by LINC, the Caring Communities program, has placed male staff members in several local elementary schools throughout the community to work with fathers of elementary school children and other fathers in the community. EHS refers fathers and father figures to support groups for fathers that these male staff members lead.

Parent Involvement in the Program.

At the time of the site visit, the program planned to establish an EHS Steering Committee comprising EHS parents and community representatives. Previously, the program had planned to establish an EHS Parent Committee. This committee would elect two representatives to serve on KCMC's Grantee Parent Committee, which in turn elects representatives to the Head Start Policy Council. At the time of the site visit, no EHS parents were serving on the Head Start Policy Council, because it meets during the day, and many EHS parents attend school during the day and work at night.

Parents also have opportunities to volunteer at the Thomas-Roque center, and the KCMC parent involvement coordinator plans to recruit EHS parent volunteers for national Head Start activities. Approximately one-third of EHS parents have volunteered to set up or clean up after parent group meetings.

The KCMC EHS program also provides parents with child development information in a monthly newsletter that includes articles on child development topics. Staff members send the newsletter to enrolled parents, nonresident fathers of children in the program, and other caregivers.

STAFF DEVELOPMENT CORNERSTONE

Staff development activities include regular team meetings and training, participation in community groups, and annual performance assessments. Fridays are reserved for staff meetings, training sessions, and completing paperwork.

Training. Staff training builds on staff strengths identified in the hiring process and through forms filled out by family development specialists when they were hired asking them to identify their areas of expertise and their training needs. Training plans also build on information obtained from staff members using the Family Development Program Self-Assessment Checklist. Staff members are cross-trained in the areas of family support and child development. Training sessions have included presentations on a wide range of topics by other community service providers, as well as an intensive eight-week class on serving infants and toddlers in high-risk families, for which staff received college credit. The course, which was conducted by University of Missouri at Columbia staff members, focused on child development, case management, and family functioning/family systems.

Staff members are encouraged to attend conferences and to participate in national training opportunities. In addition, every staff member is assigned to attend meetings of a local professional association or interagency coordinating group. Staff members are responsible for informing their colleagues about what they have learned at the meetings.

Supervision and Support. The family development coordinator reviews the case files and services delivered to each family quarterly and discusses the review with the family's family development specialist. The

review examines receipt of services and participation in activities in key areas (child development and parenting, health, nutrition, parent involvement, family development, safety, and education). The family development coordinator makes recommendations for working with the family and recommendations for staff development that will support the family development specialist in serving the family.

The KCMC EHS director and the family development coordinator provide support and supervision for family development specialists. In addition to being available for consultation as needed and meeting with family development specialists individually for quarterly case conferences on each family, the family development coordinator meets with the family development specialists together at least once a month to review a difficult case and do group problem solving to plan next steps with the family. In addition, the family development coordinator accompanies each family development specialist on a home visit at least twice a month to observe and provide feedback.

The program director conducts a formal performance appraisal of each staff member six months after he or she joins the program and annually thereafter. The program director reported that staff are paid relatively well.

Staff Turnover. During the year prior to the site visit, the KCMC EHS program had experienced some staff turnover. A new program director joined the program in January 1997, and three family development specialists left the program in early to mid 1997 and were replaced in September 1997. The staff turnover occurred as the program's focus shifted to child development--some staff members whose backgrounds were in social work decided that they were not interested in providing child development

services and left the program. The new family development specialists have backgrounds in child development.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. KCMC's approach to community building is to expand existing partnerships to focus on services to families with children under age 3 and to develop new partnerships with agencies that serve this population. The KCMC EHS program has several major partners with whom they collaborate in serving families, including the Kansas City, Missouri, School District's Parents as Teachers program, which provides parent educators to work with families; LINC, which operates the FUTURES program; and Swope Parkway Health Center, which is one of four Medicaid managed care providers in the community.

The FUTURES is the state's welfare-to-work program, which provides case management, education and training services, employment assistance, transportation assistance, and subsidized child care. The FUTURES program gives priority to serving EHS families and guarantees child care subsidies for EHS families participating in the FUTURES program.

Although Swope Parkway Health Center agreed to work with the KCMC EHS program to ensure that families receive needed health services, that has not been possible in practice, because some EHS families selected other Medicaid managed care providers. The EHS program and Swope Parkway Health Center staffs do,

however, exchange referrals. At the time of the site visit, EHS and Swope Parkway Health Center staff members were exploring new ways of working together.

The EHS program also has informal agreements with approximately 50 other agencies to conduct brief cross-trainings for staff and collaborate in other ways.

Interagency Collaboration. Staff members participate in many interagency collaborative groups, including the Case Managers Association, which holds meetings every other month to share information, discuss case scenarios in break-out groups, and help identify and prevent the duplication in services and application processes that overwhelms parents; the Coalition for Positive Family Relationships, a large group of local service providers and organizations who meet to share information and identify opportunities for collaboration; the Part C Local Interagency Coordinating Council monthly staffings; and cross-training sessions offered by LINC.

The KCMC EHS program has been working with other community groups to bring a parenting perspective to efforts to serve fathers and father figures in disadvantaged families. The program's male family development specialist attends meetings of the Full Employment Council, which is spearheading an initiative to place men in jobs, and he shares ways to appeal to men from a parenting perspective. He also attends meetings at the National Center for Fathering, which is located in Kansas City, and participates in information-sharing events sponsored by the center. The National Center for Fathering was founded in 1990 to conduct research on fathering and to develop practical resources to prepare and support fathers in meeting their responsibilities.

WELFARE REFORM

In Missouri, families are now limited to receiving welfare for five years over their lifetime, and after two years of welfare receipt, they are required to work. Child care subsidies are available to all families with incomes at or below 133 percent of the poverty level, on a sliding fee scale based on income, family size, and hours of care. TANF recipients who have children under 12 months old are exempt from the work requirement. Teenage parents receiving cash assistance who are under 18 and have not earned their high school diploma or a General Educational Development (GED) credential are required to attend school or an educational program. Approximately 40 percent of EHS families were receiving cash assistance when they enrolled in the program.

The new welfare policies have required the KCMC EHS program to make some adjustments. The new emphasis on employment and the provisions requiring teenage welfare recipients to attend school have made it difficult for the program to complete the schedule of home visits that they originally planned. Staff members have had to negotiate with parents to keep them involved in the program and agree to visit them at home less frequently. To make it easier for families to participate in EHS, the program has submitted a proposal to make EHS participation count toward satisfying the work requirement.

Families have been overwhelmed by the possibility of being sanctioned under the new rules, and family development specialists often work closely with FUTURES case managers to help families avoid being sanctioned. Families sometimes face requirements to attend a GED program or other TANF activity within a very short time but do not have child care arranged. Under those circumstances, they often take the first arrangement they can find, without consulting the program staff. Family development specialists then have to work to encourage parents to consider using higher-quality child care arrangements. Some program staff members noted that while the new TANF requirements have frightened parents, they are useful in motivating young parents to take responsibility for themselves, work toward self-sufficiency, and avoid slipping into the trench of welfare dependency.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. Program staff members have attended training sessions provided by their Resource Access Project (RAP) and by Zero to Three National Center for Infants, Toddlers, and Families. They were receiving technical assistance on home visiting from their Technical Assistance Support Center (TASC) at the time of the site visit. The

program has also received key support from its federal project officer and Zero to Three consultant.

Continuous Program Improvement. The KCMC EHS program is working closely with its local research team, which includes researchers from the Department of Human Development and Family Studies at the University of Missouri at Columbia (UMC) on continuous program improvement activities. The local research

team, which includes three researchers with expertise in child care, family development, parenting education, and multicultural and diversity issues, have been visiting the EHS program monthly to meet with its staff members, and the two groups communicate with one another frequently by telephone. EHS and UMC staff members view the program and the local research as one project--the local researchers help the program by providing training and feedback on home visits, and the program helps the local researchers by implementing random assignment and participating in focus groups.

To help with continuous program improvement, the UMC staff has conducted an intensive 8-week training course (described above), interviewed various constituencies about their perceptions of their roles and the roles of others, and conducted the Working Alliance Inventory with families and presented results to the program.

Local Research. The local research team is conducting intensive case studies with a random sample of 12 program families to explore factors that mediate and/or moderate the impact of EHS on child and family functioning. Using quantitative data from program records and surveys and qualitative data from interviews, focus groups, and family development specialists' case notes, they will construct narrative accounts of the 12 families' experiences and identify themes and patterns that appear to be related to program effectiveness.

PROGRAM SUMMARY

The KCMC EHS program, which serves many single, teenage parents and their children, provides child and family development services to families primarily in home visits. At the time of the site visit,

the program was continuing to shift its focus from family development to child development. It was planning to discontinue its formal collaboration with Parents as Teachers and to add a staff member to provide additional support for child development services. In addition, with the opening of the Thomas-Roque Child Development Center at KCMC, a new option for good-quality child care became available for up to 48 program families.

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EARLY HEAD START PROGRAM PROFILE

Family Foundations Early Head Start Pittsburgh, Pennsylvania September 22-25, 1997

The University of Pittsburgh's Office of Child Development operates an Early Head Start program for 120 families in four centers in three diverse communities in the Pittsburgh area. Across the four centers, the program serves mainly African American and white families headed by single parents, two-thirds of whom were receiving welfare cash assistance when they enrolled in the program. The centers provide services to families in home visits--family advocates visit families weekly to address child development issues, and family development specialists visit families biweekly to work with them on their goals and link them with community services. Staff members also organize group activities for parents and families at each center. Child development services focus on working with parents to improve their interactions with their children.

OVERVIEW

The University of Pittsburgh's Office of Child Development (OCD) operates the Family Foundations Early Head Start (EHS) program. OCD does not provide EHS services to families directly; instead, it contracts with four community-based organizations to host the centers. OCD provides direction to the centers on their activities and programs for families, but each host agency is responsible for management and personnel issues, such as paying salaries and benefits. EHS staff members technically are employees of the host agency staff, but they are co-supervised by OCD's Early Head Start staff.

The three Family Foundations centers previously provided Comprehensive Child Development Program (CCDP) services, and the Clairton Family Center (CFC) operated a Parent Child Center. In making the transition from CCDP to EHS, the Family Foundation Centers have stopped providing direct services to 4- and 5-year-olds and are

moving toward a more child-focused implementation of family support principles.

Community Context. The four EHS centers (three are Family Foundations centers, and the fourth is the Clairton Family Center) operate in three distinct communities in the Pittsburgh area. One Family Foundations center is located in an apartment and mobile homes in Terrace Village. That community is comprised of two housing projects in the city's Hill district, where most residents are African American. Another Family Foundations center and the Clairton Family Center are located in Clairton, a 30-minute drive from Pittsburgh. Approximately 60 percent of the residents there are white, and 40 percent are African American. The third Family Foundation center serves the communities of McKees Rocks and Stowe Township (otherwise known as Sto-Rox). Those communities are just across the Ohio River from Pittsburgh and have racially and ethnically heterogeneous populations.

Program Model. OCD's EHS program is a home-based program. Two types of home visitors work with each family. Family advocates conduct weekly visits to families to address child development issues. Family development specialists visit families every other week to discuss family development issues. Other staff members--including the child development specialist, the nurse, the nutritionist, and the community organizer--also make periodic visits to families' homes. Group activities for parents and families are provided at each center.

Families. Three-fourths of the families served by the OCD EHS program are African American, and one-fourth are white. The majority are single-parent families. Approximately 40 percent of the mothers were pregnant when they enrolled in the program. Nearly two-thirds of the families were receiving welfare cash assistance when they enrolled.

Staffing. The program's staffing structure is complex. The three Family Foundations centers have identical structures. Each has a neighborhood coordinator, who oversees the center; a child development specialist, who oversees the family advocates and conducts child assessments; two family advocates; two family development specialists; a community organizer, who is responsible for coordinating the policy council and community activities; and a child center worker, who works in the drop-in center. The Clairton Family Center has a coordinator and two home visitors, who conduct both child and family development home visits. In addition, each center has a half-time nurse from the Allegheny County Public Health Center on-site, to ensure the health of the EHS children and families, and a part-time counselor from the Family Services of Western Pennsylvania. At OCD's central office, the project director oversees the four centers. Other OCD staff

members include a child development coordinator, a family development coordinator, a data coordinator, and a medical records data collector.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The OCD EHS centers serve families living in their communities who meet the EHS eligibility requirements. Each Family Foundations center has 40 program slots--22 slots for families participating in the research and 18 for nonresearch families. The Clairton Family Center has 20 slots for EHS families--11 in the research and 9 not participating in the research. Nonresearch families are families who enrolled with children older than one year and families who participated in CCDP or other intensive programs with their older children.

Recruiting Strategies. For major recruitment efforts, center staff members canvass their communities by going door-to-door and distributing packets of materials about the program. These packets include a center brochure, a list of community resources, a newsletter, incentives (such as pencils and magnets), and additional information about services. Centers had not conducted major door-to-door recruitments in the year prior to the site visit, but the program staff members continue to recruit families by visiting Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) offices regularly to identify eligible families, approaching women who might be eligible, and encouraging word-of-mouth publicity among participants.

Enrollment. At the time of the site visit, the EHS program was not at full enrollment; about 110 of the 140 slots were filled. The centers (including CFC) had filled their nonresearch slots, and some were maintaining waiting lists for these slots.

COMMUNITY PROFILE

The three communities served by EHS share characteristics and needs that are common to Allegheny County but are also different in many respects. In part, the communities are defined by their housing communities. Sto-Rox has four housing projects that all have different characters and different resident populations. Community residents and staff members said that residents of these projects strongly identify with the project in which they live. Terrace Village consists of two housing projects, one of which is being renovated under the federally-funded Hope VI project. Clairton has one housing project; most EHS families there live in single-family homes.

As a result of the extent of public housing in these communities, Hope VI and the Allegheny County Housing Authority's push to renovate housing have been major forces in these communities. Initiatives to renovate and replace housing already have begun to relocate families and raze buildings. Allequippa Terrace, one of the housing projects in Terrace Village and a Hope VI recipient, is to become a mixed-income housing community with housing for only a portion of current residents.

The unemployment rate in the Pittsburgh metropolitan area, which was over 6 percent in 1995, is higher than the state and national rates. Clairton, the most isolated community of the three, has few job opportunities in the vicinity. Pittsburgh has some opportunities, but Sto-Rox residents without their own transportation have to rely on a public transportation system that does not accommodate nonstandard working hours.

Many county-wide providers serve all three communities. For example, the county office of the Department of Public Welfare (DPW)--the state's welfare agency--covers all three communities. Residents in the communities also tend to use the services of the same early intervention providers, area hospitals, and mental health agencies.

The range of services in each community differs, however. Sto-Rox has a wide range of accessible services, due in large part to FOR. Respondents felt that the community had sufficient services for families but that providers could do more to coordinate their services. Now, service providers mostly share information among themselves. Terrace Village also has many services for families in the community. The community environment is less open to collaboration than in Sto-Rox; in Terrace Village, there are still strong territorial claims for families. In Clairton, few providers actually deliver services within the community, and so the existing services are difficult to access. Residents have to travel to McKeesport for many services. A trip to the welfare office, for example, can take three hours in round-trip travel.

Similarly, residents' access to health care varies. Sto-Rox residents have easy access to the health services provided by the FOR health clinic, and Terrace Village residents can access clinics nearby. Residents of Clairton have fewer options for health care, and families have to travel outside of the community for pediatric care. Prior to the site visit, one hospital closed a clinic in Clairton that was providing pediatric care, resulting in the loss of a medical home for many children.

One health-related issue has affected all communities: the advent of managed care. Health Choices--mandated managed care for Medicaid recipients--was to go into effect in Allegheny County during the year following the site visit. In the meantime, four major managed care providers were heavily recruiting families from their current plans. The companies wanted to have many enrollees when mandatory managed care arrived in the county, so that they could win a Medicaid managed care contract. Often, families were not aware of what these changes meant. For instance, parents frequently did not find out that their family doctor's services were not covered under their new plan until the day of the office visit.

However, centers were having difficulty maintaining full enrollment in their research slots; Sto-Rox and Clairton Family Foundations each had about 16 families enrolled in the research. When research families leave the program, program staff members have difficulty finding replacement families who meet the research criteria. To meet the need for more research families, the Clairton Family Foundations center has extended its service area to West Mifflin, a community outside of Clairton. Currently, about 12 EHS families are from this community. Family Foundations staff in Sto-Rox are also considering extending their service area to recruit more families for the research group. Terrace Village has not extended its service area, but it has continued to serve families who move to other housing, private or public, in the Hill district.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. When families enroll in the Family Foundations centers, the child development specialist conducts assessments with their children using the *Early Learning Accomplishment Profile* and *The Receptive-Expressive Emergent Language* (REEL) scale. The assessments help parents learn age-appropriate activities for their children and gauge the children's progress. After the assessment, parents look through a list of age-appropriate objectives and select the ones they want to work on with their child. These objectives become part of a child's service plan, which is then included in the individual family service plan (IFSP). After the initial assessment, the child development specialist visits the family every six months to revise the child's service plan. When families enroll in the Clairton Family Center, they are assigned a home visitor who follows

the *Parents as Teachers* curriculum in working with the family.

Each EHS family is assigned a family advocate (Family Foundations centers) or home visitor (Clairton Family Center). The main requirements for the family advocate are a high school diploma and residency in the community. Family advocates are expected to conduct weekly home visits to work with the parents on the child development activities they selected. During these visits, family advocates work on helping the parents to play with and relate to their child. In the Family Foundations centers, home visits typically last about an hour, and each family advocate has a caseload of 20 families. In the Clairton Family Center, home visits typically last 90 minutes, and each home visitor has a caseload of 10 families. CFC home visitors, who have different responsibilities from Family Foundations' family advocates, are required to have a college degree.

Family advocates have found it difficult to complete weekly visits with every family in their caseload. Families frequently cancel their appointments or are not home for the appointments. For some families, family advocates have to make two appointments for every completed meeting. Staff members expressed concern that welfare reform will further reduce the time families have available to meet with them. At the time of the site visit, the Clairton Family Center and the Sto-Rox center had vacancies for home visitors and family advocates, so families had not been receiving regular child development home visits in these sites.

Group Child Development Activities. EHS also provides child development services through group activities. Generally, the centers offer parent groups in 6- to 12-week sessions. Depending on the objectives for a particular group, staff members select

from several different curricula, such as the *Partners In Parenting Education* (PIPE) curriculum and the *Parent Education for Low-Income Families* curriculum. At

The OCD EHS program delivers child development activities primarily by working with parents to improve their interactions with their children. Staff members work with children and parents together, primarily during home visits, to provide families with opportunities to experience joy in relation to their children, model good parenting practices, and convey the message to parents that their attachment to their children is important and related to their children's competence.

Sto-Rox, the infant-toddler group meets weekly for 8-week sessions using the PIPE curriculum. A two-member team from the program staff leads these sessions. The Terrace Village center has a young parents group that meets biweekly. Children and parents are separated for the first part of the young parents group and then are brought together for parent-child interactions. Participation in the group activities at the various centers ranges from 4 to 15 families.

Child Care Services. The OCD EHS program does not provide child care services directly to families. In the past, under CCDP, Family Foundations worked with a local child care agency, Louise Child Care, to improve the quality of the child care provided to program families. Currently, however, the program is not working with this agency, because few EHS children are enrolled in child care centers or licensed family child care homes. About two-thirds of EHS families are using informal relative

care. At the time of the site visit, staff members expected child care to become a more prominent issue for their families as the EHS children become older and their mothers are required by welfare reform to work.

The child development specialists at each program are responsible for monitoring the quality of EHS children's child care. The specialists try to assess the quality of care using National Association for the Education of Young Children (NAEYC) and Head Start standards. However, they have not been able to assess quality as they did under CCDP because few families are using licensed care and the care is not funded by the program. Under CCDP, Family Foundations paid for the child care of many program families, which made licensed family child care providers feel that they were part of the Family Foundations program. Even though the EHS program has funds set aside for child care, Family Foundations has not been paying for child care under EHS; state child care subsidies have been covering families' child care costs. As a result, the providers with whom Family Foundations used to work have less incentive to work with the program staff.

EHS has become involved in the Early Childhood Initiative (ECI), a joint effort by the United Way and area foundations to develop community-based child care (see below). One EHS center neighborhood coordinator chairs the committee in the community that is formulating the proposal for an ECI grant. Staff members in other centers are also involved in their communities' committees.

The EHS centers have drop-in child care facilities where parents can leave their children for short periods when they are attending on-site parent activities (such as those of the parent council) or meetings at

COMMUNITY CHILD CARE

At the time of the site visit, about two-thirds of EHS families were using child care. Most were relying on relatives or friends to care for their children.

All of the EHS communities share concerns about the quality and availability of child care and the effects of welfare reform on families. Respondents in all communities said that there is insufficient child care for families, especially in light of the new welfare work requirements. Parents told stories about poor quality care that children have received from providers in their communities.

To address the lack of child care, the United Way of Allegheny County has teamed with area foundations, including the Howard Heinz Endowment and the Richard King Mellon Foundation, to create the Early Childhood Initiative, an initiative to develop community-based child care. Community groups write proposals to the United Way to access this money. In Sto-Rox, the EHS community furthest along in this process, the ECI committee of LINC wrote a proposal to create an early childhood development center using empty school district buildings. The plan is to develop a center that provides comprehensive services to children ages 0 to 5.

the centers. With input from the program's Zero to Three consultant, Family Foundations was remodeling its drop-in facilities to meet the requirements for licensed infant-toddler centers, and they were hiring center workers qualified to work with infants and toddlers. OCD hopes that these centers will be used for more than drop-in child care and become places where parents will bring their infants and toddlers to engage in age-appropriate play.

Child Development Assessments. As noted earlier, when families enroll in the centers, the child development specialists conduct child assessments using the *Early Learning Accomplishment Profile* (ELAP) and *The Receptive-Expressive Emergent Language* (REEL) scale. They use the assessments to help parents select goals they want to work on with their child. These goals become part of a child's service plan. After the initial assessment, the child

development specialist visits the family every six months to conduct a new ELAP and revise the child's service plan.

Health Services. The Allegheny County Public Health Service contributes the services of two nurses to EHS. One nurse works at Terrace Village and Clairton Family Foundations, and the other works at Sto-Rox and the Clairton Family Center. The nurses play a major role in ensuring the health of the EHS children and their families. They conduct health assessments and make biweekly visits to pregnant women and women who have just given birth. Nurses also visit families at other times if the family or an EHS staff member asks them to.

Through a project called HealthLink, the program tracks families' health care. When families enroll in EHS, they sign up for HealthLink and authorize their children's

health provider to release their medical records to EHS. The family development specialists routinely ask families if they have received any medical services since their last home visit. If the family has received such services, the home visitor gets a signed release from the family, and a request is made to the physician for information about the medical services provided. EHS requests the medical information from providers and enters the collected data into the EHS medical database. Through this system, nurses and home visitors can track when children are due for immunizations and well-child visits and whether families are receiving care from multiple providers. They can then intervene with the family to ensure that children are immunized and that there is a consistent health care provider. The nurses can also help the family understand the health care information that comes from the health care provider.

A group of EHS program staff members has formed an infant mental health committee. Home visitors present problem cases, ones in which the child is not responding well and appears to have attachment problems, to the committee for advice. Several experts in infant mental health also attend these sessions to help staff members work with these families.

Services for Children with Disabilities. EHS staff members refer children with suspected or diagnosed disabilities to the Alliance for Infants, Allegheny County's gatekeeper for Part C services. After conducting an assessment, representatives from this agency refer families to one of the county's providers for Part C services, such as the Early Learning Institute or the Association for Retarded Citizens. EHS staff members work with the Part C providers by discussing families when necessary and sharing Individual Family Service Plans (IFSPs). At the time of the

site visit, 5 percent of EHS children were receiving early intervention services from one of the Part C providers, and staff members estimated that an additional 14 percent of children were at risk for developmental delays, based on a list of risk factors developed by the program and approved by the Head Start Bureau.

Transitions. An EHS family's transition from EHS begins about six months before the child ages out of the program. For three months, the number of child development home visits is reduced from four to two per month and the number of family development home visits is reduced from two to one per month. For the remaining three months, the child development home visitor visits the home monthly. Parents are given a resource guide at the end of the program to help them through the process of transitioning their children to preschool and Head Start. At the time of the site visit, a few former CCDP families were about to transition out of EHS.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessments and Service Planning. EHS staff members do not decide which services should be provided to the family. Instead, the family chooses its own objectives and decides what aspects it would like to focus on with the family development specialist. The family does a self-assessment (developed by Mid-Iowa Community Action, Inc.) that leads them to identify their priorities and goals.

Each family enrolled in the Family Foundations centers has a team of EHS staff members with whom it has regular contact: the family advocate, the child development specialist, the family development specialist,

the community organizer, the nurse, and the nutritionist. (The CFC team consists of the home visitor, the nurse, and the nutritionist.) Each member of this team, including the adults in the family, has input into the family needs assessment and the development of the family's integrated IFSP. The IFSP is developed over a period of several months, and it is updated every six months.

Case Management. Family development specialists in the Family Foundations centers help families by showing them how to apply for jobs,

The OCD EHS program is based on a family support approach. EHS staff members build on families' strengths; they help family members recognize their strengths and identify and achieve their goals. Although this basic approach has not changed, the program was shifting the main focus of its family development services from the adult, as it was when the program operated as a Comprehensive Child Development Program, to the child. Family development specialists will work with the adult as the child's parent first and as an adult second. The child-focused, parent-centered approach to family development was new, and at the time of the site visit, OCD EHS staff members were just beginning to work on adapting their family support principles to reflect this new focus.

connecting them with other service providers, helping them through social services' application processes, and providing any other support that is needed. The family development specialist is expected to visit each family in her caseload

(20 families) for one hour every two weeks; in reality, visits are completed about once a month, on average. Family development specialists are required to have a college degree. In the Clairton Family Center, the home visitors who conduct child development activities also work with families on family development goals.

Health Services. EHS has an agreement with Family Services of Western Pennsylvania to provide counseling to EHS families. The three counselors assigned to the EHS centers are being integrated into the team structure. Home visitors are introducing the counselors to all families, and families who need counseling can make appointments with the counselors.

The program nutritionist, who works half-time for the Sto-Rox center's home agency and half-time for EHS, provides similar services to program families. The nutritionist visits all families to conduct a nutritional screening and to provide advice on healthy eating. She makes additional visits if program staff members are concerned about a family's eating practices.

Father Involvement. Each of the EHS centers has at least one male staff member. These staff members had started or were planning to start programs for fathers. In Sto-Rox, the family development specialist has a core group of about six men who regularly attend the monthly meetings. Terrace Village also has an active fathers group. In general, center staff members encourage fathers to participate in all activities, but they are not always home during home visits.

Parent Involvement in the Program. Family Foundations encourages parent involvement in two ways. First, each of the centers has a parent council, composed of all enrolled families, that elects its own officers

and defines its own mission. Council activities include providing feedback to the program, giving input to the staff on hiring decisions, setting policies about the center's van usage (each center has its own van or has access to a van), and making plans for field visits. The councils also receive \$3,000 each in grant money to spend as they see fit. The program itself also has a policy council that has parent representatives from all four EHS centers. This council has similar authority for the overall program. Recently, the policy council hired the new program director and the data coordinator. Second, parents are encouraged to attend group activities, such as the parenting groups and outings.

Attendance in parent involvement activities varies across centers. In Sto-Rox, about 20 parents participate in the monthly parent council meetings. Staff members in Terrace Village said that about one-quarter of their families participate in the parent council. The Clairton Family Foundations parent council was in flux at the time of the site visit, with only a handful of parents participating. Many of the parents on the parent councils entered the program when it was a CCDP; EHS parents were just beginning to participate in these activities.

STAFF DEVELOPMENT CORNERSTONE

Training. Family Foundations/CFC uses the same approach to staff development as it uses for family development--it builds on staff members' strengths. Family Foundations provides many training opportunities, including formal training and informal training during regularly scheduled meetings. EHS staff members receive training from the OCD Family Support Training Center, which provides training for

the staffs of the family support centers in Pittsburgh on a wide range of topics, including infant and toddler development, children with special needs, infant mental health, child abuse, drug abuse, home visiting, relationship building, facilitating groups, and involving fathers. Staff members have also received cultural awareness training. Most training opportunities are open to all staff members to promote cross-training, so that the work with families is more integrated. In addition to training from the Family Support Training Center, staff members may seek training from other agencies.

During the year prior to the site visit, the child development coordinator conducted a series of training sessions on child development based on the training received from WestEd. All staff members participated in these training sessions to prepare them to integrate the child development focus into all activities. OCD staff members were planning to follow up these training sessions with additional ones that relate the new child development focus to each staff member's responsibilities.

The training agenda for fall 1997 focused on the analysis of the Head Start performance standards. Each OCD and center staff member was participating in two committees that had responsibility for analyzing a set of the performance standards. For example, the child development specialists were working as a group to analyze the child development standards. Each child development specialist was also participating on a second committee. Once the analysis of the standards was complete, the program expected to revise its work plan to ensure the program's alignment with the standards.

Staff Supervision and Support. The OCD staff meets regularly with the center

staff. Family development specialists from all four centers meet biweekly, as do the community organizers. Family advocates and child development specialists attend monthly meetings at OCD, and the child development specialists also meet separately with the child development coordinator once a month. Often, OCD staff members prepare training on some aspect of the staff members' work for these meetings. The meetings also are opportunities for staff members to exchange their ideas and resources.

Each center holds weekly meetings to discuss the families participating in the program. These team meetings provide opportunities to discuss individual cases and to share experiences. The cases come up in these meetings on a regular schedule. These formal exchanges are in addition to the informal ongoing discussions that staff members have among themselves.

Staff members generally feel that they are paid inadequately for the work they do. However, the wages for most positions are commensurate with those of other jobs in the field. In the past, the program has had to deal with disparities between the wages and benefits of the different home agencies. The program has worked hard to make salaries equitable across agencies.

Staff Turnover. Staff turnover has varied across the different centers. In some centers, staff members have worked for Family Foundations since the beginning of CCDP. Terrace Village, which serves a very hard-to-serve population, tends to have a higher staff turnover rate than the other centers. In the year prior to the site visit, EHS lost seven staff members at the centers and three at the central office. Two of the seven center staff members were dismissed for inadequate performance; the others left

for new job opportunities or for personal reasons.

COMMUNITY BUILDING CORNERSTONE

Each Family Foundations center employs a community organizer who is responsible for attending meetings in the community and working with the parent council. The community organizer also works with the parents to get them involved in the community.

Program Collaborations. The central collaborators with the EHS program are the agencies that provide on-site services to EHS families--the Family Services of Western Pennsylvania and the Allegheny County Health Department. Other collaborators include the Northern Southwest Community, which provides staff training on working with families with a history of drug and alcohol abuse; the Alliance for Infants, the gatekeeper for Part C services; and the Urban League, which provides emergency assistance.

Interagency Collaboration. Each of the three EHS communities has a different set of service providers. In Sto-Rox, the main social service agency is Focus on Renewal (FOR), the host agency for Family Foundation, and the Sto-Rox Family Foundations center works collaboratively with the other FOR programs. Family Foundations also is a key partner in a community collaborative called the Local Interactive Network for Children and Families (LINC). The neighborhood coordinator chairs the subcommittee of LINC that is developing the community's proposal for the Early Childhood Initiative (see below). The Sto-Rox center works with

WELFARE REFORM

Welfare reform already has had a major impact on families and the EHS program. Two-thirds of EHS families were receiving cash assistance when they enrolled in the program. Parents receiving cash assistance have to begin work immediately unless they are younger than 18 and in school; are verified as disabled; have a child under the age of 6 with no available child care; or are single parents of a child younger than 12 months. Adults who are not working must take an 8-week job search course as part of their "work first" activities. This course may be followed by additional job search or short-term training, depending on individual circumstances. Individuals may receive cash assistance for a maximum of five years over their lifetime.

EHS program staff members and other community members, including parents, expressed confusion about how welfare reform is being implemented. Many individuals stated that the rules continually change and that welfare case workers are not always clear on how to apply the new rules to their cases. Another factor making welfare reform hard for families is the lack of good-paying jobs for people with poor skills.

Although many EHS families have infants at home and are not yet formally affected by the work requirements, EHS staff members are finding that many parents are no longer available for home visits. Staff members reported that families kept their weekly and biweekly appointments more often under CCDP than they do now under EHS. Families that have been active program participants in the past now have too many pressures on their time to be active participants.

other providers, including the school district and the Sto-Rox Family Support Center. In Terrace Village, the Family Foundations staff works with Hill House, a community agency providing many services to residents, and with other family programs on the Hill. In Clairton, which has fewer service providers, the centers tend to collaborate with each other and the school district. Staff members at all centers work with families' case managers at the welfare department and with early intervention providers.

EHS staff members at the central office are also involved in community building. They focus on developing county-wide networks and connections and on increasing communications with other community service providers. EHS staff members have

met with those of other programs that provide early childhood education services to share resources and increase communications. Staff members at each Family Foundations site--often the community organizers--have also joined community groups that meet to discuss collaborations. In addition, each of the EHS centers has a parent representative on the policy board of the county family support program's network.

Community Building Among Parents. During the initial family assessment process, the community organizer visits each family and completes a community skills assessment, which identifies the family's skills and interests. Then, he or she

encourages parents to become involved in specific community activities.

In a group discussion, parents on the parent and policy councils credited the program with their involvement in their communities. The program did not directly connect them with community activities, but it was responsible for expanding their sense of community. The program brought them in contact with other families that share similar concerns and experiences.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. Staff members relied on a consultant from Zero to Three to help shift the program's focus from the family to the child, as required by the Head Start Bureau. The consultant visited the program several times to work with program staff on designing the drop-in facilities to meet standards of licensed infant-toddler centers. She also has encouraged the program to staff the facilities with individuals qualified to work with infants and toddlers. In addition, staff members received support from the federal project officer and benefitted from training provided by the national technical assistance team (Zero to Three and WestEd).

Continuous Program Improvement. Family Foundations and CFC collect both qualitative and quantitative data to inform the EHS director and other staff members about the direction the program is taking. Family Foundations has an on-site data coordinator who collects data that program staff members can use to evaluate their progress.

The EHS staff works closely with its local research partner, a team of researchers

from the University of Pittsburgh's Graduate School of Public Health and the Office of Child Development, on continuous program improvement. The principal investigators on the research team attend the program's weekly program development team meetings, at which the team members discuss the program, changes to the program, policies, and strategies. The program also worked with the local research team's ethnographer under CCDP and developed a close relationship. The program staff will use the ethnographer's qualitative work to improve the delivery of EHS services.

Local Research. The local research focuses on the family support approach to delivering services. The local research team, which includes experts in program evaluation, early cognitive development, and ethnographic research, will explore how this approach affects two intermediate outcomes: (1) the quality of relationships; and (2) community, family, and child empowerment and efficacy. The team will also study how these outcomes interact and how these outcomes relate to other program outcomes. Another focus of the local research is the effects of policy changes on the community, program, families, and children. The research is designed to go beyond assessing the effect of the quantity of services received on outcomes to assessing how the approach to service delivery affects program effectiveness. To address all of these issues, local researchers are collecting qualitative (mostly ethnographic) and quantitative data. They are supplementing the data collected for the national EHS evaluation with more detailed data on father-figure involvement, cultural pride, parents' psychological well-being, and economic self-sufficiency.

PROGRAM SUMMARY

The OCD EHS program provides child and family development services primarily to single parent families, many of whom receive welfare cash assistance, in home visits and group activities. At the time of the site visit, the program was adapting its family support principles to reflect a new focus on children. The program's approach to family development services was becoming more child-focused and parent-centered.

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EARLY HEAD START PROGRAM PROFILE

Bear River Early Head Start Logan, Utah November 4-7, 1997

The Bear River Head Start agency operates an Early Head Start program for 75 families in three rural counties in northern Utah and southern Idaho. The program serves primarily white, two-parent, working-poor families. The program provides child and family development services primarily in weekly home visits and weekly Baby Buddy groups for parents and children. Staff members work to foster positive parent-child interactions and enhance parents' understanding of their children's development. They also work with parents to help them achieve their personal and family goals and link them with needed services in the community.

OVERVIEW

The Bear River Head Start (BRHS) agency operates an Early Head Start program serving families across 12,000 square miles of northern Utah and southern Idaho. Headquartered in Logan, Utah, BRHS has been operating a home-based Head Start program in this seven-county region since 1966. From 1972 through 1975, BRHS was a site in the highly successful national Home Start Demonstration Program, and subsequently served as a Home Start Training Center for other home-based programs in the region. Bear River Early Head Start (BREHS) builds on these 30 years of home-based program experience by extending services to families with infants and toddlers.

BREHS serves families living in Cache and Box Elder counties in Utah and Franklin County in Idaho. The main BREHS center is in Logan; the program also holds group socializations at Box Elder County Hospital and Franklin County Head Start in Preston, Idaho.

Community Context. Local residents describe the three counties as separate, close-knit communities that are set apart by their distinctive geographic features, histories, and economies. Low-income families in these communities need job training opportunities, jobs that pay a livable wage, affordable housing, child care, transportation, health care coverage, dental coverage and services, and substance abuse treatment and prevention. The communities have in common a strong work ethic, a focus on family life, low crime rates, improving economies, and a strong spirit of collaboration among community service providers.

Program Model. BREHS is a home-based program. Weekly home visits and weekly Baby Buddy group activities are the key contexts in which program services are delivered. Staff members conduct activities designed to foster parent-child attachment and to assist parents in supporting the intellectual, social, emotional, and physical development of their child. Additional

services designed to promote these goals include child care referrals, parent discussion groups, counseling, child development associate (CDA) classes, parenting classes, breast-feeding consultation, and monitoring of children's health status and immunizations. The program's goal is to create an integrated (rather than component-focused) program so that all staff members share the same goals, especially for the child and family development cornerstones.

Families. BREHS serves mostly white families, but about one-fifth belong to other racial/ethnic groups. Two-thirds of the families include two parents. Approximately one-third of the mothers were pregnant when they enrolled in the program. Very few were receiving welfare cash assistance when they enrolled.

Staffing. The BREHS staffing structure is designed to support the work of the seven full-time and one half-time family educators (FEs) and two full-time and one half-time Baby Buddy group leaders who also work directly with families. By referring parents to cornerstone coordinators (the family development coordinator, the health/wellness coordinator, and the child care coordinator) and two mental health specialists for other health and social service needs, FEs are able to focus their efforts during home visits on facilitating positive parent-child interactions. With support from the project manager, the child development coordinator accompanies FEs on home visits to provide feedback and supervision. A male Baby Buddy group leader coordinates male involvement activities in the program. BREHS also employs a sanitation specialist and a half-time secretary. The project manager attends to matters of program administration, oversees staff training and supervision, and acts as a liaison to the BRHS program. The BRHS program director provides leadership to the staff and advocates on behalf of the Early Head Start program within the community.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The BREHS target area includes Cache and Box Elder counties in Utah and Franklin County, Idaho. The target population consists of farm families, and families in agriculture-related businesses; mostly two-parent families; mostly white families (but two areas have increasing numbers of Hispanic families--largely migrant raspberry pickers and factory laborers); and many supportive extended families. The program serves families in the target area who meet the EHS eligibility requirements.

Recruiting Strategies. Recruiting strategies included personal visits to schools (a Young Mothers Program for teen parents), the Special Supplemental Program for Women, Infants, and Children (WIC) office, thrift shops, laundromats, and other places where low-income families might visit. The staff also relied on posters, flyers, word of mouth, and referrals.

Initial recruitment went fairly smoothly, although the program staff had to help some families overcome their sense of independence and reluctance to accept government help. BREHS targeted two groups who have particular needs--Hispanics (because of greater isolation) and teenage mothers (because they are at higher risk for attachment problems). Staff members had some difficulty recruiting Hispanics because of these families' distrust of those outside their culture. One potential recruitment issue, competition with the Community Family Partnership (CFP) Program in Logan, was resolved with an agreement that CFP and EHS will not recruit each other's control group families.

Enrollment. BREHS is funded to serve 75 families, all of which are participating in the local and national research and evaluation

COMMUNITY PROFILE

BREHS serves a varied service area and population. The target area consists of three counties (Cache, Box Elder, and Franklin), which program staff members and parents describe as separate communities. Each community varies from the others, with the most marked contrast existing between Franklin County in Idaho and the two Utah counties. The counties are set apart by their distinctive geographic features, histories, and economies. Subcommunities—including the Mormon community, separate wards within the Mormon community, Utah State University, ethnic groups (Hispanic versus Anglo areas), residents of towns versus those in more isolated rural areas, professionals versus farmers, and enclaves where longtime residents do not mix with “newcomers”—exist within the larger communities.

The communities in the BREHS service area have many strengths and resources. First, the communities tend to be close-knit. Even in outlying rural areas where families are more isolated, residents tend to know and look out for one another. Although not all families belong to the Mormon Church, it has a significant presence in these communities and provides an extensive array of support services for member families, including employment training and referral, financial assistance, child care, parenting classes, substance abuse treatment, and individual and family counseling. Utah State University also brings resources—such as employment and educational opportunities, community services, and economic vitality—to the area.

Many families have two parents, at least one of whom is employed. Ninety-five percent of BRHS parents have completed high school. There is a strong work ethic and a focus on family life. Furthermore, the economy is improving and the crime rate is low. Most BREHS families are employed in factory or production labor jobs.

Bear River Head Start conducted a comprehensive community needs assessment in spring 1997 (this assessment is conducted every three years). The needs assessment was compiled by members of the BRHS Policy Council, who surveyed Head Start staff members and parents as well as a number of community leaders. It identifies job training opportunities, jobs that pay a livable wage, affordable housing, child care, transportation, health care coverage, dental coverage and services, and substance abuse treatment and prevention as areas of need for BRHS children and families. These needs are most pronounced in Idaho, where few social service programs exist and many families are isolated and insist on being self-reliant.

There is a strong spirit of collaboration among community service providers, and a number of interagency collaborative groups work together to address family needs.

studies. The program was fully enrolled by the end of summer 1996 and, at the time of the site visit, had been providing services to families for more than a year.

All but two enrolled families speak English well enough to receive services in English. About 84 percent of families are Mormons. Twenty-five to thirty percent of the enrolled families were referred by other agencies. At the time of the site visit, the

program had experienced relatively low turnover (about 19 percent since the program began). Word of mouth is sufficient to maintain a waiting list, which included 18 families at the time of the site visit.

Enrolled families bring several strengths and a variety of needs to the program. The majority are two-parent families with at least one wage earner. Most enrolled families do not have serious family problems, desire to be good parents, are committed to their children, and are connected to others in the program and community. Some enrolled families need jobs with higher wages, better housing, treatment for spousal and substance abuse, and help with problems related to immigration. Hispanic families and families living in more outlying areas also need opportunities for socialization to help fight increased levels of social isolation.

CHILD DEVELOPMENT CORNERSTONE

Weekly home visits by FEs and weekly group activities (Baby Buddy groups) to enhance child and parent socialization comprise the program's central child development activities. In addition, families are encouraged to take advantage of a number of other services designed to promote children's healthy development by providing parents with relevant information and experiences. These services include child care referrals, parent discussion groups, individual and family counseling, CDA classes, parenting classes, and breast-feeding consultation. The program also conducts child health screenings and tracks health status and immunizations.

Home Visits. FEs conduct home visit activities designed to assist parents in providing for the intellectual, social, emotional, and physical development of their infant. FEs' primary responsibility is to

promote positive infant/parent interactions to enhance and promote secure attachment between parent and child. They begin by concentrating on the FE-parent relationship as the basis for all other interventions. BREHS thinks of FEs as facilitators who are trained to follow the parents' lead, gradually introducing attachment concepts and activities. Rather than interacting directly with the child, FEs are trained to work "through the parent to the child" by promoting parents' abilities to read cues from the child and respond appropriately. FEs are expected to have a B.S. degree in early childhood, social work, psychology, or family and human development or else an infant/toddler CDA certificate, and they must have a stated commitment to forming partnerships with parents.

Program staff members seek to foster positive parent-child interactions and attachment in order to promote children's developing abilities to trust others, regulate emotions, and sustain healthy relationships with peers and others.

At the beginning of each visit, FEs write out the lesson plan for the visit with the parent. Each lesson plan includes a review of the previous visit, a hands-on infant-parent play activity, and planning for the following visit. Activities are drawn from a variety of sources, including published curricula such as *Partners in Parenting Education* (PIPE)--parent activities to facilitate attachment; *Hawaii Early Learning Profile* (HELP)--age-appropriate assessment activities that sensitize parents to children's evolving developmental capacities; *With Love and Wisdom*; WestEd's *Program for Infant/Toddler Caregivers*; *Creative Curriculum*; *Small Wonder*; *Teaching Strategies*; *Baby Your Baby*; and *First Steps*

(a language-development program). The program also maintains files with other sources of parenting information that FEs can refer to when planning activities. FEs try to elicit parent-generated ideas for activities to do on future visits. Another segment of the visit involves informing the parent of program news and events, sharing flyers and the *Baby Babblar* newsletter, and filling out a parent volunteer form.

Because BREHS staff members believe that the success of the intervention depends on FEs' effectiveness at promoting positive parent-child interactions, they had recently undertaken measures designed to lend greater support to FEs in their mission and thus increase the intensity of the intervention. Whereas FEs originally spent much of their time during home visits focusing on parental social service needs and crises, the program's revised strategy calls for them to refer such matters to the cornerstone coordinators and specialists if it seems likely that a problem will require more than a few minutes' attention. This change allows FEs to focus more attention during visits on facilitating positive parent-child interaction and enhancing parents' knowledge of child development. Another strategy designed to enhance FEs' effectiveness includes having the child development coordinator and/or project manager accompany FEs on home visits to provide them with routine consultation and feedback.

At the time of the site visit, all enrolled families were actively participating in home visits. Each FE has a caseload of between 10 and 12 families. Most FEs reported that, in an average week, they are able to complete visits with about 80 percent of their families. Although staff members originally planned for visits to last an hour and a half, FEs found it difficult to try to engage parents for that long early in their relationships with families. Both parents and FEs were somewhat apprehensive in early visits as they got to know each other, and FEs needed time to

become comfortable in their role. As their relationships with families and home visiting skills have developed, FEs have been able to complete longer visits and continue to work toward the hour-and-a-half goal for family home visits.

Group Child Development Activities.

Staff members also attempt to foster positive parent-child interactions and greater parental understanding of children's development in Baby Buddy groups. The groups also provide opportunities for both child and parent socialization. The main focus of Baby Buddy group activities is promoting as much interaction between parents and children as possible. Activities include Play and Chat (parents and children playing and talking with each other and other families); Try It Out (practicing child development and parenting activities to see how babies react and to give parents confidence in how to interact with their babies); Take and Make (activities that parents and children can do together and take home with them--to provide reward and carryover); Eat and Learn (making nutritious snacks or meals); and Table Talk (mealtime group discussions about child development topics).

Three Baby Buddy group leaders are responsible for planning and conducting the groups. Their qualifications include a background in child development or infant/toddler care and the ability and desire to work closely with staff members and parents. Baby Buddy groups are held at the Logan, Preston, and Box Elder County Hospital centers, and parents are encouraged to attend weekly. Six groups are scheduled throughout the week during both daytime and evening hours. Sixty-five out of the 75 enrolled families have participated. Attendance varies across families; the average number of sessions attended is 11 per year. Staff members found that allowing parents to choose which group was most convenient for them resulted in higher levels of participation than assigning families to

specific groups. Scheduling groups during the evening has also boosted participation among parents who work during the day.

Other Child Development Services.

The program offers other activities designed to help parents learn about their children and their own influence on their children's well-being, including a parent discussion group, individual and family counseling, CDA classes, parenting classes, and the program's monthly newsletter. The mental health specialists lead parents in weekly group discussions of parent-generated topics in the areas of child behavior and socioemotional development. They also work with individual parents and families who are grappling with parenting and child development issues (behavior management and toilet training, for example). The child care coordinator conducts CDA classes, which are open to parents who want to earn CDA certification or state child care licensure or want to become family child care providers. The BREHS program refers families to parenting classes sponsored by the Head Start program and other community agencies. Finally, the *Baby Babblér* newsletter features information on a variety of child development topics.

Child Care Services. BREHS does not provide child care directly but refers parents to Child and Family Focus (CFF), Utah's state resource and referral agency, which screens and trains providers and provides referrals to families seeking child care. A recent BREHS survey indicated that program families that needed child care either had it or had been referred to another source. Seven program families (9 percent) were linked with family child care providers through referral to CFF, and 21 families (28 percent) selected child care providers independently. About five of these qualified for subsidies under the state's Workforce Services program. With few slots available in the target area for infants in center-based care, most families use family child care providers.

At the time of the site visit, BREHS was constructing a respite or "safety net" child care facility at the Logan center, which will have the capacity to serve eight children whose parents are temporarily unable to care for them due to a crisis situation (for example, illness, drug or alcohol rehabilitation, or incarceration). This center was scheduled to open in early 1998 and will be staffed by the child care coordinator, a child care training provider, a recently hired full-time child care provider, students in the program's CDA class (who will be able to complete practicum hours at the site), and BREHS parent volunteers.

Child Development Assessments. FEs conduct monthly developmental screenings during home visits with the HELP protocol.

The assessment is conducted through play activity with the child. In addition to providing information about each child's developmental status, the assessment serves the purpose of helping parents to learn about their child's developmental capabilities as well as developmentally appropriate ways to play with their child.

Health Services. Most families have a medical home for their children. At the time of the site visit, staff members had worked with families to identify primary health care providers for 86 percent of the children. The BREHS program tracks immunizations, well-child checkups, and children's growth and follows up to ensure that children receive needed health care.

The health/wellness coordinator offers prenatal visits to all pregnant women in the program. About 8 to 12 expectant mothers have participated in prenatal visits; some of these women are now pregnant for the second time and are receiving prenatal visits again. The health/wellness coordinator also visits all newborns in the program within two weeks of birth, and all program children received health screenings within 90 days of birth or

COMMUNITY CHILD CARE

BREHS refers families who need child care to the state resource and referral agency. At the time of the site visit, nearly two-fifths of program families were using child care, primarily relative care or other family child care arrangements.

Insufficient child care is available in the BREHS service area, especially for infants, school-age children, and special needs children. Child care centers that take infants or older children are rare. Family child care is more prevalent; the Utah resource and referral agency lists 200 licensed family child care providers in its service area. In addition, there are many in-home providers who are unlicensed.

The quality of the available child care varies. Licensed providers are monitored by the state and Child and Family Focus. The quality of unlicensed providers is largely unknown and is presumed to vary greatly. Some concern exists that the state's method of making fixed subsidy payments directly to parents provides an incentive for parents to choose the least expensive child care options. A representative from Child and Family Focus reported that child care quality and professionalism have improved substantially in the past three years due to improved training and the efforts of state resource and referral agencies to get communities to focus attention and devote resources to improving child care quality.

To increase the quantity and quality of child care settings, BREHS works with Child and Family Focus to assist new providers in starting family child care businesses and becoming licensed. The program also provides CDA training to providers and EHS parents. Program staff members also attempt to raise community consciousness about the importance of quality child care for infants and toddlers in their meetings with other community agencies and by setting up booths at community fairs and shopping malls.

enrollment. In addition, the health/wellness coordinator offers breast-feeding consultation (about 10 families have participated so far).

The health/wellness coordinator also collaborates with other staff members to provide health information to families during home visits, guidance on nutritious snacks and children's developing readiness for different foods during Baby Buddy groups, health workshops for parents at the Head Start centers in the three largest communities, and assistance to qualified families in applying for Medicaid.

Services to Children with Disabilities.
Although BREHS did not specifically recruit

disabled children, 19 percent of the children enrolled at the time of the site visit had suspected or diagnosed disabilities. These problems surfaced during program assessments of children. The Family Intervention Program (FIP) at Utah State University (USU) provides services for children with disabilities. BREHS coordinates with FIP to provide Part C services. FIP conducts infant/toddler assessments and works with EHS staff to develop each family's Individualized Family Service Plan. The team updates the plan every six months, reviews how services are going, and prepares for children's transition out of BREHS at age 3 by coordinating with the school district's disabilities coordinator.

The FIP staff train EHS staff members to maintain the documentation needed for Part C services.

Transitions. BREHS shares curriculum and training approaches with Head Start and recently met with Head Start staff to plan for children's transitions out of EHS, which were scheduled to begin two years from the time of the site visit. Six months before each child's third birthday, program staff will determine the child's eligibility for Head Start and develop a transition plan that takes into account the child's health, developmental status, and progress made while in EHS. Children who turn 3 years of age after the state's September 1 deadline will remain in EHS until the following September. Program activities will be adapted to provide small-group socializations for these older 3-year-olds to better prepare them for Head Start.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. During their early home visits with families, FEs work with families to

The program staff aims to promote children's development by enhancing parents' knowledge of child development and helping parents achieve individualized personal and family goals, including reducing parenting stress, maintaining mental and physical health, strengthening family relationships, connecting with sources of social support in the community, and achieving economic self-sufficiency.

develop an Individualized Family Partnership Agreement (IFPA). The IFPA consists of an

assessment of family resources and interests, an Individualized Family Plan (IFP), a contract between the program and the family, and referral tracking forms. Currently, BREHS uses a self-generated survey of family interests and needs that builds on questions included in the Head Start Family Information System. It asks parents about their concerns as well as ways they might be able to assist other families. FEs use this information to help families define their goals and to identify steps and timelines for accomplishing them.

FEs assist families in developing both short- and long-term goals that are linked in some way to the child. They encourage parents to start with smaller, more achievable goals and to consider how they can reach these goals. Families have been working on such goals as improving budgeting skills, gaining parenting knowledge, getting more education, obtaining medical care, getting a job (or a better job), and obtaining items the family needs. The contract spells out what the program expects from parents and what parents can expect from the program. Referral tracking forms--which document family concerns, the actions taken to refer families to appropriate sources of assistance, and follow-up efforts--had recently been added to the IFPA.

The family development coordinator estimated that approximately 75 percent of enrolled families had IFPAs at the time of the site visit. Some families have resisted setting formal written goals with their FE. All families, however, are working on goals at least informally. IFPAs are reviewed and updated on a continuous basis. FEs review family goals and document progress during home visits at least monthly. The coordinators review family files with the FEs three times a year to monitor program practice and family progress and to brainstorm additional strategies for working with families.

Case Management. The coordinators and mental health specialists have taken on more of the responsibility for dealing with family social service needs. The family development coordinator assists families who need help with family violence, finances, housing, transportation, employment, public assistance, illiteracy, educational opportunities, and food and clothing by referring them to community agencies and following up to monitor outcomes. The health/wellness coordinator and mental health specialists work directly with families on family planning, family relationships, depression, eating disorders, grief, and substance abuse. When necessary, they refer families to other agencies for more intensive services. The child development coordinator helps families with special needs children get treatment services, and the child care coordinator helps families with child care needs and offers child care training.

Staff members also offer a variety of parent workshops on such topics as budgeting, communication, self-esteem and assertiveness, social support, parenting, General Educational Development (GED) test preparation, cardiopulmonary resuscitation (CPR) and first aid, diet and weight control, and making scrapbooks and activity books to keep children occupied in quiet settings.

Father Involvement. The program hired a male involvement staff person (he also serves as an FE and a Baby Buddy group leader) to encourage father/male involvement. He encourages fathers to attend home visits, Baby Buddy groups, and other program activities. The program has also tried to increase male presence at the centers by recruiting more male volunteer interns from Utah State University.

Other strategies for increasing father involvement have included seating two fathers on the Parent Council, scheduling Baby Buddy groups in the evenings,

organizing a father-child breakfast, organizing male-oriented activities such as a trap shoot, offering CPR and money management workshops, and making the center decor more gender-neutral to promote a more comfortable atmosphere for men. November was Male Involvement Month, and a contest was held to encourage men to attend Baby Buddy groups (the names of men who attended were entered into a drawing for a prize).

Parent Involvement in the Program. The program formed three parent committees (one in each county) to promote parent involvement in the program. The parent committees, which include all parents in the program, elect officers who serve on the BREHS Parent Council. In addition, each parent committee elects one representative to serve on the BRHS Policy Council. Program parents nominated and cast ballots for Parent Council officers at a family picnic held in the summer (staff members delivered ballots to families who were not able to attend). The parent committees work with the BREHS staff to organize monthly family outings and programwide events. Parents attend an average of four such events per year. In addition, parents also serve on the health services advisory group, employment screening committees, career development committee, and various subcommittees on Baby Buddy group planning, child care center startup, literacy, and male involvement. Some parents do volunteer work at the center and help with such tasks as home visit preparations, party preparations, and building maintenance tasks.

STAFF DEVELOPMENT CORNERSTONE

The project manager works with the cornerstone coordinators, the local research partner/continuous improvement partner, and the program's Technical Assistance Support

Center (TASC) and Resource Access Project (RAP) consultants to plan and implement staff development activities. These activities are grounded in a shared vision, frequent staff performance evaluations, and joint reflection and discussion of staff needs.

Training. Last year, staff members completed a survey asking them to identify their strengths and training needs. Communication, home visits, and responding to families' mental health needs emerged as main areas in which staff members need training. The project manager consulted with the cornerstone coordinators, mental health specialists, and outside consultants to plan training to meet these needs. Other topics have been added to the training agenda as specific needs have emerged.

Cross-training occurs across cornerstones; all staff members receive training in the areas of child, family, and community development. The cornerstone coordinators conduct training for other staff members in their respective areas of expertise. BREHS has also engaged in some cross-training with FIP, the local Part C provider.

Supervision and Support. Staff meetings are held every Monday. The entire staff meets as a group for one hour before breaking into smaller group sessions. FEs work with the project manager and cornerstone coordinators on home visiting skills and engage in one-on-one reflection and problem solving with another FE partner. Another hour is spent in a small group discussion with a mental health coordinator, who facilitates discussion about the special "front line" stresses that FEs face and helps them avoid burnout. Baby Buddy group leaders also have opportunities to discuss the challenges they face and to receive feedback from other staff members, including supervisors and the project manager.

To offer further support and training to the FEs, the child development coordinator had recently begun accompanying FEs on home visits. She now spends two days a week observing home visits, working with FEs to solve problems, and providing constructive supervisory feedback. All staff members receive formal feedback on their performance every three months from either a cornerstone coordinator or the project manager. Performance reviews also include staff self-evaluations.

The BREHS program encourages staff members to take classes to broaden their skills and knowledge, to get professional certification in their respective areas of expertise, and to attend professional conferences. The program pays for these activities. The Baby Buddy leaders attended a Head Start conference in Montana, and at the time of the site visit, the coordinators, mental health specialists, and FEs were preparing to go to the Zero to Three Conference in Nashville.

Staff wages exceed those of other programs in the area. Staff members are generally satisfied with the benefits they receive, but they desire better dental coverage.

Staff Turnover. At the time of the site visit, the program had experienced no staff turnover.

COMMUNITY BUILDING CORNERSTONE

BREHS staff members articulated a number of community-building goals for the program. First, they are attempting to increase the community's focus on supporting families with infants and toddlers and to continually increase community recognition of and respect for EHS. Additional goals include linking parents to

other families and resources in the community, helping to increase child care availability and quality, and increasing access to needed services for families in Idaho.

Program Collaborations. The BREHS program collaborates with many community agencies and interagency groups. Although most arrangements with agencies are informal, based on 30 years of working in the region, BREHS has formal agreements with FIP (to coordinate services for children with disabilities) and Community Family Partnership (to refrain from recruiting each other's control group families). Other agencies with which BREHS collaborates are Child and Family Focus; Baby Your Baby (a Utah agency that works with expectant mothers); Bear River Mental Health (which provides substance abuse-related services); Bear River Valley Hospital; the Supplemental Nutrition Program for Women, Infants, and Children (WIC); La Leche League; IHS Lactation Clinic; Bear River Health Department; Utah Health Department; Division of Child and Family Services (DCFS); State of Utah Workforce Services (welfare office); American Red Cross; Deseret Industries (thrift store, employability training); Food Pantry (emergency food supplies); USU Psychology Community Clinic; and the Logan Transportation Department.

Some of the most intensive and fruitful of BREHS's collaborative efforts have been with FIP, DCFS, Baby Your Baby, and WIC. In general, these community partners reported profiting from BREHS's access to and degree of contact with vulnerable families in the community. For example, FIP relies on EHS for day-to-day contact and followup with families, while BREHS relies on FIP for its expertise in disabilities. Together, the two agencies promote greater access to continuous services for special needs children. In its efforts to reach families, DCFS profits from BREHS's access to families and the relatively nonthreatening

nature of its relationships with families. In turn, BREHS relies on DCFS to monitor children's safety and to intervene when necessary. Finally, collaborations with Baby Your Baby and WIC have aided BREHS's recruitment efforts and have also enabled low-income families with infants to receive a broader array of services over a more sustained period of time.

Interagency Collaborations. BREHS staff members also participate in interagency collaborative groups. With 25 to 30 other service providers, BREHS participates in the Local Interagency Council, which meets monthly to address community issues, share information and referrals, and strategize about how to collectively create and maintain a seamless system of services for families in need. Additionally, BREHS participates in the Interagency Self-Sufficiency Council, another group of community agencies that meets to discuss the needs of and provision of services to individual families. BREHS staff members also attend meetings of groups of community service providers concerned with safety and quality in child care (the Coalition of Child Care Providers), children's health care (Health Services Advisory Group), and child safety (Safe Kids Coalition).

Community Building Among Parents. The BREHS program also fosters social support among program families. The Baby Buddy groups are designed to help parents form social networks that will outlast their program participation. A number of parents reported appreciating the opportunity to "get out of the house" and join other adults and children at the center.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. As noted earlier, the program has worked closely with its Technical Assistance Support Center

WELFARE REFORM

Utah's welfare reform program, the Family Employment Program (FEP), was implemented statewide in July 1996. The provisions of the plan were originally implemented in January 1993 under a welfare reform waiver (the Single Parent Employment Demonstration Program). Two major emphases of the plan are supporting employment through individualized self-sufficiency plans and child support enforcement. The plan requires immediate and universal participation in employment-related activities (employment, education, mental health treatment, or some combination thereof), and it has instituted a 36-month lifetime limit for cash assistance. Up to 20 percent of the state's caseload can be exempted from the time limit due to hardship, domestic violence, disability, or other special circumstances. Teenage parents are required to live in their parents' household and to attend school or work. Parents who accept employment can keep more of their earnings, receive transitional Medicaid for up to 24 months, and receive a state child care subsidy based on a sliding fee scale as long as they remain eligible.

Idaho's welfare reform program, Temporary Assistance for Families in Idaho, is very similar to FEP. It places a 24-month lifetime limit on cash assistance and requires recipients to earn their benefits through work

BREHS staff members and families had not yet been affected by the new limits on cash assistance, and, at the time of the site visit, they were not apprehensive about the welfare changes. Very few program families were receiving cash assistance when they enrolled in the program. Public reaction to the change has been mostly positive, reflecting citizens' strong work ethic and preference for self-reliance. The unemployment rate is low, and jobs (albeit low-paying ones) are widely available. A high proportion of program families are already wage-earning families, and families that currently receive assistance are still two years away from potentially losing their benefits. Families and staff members were more concerned about low wage levels for working parents and the comparatively high costs of housing and other necessities in the area.

(TASC) consultant to plan staff development activities. The program director has also discussed program issues and ideas with this consultant. The program's Resource Access Project (RAP) consultant provided materials and discussed procedures and ideas with the program staff. The program has also received key support from its federal project officer.

Continuous Program Improvement. The program is constantly being refined as staff members see things that are not working or could be working better. They monitor needs of families, the staff, and the community and seek feedback on program

practices from parents, the staff, TASC and RAP consultants, and the program's continuous improvement partner (the local research team).

A team of researchers from Utah State University's Department of Family and Human Development, with expertise in infant/toddler development, attachment, play, parenting, and program evaluation, serves as the BREHS program's local research partner. The principal investigator for the local research team gives formal continuous improvement feedback to the program once a year but also speaks informally with the project manager on a frequent basis. This

investigator has worked with the staff members to help them articulate their theories of change and has helped them identify strategies for bringing about desired outcomes.

Local Research. In collaboration with BREHS staff, the local research team is conducting an evaluation of the BREHS program. The main focus of the first phase of the evaluation was BREHS's startup and planning, hiring of staff, staff training, facility development, curriculum planning, community development, health services planning, parent involvement planning, social services planning, disabilities services planning, and overall continuous program improvement process. The evaluation examined staff ratings of program performance and parent ratings of their relationships with FEs and the quality of home visits. Although most staff members rated the program's performance on each program objective as "adequate" or "perfect," some of the staff noted a need for improvement in the areas of father involvement, child care services, transitioning, IFPs, and community collaboration. Staff members also noted the need to focus more intensely on parent-child interactions during home visits and Baby Buddy groups. On average, parents rated their relationships with FEs and the quality of home visits very highly. Year One results have been shared with the program in a Continuous Program Improvement Report.

The local research builds on the experimental design implemented by the national evaluation and emphasizes two main outcomes: security of attachment and development of play. It focuses on issues related to secure infant attachment and includes examining complexity and mastery motivation in object play, mutual responsiveness and positive affect in social play, and parents' positive parenting, mental health, adaptive decision making, and self-sufficiency. The main research objectives are to examine the impact of EHS on infant

attachment and play in relation to parenting and, in turn, to examine the relation of attachment and play to later social and cognitive competence. The research team recently added videotaped observations of father-child interactions when the target children reach 14 months of age to its research plan.

PROGRAM SUMMARY

The BREHS program serves primarily white, two-parent, working-poor families living in rural areas in Utah and Idaho. In weekly home visits and weekly Baby Buddy group activities, program staff members focus on promoting positive parent-child interactions and strengthening parent-child relationships. They also work with parents to help them work toward personal and family goals. At the time of the site visit, the program was helping family educators focus more of their time during home visits on child development activities by arranging for other staff members to work with families on social service needs and crises. The program was also enhancing processes for providing consultation and feedback on home visits to family educators.

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EARLY HEAD START PROGRAM PROFILE

Washington State Migrant Council Early Head Start Yakima Valley, Washington November 3-6, 1997

The Washington State Migrant Council, the largest Hispanic-operated and Hispanic-serving organization in the northwest, operates an Early Head Start program for 75 intrastate migrant families in six small towns in Yakima County, Washington. The program serves primarily first-generation Mexican Americans who migrated to Washington to work on farms. The majority speak only Spanish. The program provides child and family development services primarily in biweekly home visits and group activities for parents and children. Child development services focus on establishing supportive relationships and enhancing the social and verbal contexts for early childhood development. The program emphasizes sensitivity to Mexican American heritage and culture and sensitivity to families' concerns with acculturation.

OVERVIEW

The Washington State Migrant Council (WSMC) operates the Early Head Start (EHS) program in Yakima Valley, Washington. The WSMC is a private, nonprofit organization founded in 1983 to provide social and educational services to migrant and seasonal farmworkers and rural poor families. WSMC is the largest Hispanic-operated and Hispanic-serving organization in the northwest. WSMC services include employment and job training, WIC, ESL/GED instruction, housing, family literacy, parenting, and school-based programs. WSMC also administers 26 Migrant Head Start programs, five regular Head Start programs, and 12 state-funded Early Childhood Education and Assistance Programs (ECEAPs). In addition to serving preschoolers, the Migrant Head Start programs have been serving infants and toddlers since 1983.

Community Context. The WSMC EHS program serves six small cities in Yakima County, an approximately 4,000-square mile agricultural region east of the Cascade mountains populated largely by Mexican and Mexican American migrant and former migrant ("settled out") farmworkers. More than half of county residents live in poverty. The county has the largest number of migrant and seasonal farmworkers in the state. The cities the WSMC EHS program serves are concentrated in the more rural areas. Compared to the county as a whole, each of these cities includes a disproportionate number of poor, Hispanic, and farmworker residents.

Scarce housing, homelessness, violent crime, and high teenage pregnancy rates are problems in Yakima County. Many pregnant mothers receive no prenatal care or receive it late in their pregnancy. A lack of child care and public transportation hinders

people from accessing services. There are, however, also several major social service providers, including the WSMC and the Yakima Valley Farmworkers' Clinic.

Program Model. The WSMC EHS program provides child and family development services primarily in home visits and group activities. Each family receives services from two home visitors: a home educator and a case manager. The program focuses on developing supportive relationships, beginning with those between staff members and parents, as a means to fostering child growth and development. The program also emphasizes sensitivity to Mexican-American heritage and culture and to families' concerns with acculturation.

Families. Nearly all of the families served by the WSMC EHS program are Hispanic. Nearly two-thirds of these families do not speak English. The majority are two-parent families. Nearly one-fourth of mothers were pregnant when they enrolled in the program. Approximately one-fourth of the families were receiving welfare cash assistance when they enrolled.

Staffing. In the year prior to the site visit, the program experienced major changes in its staff, including its leadership. Specifically, the program was formerly part of the WSMC Migrant Child Institute, an arm of the WSMC devoted to new programs and demonstrations. At that time, the EHS program director also directed the Migrant Child Institute, and an education/disabilities coordinator ran the program. During the year prior to the site visit, the Migrant Child Institute was dissolved, and the EHS program director and coordinator both resigned to take other jobs. At the time of the site visit, the WSMC EHS program had a new program director; he is also the regional director of Head Start and ECEAP.

A new program coordinator was managing the day-to-day activities of the program. There was a two-week gap between program directors and a six-month gap between program coordinators. At the time of the site visit, the director and coordinator had both been in their new positions for approximately seven months. In addition to the program director and coordinator, the program staff consists of five home educators, two case managers, a health coordinator, and an administrative assistant.

RECRUITMENT AND ENROLLMENT

Program Eligibility. To be eligible for the WSMC EHS program, families must have incomes at or below the poverty level, have a child under 1 year old, and live in Toppenish, Granger, Mabton, Sunnyside, Grandview, or White Swan, Washington. In addition, families must be intrastate migrants. In White Swan, which is not a research site, the family must have a child younger than age 3.

Recruiting Strategies. The WSMC EHS program outreach is comprehensive. EHS staff members post flyers in the community and canvass door-to-door to distribute flyers and leaflets and ask about families' interest and eligibility. They also inform schools and other social service providers in the community about the program and advertise on the Spanish radio station. Program staff reported that most enrolled families came to the program through referrals from other service providers.

Enrollment. The WSMC EHS program is funded to serve 75 families. The program originally planned to serve 131 families, 95 of whom would participate in the national evaluation research (the

COMMUNITY PROFILE

The WSMC EHS program serves six small cities in Yakima County, an approximately 4,000-square-mile agricultural region east of the Cascade mountains populated largely by Mexican and Mexican American migrant and former migrant ("settled out") farmworkers. Yakima County is divided informally into the "Upper" and "Lower" Valley regions. The largest city in Yakima County is Yakima.

The program coordinator estimates that at least 60 percent of the residents of Yakima County live below the poverty level. The county unemployment rate is approximately 13 percent during the growing season, and approximately 50 percent of the population receives welfare cash assistance. The county has the largest number of migrant and seasonal farmworkers in the state (accordingly, unemployment rates shift dramatically between the growing and nongrowing seasons).

The cities the WSMC EHS program serves are concentrated in the more rural Middle and Lower Valley areas and include Toppenish (population approximately 8,000), Granger (population approximately 2,000), Mabton (population approximately 1,500), Sunnyside (population approximately 12,000), Grandview (population approximately 8,000), and White Swan (population approximately 2,700). Compared with the county as a whole, each of these cities has a disproportionate number of poor, Hispanic, and farmworker residents. National and state surveys of agricultural workers, moreover, have shown farmworkers to be disproportionately poor, young, male, of low education, and highly illiterate.

The county has many problems, especially in the cities the WSMC EHS program serves. Adequate housing is increasingly scarce: currently, there is a two-year wait for public housing. Homelessness is perceived to be a growing problem, as is violent crime--there is an increasing presence of youth gangs in the Yakima Valley. In 1994, approximately 10 percent of all children were referred to Child Protective Services. The county teen pregnancy rate is the highest of any county in Washington State. Approximately 18 percent of all births are to women 19 and younger, and 27 percent of all children born either have not received prenatal care or have received late prenatal care. Finally, law enforcement officials view Yakima county as a major illegal drug trafficking area in the country.

Scarce housing, homelessness, violent crime, and high teenage pregnancy rates are problems in Yakima County. Many pregnant mothers receive no prenatal care or receive it late in their pregnancy. Although Yakima County has several major social service providers, a lack of child care and public transportation hinders people from accessing services.

In other respects, Yakima Valley is a service-rich community. The major community-based social service organizations (in addition to the WSMC) are the Yakima Valley Farmworkers' Clinic (a federally and state-funded clinic), the Opportunity Industrialization Centers (which offer dropout prevention programs and other youth services), and the Enterprise for Progress in the Community organization (also a recipient of Head Start grants). The state DSHS also has a strong presence in the community. The EHS home visitors and case workers described families as frequently expressing confusion about which staff members belong to which social service agency.

research excludes families enrolled at one of the programs before the evaluation began).

The new program directors scaled back the original plans, in part because of difficulties

in recruiting and retaining families (due to research requirements, families' ineligibility for the research because of previous participation in similar programs, and families' itinerant lives). The new program management has also aimed to recruit families that are distributed as equally as possible among the five cities the program serves.

At the time of the site visit, the program had enrolled 96 families, but it had also lost approximately 25 families. Of the 71 remaining families, 53 are research families. Of the 25 families who dropped out of the program, about half are in the research sample. Most of the families who dropped out of the program moved back to Mexico or to another region. The program maintains a waiting list so that a family that drops out can be replaced as soon as possible. In replacing families, the program aims to maintain as even a distribution across sites as possible. The program director believes that this is the most equitable system for both the sites and the program personnel, who are assigned cases according to geography.

Families in the program are principally first-generation Mexican Americans who came to the region to work on farms. Approximately 70 percent speak only Spanish.

CHILD DEVELOPMENT CORNERSTONE

Home Visits. Child development services include biweekly home visits from home educators and biweekly center-based parent education/group socialization activities. Each EHS family is assigned a regular home educator who visits the parent and child approximately twice a month for

about an hour each time. Each home educator has a caseload of approximately 12 families. The home educators are required to have related experience, and they must have a child development associate (CDA) credential or higher degree (A.A. or bachelor's degree) in child development within one year of joining the staff.

The WSMC EHS program's approach to child development focuses on establishing supportive relationships to foster child growth and development. Trusting and respectful relationships between staff members and families are viewed as the gateway to families' engagement in the program and to enhanced child development. The program also emphasizes the social and verbal context(s) of early development because it believes children thrive in engaged, verbal, and communicative contexts. The importance of talking to children is a recurring theme. The program also emphasizes sensitivity to Mexican American heritage and culture, to families' concerns with acculturation, and to parents' own goals for their children.

The home educators talked about the initial importance of establishing a schedule with the mother (or primary caregiver)--of making sure that she understands that the home educator will be there when she says she will and that the parent should plan to be home at the time of the scheduled appointment. Home educators also discussed the importance of establishing rapport with the parent to gain her trust and attention, to provide her with social support (someone to talk to), and to bolster her self-esteem and confidence as a person and as a

parent. The parent educators focus on visiting the mother and child but include the father and other family members who want to participate.

The home educators (who are all Hispanic) understand Mexican American heritage and culture, which makes it easier to form trusting relationships with the parents. At the same time, the home educators work on familiarizing parents with mainstream American culture, encourage parents to learn English, and appeal to what is perceived to be an ambition of many program participants--for their child to succeed in America. Staff members struggle with balancing respect for Mexican culture and practices and concerns about some of the "old-fashioned" childrearing views and customs program families practice.

Home educators focus on teaching parents about early childhood development. Home educators make parents aware of the importance of their children's first years and of children's sensitivity to their environments during this time. In Mexico, "children should be seen and not heard," and talking to infants often is viewed as ridiculous. The home educators also work to make sure that the parent has realistic expectations about what her baby can and will do and to enhance the parent's sensitivity to her baby's needs and signals. Home educators pay careful attention to each parent's and child's particular situation and needs and tailor their services accordingly. Approximately 70 percent of home visits are conducted exclusively in Spanish.

Initially, the home visitor administers an *Ages & Stages Questionnaire* to assess the infant's health and development. Next, the home educator completes an individual family service plan (IFSP) based on this

assessment, other observations made during the home visit, and parents' input. Then, in accordance with IFSP, the home educator begins to introduce different activities for the parent to do with her baby. Four sets of formal guidelines and curricula guide the home educators' activities: (1) the National Association for the Education of Young Children (NAEYC) standards for early childhood education; (2) the *Growing Birth to Three* curriculum, which centers on developmental milestones; (3) WestEd's *Program for Infant/Toddler Caregivers* curriculum, which focuses on enhancing parental responsiveness to infants' cues; and (4) the *Small Wonders* curriculum, which also centers on developmental milestones.

As services are implemented, the first priority of the home educator is to monitor and enhance early infant development. The *Ages & Stages Questionnaires*, the home educator's observations, and parents' input are all used frequently both to assess infants' progress on developmental milestones and to help guide home visit activities. For example, if the infant is lagging in motor skills or the parent has identified motor development as an area of concern or interest, the home visitor will introduce activities for promoting motor development. Home visitors provide parents with ideas and activities to implement between visits. Often, other family members, or friends or neighbors, are in the home at the time of the home visit. Home educators frequently involve others in the activities of the visit--both to extend EHS program benefits to others and as a way of keeping the target parent and child focused. All home visits are carefully documented on a Home Visit Form, then logged onto the Child/Family Service Episode Record. Each visit ends with a discussion of what the parent would like to do during the next visit.

Group Child Development Activities.

Biweekly 90-minute parent education/group socialization meetings are offered at WSMC early childhood classrooms in each of the five cities the program serves. Program families attend the meeting located closest to them. All family members are invited, and transportation is provided if necessary. Home educators conduct these meetings, which are designed to bring EHS program children together to introduce them to a group setting and to a classroom environment, bring EHS program parents together for networking and social support, and provide parenting education. These meetings generally consist of group recreational activities for the children and presentations to and/or discussions with the parents. Presentation and discussion topics vary according to parents' needs and interests. Parents might hear a presentation about the importance of reading to children, make books with their older children, or make books to read to their infants. About half of the families regularly attend the group meetings. In response to parents' feedback, however, the program is considering moving the group meetings to weekends so that more families can participate.

Child Care Services. The WSMC EHS program does not provide child care directly. The number of EHS children receiving child care is estimated to vary between none and approximately 50 percent, depending on the time of year (time in the growing season). Most of these children are cared for in informal family child care arrangements, the cost of which is subsidized by the state Department of Social and Health Services (DSHS). About 10 percent of these children receive Migrant Head Start services. At the time of the site visit, the WSMC did not have formal procedures for monitoring EHS children's

child care situations, although both home visitors and case managers worked with parents on how to select high-quality care for their children.

Child Development Assessments. As noted earlier, home educators assess children's developmental progress frequently to guide home visit activities. They use the *Ages & Stages Questionnaires*.

Health Services. At the time of the site visit, the WSMC EHS program had just hired a health coordinator. The health coordinator is responsible for assessing children's health, working with families to make sure that children have a medical home, and ensuring that they are up-to-date on immunizations and health and dental care. Children with observable health problems are referred to other service providers, most frequently the Farmworkers' Clinic, a comprehensive medical and dental facility with which the WSMC has a friendly relationship. The state- and federally-funded Farmworkers' Clinic is most likely to be EHS participants' primary health care provider. Children's dental care is a special concern of the health coordinator, because many families who have recently immigrated put their children to bed with a bottle of sugar water, which is a common cause of tooth decay.

Services for Children with

Disabilities. The Part C provider in Yakima County is the Yakima Valley Memorial Hospital Child Health Services Program, a Yakima-based program providing medical, dental, mental health, and educational services at its center and in families' homes. This program has interagency agreements with all of the Yakima County school districts and with the WSMC to refer and coordinate services for young children with disabilities. Families who have children

COMMUNITY CHILD CARE

Child care services, especially for infants and toddlers, are perceived to be sorely lacking in the community. Except for Migrant Head Start, which serves infants, toddlers, and preschoolers, the infant and toddler care that exists generally takes the form of informal arrangements and family child care.

To address the community's need for child care while respecting the preferences of this population for family child care, the WSMC EHS program had planned to establish a home care training program to teach family child care providers to provide high-quality care. The home care training program was just getting under way when the program leadership changed, and it was delayed. The current program directors intend to implement this training in the future.

EHS staff members noted that parent education services are likely to contribute indirectly to enhancing the quality of child care in the community for both EHS and other children. EHS parents are likely to care for children other than their own, and neighbors, friends, older siblings, and other family members who are in the home during the provision of the parent education curriculum are also likely to provide formal and informal child care for EHS and other children.

with disabilities are overrepresented in the Yakima Valley. Easily detectable and preventable infant and toddler disabilities frequently go undetected until children attend Head Start or public school. With EHS, a substantial increase in early detection of childhood disabilities is likely. At the time of the site visit, four EHS children (seven percent) had suspected or diagnosed disabilities.

Transitions. When children are 2-1/2 years old, the program will initiate a discussion with parents about transitioning out of EHS. Program staff members will review available child care options and help parents arrange visits to different child care and early education/child development programs. Options for 3-year-old EHS graduates will include Migrant Head Start, Head Start, and Early Childhood Education and Assistance Program. EHS staff

members will convene meetings between parents and relevant staff members in these programs.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Family development services are concentrated in biweekly home visits from case managers. Case managers focus on family needs beyond the development of the target child, including housing, clothing, parent education (for example, ESL training), and employment needs. Initially, the case managers work with the families to complete a Family Needs Assessment in which parents identify family resources (such as, food, housing, transportation, a phone, social support) as “adequate,” “somewhat adequate,” “inadequate,” or “not

applicable.” This needs assessment becomes the basis for the Family Partnership Agreement, a written contract outlining family goals, responsibilities, and timetables for completing goals. This agreement is updated frequently. Case managers refer families to other service providers and programs, usually within the WSMC, as necessary.

Case Management. Each EHS family is assigned a regular case manager who visits the family approximately twice a month for about an hour each time. Each case manager works with approximately half of the families. The case managers are required to have an A.A. degree in a related field or proven comparable experience in working with youth, parents, and school personnel.

As with the child development cornerstone, the WSMC EHS program’s approach to family development revolves around a trusting and respectful relationship between staff members and families, is highly individualized according to the situation of the family and the parents’ expressed needs, and involves careful attention to culture and acculturation.

Case managers spoke of family goal setting as a goal itself. Many families go from crisis to crisis without having strategies in place to deal with them. Thus, as case managers work with families, they try to foster families’ abilities to identify goals and anticipate future needs, as well as to nurture families’ confidence and skills to accomplish their goals. Case managers

spoke of the importance of parents becoming more self-sufficient, even in seeking help and services, and of the difficulty of balancing “doing for” the families with “doing with” them.

Father Involvement. Although staff members work with both fathers and mothers and encourage fathers’ participation, the program has not taken additional specific steps to encourage fathers’ involvement in program services beyond inviting them to participate in the home visits and group socialization meetings. Staff members described fathers as particularly difficult to engage because traditional Mexican culture views the family and childrearing as women’s work. Program staff estimated that fathers participate in approximately one-third of the program’s home visits and group activities.

Parent Involvement in the Program. Finally, all EHS parents are invited to attend monthly parent meetings, called “informationals.” These meetings also served as the incubator for the parent policy council. The program director runs the policy council meetings, but he is working to serve more as a meeting facilitator, with the parents managing the meetings. These meetings are used to provide parents with information on various topics (including EHS services themselves) and to encourage parent participation in EHS program planning and development. In addition, both the informationals and the policy council meetings have provided times for members of the community to present information on such topics as cardiopulmonary resuscitation (CPR), housing, welfare and immigration reform, and fire safety.

STAFF DEVELOPMENT CORNERSTONE

Training. The WSMC EHS program developed a comprehensive staff training plan that incorporates the WSMC staff development guidelines. At a minimum, home educators and case managers must have completed or be working on CDA certification. Case managers are required to have an associate's degree in a related field or proven comparable experience in working with youth, parents, and school personnel. In addition, staff members regularly attend local and regional trainings and workshops on topics such as family resource coordination, CPR, early childhood health, nutrition, and child maltreatment.

The WSMC will pay or reimburse staff for workshops and courses, including higher education course work (up to \$1,200 per year). Shortly before the site visit, the WSMC had sent all EHS staff members except the health coordinator to a three-day conference for the Washington Association for the Education of Young Children (WAEYC). The program directors also inform staff members of relevant training opportunities within the agency and larger community.

The WSMC has developed individualized staff development plans to document staff members' training goals and accomplishments. All employees maintain a personnel file that contains their staff development plans, documentation of each training session they attended, and certification they received. Staff development plans are reviewed annually in meetings between each staff member and a certified career and guidance counselor or the EHS program coordinator.

Supervision and Support. The entire EHS staff meets weekly for approximately two hours for program updating and planning. These meetings provide an opportunity for informal training and social support through sharing of ideas, problems, and solutions. Staff members also conference each family's case quarterly. At the time of the site visit, there was no ongoing field supervision. The program coordinator, however, had recently started to accompany home educators on home visits and to attend group meetings and activities.

Staff Turnover. As discussed earlier, the program experienced major staff turnover in the year prior to the site visit. The program director and coordinator left, one of the home educators resigned and was replaced, and another home educator was added. The EHS coordinator expressed concern that these changes and the gap between program coordinators had hurt staff morale. At the time of the site visit, he was working actively to raise morale, especially by giving staff members more individualized attention and positive feedback. The program coordinator views staff wages and benefits as on par with similar jobs with other service providers in the community.

COMMUNITY BUILDING CORNERSTONE

The WSMC EHS program addresses community development indirectly through the child development, family development, and staff development cornerstones. The EHS program expects to enhance the development of this community's youngest citizens, which eventually will enhance the community as a whole. In addition, as EHS services increase parents' education and self-sufficiency, parents will become more productive citizens, role models, advocates,

WELFARE REFORM

Approximately 70 percent of EHS families are estimated to be eligible for TANF. One-fourth were receiving cash assistance when they enrolled in the program. At the time of the site visit, the Washington State TANF program, called WorkFirst, was about to begin operating (November 1, 1997). The WorkFirst program specifies that after two years of welfare receipt, recipients must participate in work activities. These activities include paid employment, job training, community service, and vocational education training (for up to 12 months). Families also may not receive cash assistance for more than five years over their lifetime. New parents are exempt from Work First for 12 months. By June, 1999, however, this exemption will be cut to 12 weeks. To remain eligible for benefits, unmarried minor parents and unmarried pregnant minor applicants must live in the most appropriate living situation as determined by the DSHS. Minors must be actively working toward a high school diploma or GED.

EHS staff members, as well as other community social service providers, were anticipating that welfare reform would result in increases in families' need for child care. Accordingly, they were working on educating families about child care quality. At the time of the site visit, the EHS program was planning to implement a home care training program to enhance the quality of care provided by family child care providers. The program coordinator also expressed concern that the welfare reform requirements will make parents less available for home visits. In response to this concern, program staff members were discussing the possibility of conducting more home visits during evening and weekend hours.

In the meantime, EHS staff members described parents as highly aware of changes in the welfare system yet highly confused as to exactly what these changes and their implications are. Many of the parents felt that welfare caseworkers are not helpful and often treat their clients disrespectfully.

Staff members expressed concern that the welfare reform requirements are too demanding and that, by forcing poor young parents into dead-end, low-skill jobs, they will prevent these parents from becoming fully self-sufficient. The parents themselves echoed these concerns: one remarked, "They want us to live on a Dairy Queen job."

and community leaders. The EHS director hopes that more Hispanic Americans will assume community leadership positions. The program also expects that the parent education and monthly parent meetings will link EHS parents in new ways and enhance their community. Staff training activities are

expected to support staff members as role models and advocates in the community.

Program Collaborations. Currently, the WSMC's sole formal agreement is with the Yakima Valley Memorial Hospital Child

Health Services Program (the county Part C provider).

Interagency Collaboration. The WSMC does, however, communicate and collaborate with the other major service providers in the community. The WSMC is part of the Yakima County Interagency Coordinating Council, and WSMC staff members serve on other service providers' boards of directors and committees. In addition, the WSMC periodically joins forces with the state DSHS to offer workshops (such as a conference on child abuse and neglect).

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The program has consulted both its Technical Assistance Support Center (TASC) partners and training and technical assistance staff from Zero to Three for assistance with family partnership agreements and service integration. The program has also received technical assistance from the state educational service district, which provides training and technical assistance to schools, Head Start, ECEAP, and EHS. In addition, the program has received support from its federal project officer.

Continuous Program Improvement. An independent consultant assists the program with continuous improvement. He views his task as having two parts: (1) evaluating process, and (2) evaluating outcomes. The process evaluation involves checking service and case management records to ensure that services have been delivered and documented. The outcome evaluation will examine the home educators' skills in delivering the parenting education curricula and assess both staff members' and

parents' knowledge, including their knowledge of developmental milestones.

Local Research. A team of researchers from the University of Washington's Center for the Study and Teaching of At-Risk Students is serving as the WSMC EHS program's local research partner. Team members' areas of expertise include special education, education of at-risk children and youth, and educational program evaluation. One of the local research data collectors attends the program's weekly staff meeting to facilitate collaboration and coordination among program and research staff.

The local researchers are examining the effects of EHS on early childhood development, especially social and language development, with a particular focus on the role of Mexican American culture in influencing both service effectiveness and child development. They are addressing research questions about the influences of families' culture and acculturation on early child development; the effectiveness of EHS services for this special population; and the interaction between program and family processes, and the influence of this interaction on early child development.

The program director noted that working with the local research team has also informed continuous improvement activities. Specifically, discussions with the local researchers have led program staff members to emphasize early communication skills and verbal interactions in their work with the families.

PROGRAM SUMMARY

The WSMC EHS program provides child and family development services to Mexican American families in biweekly

home visits and group activities. At the time of the site visit, the new program leaders were rebuilding staff morale following a period of staff turnover. They also intended to resume planning for a home care training program to improve the quality of care provided by family child care providers.

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PART 3:
MIXED-APPROACH PROGRAMS¹

¹At the time of the site visits in 1997, the revised Head Start Program Performance Standards had not officially gone into effect and the programs had not yet been monitored. Following these two events, some programs instituted changes that are not reflected in these profiles.

EARLY HEAD START PROGRAM PROFILE

Clayton/Mile High Family Futures, Inc., Early Head Start Denver, Colorado October 14 - 17, 1997

Clayton/Mile High Family Futures, Inc., a partnership between a foundation and a child care resource and referral agency, is operating an Early Head Start program for 100 families in Denver, Colorado. The program serves low-income families from diverse racial and ethnic backgrounds. It provides child and family development services in three ways, depending on family needs and preferences: (1) in weekly home visits, (2) through center-based child development services and monthly home visits, and (3) in a parent-child cooperative that meets twice a week and monthly home visits. Child development services focus on enhancing parent-child relationships and helping parents meet their children's needs.

OVERVIEW

Clayton/Mile High Family Futures, Inc. (C/MH) operates an Early Head Start (EHS) program in northeast Denver, Colorado. C/MH is a partnership between the Clayton Foundation--which staffs, administers, or donates space for a variety of educational programs in Denver, including Head Start--and the Mile High Child Care Association, a local child care resource and referral agency. The two organizations have been working together since they initiated their Comprehensive Child Development Program (CCDP) in 1989.

Community Context. C/MH EHS serves families in northeast Denver. The community has seen an increase in crime, drug use, and gang activity in the past 10 years. Northeast Denver is rich in services; however, families often face barriers when they try to access them. Because Denver has been experiencing a period of sustained growth, the housing and job markets are

very tight, making affordable housing less available as well as decreasing unemployment. The supply of affordable, high-quality child care is not sufficient to meet the need for it. City and state community leaders are highly committed to improving the quality of services for low-income children, and the mayor and governor have coordinated a number of high-level initiatives to work on child-related issues.

Program Model. The C/MH EHS program is a mixed model with three main modes of service delivery. All families have a family development specialist who visits them regularly at home. Some families receive services primarily through weekly home visits. Other families enroll their child in the program's child development center and receive monthly home visits. Finally, some families participate in the parent/child cooperative (co-op) group twice a week at the child development center and receive monthly home visits.

Families. The families served by the C/MH EHS program are diverse. Two-fifths are Hispanic, one-third are African American, and the rest belong to other racial and ethnic groups. Nearly half of the mothers were pregnant when they enrolled. About half of the families include two parents. One-fourth were receiving welfare cash assistance when they enrolled.

Staffing. C/MH EHS employs five family development specialists who conduct home visits, as well as two child development specialists and two teachers who provide child care in the center and facilitate the morning session of the co-op. The family service coordinator supervises the family development specialists and the family development team, which includes the family/staff education specialist, the health/wellness specialist, the nutritionist, and the male involvement/education, training, and employment specialist. They work with the family development specialists to meet family needs and provide services, and work directly with families as needed. The child development center director supervises the child development specialists and teachers and also facilitates the parent center committee and the program's toy lending library. The administrator of child development services supervises all aspects of the program's child development services and develops and conducts training in the child development area. This individual also supervises the infant/mental health specialist, who works with staff members and works directly with children and families who have mental health concerns. The data manager maintains the program's management information system and supervises the data/records technician. The program director supervises the project secretary and the receptionist/clerical assistant, and she provides overall leadership to the staff and

works with community service providers to create and maintain community collaboration.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The C/MH EHS program serves families who live in neighborhoods covering 15 zip codes in northeast Denver, have incomes below the poverty level, and have a child under age 3.

Originally, the program accepted only first-time mothers. The administrators found that this requirement greatly limited the number of enrollees. In January 1997, the enrollment criteria were expanded to include families that have one child and are expecting another, as well as families that have two children, one of whom is under 10 months old.

Recruiting Strategies. Staff members have used multiple strategies to recruit families, including distributing flyers, encouraging word-of-mouth referrals, distributing materials through mass mailings from social service agencies, and seeking referrals from other service providers, including high schools. C/MH staff members recruited families primarily through seven local health clinics that offer prenatal and early childhood medical care. EHS staff members visited the clinics every two weeks to review the files and complete a C/MH EHS family recruitment form for those who might be eligible for EHS. Using these forms, a recruitment team contacted each family to inform its members about the EHS program and to determine whether the family met the income eligibility requirement and, if they were eligible, encouraged them to apply. Staff members reported that their new ability to serve Spanish-speaking families was an important factor in enrolling families quickly.

COMMUNITY PROFILE

C/MH EHS serves families living in northeast Denver, Colorado. Denver is a booming city that has grown substantially in the last 10 years. The housing and job markets are very tight, and the cost of living has increased. The vacancy rate in Denver is three percent, and there is a shortage of low-income housing.

In the past, northeast Denver was the center of the city's African American community. Now, more Hispanic families have moved to the area, and the need for services for the bilingual community has been growing.

Crime, drug use, and gang activity have increased in northeast Denver in the past 10 years. Staff members reported that more young mothers are participating in gangs. Violence and personal safety are a major concern among staff members and parents. Staff members believe that they may be in danger during home visits. Some of the EHS parents mentioned that their goal is to move out of the neighborhoods served by the program, because the environment is not conducive to raising children. Other parents prefer to stay in their current neighborhoods, because family and friends have lived there for generations, and the members of the community serve as important African American role models for young children. Staff members reported that to help combat crime, the city has developed a program in which police officers are encouraged to live in the communities they serve.

Local service providers and EHS staff members reported that many services are available in the community, but they are often insufficient to meet the need for them. In particular, the supply of affordable, high-quality child care is insufficient, and affordable housing is lacking. Families sometimes have trouble getting into programs or accessing particular services. Staff members may hear that a particular program has openings, but when the family applies it is told that the program is full.

Hispanic families have moved to the area, and the need for services for the bilingual community has been growing. Many service providers have responded by employing bilingual staff members; however, EHS staff members are often asked to accompany families when they visit other service providers. Staff members reported that Hispanic family members are especially unsure about how to access services and are reluctant to speak for themselves. Undocumented immigrants who participate in the program present additional challenges, because they are reluctant to seek any additional services.

Funders have encouraged service providers in Denver to coordinate services for low-income families. The network of community health clinics is very strong and provides high-quality health care for low-income families. Many other successful collaborations have been developed. One example is a residential program for single parents in a Department of Housing and Urban Development (HUD) building called Warren Village, which is funded by HUD, the United Way, local corporations and individual donors. Warren Village has been serving single-parent families for 23 years, providing housing, child care, parent education, and education and training. Families can live in Warren Village for a maximum of two years. A few EHS families live there.

Enrollment. The C/MH EHS program is funded to serve 100 families, 75 of whom are participating in the EHS evaluation research. (The families who are not participating in the research include families who had been in CCDP and families with children who are too old to meet the research eligibility requirements.) The program reached full enrollment in early October 1997. At the time of the site visit, 120 children in 107 families were enrolled, and the program was actively serving 104 children in 90 families.

The families served by the program are culturally diverse; about one-third are African American and two-fifths are Hispanic. Because the program previously had no bilingual staff members, the majority of families served in the past were African American. In June 1997, however, the program hired two Spanish-speaking family development specialists to serve Hispanic families.

Staff members reported that families bring a variety of strengths to the program, such as a desire to learn, father involvement in family life, motivation to make life better for their children, and decreasing reliance on welfare. Families also have a range of needs, including housing, transportation, help gaining confidence to speak on their own behalf, and help overcoming language barriers.

CHILD DEVELOPMENT CORNERSTONE

The C/MH EHS program works directly with children to ensure that they are getting what they need for healthy development. The program also works with parents and other caregivers to support children's growth

and to facilitate effective bonding. Staff members have developed

Staff members believe that they will improve child development by enhancing the relationships between parents and children, working with parents and caregivers to support their ability to meet each child's individual needs, and helping parents and caregivers develop strong affectional and emotional bonds with the children in their care.

age-appropriate curricula that they use with parents and children to help meet these goals.

The program provides child development services in three ways: home visits, a parent/child cooperative (co-op) group, and center-based child care. Family needs and preferences determine which kinds of services individual families receive. During the course of their participation in the program, EHS families might receive child development services in all three ways.

Home Visits. Using the *Partners in Parenting Education* (PIPE) and WestEd's *Program for Infant/Toddler Caregivers* curricula as starting points, the staff developed a comprehensive prenatal curriculum called *Celebrating the Birth of a Child*. All expectant mothers work with their family development specialist on this curriculum during weekly prenatal home visits. After the infants are born, mothers continue to receive home visits for approximately six months. At that time, they might choose to join the co-op group or use center care and receive less-frequent

home visits. Of the families who had been enrolled by the time of the site visit, more than one-third had enrolled after their child was born and did not receive the prenatal curriculum. In addition, most of those who enrolled during pregnancy had enrolled close to their due date, so their experience with the prenatal curriculum was limited.

After infants are about 6 months old, parents work with their family development specialist to determine whether they will continue to receive weekly home visits (87 children in 73 families), participate in a parent co-op group twice a week on the Clayton campus (5 children and their parents), or receive full-time child care at the child development center on the Clayton campus (12 children).

Families that receive services at the child development center (either through the parent co-op or full-time child care) receive monthly home visits from their family development and child development specialists. The two staff members work as a team with each family. Visits by the two staff members may occur together or separately, depending on the planned topics and the family's needs. Home visits with center and co-op families usually last from 60 to 90 minutes.

The family development specialists have caseloads of about 23 families, including a mix of families who receive program services in home visits, in the co-op, and in center-based care. Family development specialists must have a bachelor's degree or extensive home visiting experience. When the program began, the frequency of home visits among families who received services primarily in home visits ranged from once a month to once a week, depending on families' needs. At the time of the site visit, all new families were

receiving weekly home visits and staff members were encouraging other families to accept weekly visits. At the time of the site visit, about half of the families were receiving monthly home visits and half were receiving two visits per month. The family service coordinator monitors the quality of home visits by reviewing the service plans completed by the family development specialists.

At the time of the site visit, the program was working to focus more on child development during home visits. Family development specialists use a curriculum the staff developed from the *Partners in Parenting Education* (PIPE) curriculum and WestEd's *Program for Infant/Toddler Caregivers*. Parents and staff members work from binders that include background reading on a variety of parenting, child development, and health topics and suggested activities related to each topic.

Parent/Child Cooperative. The co-op group meets two days a week, for six hours each day, at the C/MH child development center. The activities and discussions during the morning session with the mothers and infants focus on parenting and child development. The morning sessions are facilitated by the child development specialists, a center teacher, and the infant/mental health specialist. During the afternoon session the family/staff education specialist works with the mothers on parent-focused issues such as education, training, and employment while their children nap. Staff members also discuss and reinforce the information learned during the morning activities.

Center-Based Child Development Services. Full-time child care at the center is available for children who have developmental delays or mild medical

challenges, children who require respite care because parents are experiencing medical or mental health issues, or children of parents who need extra support. At the time of the site visit, C/MH was providing full-time child care for 12 EHS children in its child development center. The center is able to serve a total of 20 children. (It was not fully enrolled at the time of the site visit because some staff positions were not filled.)

The maximum group size is six infants or eight toddlers. The child-adult ratio in the rooms for children receiving full-time child care is three to one for infants and four to one for toddlers. At the time of the site visit, the program took a team approach to providing care and did not assign each child to a primary caregiver.

All center staff members and the family development specialists have received training on the *High/Scope* approach, which is used along with PIPE in the center. Child development specialists serve as the lead teachers in each classroom. They must have a bachelor's degree and experience working with children. Center staff members must have or be working toward obtaining their child development associate (CDA) credential. The child development specialists are assisted by teachers, who must have experience working with children.

The center director monitors the quality of care in the center every month, using an observation tool designed by NAEYC. A representative from the Ready to Succeed partnership conducts quality assessments at the EHS center every quarter.

At the time of the site visit, the center was conducting a self-study for accreditation by the National Association for the Education of Young Children (NAEYC).

Other Child Care Services. Program administrators are determining how to meet the demand for high-quality, full-time child care. Not all of the families that need child care can be served by the EHS center. At the time of the site visit, 6 children were being served by centers in the community, and 14 were in family child care or other child care selected by the family.

Because high-quality care is not widely available in the community, the administrator of child development services plans to visit child care centers and family child care homes to determine whether they meet the EHS performance standards. C/MH plans to refer families only to centers and family child care providers that meet EHS standards. The program anticipates that finding high-quality care, especially high-quality center-based care, will be difficult.

Child Development Assessments. Family development specialists and child development specialists conduct formal screenings of children's progress toward developmental goals at enrollment and when the children are 4, 8, 12, 18, 24, and 36 months old. Before the children are 4 months old, staff members use the *Denver Developmental Screening Test*. For all subsequent screenings, they use the *Ages and Stages Questionnaires*.

Health Services. The program assists families that do not have a medical home in finding one. The EHS health/wellness specialist works with other EHS staff members to ensure that families are up-to-date in their medical appointments.

The health/wellness specialist attempts to visit pregnant mothers three times before their child is born and once after birth. This specialist gives the mothers a health diary to keep for themselves and for their child through the child's second birthday.

COMMUNITY CHILD CARE

As noted, the C/MH EHS program cannot provide child care for all program children in its child development center, and some families need to arrange child care with other providers in the community. At the time of the site visit, about ten percent of EHS families were using community child care, and more families needed care.

A significant strength of the community is its commitment to programs that serve young children. Colorado has had a state-funded preschool program since 1992. It serves approximately 1,500 at-risk 3- and 4-year-old children in Denver. The governor and the mayor have commissioned a variety of panels to study such topics as the availability of child care and the effects of welfare reform requirements on children. One community partner reported, however, that other groups have launched state-level efforts to reduce government support for programs designed to serve children under age 3. A new initiative, called Educare, brings together the business, education, and child care communities concerned with early child care and education. The C/MH executive officers are often included on advisory panels that oversee programs that serve children in Denver.

Despite the commitment to programs for young children, the EHS staff reported that there is a shortage of high-quality child care that low-income families can afford. Only two local child care centers serve low-income families (not including the EHS center). Staff members reported that one delivers excellent care, but the other does not. Both centers have long waiting lists. Many churches provide child care, but they do not always provide high-quality care.

During the past year, Denver's Head Start program has experienced major changes. The Clayton Foundation was named the interim grantee for the city until new grantees could be named. The City of Denver and Rocky Mountain Ser began administering the Head Start program in July 1997. Clayton will administer part of the city's portion of the program, thus continuing to provide services on the Clayton campus for children from birth to 5 years.

The C/MH EHS program is participating in a multi-agency child care collaboration, Ready to Succeed. Under this program, seven child care centers participate in toy lending, collaborate in offering parent education classes, offer child care training for center and family child care staff members, and support each other as they seek NAEYC accreditation. The group advocates and works for improvements in the quality of care available in the community.

The health/wellness specialist sends reminder letters to parents about well-child checkups and immunizations, which she monitors monthly. The program recently finalized a contract with Denver Health and

Hospitals to secure dental screenings for all EHS children. To increase its ability to deliver and monitor health services, the program plans to create a health coordinator position.

Mental health services are provided by the program's infant mental health specialist and the Mental Health Corporation of Denver. The infant/mental health specialist works with staff members, works directly with children and families that have mental health concerns, and facilitates a support group for parents. The EHS program has a formal agreement with the Mental Health Corporation of Denver to provide a range of services to EHS families, including short-term counseling.

Services for Children with Disabilities. Any concerns about developmental delays are discussed with parents, and those areas are targeted for emphasis in planning home visits and center and co-op activities. If staff members have a concern about how a child in the center or co-op is developing, the speech therapist conducts an observation and provides feedback to the child's teacher and home visitor. Staff members confer and decide whether a referral should be made to the Part C provider. For children served in home visits, the family development specialist discusses any concerns with the family service coordinator, and the two decide whether a referral should be made to the Part C provider. At the time of the site visit, nine percent of the children had a suspected or diagnosed disability, and three percent had been referred to the Part C provider.

Transitions. At the time of the site visit, staff members were reviewing the program's transition planning process and writing plans for the few children who were within six months of their third birthday. The existing procedures specified that six months before a child turns 3, the family development specialist will conduct a transition meeting with the family to identify goals for the next six months and to make plans for the focus child and other family

members. If the child is cared for in the child development center, the child development specialist will also participate in the transition meeting. Staff members will work with the family to apply for Head Start and accompany the parents when they meet their child's Head Start teachers. If the child is not ready to move to a Head Start classroom, staff will work with the family and help to make the transition as smooth as possible.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Staff members conduct needs assessments that highlight areas families may choose to work on. The family development specialists use the Head Start model of family needs assessment to work with families on developing their individualized family plan. During the first few home visits, the family development specialist works with the family to complete the family needs form, which identifies needs in 19 areas, ranging from child care to nutrition, mental health, and communication skills. The form is reviewed and updated every six months.

Case Management. As part of the case review process, every 6 months the family development specialists complete an individual family plan review form that documents the family's goals and action steps and a family goal attainment checklist that reviews each family's progress toward achieving its goals. After case reviews, which include all staff members who work with a particular family, the family development specialist presents the plan review to the family, and together they plan a strategy for achieving goals. Every month, families complete a services checklist,

C/MH EHS staff members believe that family development outcomes improve when they work with families to develop strengths, help families see the importance of maintaining physical and mental health, and help families move toward meeting education and training goals.

which documents the types of planned and emergency services they used.

To reduce the case management functions required by EHS and the other agencies, the program staff members would like to coordinate plans with the family service plans developed by other agencies for families receiving Temporary Assistance for Needy Families (TANF). The staff plans to work on this goal in the coming year.

During home visits, family development specialists work with families on setting and meeting education and employment goals. The family services team works with other C/MH staff members and EHS families to help them meet their goals. The family services team is responsible for conducting family orientation sessions; fostering parent-child relationships in programs presented during the afternoon parent co-op sessions, at educational group meetings, and in enrichment activities, such as field trips and special events; promoting improvements in the home environment and in family functioning by participating in family plan development and review, running the co-op mother's group, parent support groups, and education groups; and providing support to males involved in the program through individual activities and male support groups.

In addition, the family services team is responsible for maintaining a close link between C/MH EHS and other service providers in the community so that families and staff members are able to find the services that are available. The team provides transportation or tokens for public transportation to families with education, training, employment, and medical appointments.

Education and Employment Services.

The family services team helps staff members and families working toward meeting family economic self-sufficiency goals. The male involvement/education, training, and employment specialist assesses adult employment readiness and skills, facilitates an employment support group, and prepares workshops on education, training, and employment, as well as on special topics such as budgeting and tax return preparation. Job placement and vocational/career counseling services are also offered. C/MH has a formal agreement with Adult Learning Source (ALS) to provide General Educational Development (GED) classes to EHS parents as needed.

Nutrition Services. Families have been very involved in nutrition activities since the program received a nutrition grant in February 1997. A nutritionist works with program staff members and approximately 13 percent of the families.

The nutritionist has developed a nutrition assessment that is being tried with families. The nutritionist has also compiled nutrition education materials to be used as a followup to the nutrition assessments. The staff is considering whether to adopt a Spanish nutrition curriculum. The nutritionist has reviewed the menus at the child development center and made

suggestions about how to improve the selection of foods offered to children.

Share Our Strength, a program partner, has been conducting weekly cooking classes at the EHS offices on campus. The classes are very popular, with approximately 12 parents attending each session.

Emergency food boxes are also available if families need them.

Father Involvement. The male involvement/education, training, and employment specialist also works with fathers and other males involved in EHS children's lives to promote their participation in the program. This specialist offers education opportunities, including a 30-week pre- and postnatal curriculum for fathers; facilitates support groups; and provides individual support through phone calls and visits to the work site or home. At the time of the site visit, six males were participating in these activities. A small percentage of fathers are active in the center and co-op activities and in the weekly home visits with mothers and children. Staff members have tried to make the program more male friendly by hanging posters of fathers and children in the EHS offices and in the center.

Parent Involvement in the Program.

The family services team promotes parent involvement in a variety of educational and recreational events, including trips to museums and other sites in Denver, parent seminars on various self-sufficiency-related topics, and an annual family picnic. Staff members publicize activities through a newsletter, calendar, and phone calls. They monitor attendance and follow up with the families to encourage participation and to learn about the reasons families were unable to attend an event. Typically, 10 to 15

families are invited and participate in individual events.

C/MH uses a variety of strategies to involve parents in activities at the child development center. Through Ready to Succeed, the program employs an EHS parent as a parent outreach coordinator, who maintains the program's toy lending library and encourages parents to participate in program activities. Other parents may volunteer to staff the toy lending library.

The family services team conducts advocacy training for parents and will encourage parents to participate in the policy council and the parent center committee. Before the fall of 1997, the Clayton Foundation formed separate policy councils for EHS and Head Start. At the time of the site visit, Clayton had received permission to form a joint policy council for EHS and Head Start to cover services for children from birth to 5 years old. Parent membership on the joint policy council will be determined by election, with three parent delegates from EHS, three from Head Start, and three from the community. Ballots will go to all EHS families, and family members will be encouraged to choose one delegate from each of the three program delivery modes: home visiting, the center, and the co-op.

Parents of children enrolled in the center or using the co-op are invited to participate in the parent center committee, which participates in decisions made about the center. The center committee meets monthly. Approximately 12 parents attend. They eat dinner together, discuss issues and activities related to the center, and discuss a parenting or child development topic.

STAFF DEVELOPMENT CORNERSTONE

C/MH seeks EHS staff members who want to grow and develop in their positions and who feel comfortable supporting families and allowing families to make their own decisions. The staff is involved in program development at all levels. Staff members have participated in curriculum development, and their input is sought during the program planning process.

Training. At the time of the site visit, the new team of supervisors was in the process of assessing how much and what types of training staff members had received, and whether they should consider adopting a more individualized approach to training. The supervisors track the training needs of each staff member and are working to develop a new technical training plan.

Staff training needs are assessed by a staff survey of training interests. Supervisors also observe staff members as they work with families and children and assess whether staff performance meets program goals. At the time of the site visit, all EHS staff members were cross-trained and knowledgeable about all components of the C/MH program.

The center is closed one day a month so all staff members can participate in an in-service meeting. This can be difficult for parents, but the former program supervisors believed that common training for all staff members was a prerequisite for quality programming. In the past year, staff members completed training on the *Parent-Professional Partnership* and *High/Scope* approaches. In addition, the program's training and technical assistance partner, Child Development, Inc. (CDI), ran a training session on family support issues. At the time of the site visit, the program was

planning to focus upcoming training for the family development specialists on increasing their knowledge of child development and how to best deliver the child development curricula.

Supervision and Support. The center director conducts group supervision twice a month. At the time of the site visit, the new family development coordinator had not yet formalized a supervision plan for the family development specialists. The coordinator planned to meet individually with each family development specialist twice a month and hold a group discussion once a month.

Staff members are encouraged to attend professional meetings, and usually four staff members attend the regional Head Start conference. Staff members rotate attendance at other conferences so that all are able to attend at least one meeting over the course of a few years. Staff members can also compete for scholarships to study child development through the Ready to Succeed partnership.

Staff Turnover. In the year prior to the site visit, many staff members have left the program. From May through August 1997, three supervisors left, including the project director, the early childhood development coordinator, and the family services coordinator. Two out of five family development specialists, three of four child development specialists, and three of five classroom teachers also left.

At the time of the site visit, the supervisory positions and family development specialist positions were filled, but the program had been unable to fill the three child development specialist positions. The center director reported that the program had had difficulty finding good people willing to take the child development specialist position because a bachelor's

WELFARE REFORM

Colorado's new welfare policies limit the amount of time individuals can receive cash assistance to five years over their lifetime. After two years, TANF recipients must work. Counties have the option of exempting parents of very young children from the work requirement. Approximately one-fourth of EHS families were receiving cash assistance when they enrolled. Child care subsidies are available to parents with incomes below 130 percent of the poverty level (or up to 185 percent of the poverty level at county option).

Welfare reform has greatly increased the need for child care, and the program, community service providers, and families are adjusting to the new requirements. Child care reimbursement rates have been raised, which should improve the quality of care available to families who use child care subsidies. With welfare reform, staff members are finding it more difficult to schedule home visits and to keep families participating in the co-op group. In light of the new work requirements, program personnel are evaluating whether to drop the co-op portion of the program and to provide more child care slots in the center. Staff members are making more home visits in the evening and on weekends to provide more flexibility to families participating in work or education activities.

The program's community partners reported that many Denver service providers and businesses are providing support for families to help them meet the welfare requirements. For example, foundations have launched job preparation programs, and the regional transportation department provides free transportation for people leaving welfare for work or education activities.

degree is required and the program does not pay enough to attract good candidates. The need for additional teachers was being reassessed.

Staff members reported that during the vacancies and staff changes, morale was low. Staff members were pleased that the new supervisors, including the new program director, were in place, and they were optimistic that morale would improve. At the time of the site visit, the program had applied for quality improvement funds to hire two more bilingual home visitors, a training and staff development coordinator, and a bilingual parenting specialist.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. C/MH continues to develop its relationships with other community service providers. C/MH staff members collaborate with a number of community partners that they worked with when the program was a CCDP. The Adult Learning Source is located on the Clayton campus and provides GED classes for EHS parents. The Mental Health Corporation of Denver provides adult mental health services for EHS parents. EHS staff members serve as "warm welcome" volunteers for the Colorado *Bright Beginnings* project. (In this

program, every new mother receives a home visit and infants are given a gift.) The Colorado Lawyers' Committee continues to provide EHS families with free legal services.

Interagency Collaboration. C/MH staff members also participate in the community as members of local interagency coordinating and advisory groups, including the group that meets to advise the Part C provider, the Colorado resource group that meets around issues of family needs and joint training, and the board of a program that delivers home visiting services. The male involvement specialist serves on the governor's fatherhood task force. The family service coordinator would like each staff member to serve as the program's representative in at least one community group.

Community Building Among Parents. C/MH EHS fosters community among EHS parents by encouraging them to develop relationships with other parents in the co-op groups and to participate in the policy council, center committee, and informal activities, such as weekend educational and recreational trips. Approximately 20 EHS parents participated in the program's annual picnic.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The C/MH EHS program has received key support from its TASC, RAP, and Zero to Three consultants, as well as its federal project officer.

Continuous Program Improvement. At the time of the site visit, two faculty members from the Center for Human

Investment Policy at the Graduate School of Public Affairs, University of Colorado at Denver, were serving as C/MH's continuous program improvement (CPI) consultants. They worked closely with C/MH before the EHS grant application process began.

The CPI team has worked with the staff to develop forms that track key program activities for each family, which can be used in case management as well as for documentation; worked with staff members to explore their theories of change; encouraged the C/MH program to become a "learning institution" that uses information gleaned from experience to plan for the future; and recommended changes in the case review process. At the time of the site visit, the program director reported that the program was assessing its relationship with the CPI consultants and planned to reexamine program improvement plans.

Local Research. A team of researchers from the University of Colorado's Health Sciences Center and Denver University is serving as the C/MH EHS program's local research partner. In addition to conducting research, the local researchers collaborated with the CPI consultants to describe the program's community and to build relationships with community service providers. The University of Colorado researchers, whose backgrounds are in psychiatry, psychology, and human development, are experts on the socioemotional development of infants and toddlers, interventions targeting families in poverty, and risk research, and they have extensive experience conducting large-scale, longitudinal research projects.

The local researchers are focusing on understanding which parts of the program work best for whom, with an emphasis on understanding individual differences in each

child's development and caregiving context. They are examining program impacts on empathy, emotional regulation, and language; studying the influence of mother-staff relationships on maternal attitudes, caregiving behaviors, and other supportive relationships; assessing the extent to which these mediators are related to child outcomes; analyzing the relationship between service use and child outcomes; and examining the moderating effects of mothers' personal resources on the intervention. They are supplementing the national data collection with playroom observations of the families, process observations, and ethnographic observations and interviews.

PROGRAM SUMMARY

The C/MH Early Head Start program provides child and family development services to diverse low-income families, including Hispanic families with limited English proficiency. The program provides child and family development services to some families in its child development center, either in center-based child care or a parent/child cooperative, and to all families in home visits. At the time of the site visit, a new team of supervisors had recently joined the program. Staff members were beginning to place greater emphasis on child development in home visits, and they were planning to identify high-quality child care arrangements to which they could refer families who could not be served in the child development center.

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EARLY HEAD START PROGRAM PROFILE

School District 17 Early Head Start Sumter, South Carolina October 20-22, 1997

School District 17 in Sumter, South Carolina operates a new Early Head Start program for 75 families. The Sumter School District 17 Early Head Start program provides center-based and home-based child development services to pregnant and parenting primary and secondary school-age students and young high school graduates who are employed. Most of the parents in the program are African American, teenage parents. Parents are required to spend time daily with their children in the centers, where caregivers model good parenting practices, learn about parents' concerns, and respond to them. Parent educators conduct weekly home visits with families whose children are not enrolled in the centers and less frequent home visits with other families to work with them on parenting and child development, help them identify their needs and goals, and link them to services in the community. Child development services are focused on teaching parents to take responsibility for themselves and their children, teaching them how to access resources they need to be better parents, and providing high-quality child care that is child-centered, child-directed, and adult-supported.

OVERVIEW

School District 17 operates the Early Head Start (EHS) program in Sumter, South Carolina. District 17 also operates a Title 1 preschool program for 4-year-old children, and all schools in the district have extended care programs providing child care to school-age children after school. EHS is the first program for teenage parents and their children operated by District 17; however, it builds on the District's Act 135 Parenting Program. The EHS program provides services in three locations: (1) Sumter High School, (2) South Sumter Resource Center, and (3) the Instructional Center.

Community Context. The School District 17 EHS program serves all of Sumter County. Sumter is a diverse county

with a population that is approximately half white and half African American. About 40 percent of the population lives in rural parts of the county. Among the key problems facing the community are violence, school dropout, teenage pregnancy, and drug and alcohol abuse. Local service providers have formed collaborative groups to address these problems.

Program Model. Sumter School District 17 operates a mixed-model EHS program. The program provides center-based child development services to families in which parents are attending school, attending an adult education or training program, and/or working, as well as to other families in which the child is eligible for therapeutic child care or in which a parent will spend at least two hours per day with

the child in the center. It provides home-based child development services to families that do not want center-based child care, that are on the waiting list for center-based care, or that have discontinued adult education, training, or working. At the time of the site visit, approximately two-thirds of EHS families were receiving center-based child development services.

Families. Most of the families served by the Sumter EHS program are African American; a small proportion are white. Most of the parents are single, teenage mothers. Less than one-fifth are 20 or older and only about 5 percent are married. Approximately one-third of the mothers were pregnant when they enrolled in the program. Approximately one-third were receiving welfare cash assistance when they enrolled.

Staffing. Since the Sumter EHS program began, it has reorganized its staff structure to build more effectively on staff expertise. In each center, a lead teacher oversees the work of teacher/caregivers and caregiver aides. The education/child development coordinator supervises and provides training for the lead teachers, monitors care provided in the centers, serves as a liaison with the school district, and oversees transportation services to the centers. The health/nutrition/disability coordinator and a health educator work with families and community health care providers to ensure that families have a health home and receive needed health services. The social service/family involvement and mental health coordinator oversees recruitment and enrollment, and she supports the work of three parent educators, who provide home-based services. The program director supervises and supports the coordinators, and she plays a leading role in several community collaborative groups. At the time of the site visit, the program had recently received a

Head Start Quality Improvement grant and planned to add a parent educator and a lead parent educator to the staff.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The target population of the District 17 EHS program consists of pregnant or parenting students and former students who live in Sumter County and meet the EHS eligibility criteria. To be eligible, the pregnant or parenting students must be attending middle or high school at the time of enrollment. Mothers under 26 years of age who are in adult education or General Education Development (GED) classes at the time of enrollment are also eligible. Mothers who are 21 years old or younger and have graduated from high school are eligible for EHS if they are attending a higher education institution or working at the time of enrollment.

Recruitment Strategies. EHS staff members are using multiple strategies to recruit families. They have made presentations at the Department of Health and Environmental Control (DHEC) prenatal clinic and encouraged the clinic staff to make referrals to the EHS program. They have also arranged for announcements on the local cable television station, and they have sent flyers to local radio stations, which got good coverage. Staff members have visited the Department of Social Services (DSS) several times and provided application forms that can be given to interested families. In addition, they have made presentations at schools and have developed good relationships with guidance counselors and the staff in the attendance office who may know eligible students. Staff members have talked to groups, such as sororities and groups of ministers, whose members may know pregnant girls and whose minds are open to programs for

COMMUNITY PROFILE

Sumter is located in central South Carolina, about 45 miles east of the state capital (Columbia) and about 100 miles north of Charleston. Sumter County is a diverse county with a population that is mostly white (55 percent) and African American (43 percent). About 40 percent of the population lives in rural parts of the county. About one-fourth of families with children under 5 years old had incomes below the poverty level during the year prior to the 1990 census.

Sumter, which used to have an agricultural economy, has transitioned to a largely industrial economy. Manufacturing industries account for 31 percent of local employment, while wholesale/retail trade and services account for 21 percent and 16 percent, respectively. Shaw Air Force Base is located in Sumter and accounts for 20 percent of area employment. Sumter has a relatively stable economy, but the median family income is considerably lower than in South Carolina as a whole, and unemployment is higher.

Sumter was described by EHS staff members as "class-oriented and class-conscious." Neighborhoods tend to be segregated, but not completely, due as much to differences in socioeconomic status as to differences in race. All of the public schools, however, are integrated. Community representatives noted that a Unity program, implemented in collaboration with the National Association for the Advancement of Colored People, has brought a wide range of community groups together to work toward racial harmony.

A distressing number of students drop out and fail to graduate from high school. On average, about half of eighth graders entering high school fail to go on to graduate. Reflecting the school dropout problem, 12 percent of teenagers are not attending school. Pregnancy rates among 14- to 17-year-olds are high (5 percent).

Violence was reported by staff members to be a serious problem in Sumter. Family violence was described as "a way of life" and is rarely reported. Guns are easy to obtain. Drug-related violence tends to be limited to the housing projects and trailer parks, but many families with children, including some EHS families, live in these areas.

Alcohol use by teenagers was also cited by EHS staff members as a problem, and they described drugs as easy to obtain. In 1997, 45 percent of high school students reported drinking alcohol, and 27 percent reported using marijuana monthly.

Many services exist to meet the needs of disadvantaged families and children. A recent community needs assessment, however, identified unmet service needs in a number of areas, including emergency and affordable permanent housing, job training, case management, affordable child care, transportation, and substance abuse treatment. To some extent, services to meet these needs exist, but some families who need services are reluctant to seek them because of the time and commitment required, lack of information about available services, or mistrust of the system. Other needy families do not seek services because they believe that families should not get handouts and they fear stigmatization.

Local service providers have been collaborating for several years to address community issues and unmet service needs. They noted that collaboration has taken a long time, but it is growing as service providers gain a better understanding of what other agencies and staff members do and as positive collaborative experiences build on each other. All local service providers participate in the Interagency Council, and subgroups of providers have formed other collaborative groups to address particular issues or needs. For example, concerns about children's health have prompted collaboration to ensure that children have medical homes and receive needed health services. Collaborative groups have also been formed to address the need for affordable housing and to promote coordination of services to prevent teenage pregnancy and alcohol and drug abuse. Local service providers reported that "turf issues" and difficulty seeing the "big picture" of how agencies fit together have posed the greatest challenges to collaboration. They noted that personal relationships developed in face-to-face meetings and staff continuity over time have been important in promoting collaboration.

pregnant and parenting teens. The program hired three outreach workers--who were teenage mothers from the program--to work one day per week during the summer. These workers contacted girls they know who are pregnant and arranged appointments for staff members to visit the girls. Program staff members also asked participating mothers to provide the names of other eligible pregnant or parenting teenage mothers and offered a \$50 savings bond to the mother who provided the most referrals leading to applications. The program has received many referrals from staff members in the adult education program, the DHEC prenatal clinic staff, and the DSS staff, as well as many inquiries from potential applicants.

Enrollment. The District 17 EHS program is funded to serve 75 families. At the time of the site visit, 76 families, including 88 children, were enrolled. Sixty of these families are participating in the EHS evaluation research (16 families were enrolled before the research began). Since the program began enrolling families, 10 families have been removed from the program rolls because of lack of participation.

Most of the enrolled students are African American. More than 85 percent are teenagers. Most participate in the National School Lunch Program. Many have employed parents and families who provide social and financial support, but about one-third were receiving welfare cash assistance when they enrolled. Their greatest needs are support for continuing their education, including financial assistance, child care, transportation, and housing assistance. They also need help developing good communication skills, learning to be more assertive, improving their parenting skills, and developing self-sufficiency skills.

CHILD DEVELOPMENT CORNERSTONE

Overview. The District 17 EHS program provides child development services in child development centers, as well as parenting education by teachers in the centers and by parent educators during home visits. At the time of the site visit, 53 families were receiving center-based child development services, and 23 families were receiving home-based child development services. Families whose children receive care in the centers receive home visits by parent educators at least twice a year, and many receive visits monthly. Parents who drop out of school, discontinue adult education or training, or stop working receive child development services during home visits by parent educators, which are scheduled weekly. If these parents are willing to spend at least two hours daily with their child in the center, their child may continue to attend the center, and they receive home visits monthly. Children enrolled in the centers who are at risk of abuse or neglect receive higher-quality therapeutic child care and receive home visits twice a month.

The Sumter EHS program staff members believe that their program will improve child development outcomes by teaching parents to take responsibility for themselves and their children, teaching parents about their children's development, teaching them how to access resources they need to be better parents, and providing high-quality child care that is child-centered, child-directed, and adult-supported.

Center-Based Child Development

Services. The program provides regular and therapeutic child care in on-site child development centers at three locations: (1) Sumter High School, (2) South Sumter Resource Center, and (3) the Instructional Center, an alternative school in the Jackson Wing of the former Edmunds High School. The Sumter High School and South Sumter Resource Center child development centers operate for 10 months (during the school year). The center at the Instructional Center operates year-round.¹ One caregiver from each of the two 10-month centers will move over to work at the Instructional Center during the summer to provide continuity of care for children from their centers who need child care during the summer months while their parents are in summer school or working. The Sumter High School center operates from 8:00 a.m. to 4:00 p.m. The centers at the South Sumter Resource Center and the Instructional Center operate two 4-hour sessions, one in the morning and one in the afternoon. If parents of children enrolled in these centers need full-day care and meet eligibility requirements, they may receive extended care funded by the state's ABC Voucher program. Parents must pay \$3 to \$5 per week for child care funded by the ABC Voucher program. At the time of the site visit, 12 families were receiving subsidies for extended care.

Center staff members subscribe to the *High/Scope* philosophy that programs should be child-centered, child-directed, and adult-supported. The program uses the *High/Scope* infant/toddler curriculum, which provides a framework rather than a highly structured curriculum and incorporates other materials such as those from WestEd's *Program for Infant/Toddler Caregivers*.

The Sumter Head Start program uses the *High/Scope* curriculum, so the coordinator expects that using it in the EHS program will facilitate children's transitions into Head Start.

Therapeutic child care is funded by Medicaid for infants and toddlers who are at high risk of being abused or neglected. The program uses a checklist for assessing risk factors and determining whether children will receive therapeutic child care. At the time of the site visit, 23 children were receiving therapeutic child care, 11 at the South Sumter Resource Center, 6 at Sumter High School, and 6 at the Instructional Center.

Center staff members work with the families of children in therapeutic child care to develop an individual treatment plan, which is reviewed and revised quarterly. Primary caregivers in the centers develop individual daily lesson plans for children in therapeutic child care and record observations of children's progress daily. The lead teachers review the daily reports and prepare summary reports weekly. Primary caregivers for children in therapeutic child care must have special training. Center staff members talk weekly with Medical University of South Carolina (MUSC) staff members who offer guidance in providing therapeutic child care.

Each child is assigned to a primary caregiver, who cares for no more than four children if providing regular child care and no more than three children if providing therapeutic child care. Maximum group sizes range from 10 for infants to 14 for toddlers. Primary caregivers are assigned to children soon after they enroll, based on observations of their interactions with caregivers. In the case of infants, the staff tries to match temperaments and avoid assigning too many "lap babies" to one caregiver. When children move from the

¹Because the new welfare requirements are increasing the need for child care, the program anticipates that it will need to keep at least two of the centers open during the summer of 1998.

infant room to the toddler room, they are assigned to a new primary caregiver. Primary caregivers facilitate the transition between rooms by spending time with the child in his or her new room for several weeks before the room change is made.

The Sumter EHS program participates in the Child and Adult Care Food Program, which provides snacks for children in the child development centers. Lunches are provided by the school district with funding through the National School Lunch Program. Nearly all of the children qualify for free lunches.

At all three child development centers, parents are expected to bring their children to the center themselves and to spend half an hour per day before or after school in the center with their children. Parents are welcome anytime, and some spend more time with their children in the center. During this time, center staff members build relationships with the parents and model good parenting practices. The program uses the *Partners in Learning* curriculum, which allows parents to choose activities to engage in with their children. Parents are also expected to attend a one-hour parenting session facilitated by a parent educator at the center each week.

Parents are also encouraged to keep a journal and to write in it at least twice a week. Parents write about their children and what is happening in their lives. Center staff members read the journals and enter responses.

Home Visits. Every family is assigned a parent educator who visits the family at home and provides both child and family development services. Parent educators

attempt to visit families whose children receive regular child care monthly and to visit families whose children receive therapeutic child care twice a month. They plan weekly 90-minute home visits with families whose children are not enrolled at one of the EHS centers. The parent educators use *Parents as Teachers (PAT)* and *Early Learning Accomplishment Profile (ELAP)* resource materials to plan child development activities during home visits. Using the PAT curriculum and other resource materials, the parent educators help parents understand what can be expected for their child at each stage of development and work with parents and children on appropriate learning activities.

Group Child Development Activities.

Families receiving home-based child development services are encouraged to attend parent support group meetings at the child development centers. During the summer, group meetings are held weekly with families receiving home-based services, and during the school year, these meetings are held monthly.

Other Child Care Services. The District 17 EHS program provides center-based child care to about two-thirds of enrolled families. As EHS families' needs for child care increase, program staff members anticipate that they will need to make referrals to other child care centers in the community. At the time of the site visit, they were planning to monitor the quality of care provided to EHS children by the other centers and to work with the centers to provide child development services to EHS children. At the time of the site visit, program staff members were also considering developing a collaborative agreement with a family child care provider, who would be trained by the EHS program to care for EHS children.

COMMUNITY CHILD CARE

The district 17 EHS program provides center-based child care to families that need child care. Some EHS families need child care during nonstandard hours and must rely on relatives or friends for child care.

EHS staff members reported that there are very few other child care centers in Sumter, and in general, the quality of care they offer is minimal. Centers were described as having a preschool focus and lacking a knowledge base about infants and toddlers. Family child care exists, but it is very expensive. As a result, many families rely on informal care by relatives, neighbors, or friends.

Child Development Assessments.

Center staff members use the ELAP to assess children's progress and plan daily activities. Staff members discuss the ELAP results with parents and give them an opportunity to develop their own goals for their children. Using the ELAP, center staff members develop an individualized daily plan for each child. Staff members record observations of children's progress in these activities weekly. The staff expects to assess children's progress using the ELAP twice a year.

Health Services. Parent educators, the program's health educator, and the health/disabilities/nutrition coordinator help families make health care appointments and follow up to make sure that children get the health services and immunizations they need. Program staff members also make sure that EHS children receive the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) developmental screenings (which include the *Denver Developmental Screening Test II*) to which they are entitled. Parent educators watch out for health problems and ask the health educator or the health/disabilities/nutrition coordinator to follow up on any problems they detect. The health educator and the

health/disabilities/ nutrition coordinator also observe children in the child development centers to detect signs of health problems. Parent educators sometimes accompany parents on initial health care visits to increase their skills and self-esteem in dealing with health care providers.

Other Child Development Services.

At the time of the site visit, MUSC was planning to offer intensive home-based treatment to EHS families of children at high risk of abuse and neglect. The treatment includes 8 to 12 weeks of therapy with a therapist who is available 24 hours a day.

Services for Children with Disabilities. BabyNet is the local Part C program operated by DHEC. In South Carolina, families with a child under age 3 who has a diagnosed disability are eligible to receive Part C services. BabyNet develops an individual family service plan for families of children with disabilities who are receiving Part C services, and all service providers, including the Sumter EHS program, follow that plan. At the time of the site visit, one child had been referred to the EHS program by BabyNet, and two other children were reported to have disabilities. The health/disabilities/nutrition coordinator

attends BabyNet staff meetings and follows up to try to recruit families that are eligible for EHS.

Transitions. The Sumter EHS program starts preparing children for the transition into Head Start in February of the year they will graduate from EHS. Parent educators help families with the required paperwork, ensure that information about disabilities is conveyed to the Head Start program (which is not operated by the school district), and facilitate a meeting with the Head Start staff. Program staff members also take the graduating children on a field trip to the Head Start program. The program has arranged with Head Start to consider applications from EHS children early in the Head Start enrollment period to ensure that there are enough spaces for all EHS children. During the year prior to the site visit, 10 children made the transition to Head Start.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessments and Service Planning. Parent educators attempt to develop an individual family service plan (IFSP), using the Head Start Family Needs Assessment, with all families within 30 days after they enroll. At the time of the site visit, parent educators had completed IFSPs with about half of enrolled families and had begun developing them with an additional 40 percent of families. Parent educators update the plans continuously, as families achieve their goals and move on to new ones. They build on the individual treatment plan developed by the center staff with families whose children receive therapeutic child care. At the time of the site visit, the Sumter EHS program was planning to use the new Head Start Family Information

System Family Partnership Agreement forms.

Home Visits. Parent educators provide family development services during their home visits with families to evaluate their physical and social environments and assess the quality of their interactions, teach parenting skills, enhance the informal support available to the young parents, and link parents with and promote appropriate use of community services. Parent educators also talk with parents often by telephone, at the child development centers, in their office, and when accompanying them to appointments.

Family development services, which are provided during regular home visits, are based on the belief that long-term gains in the parent-child relationship and child competence cannot be expected when the intervention is primarily in the child care environment, removed from the family environment. The staff also believes that teenage parents should be held responsible, with assistance, for caring for their children.

At the time of the site visit, the three parent educators were responsible for conducting home visits with all enrolled families. They had caseloads ranging from 17 families (the parent educator who is assigned to families with children in therapeutic child care) to 29 families. Families receiving home-based services were evenly split between the two parent educators whose caseloads do not include families with children in therapeutic child care, so that they each have 10 to 12 families with whom they need to schedule weekly

home visits. At the time of the site visit, the program had recently received a Head Start Quality Improvement grant which provided funding for additional parent educators. Staff members were interviewing candidates for two additional parent educators (a lead parent educator and a regular parent educator) and expected to reduce the caseloads of the current parent educators.

Parent educators are required to have a high school diploma, two years of experience working in child care and working with families, and plans to obtain further training and PAT certification. A bachelor's degree is highly desired, and two of the current parent educators have bachelor's degrees. The social services/family development and mental health coordinator, who supervises the parent educators, seeks candidates who are enthusiastic about working with children, are aware of their own strengths and weaknesses, have good verbal and writing skills, can work independently and follow through on tasks, can work well in teams, and are not afraid to conduct home visits.

Education Services. The Sumter EHS program provides mathematics tutoring once a week for EHS parents who are Sumter High School students, and tutoring is also provided weekly at the South Sumter Resource Center. Program staff members would like to provide tutoring more frequently.

Parents are invited to participate in the in-service training sessions and the child development associate (CDA) classes for the staff. Starting in spring 1998, parents also have the opportunity to complete child development classes at the high school and receive credits for them, which may lead to an early childhood development certificate from Central Carolina Technical College, which is located in Sumter.

Health Services. The District 17 EHS program ensures that all pregnant teenage mothers receive prenatal care by collaborating with local health care providers, primarily the health department clinic that serves Medicaid clients. Staff members refer pregnant mothers to Tuomey Hospital for free prenatal classes and car safety classes.

Other Services. The program provides transportation to enable parents to access needed services. Transportation is offered on a need-only basis, unless parents are attending Sumter High School. Buses pick up children and parents and bring them to the child development centers. At the time of the site visit, 44 families were receiving transportation to the centers. Parent educators assist parents in obtaining transportation aid available from Medicaid or the Family Independence program (South Carolina's new welfare program), and they often provide transportation themselves when parents are stranded or have occasional transportation needs.

The EHS program offers incentives to parents for participating in activities and meeting expectations. Parents receive a "big buck," which has spaces for "little bucks." They receive a "little buck" each time they attend a meeting, take their children to get immunizations, are on time to appointments, or attend a workshop. When they fill up their "big buck" with "little bucks" they can turn it in for items such as diapers.

The EHS program provides opportunities for parents who need financial assistance to perform minimal services in exchange for assistance. Parents who need money for textbooks or registration fees to enroll in GED or adult education classes or need money for special items for their infant help the office staff with filing or assist in the centers in exchange for assistance.

Father Involvement. The District 17 EHS program encourages the fathers of participating children to take part in the program and become involved in their children's lives. In August 1997, six fathers were actively participating in program activities. At the beginning of the 1997-1998 school year, the Sumter EHS program entered into a new agreement with the Salvation Army Boys and Girls Club, which will recruit fathers identified by the EHS program for recreational activities, parenting classes, and job training that it offers. The program has also entered into an agreement with the local Head Start program to include five EHS fathers in its new fathers program.

Parent Involvement in the Program. Parents of children in each center are invited to participate on the center's parent committee, which elects two parents and two alternates to serve on the EHS Policy Council. Parents receiving home-based services also have a representative on the Policy Council. The EHS Policy Council meets monthly. Parents also serve on various committees, including the executive, grievance, internal dispute, personnel, and finances committees. Parents volunteer in the EHS centers, where they read to children and help center caregivers, and at the EHS administrative offices, where they help with copying, typing, preparing application packages, and other tasks.

The Sumter EHS program sponsors many training sessions, workshops, and other events for parents throughout the year. At the beginning of each year, the program holds an orientation session for parents, in which staff members explain the program and its rules and regulations. At that time, parents receiving center-based care select a class time and center, and they receive a yearly calendar that provides detailed information about the program and its components, a community resource list, and

dates for program activities. In addition, parents have been offered tickets to the "Little Theater," have been invited to participate in the Family Fun and Health Fair, have been encouraged to attend cardiopulmonary resuscitation (CPR) and first aid training, and have been invited to attend the Parent Disabilities Conference. The program also hosts a Holiday Fest and an end-of-the-year banquet annually.

STAFF DEVELOPMENT CORNERSTONE

Training. The Sumter EHS program develops an annual staff training plan based on staff members' responsibilities and observations of their performance of assigned tasks, staff members' input regarding training they need, and advice from technical assistance providers. Parent educators have received training in a variety of areas, including various aspects of child development, therapeutic child care, PAT curriculum, multiculturalism, conflict resolution, child abuse and neglect, communication and interviewing skills, and conducting home visits. Center caregivers have received training on therapeutic child care, the High/Scope curriculum, disabilities and early intervention, curriculum and child growth and development, management skills, CPR, conducting ELAP assessments, and family-staff communication. Health educators have received nutrition and PAT training.

The EHS program also encourages staff members to seek other staff development opportunities by reimbursing them for tuition, up to \$325. Central Carolina Technical College offers training to obtain the Advocates for Better Child Care (ABC) child care credential for center-based caregivers and to obtain the CDA. The EHS program will provide a CDA advisor at no

charge. The EHS program encourages child care center aides to get their CDA credential. The program also encourages parent educators to get PAT certification, and two parent educators are pursuing a CDA home visitor certificate.

Some funds are available for memberships in professional organizations, subscriptions to professional publications, and professional license fees. Staff members may arrange for time off to attend professional meetings.

Staff Supervision and Support. The EHS program director and coordinators hold regular weekly meetings to provide supervision and support to staff members. The program director meets weekly with the three coordinators to assess progress in meeting weekly goals. The coordinators meet weekly with the staff members they supervise. In addition to the scheduled meetings, coordinators are available as needed for consultation on specific cases or situations.

The education/child development coordinator meets weekly with lead teachers to discuss the therapeutic and regular child care they provide (addressing daily plans, whether strategies are working or not, and paperwork) and to provide training. Lead teachers in each center meet with primary caregivers for half an hour per week. Staff members involved in providing therapeutic child care also participate in a weekly consultation with staff from MUSC.

The social service/family involvement/mental health coordinator meets with parent educators for two hours weekly. MUSC staff members participate during part of each weekly meeting. In addition, the social service/family involvement/mental health coordinator accompanies each parent educator on at least

one home visit per month, either at the parent educator's request or when a family is facing a crisis. The coordinator and parent educators also meet for group staff meetings when parent educators need advice and guidance on how to serve a particular family.

The program director and coordinators also participate in weekly meetings that support their work. The program director meets weekly with a District 17 administrator who makes recommendations and seeks approval from the Board of Trustees for program changes when necessary. The director and coordinators meet weekly with MUSC staff members to discuss program improvement.

Formal performance assessments are conducted with staff members once a year. In addition, the coordinators discuss job performance with staff members throughout the year in individual conferences. Salaries are based on the District 17 salary scale. Staff members receive fringe benefits that are much more generous than those offered by local child care providers.

The Sumter EHS program sponsors activities to encourage good staff morale. The staff has an advocacy committee and a hospitality committee, which often work together and plan monthly staff activities. The program has an incentive plan by which all staff members who miss less than one or two days during the month get part of the "pot" (proceeds from selling doughnuts and from other fund-raisers). The program hosts parties for the staff during the winter and at the close of school. The program director has placed a suggestion box at each center to give staff members opportunities to contribute ideas and activities that would benefit the program.

WELFARE REFORM

Implementation of welfare reform changes began in October 1996 in Sumter County (in most other South Carolina counties, changes in welfare policy under a federal waiver began prior to 1996), and at the time of the site visit, a representative of the Department of Social Services indicated that officials were just beginning to get a feel for what they were doing. In South Carolina, welfare recipients are now limited to 5 years of cash assistance over their lifetime, and cash assistance is limited to no more than 24 months out of 120 consecutive months. Recipients must engage in work as soon as they are judged able to do so; however, parents of infants under 1 year old are exempt from the work requirement. Families may receive up to 24 months of transitional Medicaid and child care benefits. Approximately one-third of EHS families were receiving cash assistance when they enrolled in the program. EHS staff members expected that the new work requirement and limits on cash assistance would increase the need for child care and for extended child care hours.

At the time of the site visit, welfare reform changes had not yet had major impacts on EHS families. Program staff members reported that many families did not yet understand the ramifications of the new rules and saw them as just another threat. The Sumter EHS program, however, had begun planning changes to respond to the changing needs of families. Although the staff had planned to keep only one of the child development centers open during the summer, the staff anticipated that it would be necessary to keep two and possibly all three of them open to accommodate the needs of parents who must work. The staff was working with the ABC Voucher program to arrange subsidies for care during the summer. Staff members also noted that many of the young mothers receiving Temporary Assistance for Needy Families (TANF) cash assistance were getting jobs during nonstandard hours, and staff members were beginning to look for funds to enable them to keep the EHS centers open 24 hours a day. Because more young parents were getting jobs, the need for child care had increased, and the program had begun working with the ABC Voucher program to take more applications and make arrangements to refer parents to other centers in the community. Ensuring high-quality child care in these arrangements, however, will present a challenge for program staff.

Because the new welfare rules emphasize employment and discourage young parents from finishing school, the program director reported that the EHS program's eligibility rules may need to be changed to include not only young parents who are in school or training but also young parents who are employed. Sumter EHS staff members also anticipated that they would need to offer more parent training to build self-sufficiency skills, such as money management. Finally, the program had entered into a work support agreement that allows TANF recipients to assist in the EHS centers.

Staff Turnover. At the time of the site visit, staff turnover had been low. Since the program began, three center caregivers had left the program and been replaced (two left

shortly after the program began). One parent educator left the program in the summer of 1997.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. The District 17 EHS program has written agreements to collaborate with nine agencies. EHS staff members also collaborate informally with many local agencies and programs. Four of the written agreements include the provision of services to EHS staff members or families. The agreement with the Wateree Head Start program includes cross-training of staff and cross-referrals of families and invites participation by an EHS parent on the Head Start Education Advisory Committee. In addition, the education/child development coordinator serves on Head Start's Transition Committee, offers workshops for Head Start parents transitioning to public school, and coordinates with other Head Start education coordinators and public school coordinators in implementing the *High/Scope* curriculum. As noted earlier, the Head Start program has also agreed to include five EHS fathers in its new fathers program.

The collaborative agreement with Central Carolina Technical College will provide an opportunity for EHS parents who are students at Sumter High School to take child development classes taught by a Central Carolina Technical College staff person at Sumter High School starting in spring 1998. As noted earlier, they will receive college credit toward a certificate in early childhood development. The agreement also includes opportunities for Central Carolina Technical College to use the EHS classrooms for laboratory experiences for its students and to provide staff members with ABC-approved credits for the 15 hours of annual training required.

The agreement with the Clemson University Extension Service includes prenatal and parenting classes for teenage parents, as well as other staff and parent

training. The Extension Service works with EHS families on budgeting, home management, and other topics that parents select. At the beginning of the 1997-1998 school year, the Sumter EHS program entered into a new agreement with the Salvation Army Boys and Girls Club, which will recruit fathers identified by the EHS program for recreational activities, parenting classes, and job training that it offers.

Interagency Collaboration. The EHS program is a member of the Teenage Pregnancy Prevention Collaboration Council, which has met monthly since 1989 to plan for unmet needs and to refine interagency agreements. It is coordinated by the Clemson Extension Service. Participation in this group facilitates referrals among agencies.

EHS staff members also participate in the meetings of many other community agencies, including the Interagency Council (a collaborative group of all Sumter agencies formed five or six years ago), Wateree Children's Council (BabyNet local interagency coordinating group), and Project Ideas, and they serve on several agency advisory boards. EHS staff members play a leading role in the Interagency Council, which meets monthly to discuss upcoming funding opportunities, strategies, activities, and resources. The program director belongs to various community and state councils on child care and parenting. The director serves on the Advisory Board of the Salvation Army Boys and Girls Club and is active in the South Carolina Head Start Directors Association. The social services/parent involvement and mental health coordinator serves on the Community Disabilities Board and the YWCA board. The health/nutrition/disability coordinator is an active member of the March of Dimes, BabyNet, and Tuomey Regional Hospital Family Center advisory groups.

Community-Building Among Parents. The District 17 EHS program promotes community building among parents by encouraging participation in each center's parent committee. The program was also planning to identify opportunities for parents to become involved in the community through volunteer activities and employment opportunities. The EHS program will sponsor four social functions for families per year.

Community Support for EHS. The EHS program encountered some initial opposition in the Sumter community, but support for the program has grown as community members have become more familiar with the program. Some community groups were opposed to the EHS program (for example, the Chamber of Commerce and some white church groups) because they prefer sending a pregnancy prevention message rather than supporting intervention for teenage parents. Local ministers raised questions about whether the EHS program would promote marriage among the teenage mothers. Other opposition arose from concerns that local tax dollars were paying for the program, and that the program would promote teenage pregnancies.

In response to the opposition, the EHS program prepared a flyer addressing seven myths about the program. It also held community meetings and invited community members to visit the program to learn about what it is doing. Program staff members and school district officials believe that these efforts have increased public acceptance of the program. EHS has received many requests to expand to other neighborhoods.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The EHS program received technical assistance in setting up its centers from Wateree Head Start, the state Head Start Collaboration office, the Department of Education, and Shaw Air Force Base Child Development Center. Wateree Head Start social services has invited staff and parents to attend its training workshops.

The EHS program has asked representatives from the Technical Assistance Support Center (TASC) and the Resource Access Project (RAP) to assess the program and its technical assistance needs. These representatives, however, have asked the program to make specific requests for technical assistance. At the time of the site visit, EHS staff members were planning to work with their TASC representative on interactions with toddlers. Program staff members have attended regional workshops on fiscal management, new program orientation, and disabilities.

The program also receives support in providing therapeutic child care through weekly telephone consultations with Medical University of South Carolina staff. In addition, the program has received support from its federal project officer and Zero to Three consultant.

Continuous Program Improvement. A team of researchers from the Medical University of South Carolina's Family Services Research Center is the Sumter EHS program's partner for continuous program improvement and for local research as part of the national EHS evaluation. The MUSC team, which is led by a psychiatrist with expertise in services for substance-abusing

and mentally-ill families, first met with the EHS staff after receiving the EHS grant.

To help the District 17 EHS program with continuous program improvement, MUSC staff members plan to (1) conduct a survey of the program staff every six months and provide feedback to the program; (2) assess whether the program is meeting standards for therapeutic child care and intensive home-based services for families at risk, using an existing protocol and providing weekly feedback; (3) document the in-home parenting services and provide feedback; (4) conduct interviews with key community leaders and agency heads; (5) conduct focus groups with a subset of participants; and (6) assess how well EHS is integrated into the school district and provide feedback to the program and, eventually, to the school district. At the time of the site visit, the local research team had recently worked with the staff to implement a time sampling procedure to assess how staff members' time is spent. The local research team leader meets with program staff weekly by telephone or in person to share information and discuss families.

Local Research. The local research will extend the national evaluation to examine the differential effects of intensive EHS services in a target population of teenage mothers affected by substance abuse or mental illness. Specifically, the local researchers will explore whether teenage mothers with substance abuse or mental illness who receive intensive home-based treatment or therapeutic child care have decreased substance use, improved mental health, and better school and family outcomes than their counterparts in the comparison group. The local research will also explore patterns of parent and child outcomes over time in families receiving

regular EHS services, EHS therapeutic child care, and EHS intensive home-based treatment. The local research team is conducting assessments of parent and child outcomes at enrollment and 6, 12, 18, 24, and 36 months after enrollment, and staff members are collecting information on services biweekly. The local research team is also collecting qualitative information to document service planning and referral processes, parents' experiences in the program, and the process of program intervention.

PROGRAM SUMMARY

The Sumter EHS program serves primarily teenage parents and offers much-needed child care services to enable them to continue their education or pursue a job. The program provides state-funded therapeutic child care, with lower staff-child ratios, to eligible at-risk children. For parents who are not in school and do not have a job, the EHS program provides child development services in weekly home visits. At the time of the site visit, the program had recently received Head Start Quality Improvement funds and planned to add new staff members to strengthen its home visiting services. At the time of the site visit, the program was also taking steps to adapt its services to the changing needs of families affected by welfare reform.

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EARLY HEAD START PROGRAM PROFILE

Early Education Services Early Head Start Brattleboro, Vermont September 16-18, 1997

The Brattleboro, Vermont, school district's Early Education Services office operates an Early Head Start program for 75 families in rural Windham County, Vermont. The Early Head Start program builds on the school district's experience operating a variety of programs for low-income parents with young children. The program serves primarily white families, half of whom include two parents. The program provides child and family development services primarily in home visits, but also provides center-based child development services for a small number of families and brokers child care for 17 children in family child care homes and center-based settings in the community. The program also organizes play groups and monthly parent-child group activities. Teams of staff members work with families to build on their strengths and achieve their personal and family goals, and they link families with needed services in the community. Child development services are designed to promote strong parent-child relationships and positive interactions.

OVERVIEW

The Brattleboro, Vermont, school district's Early Education Services (EES) office operates the Early Head Start (EHS) program. EES previously operated a Comprehensive Child Development Program (CCDP) and an Even Start Literacy Program, and it receives funding from numerous private, local, state, and federal sources for a variety of services. The agency serves 140 families through the various funding sources. These funding sources include Brattleboro Township, the Vermont Department of Health, the Vermont Department of Social and Rehabilitation Services, Reach Up (the state's welfare program), the U.S. Department of Education, and others. EES also operates the Healthy Babies program and a Vermont Parent Child Center. The agency's CCDP program demonstrated positive effects on

children's cognitive development, families' employment and income, and parenting attitudes.

Community Context. The EES EHS program serves families who live throughout Windham County, a primarily rural area in the southeastern corner of Vermont. Brattleboro, the county's largest town, has a population of approximately 12,000 people. The majority of county residents live in outlying areas of the county.

Community involvement among residents of the county is high. Many people are involved in human services organizations, churches, the arts, and environmental groups; a high proportion of Brattleboro residents participate in town meetings. Community service providers collaborate closely to serve families and share resources.

Program Model. The EES EHS program is a mixed model--it is a home-based program that also provides center-based child development services for a small number of families. Parent/child educators provide child development, parent education, and case management services to EHS families during weekly home visits. Program staff members also encourage families to participate in a broad range of educational programs, workshops, play groups, and social events offered by the program. In addition, the program operates two child care centers, one at the EES center, and one at Brattleboro Union High School.

Families. Most of the families served by the EES EHS program are white, but a few belong to other racial and ethnic groups. Approximately half of the enrolled families are two-parent families. About 13 percent of mothers were pregnant when they enrolled in the program. One-third of the families were receiving welfare cash assistance when they enrolled.

Staffing. Ten parent/child educators receive support from a multidisciplinary management team of specialists. Three management team members--the home-based program coordinator, the nurse/health educator, and the early childhood educator--supervise the parent/child educators, coordinate parent education workshops and other group events for families, conduct staff training, and coordinate services with community partners. Other members of the management team include a parent/community coordinator, who manages parent involvement and policy council activities and works on building community partnerships; an adult services coordinator, who oversees family development services and supervises two employment and training specialists, a literacy tutor, and a men's program coordinator; and a child care coordinator,

who works with families to arrange good-quality child care arrangements and supervises the program's two child care centers. The program also employs a data manager and a data entry clerk to maintain the program's management information system. The program director provides overall leadership to the management team, works to enhance collaboration and coordination among community service providers, and plays a leadership role in raising community awareness about the needs of families with young children.

RECRUITMENT AND ENROLLMENT

Program Eligibility. To be eligible for the EES EHS program, families must have incomes at or below the poverty level, have a child younger than 1 year, and live in Windham County.

Recruiting Strategies. The EES EHS program recruits families through referrals from other agencies and programs, advisory board members, high school counselors, area psychologists who work with families, and other community members. Information about the program also spreads by word of mouth. For example, enrolled families recommend the program to their neighbors and relatives. Other families learn about the program through participation in community play groups organized by EES. The health department refers families to EES EHS when they sign up for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services. EES EHS also recruits families who are participating in the Healthy Babies program and families referred by Reach Up, Vermont's welfare reform program.

Enrollment. The EES EHS program has the capacity to serve 75 families, and staff members expected at least 65 families to participate in the EHS evaluation

COMMUNITY PROFILE

Windham County is a primarily rural area located in the southeastern corner of Vermont. Brattleboro, the county's largest town, has a population of approximately 12,000 people. An additional 28,000 people live in outlying areas of the county.

A significant strength of the community is the level of community involvement. Many residents participate in town meetings, the United Way, churches, and town fairs. Others are involved in human services organizations, the arts, and environmental projects. The economy in Windham County is relatively strong, the unemployment rate is low, and jobs are available in the service and tourist industries. EHS families typically work in service industry jobs.

Although the county is characterized by a strong community spirit, families living in outlying areas face social isolation, especially during the winter months. As a rural community, Windham County lacks some services that low-income families need, including transportation services and an adequate supply of affordable housing. The county also lacks sufficient numbers of child care slots for infants and mental health services for families and young children.

The level of collaboration among service providers is high, and agencies work closely around the needs of individual families. Health services are readily available in the area, and most primary care is provided by private physicians. Most physicians accept patients covered by the state's health insurance program for poor children and pregnant women. Service and resource gaps exist, however, in several areas, including housing subsidies and affordable housing; supervised housing for teen parents; transportation, especially for families living in outlying areas; quality child care for infants; adult education and training; affordable mental health services for young children and families; and vocational rehabilitation, adult assessment, and supported employment.

research. At the time of the site visit, the program was fully enrolled. Several factors prevent all families from participating in the research. EES transitioned a number of CCDP families (who are not eligible for the research sample) into EHS. Because EES did not shut down enrollment during the transition from CCDP to EHS, other families were enrolled before random assignment began. Finally, EES has a contract with Reach UP, Vermont's welfare reform program, which requires the agency to provide services to all teenage parents.

Because teenage parents enrolled in EHS cannot be assigned to the comparison group, they cannot participate in the research.

Enrolled families bring a number of strengths to the program. More than half are two-parent families with fathers who are involved with their children. Many families have strong ties to the community, and most stick with the program. Parents are motivated to learn more about their children's development and to improve their economic situations through education and

employment. At the same time, EHS families face significant challenges. Almost all families have incomes below the poverty level, and many lack the education necessary to obtain jobs that provide adequate income to support their families. Families who live in rural areas face social isolation, especially during the winter months. Some families have mental health needs.

CHILD DEVELOPMENT CORNERSTONE

The EES EHS program provides child development services to all families during home visits and to some families in its child care centers or other contracted child care arrangements. The program also encourages families to participate in a variety of group activities, such as play groups, family outings, parent support group meetings, and parent education seminars.

Home Visits. The program assigns one parent/child educator to each family. This person meets with families weekly for 60 to 90 minutes to work on child and family development. At the time of the site visit, parent/child educators were able to complete about 80 percent of scheduled home visits. Cancellations by families and transportation problems prevented parent/child educators from completing some home visits.

Because the parent/child educators are trained as generalists (the minimum requirement for the job is a two-year associate's degree), they consult with a multidisciplinary team of specialists about more complex or difficult issues, such as issues of substance abuse or domestic violence. However, parent/child educators are the families' main contact with the program, and they continue to coordinate EHS activities with the parents.

The program strives to provide regular, age-appropriate child development activities to all children that are consistent with child development goals set by parents and with needs identified through regular screenings and assessments in which parents participate. Activities are designed to promote strong parent-child relationships and positive interactions.

The early childhood coordinator and the parent/child educators draw on a variety of resources to plan child development and parent education activities for each home visit. Examples of curricula and other resources they draw from include the *HELP . . . at Home* (Hawaii Early Learning Profile) curriculum, T. Berry Brazelton's *Touchpoints*, *The Emotional Life of the Toddler*, and the *Parents as Teachers* curriculum. EES has also developed a set of best practice standards for the child development and parent education services provided during home visits.

Typically, time during a home visit is split equally between parent education, facilitation of parent-child activities, and family development issues. The parent/child educator talks with the parent about the child's developmental stage or other issues related to the child's development and provides written information, videos, activities, and other materials related to that topic. Parent/child educators also facilitate an activity with the parent and child during each visit that reinforces the discussion and models positive interaction. Parent/child educators often leave toys and other materials in the home and suggest activities that parents and children can do together

during the week. However, home visits are individualized according to families' needs and interests, and parent/child educators modify planned activities when necessary to address issues that emerge during the visit.

Center-Based Child Development Services. EES operates two child care centers. One center, which began operating under the CCDP, serves teen parents at Brattleboro Union High School. It has eight full-time slots for a mixed-age group, and the maximum child-staff ratio is 8 to 3. Half of these slots are available for tuition-paying families, and half are reserved for teen parents enrolled in EHS. The second center, The Birge Nest, is housed on-site at the EES center and has six full-time slots for children of mixed ages from 6 weeks to 3 years. The maximum child-staff ratio at The Birge Nest is 3 to 1.

Although they draw on a broad range of resources, both centers use *The Creative Curriculum for Infants and Toddlers*, developed by Teaching Strategies, as their primary infant/toddler curriculum. Through a contract with Teaching Strategies, EES played a role in developing this curriculum.

The amount of time children attend the centers varies from three half days to five full days each week. In both centers, children are assigned to primary caregivers. EHS slots at both centers are available on a first-come, first-served basis to EHS families (teen parents at the high school center) who need child care so that parents can work or attend school and to parents who need respite or crisis care.

Group Child Development Activities. In addition to the parent education and parent-child activities provided during weekly home visits, the EES EHS program provides a variety of opportunities for

families to participate in group activities. The agency has organized play groups at the center and in several outlying communities for EHS families and community members. A monthly Healthy Babies group for parents and children focuses on infant/toddler health issues and provides an opportunity for parents to socialize with one another. The EES EHS program organizes other parent education workshops and series on a variety of topics. A "Get Real" parent support group for men also meets monthly.

At the time of the site visit, the program had recently enrolled a large number of new families who were not yet fully involved in the program. As a result, only about 10 percent of all EHS families had participated in group events and activities.

Child Care Services. At the time of the site visit, approximately 30 percent of EHS children were in a full- or part-time child care arrangement. For families whose children are in child care, the EES EHS program ensures that families receive high-quality care in several ways. First, the child care coordinator and parent/child educators work together to identify centers or family child care homes that provide quality care and have openings that meet families' needs. An EHS staff member accompanies parents on visits to centers or family child care providers to gather information about potential child care arrangements. The staff member, typically the parent/child educator, helps the family ask the questions that will allow the family to make an informed decision about the quality of care.

When the family selects a child care provider, the Windham Child Care Association (WCCA), the local child care resource and referral agency, writes a contract between the provider and the EES

COMMUNITY CHILD CARE

Approximately one-third of EHS families need child care. Some receive child care in the EHS centers, while others are cared for by community child care centers and family child care providers under contract to the EHS program.

Program staff members describe the quality of child care in Windham County as ranging from mediocre to excellent. Not enough good-quality slots are available, especially for infants.

Windham Child Care Association (WCCA) serves as the county's child care resource and referral service. WCCA works to identify new child care providers, encourage unregulated providers to become licensed or registered, provide training to child care providers, and refer families in need of child care to appropriate providers. Vermont recently increased the level of its child care subsidy, which has had a positive impact on the quantity of child care available in the county. Although good-quality child care is available, there are not enough good-quality slots for infants. Regulated child care for infants is not available at all in some outlying areas. In August 1997, not a single licensed or registered infant child care slot was open in Brattleboro. As more parents participate in Vermont's welfare reform program and enter the work force, regulated child care is becoming more difficult to obtain, especially for parents who work outside of the traditional 9-to-5 schedule.

The EES EHS program is involved in several community efforts to improve the quality of child care. In addition to providing training and technical assistance to providers used by EHS families, the child care coordinator serves on WCCA's training advisory board and conducts periodic WCCA-sponsored training sessions for community child care providers. The coordinator is also a key organizer of Windham County's Starting Points Early Childhood Education Network. Vermont is one of six states taking part in the Starting Points Initiative funded by the Carnegie Foundation to develop early childhood education networks in an effort to improve child care quality.

EHS program and manages the contract. (However, beginning in October 1997, EES EHS was planning to manage these contracts directly.) The EES EHS program pays for the care of 17 children, either in part or in full.

The EES child care coordinator makes periodic announced and unannounced monitoring visits to centers and family child care homes in which EHS children receive

care, communicates regularly with child care providers by telephone, and provides training and technical assistance to providers who care for EHS children. Parent/child educators may also accompany parents on visits to child care providers to observe their children in care and, if needed, may visit children in child care to conduct child development activities.

Third, EES has a contract with WCCA to provide drop-in care for EHS families. When EES EHS is conducting parent group activities, the parents can call WCCA to make child care arrangements for their children. Care is usually provided on-site at the main office. The building houses both the child care center that can be used during off-hours for these meetings and a small drop-in child care area. WCCA provides staff members for child care during parent meetings.

EES is the payer of last resort for child care. Most families are eligible for a state child care subsidy, and that money is used first. EES supplements the subsidy to meet the provider's charges for child care, up to a maximum amount, for parents who need child care to work or attend school and for parents who need respite or crisis care. Some parents prefer to select child care on their own, and the EES EHS program will subsidize any child care parents select as long as the provider is licensed or registered and will permit EES staff to visit the family child care home or center and provide training and technical assistance.

Child Development Assessments.

Parent/child educators conduct developmental screenings about every four months using the *Ages and Stages Questionnaires* developed at the University of Oregon. This tool was developed for use by parents, and the parent/child educators find that parents enjoy using it to track their children's development. The early childhood coordinator reviews the questionnaires for evidence of developmental delay and uses them to prepare an individualized child development plan to guide the parent/child educator and the parent in planning home visits and activities during the next four months.

Health Services. An EES nurse coordinates child health services and works closely with the Vermont Department of Health to ensure that each child has a medical home. Within about three months of enrollment, the nurse visits each family to conduct an initial health and nutritional assessment and to identify health needs. Many area pediatricians accept patients covered by Dr. Dynasaur, Vermont's health insurance program for poor children and pregnant women, so it is not difficult to find a physician for each child. Consequently, virtually all EHS children have a medical home and receive regular well-baby visits and appropriate immunizations. The nurse also coordinates the EES Community Health Advisory Committee.

Services for Children with Disabilities. At the time of the site visit, approximately 10 percent of the EHS families had children with disabilities. To serve these families, staff members work closely with the Family, Infant, and Toddler (FIT) program, the area's Part C provider. Program staff members usually identify children with suspected disabilities or delays based on observation during home visits or based on the results of the *Ages and Stages Questionnaires*.

If a parent/child educator or other staff member suspects a disability or delay, the early childhood educator contacts someone at the FIT program to request additional evaluation and observation. When the FIT program representative determines that a child is eligible for early intervention services, the two agencies hold an initial joint team meeting to plan services for families, and staff members communicate regularly to coordinate services, share information, and exchange referrals.

Transitions. Approximately six months before families must leave the EHS program, home visitors will initiate transition planning as part of their case management process. A team of staff will begin meeting with the family to develop goals and plans for the remaining months of program participation. These goals and plans will focus on how to meet immediate goals by the end of the program and on connecting the family with other resources for meeting long-term goals. This planning process will include planning for the child to enroll in a preschool program, usually Head Start or EES's preschool program, called Esteyville. For some children, the transition plan will call for the child to remain in his or her child care program.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Parent/child educators visit families weekly (as part of the home visit described under the child development cornerstone) to establish a trusting relationship, develop and review goals and plans, and help families obtain needed services. Within 90 to 120 days after enrollment, one of the program's two social workers (the adult services coordinator and the home-based program coordinator) visits each family to complete the Family Assessment Profile (FAP). Based on the results of the FAP and families' priorities and interests, parent/child educators work with families to establish goals, plans, and timelines. Goals are established for parents and children and are updated at least once every three months.

Case Management. EHS staff members conduct case management using a

team approach. Every three months the agency holds "Family Updates in a Nutshell" (FUN) meetings to review the status of each family, review the family's goals, and plan services for the next three months. All staff members involved with the family attend FUN meetings. Staff members also call Coordination of Services (COS) meetings with the family's interdisciplinary team as needed to address crises and emerging issues. Families do not attend FUN meetings but sometimes attend COS meetings, as do community agency personnel when appropriate.

Parent/child educators have several specialists with whom they can confer about a family. These specialists include the social worker who has been assigned to the family (the two social workers are each assigned one-half of the caseload) and four specialists who work under the supervision of the adult services coordinator (two employment and training specialists, a literacy tutor, and a men's program coordinator). Parent/child educators may also consult with the nurse/health educator, the early childhood coordinator, the parent involvement/community coordinator, and a mental health consultant.

Program staff members believe that family development services should build on the strengths and competencies of families. They also believe that developing strong relationships with families that are based on mutual respect is a necessary foundation for their home-based component.

Education and Employment Services. The two employment and training specialists

work with parents to prepare them for employment. The specialists usually work one-on-one with parents to address a variety of job readiness issues, identify career goals, enroll them in appropriate training and education programs and obtain financial aid, and conduct job searches. Two small companies in the area regularly hire EES parents for part-time positions, providing parents with an opportunity to learn basic job skills and become familiar with the world of work. When parents are ready, the employment specialists may also refer family members to group programs, such as Job Clubs operated by Reach Up.

The literacy tutor works with about 8 to 10 parents at a time and visits these families about once a week. Some parents need only a few visits, and others receive literacy services for a year or more. The literacy tutor receives some referrals from the completed FAPs and relies on parent/child educators to ascertain families' literacy needs. For parents who need to work on basic literacy skills, the tutor uses children's books, the *Mother Read* curriculum from the Even Start program, and other resources. She works with other parents to prepare them for the General Educational Development (GED) examinations. EES's literacy tutor was originally funded by Even Start, but that funding ended in June 1996. Beginning in October 1997, the position was to be funded by EHS and some Goals 2000 funding from the state.

Financial Assistance. EES provides several avenues of financial support to EHS families. First, EES helps families who have special needs to apply to a local Realtor's Fund and other local funds for small monetary grants for one-time purchases.

Second, if other resources are not available, EES can provide small grants

(usually \$100 to \$150) to families from a Family Assistance Fund. Typically, these grants go towards a security deposit or one-time purchase, such as a new bed for a 3-year-old child. EES staff members make sure that the money will really get the family through its crisis instead of perpetuating the family's need for assistance. When a family asks for financial assistance, social workers have an opportunity to work with the family on budgeting and financial management.

Third, EES maintains a loan fund to provide families with low-interest loans. A local bank contributed \$5,000 as collateral for the loan fund and provides the loans to families at a 2 percent interest rate. Families applying for loans do not have to provide their own collateral. Typically, these loans help families with such expenses as repairing or buying a car, paying for car registration and insurance, putting up a security deposit, or covering legal fees. The adult services coordinator reviews the loan applications. This individual rejects about half of them after looking at the family's income and their expenses. The other half go to EES's loan committee for approval.

Health Services. EES has a nurse/health educator on staff who coordinates health care issues for EHS families. The nurse visits each family to conduct a family health assessment after the parent/child educator has developed a relationship with the family, usually within 90 days. This typically occurs about three months after the family's enrollment in the program and after the social worker has completed the FAP. The nurse also helps parent/child educators address health issues with families and locate physicians, dentists, and other health care providers. To educate parents about nutrition, the nurse/health educator organizes quarterly Food Fests for program families. The most recent Food

Fest was a vegetable dinner. Families brought vegetable dishes to share, and the program published some of the recipes in its newsletter.

Other Services. EHS staff members work with many other community service providers to obtain and coordinate other services for families. A mental health consultant works with the staff to address mental health issues, to provide precounseling services to program families, and to assist the program personnel with locating appropriate mental health service providers. For families who receive welfare, the EES EHS program works closely with Reach Up to pool resources and coordinate services for specific families. The program also works closely with area child care providers and health care providers who serve EHS families. Staff members refer EHS families to Vermont Adult Learning, the Community College of Vermont, the Vermont Student Assistance Corporation, the Office of Employment and Training, the local consumer credit counseling service, Youth Services, and other service providers.

Father Involvement. EES has a men's program coordinator who plans activities for EHS fathers and other male members of the community. A men's support group meets once a month to provide a forum for men to talk and support each other in their roles as fathers. The men's program coordinator also conducts home visits to fathers to provide information about the program and to encourage their participation. In addition, the men's program sponsors group events for families, such as an annual Mother's Day breakfast and recreation outings. EES recently formed an advisory committee for the men's program to help the coordinator enhance program services to men. Finally, the men's program coordinator is leading an effort within EES to make programs more

inclusive of men. For example, EES modified its enrollment forms and letter of commitment to provide space for two parents to sign.

Parent Involvement in the Program. The program worked hard during the year prior to the site visit to develop a strong policy council and to encourage parent involvement in the program and the community. The EHS policy council plans social activities for parents, and representatives participate in interviews with candidates for staff positions. A finance committee works with the program director to develop the annual budget and helps the director present the budget to the board of directors.

Parent involvement for many families is an evolutionary process. New families begin by developing a strong relationship with their parent/child educator and gradually begin to interact with other EES staff. Once they become more familiar with the program and have established trusting relationships with staff members, many parents become interested in participating in group activities, such as play groups, parent education workshops, the policy council, and social activities. As parents build their social skills and become more comfortable with group interaction, they begin to increase their involvement in the broader community. A parent involvement/community coordinator works to get parents involved in group activities and to connect parents with community groups and events.

STAFF DEVELOPMENT CORNERSTONE

Training. An EES staff training committee developed the staff training plan for 1997 based on the results of a staff

questionnaire about training needs. One Friday morning each month is reserved for staff training. Depending on the topic, the training session is conducted by either an EES staff member or someone brought in from the outside. Some recent training topics included substance abuse, human development, and family systems; infant nutrition; separation and divorce and their effects on children; trauma in families; language development; and body image. Although time for practicing new skills is not usually built into training sessions, it is encouraged during individual and group supervision meetings.

All EES staff members are encouraged to attend the monthly training sessions, and EES invites staff members from collaborating agencies in the community to participate as appropriate. For example, if training is planned about a health topic, EES will invite staff members from the health department.

EES staff members are also able to access money put aside by EES to further their education. Each EES staff member can access up to \$200 per year to attend workshops and conferences. Staff members without a bachelor's degree can receive \$300 per semester for college classes. Staff at all levels, including caregivers from the child care centers and parent/child educators, are encouraged to attend training sessions and conferences sponsored by other organizations. During the past year, staff members have attended training sessions on mental health issues, organizing parent groups, infant/toddler nutrition, caring for children with special needs, infant and toddler development, and many other topics. Staff members have received academic credits for attending some of these training sessions.

Supervision and Support. The home-based program coordinator, the early childhood coordinator, and the nurse/health educator meet individually with the parent/child educators under their supervision every week for 60 to 90 minutes. The supervisors also review the parent/child educators' contact sheets on a daily basis. In addition, supervisors hold a group supervision meeting with the parent/child educators once a month to discuss issues common to all families. These meetings provide staff members with an opportunity to share experiences, reflect on their work, and strategize about the issues they face.

The EES EHS program provides staff support to sustain motivation and prevent burnout in several ways. The entire staff participates in an annual meeting, called an "Advance," to reflect on program activities during the previous year and to plan activities for the coming year. Staff members form committees to work on specific issues of interest to them, such as involving volunteers, case management, and technology. EES also has a wellness committee that plans fun activities for the staff, such as picnics, games, and hikes. Peer support among the staff members is encouraged, and new staff members are assigned formal mentors.

Salaries of parent/child educators are slightly higher than salaries for comparable positions at other local agencies, and salaries of management team members are significantly higher than those of comparable positions in the community.

Staff Turnover. Because staff members receive adequate levels of support and compensation, staff attrition has been moderately low. In the year prior to the site visit, 3 of 35 staff members (two parent/educators and 1 assistant bus driver) left the agency.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. EES has an active Community Advisory Board and six advisory committees that focus on specific service areas. These boards and committees involve 54 community members in the program and provide an opportunity for community members to interact with the program around issues of interest to them. In addition, EES has 14 formal collaborative agreements with service providers and other agencies in the county, including Brattleboro Child Development, Vermont Department of Health, Vermont Department of Employment and Training, Southeastern Vermont Career Education Center, 5-C Head Start, and Parks Place Community Center.

EES has worked to increase collaboration with other community service providers. For example, during the year prior to the site visit, EES enhanced its collaboration with 5-C Head Start in several ways. A 5-C Head Start staff member now has office space at the EES center and participates in staff training sessions and on committees. At the time of the site visit, Head Start was planning to place nine children in the Esteyville preschool program operated by EES. EES and Head Start were also cosponsoring a parent education series open to the entire community called "Parenting in the '90s."

Funded by the Vermont Success by Six program, EES's Newborn Visiting Program reaches out to the parents of every child born in the school district with a letter of welcome and an offer of a home visit. EES recruits, trains, and supervises volunteers from the community to conduct these home visits to families with newborns. When volunteer home visitors identify families who need additional services, EES staff

members can make further referrals and enroll the family in EHS or another EES program as appropriate.

Interagency Collaborations. EES is also involved in several interagency collaborative groups in the community. The Alliance for Building Community is a coalition of agencies that coordinates human services and education services to families with children and promotes collaboration among agencies and providers. This organization is gradually evolving into a governance group of county service providers. As one of 16 Vermont Parent Child Centers, EES participates in an annual state advocacy event called the Doll's Campaign.

EES staff members serve on 38 community boards, task forces, and teams. Examples include the Domestic Violence Task Force, the Child Protection Team, the board of the Brattleboro Child Development Center, the Drug Free School Committee, and the Part C Advisory Team.

Finally, the EES center provides an important vehicle for community involvement and collaboration. WCCA is housed in the center, so that child care referral services and EES are co-located. The center also provides space for play groups open to the community, and many community groups use the center's large conference room for meetings and events.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. During the year prior to the site visit, staff from Zero to Three visited the EES EHS program and provided technical assistance in the areas of continuous improvement and staff development. In addition, a Technical

WELFARE REFORM

Vermont has operated its welfare reform program, Reach Up, since July 1994 when a federal waiver was granted. Vermont's current Temporary Assistance for Needy Families (TANF) plan incorporates all features of this waiver. The state requires single parents to obtain work or accept subsidized employment after 30 months, and adults in two-parent families are required to accept work or subsidized employment after 15 months. Parents of children under 18 months are exempt from the work requirement. Teen parents must live with parents or in another supervised living situation and must attend school. Parents who accept employment can keep more of their earnings before losing cash assistance, receive transitional Medicaid for up to 36 months, and receive the state child care subsidy based on a sliding scale as long as they remain eligible. Approximately one-third of EHS families were receiving cash assistance when they enrolled in the program.

EES has two employment and training specialists who are partially funded by Reach Up. They encourage families to begin working with the Reach Up program as early as possible to identify career goals and plan for future employment. For the most part, EES has been successful in helping parents obtain employment before they reach their time limit. Program staff members feel that some aspects of welfare reform have had a positive effect on families. Through Reach Up, parents can receive more services, working parents can earn a higher level of income and continue to receive assistance, and parents can receive extended benefits after they begin working. However, in order to begin working, some parents need specific services, such as vocational rehabilitation, that are not available in the community.

Welfare reform and the increased number of program mothers entering employment have increased the challenge of completing weekly home visits. Parent/child educators try to conduct visits in the evening but find that families are often tired and busy preparing for the next day. When work prevents parents from completing weekly home visits, parent/child educators sometimes visit children in child care once a month to perform a child development activity rather than conducting a home visit. The parent/child educator then talks with the parent by telephone or during the next home visit about the visit to the child care center.

Assistance Support Center (TASC) consultant provided training for the EHS policy council when it was formed. The program also received key support from its federal project officer.

Continuous Program Improvement.

Continuous program improvement is primarily the responsibility of the EES management team, which uses data collected

by the program to evaluate it and track what is happening to families and how they are moving along toward their goals.

Local Research. A team of researchers from Harvard's Graduate School of Education is serving as the program's local research partner. The local research team, headed by one of the nation's leading language researchers, is focusing on parent-

child interactions as a context for language and literacy development and socioemotional development. The two key research questions are (1) How do families living in rural communities interact with children, linguistically and socially? and (2) Does EHS have an impact on patterns of family interaction? In addition to the data collected for the national EHS evaluation, local research staff members will interview and collect observational data on 130 families and follow 8 of these families more intensively in an ethnographic study.

During the summer, graduate students working with a Harvard research team piloted qualitative data collection for the proposed studies of EHS fathers. The team also received a small grant from the Harvard Project on Schooling and Children to do more in-depth interviews with some families about childrearing practices. The team will conduct a seminar this fall with the Harvard Law School in which 12 to 14 students will conduct these in-depth interviews using oral history methods. After the data are collected, the team will hold a conference at Harvard to present these case studies.

The local research team is also working with the home-based program coordinator and the early childhood coordinator to develop a detailed description of the program's home-based component. Local researchers from Harvard have conducted three training sessions for the EES staff during the past year. Two training meetings focused on completing and using the AIMS questionnaire, and a third one presented information about language development.

PROGRAM SUMMARY

The EES EHS program provides child and family development services primarily to rural white families in Vermont though

home visits, center-based child development services, and group activities designed to promote strong parent-child relationships. Teams of staff members also work with families on their personal and family goals and link them with needed services in the community. The program is working with the welfare agency to encourage families to begin planning for future employment as early as possible, and program staff members are assisting families in finding employment before they reach the time limit on cash assistance.

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EARLY HEAD START PROGRAM PROFILE

United Cerebral Palsy Early Head Start Fairfax County, Virginia September 29 - October 1, 1997

United Cerebral Palsy of Washington, DC, and Northern Virginia operates a new Early Head Start program for 75 families in Fairfax County, Virginia. The program serves an extremely diverse group of working poor families, including military families. Many of the families are immigrants who do not speak English or do not speak it well. The Early Head Start program provides child development services to some families in a child care center, some families in family child care, and some families in weekly home visits. Families with children enrolled in the child care center or in family child care receive family development services in monthly home visits. Families are also invited to group socialization activities twice a month. The program provides inclusive services to children with disabilities and works to foster inclusive services for all children in the community.

OVERVIEW

United Cerebral Palsy (UCP) of Washington D.C. and Northern Virginia operates the Early Head Start (EHS) program in Fairfax County, Virginia. UCP has a 45-year history of providing community services to the Washington, D.C., area, including respite programs and adult day programs for individuals with disabilities. Although UCP provides a number of diverse programs and services, including a Therapeutic Nursery Program for 3- to 5-year-old children with disabilities, EHS is UCP's first program for infants and toddlers.

Community Context. UCP EHS serves families who live in a densely populated, suburban area of southern Fairfax County, Virginia. The community is very diverse; it includes very wealthy and very poor families, immigrants and people who were born in the area, and families who

work for the military and live at the Fort Belvoir Army installation and families who are not associated with the military. The community lacks good employment opportunities for low-skilled workers, and it lacks services that low-income families need, such as affordable child care, housing, and public transportation during nonstandard work hours. Community leaders and service providers are working together to meet these needs.

Program Model. The UCP EHS program is a mixed model with three modes of service delivery. EHS staff members provide child care for 16 children in a child care center; the program trains, monitors, and reimburses 15 family child care providers who care for 25 children; and EHS staff members conduct weekly home visits with 34 children. Families served primarily by the child care center and family child care providers also receive case management and

family development services during monthly home visits.

Families. The UCP EHS program serves a very diverse group of families. One-third are African American, one-third are Hispanic, and one-third belong to other racial/ethnic groups. About half of the families include two parents. About 10 percent of the mothers were pregnant when they enrolled in the program. Approximately one-sixth of the families were receiving welfare cash assistance when they enrolled.

Staffing. Many of the EHS staff members work with children and families. Two home visitors plan and conduct weekly home visits. Two teachers plan and lead the classroom activities at the center, and five teaching assistants help them care for the children.

These staff members receive support from several managers. The child development services manager supervises and trains the family child care providers and the child development staff. The family/community development services manager conducts family development home visits, supervises the home visitors, and develops and maintains community collaborations. The program director provides overall leadership to the staff, and she also serves as a key link to the community.

RECRUITMENT AND ENROLLMENT

Program Eligibility. UCP EHS serves families who live along the Route 1 corridor from the Interstate 495 beltway to Lorton, Virginia, are residents of Fairfax County but do not reside in Alexandria City; and meet the EHS income eligibility criteria.

Recruiting Strategies. UCP EHS staff members use multiple strategies to recruit families. The Fairfax Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) allows the EHS program to staff an information table at the WIC office on check pickup days (twice a month). This has been the most effective recruitment strategy. Referrals from other community service providers--especially from county public health nurses--and from participating parents have led to the identification of potential participants. In addition, EHS staff members have worked with the county Office of Early Intervention and the area's Part C provider to identify eligible mothers who have had high-risk pregnancies. Staff members have also recruited participants at the local immunization clinic and have canvassed neighborhoods to find interested, eligible families.

Enrollment. UCP EHS first reached full enrollment in September 1996. To reach this goal, it enrolled families with children who were more than 12 months old and were not eligible for the national EHS evaluation sample. At the time of the site visit, the UCP EHS program was fully enrolled and serving 75 children, 44 of whom are participating in the national evaluation. As older children age out of the program, new families who are eligible for the research will be enrolled.

The enrolled families reflect the diversity of the community, which is largely African American, Latino, Pakistani, and Anglo. Approximately one-third of the families primarily speak Spanish or a language other than English. The enrolled families also include the military poor who live in the community and on the Fort Belvoir Army installation. Fifteen percent of the families include an infant or toddler with a disability. Enrolled families bring a

COMMUNITY PROFILE

UCP EHS serves families living along the Route 1 corridor in southern Fairfax County, one of the largest and wealthiest counties in the state of Virginia. The county is known for its ethnic and cultural diversity--in 1995, 25 percent of all county residents reported that they spoke a language other than English in their home. Compared with the entire county, southern Fairfax County is highly diverse, with more than 50 languages spoken by children in the local schools. The population of southern Fairfax includes more African Americans (33 percent) and Hispanics (10 percent) than the county overall (8 percent African Americans and 8 percent Hispanics). The median household income in Fairfax County is around \$70,000; in southern Fairfax it is \$52,000. The county includes the very wealthy, and the cost of living is among the highest in the nation. Four percent of families in Fairfax County live at or below poverty, however.

The Fort Belvoir Army Installation adds to the diversity of the community. Many people who work at Fort Belvoir live in the community served by UCP EHS. The military families in the community have unique concerns because often the spouse or partner is posted at another army facility for long periods of time.

The area served by the program is suburban and mostly service-oriented. There are many strip shopping malls, hotels, and restaurants. Low-skill, low-paying jobs are available in the community, but with the high cost of living, many families are unable to get out of poverty by taking service positions. There are few major manufacturers or industrial employers in the area. Computer companies are booming in the area, but college degrees are required for positions with those companies. Because the area is suburban, transportation is a problem. There are public buses that run throughout the county, but most of them have schedules that meet the needs of people who work "standard" hours, with less-frequent stops at night and on the weekends.

Local service providers reported that although there seem to be many services available, the need is greater than the supply. Because of language barriers and the lack of transportation, many families are unable to take advantage of the services offered in the community. An influx of refugees and undocumented families has greatly increased the demand for services. Recently, local churches, which have historically played a large role in serving low-income families, have reported that they are overextended. Service providers reported that affordable housing, medical services for adults without health care coverage, mental health care for children and adults, and services for children with disabilities are very difficult to arrange for families. Many families without health insurance use emergency room services when they have to be seen by a doctor. The community also lacks affordable child care.

Community leaders and service providers are working together to meet these needs. The local community service providers meet monthly for a luncheon that includes an invited speaker who discusses what his or her organization is doing in the community or discusses an important community issue. The service providers reported that they work with each other to reduce duplication of services and meet family needs. Some service providers mentioned that there are no problems with collaborating with other community agencies, but others and UCP EHS staff members reported that some organizations continue to resist collaboration or are not particularly helpful.

variety of strengths to the program--they are resourceful and want to work. They also have a wide range of problems, including immigration issues; language barriers (some parents are illiterate in their native language and must first become literate in that language before learning English); lack of self-confidence; and marital conflict and abuse.

CHILD DEVELOPMENT CORNERSTONE

Overview. UCP EHS provides child development services in three ways: (1) EHS staff members provide full-time care for 16 children from military families at the U.S. Army's Fort Belvoir North Post Child Development Center (CDC)--under a formal agreement with the army, EHS staffs two rooms in this center and will soon add a third; (2) 15 family child care providers who have been trained and approved by the EHS program provide full-time care for 25 children; and (3) EHS staff members visit 34 children in their homes weekly to provide child development services and to help families find high-quality child care if they need it. Families receiving child care at the CDC interact with EHS staff members on a daily basis when they drop off and pick up their children from care, receive monthly home visits from the family/ community services manager, and occasionally receive home visits from their child's teacher. Families served by EHS-referred family child care providers are invited to educational and recreational events sponsored by the EHS program and receive monthly home visits from the family/ community services manager or a case manager.

The program offers parents the choice of how they will receive program services

and is flexible in allowing parents to move from one service delivery mode to another. Military families may choose the child development center, EHS family child care, or home visits, while nonmilitary families may choose EHS family child care or home visits. As children get older, more families request a change from home visiting services to center or family child care. Depending on the numbers of children enrolled in the CDC and the EHS family child care homes at the time of the request, a family may have to

UCP EHS staff members believe that they will improve child development outcomes by helping parents and child care providers create high-quality, developmentally appropriate environments for the children in their program. Staff members emphasize that delivering inclusive services for children with disabilities is an important goal. They believe that by fostering inclusive services in the community they improve the quality of care available for all children.

wait to enroll in the center or family child care. The program has been successful, however, in meeting families' needs for full-time child care within a few months of their request. Parents who need part-time child care are not eligible for free EHS child care; their home visitors help them find other affordable, high-quality child care.

Center-Based Child Development Services. At the CDC, the maximum group size is eight children, and the child/caregiver ratio is three to one or four to one, depending on the time of day (half of the staff members work in the morning and the

other half begin later in the day). Each classroom has one lead teacher (teachers must have a bachelor's degree in early childhood education or special education, or a child development associate [CDA] credential); and three to four teaching assistants (assistants must have a high school diploma or General Educational Development [GED] diploma and work experience with infants and toddlers).

Family Child Care Services. The child/caregiver ratio in approved family child care homes complies with the county regulations. Family child care providers must have a permit to operate in the county or a state license, and they must have or be willing to obtain their CDA credential.

The child development services manager conducts an in-depth screening of all potential family child care providers. Even if a provider is not approved to become an EHS caregiver, the provider benefits from the feedback about the areas of concern and is invited to attend training at the EHS office. The child development services manager monitors the quality of care provided by EHS-funded family child care providers and by CDC staff members on a monthly basis. Monitoring visits are sometimes unannounced and sometimes announced. Army officials also conduct unannounced inspections of the CDC. UCP EHS adapted a monitoring form developed by the county to evaluate the quality of care in the family child care homes. Program staff members developed a monitoring form to evaluate quality of care in the center.

The program tries to match families who want family child care to providers who share the same culture and speak the same language. Some families, however, prefer an English-speaking provider.

Home Visits. Families who are served exclusively through home visits are visited weekly by their home visitors. Fathers are invited to attend all home visits, and staff members schedule visits to include fathers if they wish to be present. Home visitor caseloads are 10 children per home visitor, or approximately seven or eight families per home visitor. (At the time of the site visit, more families received child development services through home visits than usual because the program had recently reduced the number of children served in the center to 16. The number of children served in the center will increase to 24 when the program is able to use an additional room at the CDC.) Home visits last two hours, on average, and consist of a variety of activities that include direct interaction with the child, modeling of play and interaction behaviors for the parents, and discussion with the parents about the child. Home visitors must have a bachelor's degree in early childhood education or special education or a CDA credential.

Group Child Development Activities. Twice a month, families receiving home visits are invited to the EHS office for an afternoon of socialization. Socialization activities have resulted in the development of friendships among EHS families. Participation in groups is open to everyone, but participation is typically low (12 families), especially among families receiving center and family child care.

Other Child Care Services. Families that receive home visits through the program but do not receive free child care from EHS may also need child care. The child development services manager and the home visitor assist families in identifying high-quality care, and the home visitor may conduct a visit with the parents to the child care setting. Home visitors also help

COMMUNITY CHILD CARE

At the time of the site visit, a few EHS families were using relative care or other community child care arrangements. Most families with children in child care were using EHS center-based or family child care.

The supply of affordable, high-quality, inclusive child care in the area is insufficient. Families need care for infants and toddlers, as well as services for children with disabilities and for preschoolers. Few child development or child care services are available for 3-year-olds, which has made it difficult to place children making the transition out of EHS.

The county offers training for family child care providers. However, it is far from the Route 1 corridor (about one hour by bus); therefore, few providers have participated.

To improve the quality of child care in the community, the program offers training to all child care providers in the community free of charge. Child care providers learn about the training from the county Office for Children, which issues permits to child care providers; from other child care providers in the community who are providing services for EHS children; and by word of mouth.

families apply for child care subsidies. When a child is enrolled in family child care, the home visitor may conduct some visits at the family child care setting and work with the provider on quality.

Child Development Assessments.

Center teachers, case managers, and home visitors conduct formal assessment of progress toward early education and parenting goals when children first enter the program and every six months thereafter using the *Denver Developmental Screening Test*.

Home visit and center activities are individualized to meet any needs identified during the screening test. EHS staff members planned to work with family child care providers to help them learn how to incorporate screening information into their

daily schedules for the children in their care. Home visitors develop lesson plans for each visit based on parent interests and any needs identified in the assessments.

Health Services. When a family enters the program, health needs are assessed and staff members determine whether the family has a medical home. Department of Defense (DOD) employees who participate in the program have health care services in place and readily available to them. The majority of the non-DOD families have Medicaid when they enter the program, and they are served by a local health clinic or by doctors who accept Medicaid patients.

EHS staff members encourage and help families who are eligible for Medicaid to apply. Staff members reported that one of their biggest challenges is securing health

care services for undocumented families. Home visitors and the family/community services manager track children's receipt of immunizations, well-child examinations, and treatment for health problems.

The EHS program works with other local agencies, including the Fairfax County Public Health Department, to ensure that families receive health services. UCP EHS has arranged for a county health nurse to serve as the liaison to the EHS program, thus facilitating communication between the program and the health professionals serving the EHS families. EHS staff members encourage families to participate in the WIC program. The EHS program director, home visitors, family/community services manager, and the center-based teachers monitor families' health care needs and remind parents to keep up with medical appointments.

Services for Children with Disabilities. One of the goals of the UCP EHS program in the area of child care is to make sure that all care settings are inclusive. The CDC and all of the family child care homes to which EHS families are referred are capable of providing services for infants and toddlers with disabilities. The program works with family child care providers who believe that it is too difficult to care for a child with special needs, as well as parents of able-bodied children who have fears about placing their child in settings that include children with special needs. The EHS program provides training about inclusion for the CDC staff, family child care providers, and EHS parents.

UCP EHS has a formal agreement with the local Part C provider to collaborate and coordinate services for children with disabilities. The Part C provider maintains an office at the EHS headquarters and

regularly scheduled screenings, intervention team meetings, and meetings with parents on site. The Part C provider has worked closely with EHS staff members to prepare them to care for children with special needs, including a child with a feeding tube who is cared for at the CDC. Part C staff members and the program director have trained CDC staff members on how to meet the special needs of an individual child and to conduct therapeutic interventions in the context of a group activity that all of the children can enjoy. At the time of the site visit, 15 percent of the children enrolled had a disability and were receiving Part C services.

Transitions. Staff begin to work with families to plan their transition from EHS when the children are within six months of their third birthday. Staff assist parents in applying for Head Start, and they explore other possible options if Head Start is not an available or appropriate placement. The program administrators have met with Head Start grantees to introduce them to the program and to discuss the best way to help families access Head Start services. At the time of the site visit, 17 3-year-old children had made the transition out of EHS into Head Start.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. Within 45 days of enrolling in the program, all families complete a family needs assessment. Based on the information from the assessment and informal discussions, the family/community services manager or home visitors work together with families to complete an Individual Family Partnership Agreement (IFPA). The IFPA includes statements of goals the family

is working toward, a strategy or resource to assist the family in meeting each goal, and a course of action. Each time they meet or talk by phone, EHS staff members and families discuss progress toward meeting the stated goals and update the IFPA to include any new needs or goals that have been identified and drop those needs that have been met or goals that have been achieved.

Case Management. Families that receive services in the child care center or the family child care homes receive monthly home visits from the family/community services manager or a case manager. During home visits, the family/community services manager or case manager works with the families to determine what their needs are regarding education, employment, and mental and physical health services and to

The UCP EHS family development cornerstone rests on the belief that the program staff should work with families to access the tools necessary for self-empowerment. UCP EHS staff members assist families in identifying and working toward their family development goals. The program provides families with a "buffer zone" to support them as they move toward self-sufficiency, and the program provides family members with tools to help them achieve their life goals.

help them get the services they need. The family/community services manager has a caseload of 35 families. Case managers have caseloads of 20 families. Home visits last between one and two hours. In addition, teachers of children receiving care in the

child development center visit families at home.

Families receiving EHS child development services through home visits receive family development services during their weekly home visits. The same home visitors who provide child development activities work with families to identify their strengths, needs, and goals and help them get the services they need. The amount of time during home visits that is devoted to family development services varies depending on family needs.

The family development services provided include case management, education and career counseling, literacy referrals, counseling about immigration issues, emergency assistance, and referrals to other community agencies for education and employment services, physical and mental health care, and other social support services. Program staff members work with families to help them access the services that are available in their community.

Education and Employment Services. UCP EHS has an informal agreement with the Maximus Corporation, which provides support for families around issues related to welfare reform. EHS staff members assist families in identifying their education and employment goals and refer them to Maximus for help in reaching those goals.

Many families are interested in taking English as a Second Language (ESL) classes. UCP EHS has developed an informal relationship with the Fairfax County Public School ESL coordinator, and together they make sure that EHS families find a class that meets their needs. EHS staff members are still working to identify a conveniently located provider of literacy training for non-English speakers who are

illiterate in their native languages. This search has been a challenge because such classes are seldom offered in the local community.

Health Services. The county health office works with the EHS staff to arrange for family physical and mental health care. The program director has a degree in social work and reviews all cases home visitors bring to her attention that might require a referral for mental health services. Families with adult mental health needs are referred to the community mental health center or to the local victim's assistance program, as appropriate.

Other Services. UCP EHS helps families obtain emergency assistance from other community agencies when necessary. Staff members refer families to local homeless shelters and to shelters for victims of domestic violence. Cooperating agencies also offer emergency food and supplies.

EHS staff members work closely with families to assist them in resolving immigration issues. The staff has worked with community service providers of all types to sensitize them to the needs of families with immigration and language issues. Staff members reported that they played a large role in making providers more responsive to the immigrant community. Unlike when the program first began, EHS staff members are called upon less often to serve as translators for county and other community service providers.

Parent Involvement in the Program. The program involves parents by offering opportunities to work together on the EHS Policy Council and its committees, such as the Family Child Care Committee, the Child Care Center Committee, and the Home Visitation Committee. Parents who receive services through home visiting also participate in socialization meetings twice a

month at the EHS office. Socialization activities are designed to foster community among the parents. The EHS team also sponsors educational and recreational programs for all program families. At the time of the site visit, women were more active in program activities than men. The program made increased male involvement a goal for 1998.

STAFF DEVELOPMENT CORNERSTONE

UCP EHS's approach to staff development includes four main activities: (1) implementing the training plan developed by the program director; (2) increasing the cohesiveness of the staff by holding monthly staff meetings; (3) providing individual staff support and personal development planning during regular meetings with the family/community services manager and the child development services manager; and (4) preparing yearly staff performance reviews.

Training. All staff members receive training to orient them to UCP and EHS. Training needs have been identified through staff surveys and observation of staff members as they are doing their work. Some of the child care assistants are learning Spanish to facilitate their communication with parents. The child care assistants have spent some time helping at UCP's Therapeutic Nursery Program, allowing them to observe how young children with disabilities are cared for in another UCP program. The CDC staff is also encouraged to take advantage of the training opportunities offered by the Fort Belvoir North Post Child Development Center, which complement the training offered by the UCP EHS program.

The child development services manager works with the program director to

implement the staff training plan. The EHS child care staff, program-approved family child care providers, and other family child care providers in the community are offered free training to obtain the CDA credential, which is required within 12 months of hire for center staff and home visitors and within 18 months for family child care providers. Before UCP EHS offered the CDA training, it was prohibitively expensive and was not available in the local community. Holding the classes at the EHS office allows more community members to take advantage of the CDA program, while at the same time improving the quality of care that is available. The program offers weekly two-hour training classes that meet CDA requirements.

At the time of the site visit, five assistant teachers and one lead teacher had completed all of the required CDA training and documentation and were waiting for an evaluation visit from the National Association for the Education of Young Children (NAEYC) observers. The 15 EHS family child care providers were at different stages of the CDA process. About half were far along in accumulating the required number of training hours, and the others were just starting to attend training. The two home visitors were in the process of getting their CDA. They have met the requirements for the number of training hours and experience, and they were planning to submit their applications in December 1997.

Supervision and Support. Staff members meet monthly to share information and discuss program issues. The program director reviews the monthly reports on each child and family and provides supervision for the staff as needed. Home visitors meet weekly with the family/community services manager to discuss family issues and staff concerns. Each staff member has a personal

development plan, which is reviewed and updated regularly. Formal performance reviews are done annually.

Center teachers, family child care providers, and home visitors complete monthly reports on every child that include information on the child's health and developmental progress in key areas. Areas of concern are identified and staff members develop a plan to address them. The program director reviews the monthly reports and provides feedback and supervision to assist staff members as needed.

The EHS CDC staff members reported that they are paid lower wages than other staff members at the center who are employed by the army. The rest of the EHS staff members reported that their wages are in line with what they would be paid for the same work at other comparable organizations.

Staff Turnover. The staff turnover rate in the year prior to the site visit was 44 percent, with 7 out of 16 positions vacated. The child development services manager position was vacated in November 1996 and filled in January 1997. One home visitor left the program, and five teacher assistants left the CDC. At the time of the site visit, the program director was deciding whether the home visitor would be replaced, given the planned addition of eight new slots at the CDC. The teacher assistant positions were filled.

COMMUNITY BUILDING CORNERSTONE

Because UCP EHS is a new program in the community, staff members have invested time in getting to know other private and

WELFARE REFORM

In March 1995, Virginia passed a welfare reform law called the Virginia Independence Program (VIP). Fairfax County implemented the employment component of the law in April 1996. Parents with children under 18 months, and women in the fourth to ninth month of pregnancy, are exempt from the employment requirements. In Virginia, families may receive benefits for 24 months if no one is working. In Fairfax County, child care subsidies are available for families receiving Temporary Assistance of Needy Families (TANF) benefits, and for families whose members are working or are in an approved educational/training program and are earning less than 50 percent of the county median income. Eligible TANF families pay no fee for the child care they use, and families earning 50 percent or more of the county median income pay a sliding fee based on their income. When they enrolled in the program, about one-sixth of EHS families were receiving cash assistance. Program staff members reported that a few EHS families will soon reach the 24-month limit.

Many community service providers believe that the new welfare reform requirements will have a major impact on how they work with families. Because family members will be working, they will need services that are available at different times, mostly in the evenings and on weekends. Some organizations have moved to make services available during nontraditional hours, but most have not. UCP EHS staff members reported that it has been more difficult to schedule home visits with families whose members are working or participating in education and training activities.

Since welfare reform, the demand for child care has increased, EHS staff members' eagerness to open another room in the CDC has increased. The staff members remain flexible as they attempt to offer services that meet the needs of families affected by welfare reform.

public service providers in the area. They have taken many opportunities to participate in community activities and collaborate with other service providers. UCP EHS aims to reduce the duplication of services that are already available to the EHS families while working to make sure that all of the gaps in services are filled.

Program Collaborations. Many of the services that EHS families receive are arranged under contract or by agreement with community organizations and agencies. A key collaboration is with the Fairfax

County Public Health office to ensure that families have a medical home. The program has also developed a formal collaboration with the local Part C provider, the IDEA Center, which assesses EHS children and coordinates with EHS staff to develop service plans for EHS children with special needs. UCP EHS also has a formal agreement with the U.S. Army to provide child care services at the Fort Belvoir North Post Child Development Center for Department of Defense employees who are participating in EHS.

The program is collaborating with several other agencies, including the Maximus Corporation. The Maximus Corporation provides support for families around issues related to welfare reform. The program has also been in contact with local housing organizations and community development groups.

Interagency Collaboration. UCP EHS staff members serve on interagency coordinating councils and participate in community service provider organizations. Home visitors and the family/community services manager attend a monthly luncheon discussion series for service providers.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The UCP EHS program requested and received home visitor training from the Technical Assistance Support Center (TASC) at the University of Maryland. In addition, the program received key support from its federal project officer and the Zero to Three national technical assistance team.

Continuous Program Improvement. A team of researchers from The Catholic University of America's Department of Education is serving as the UCP EHS program's partner for continuous program improvement and for local research. The continuous improvement work has included surveying the home visitors and establishing the problem-solving approach now used by the staff with families and among themselves. The local research team has also worked closely with program staff to develop the program's theory of change and to refine program goals and procedures in the areas of needs assessment and family development.

At the time of the site visit, much of the early continuous improvement work was completed, and the program director reported that she was generating a new plan for how to use their remaining continuous improvement resources. The program director has targeted literacy and father involvement as two areas for continuous improvement.

Local Research. The local researchers, who have backgrounds in education and social work and are experts in special education, psychological assessments, and services for families with children with disabilities, are conducting research aimed at understanding the impacts of EHS on children with disabilities and the policies and practices that EHS programs nationally can adopt to better serve infants and toddlers with disabilities. Using data from both the national evaluation and local research, the local researchers are studying the effects of EHS participation on families with disabilities and examining the impact of staff training on making services inclusive of children with disabilities. The local researchers are also studying the empowerment of families who have children with and without disabilities and how they mobilize and use community resources; the impacts of inclusive services on parents and staff members; and appropriate assessment.

PROGRAM SUMMARY

The UCP EHS program serves diverse families, many of whom do not speak primarily English. Families can choose how they would prefer to receive services: (1) in the child development center, (2) in EHS-sponsored family child care, or (3) in weekly home visits. The program provides inclusive services to children with disabilities and works to promote inclusive

services in the community. At the time of the site visit, the program was planning to offer more slots in the child development center. It was also planning to pursue the goals of increasing father involvement and improving literacy.

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EARLY HEAD START PROGRAM PROFILE

**The Children's Home Society of Washington -- Families First Early Head Start
South King County, Washington
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The Children's Home Society of Washington operates the Families First Early Head Start program for 120 families in South King County, Washington. The Early Head Start program builds on the agency's experience as a child welfare agency. The program serves diverse families, half of whom were receiving welfare cash assistance when they enrolled. The program provides child and family development services in two ways: (1) in weekly home visits, or (2) in child care centers operated by the Children's Home Society, with monthly home visits. All families also receive monthly home visits from a public health nurse and are encouraged to attend weekly parenting education classes. Child development services focus on building supportive relationships, especially between parents and children.

OVERVIEW

The Children's Home Society (CHS) of Washington operates the Early Head Start (EHS) program in South King County, Washington. The CHS is a large, private, nonprofit organization founded in Seattle in 1896 as a general child welfare agency. CHS services include home visiting, child care, parenting education, family support services, career counseling, foster care and adoption services, professional training, residential care, volunteer programs, and advocacy. The South King County office of the CHS, which administers the EHS program, previously operated a Comprehensive Child Development Program (CCDP).

Community Context. King County, Washington, is in the northwest corner of the state and includes the Seattle-Tacoma metropolitan area. This EHS program

serves South King County (the southernmost part of King County, directly south of Seattle), which is growing rapidly. The South King County population is predominantly white. The CHS EHS program targets three cities that are among the poorest in South King County. Housing, transportation, and affordable child care--especially for infants--are among the most pressing community problems. Although South King County has many problems, it is also a service-rich region characterized by an unusual degree of collaboration and coordination among service providers.

Program Model. The CHS EHS program is a mixed model; some families receive weekly home visits, and some families receive child care in CHS child care facilities and monthly home visits. The program has three primary focuses: (1) the development of a secure infant-mother attachment, which is anticipated to serve as

a springboard for both mothers' and children's subsequent development; (2) the promotion of family health and well-being; and (3) the promotion of long-term family self-sufficiency. The focus on early infant-mother attachment represents a refinement to the CCDP model, which emphasized family development.

Families. Slightly more than half of the families served by the CHS EHS program are white, one fourth are African American, and the remainder belong to other racial and ethnic groups. Half of the families are single-parent families. Two-thirds of mothers were pregnant when they enrolled in the program. Nearly half of the families were receiving welfare cash assistance when they enrolled.

Staffing. The CHS EHS program has 40 staff members working for the CHS EHS program, 33 of whom are full-time CHS employees. Of these 33, 20 work full-time for EHS, and 13 split their time between the EHS program and other programs or responsibilities. Most of these 20 staff members are coordinators of one particular type of service (for example, home visiting) or direct service staff (home visitors, family advocates, or teachers). In addition, the CHS EHS program has contracted with seven non-CHS professionals (for example, an ethnographer and public health nurses) to work at least part-time for the EHS program.

The program director, who is also the director of the CHS South King County office, participates chiefly as an overseer, while the program coordinators are more fully involved in the day-to-day management of the EHS program. The program director previously directed the CHS CCDP program. The program director is highly experienced and provides critical leadership to the program staff. She also plays a key

role in the larger community network of social service agencies.

RECRUITMENT AND ENROLLMENT

Program Eligibility. The CHS EHS program has different eligibility requirements, depending on whether families will participate in the national EHS evaluation. All families must have incomes at or below the poverty level and live in the catchment area. For research families, the program initially planned to enroll only pregnant women but modified its eligibility criteria to include mothers with infants up to six months old to facilitate the enrollment process. For nonresearch families, children must be between 6 and 18 months old.

Recruiting Strategies. The CHS staff use multiple strategies to recruit families. Staff members contact hospitals, obstetrician-gynecologists, and public health agencies to seek referrals. They also post flyers in the community and wear buttons that say, "Pregnant? Ask me about Early Head Start." In addition, the program has placed advertisements in newspapers. The program director identified the program's close working relationship with the South King County Department of Public Health as the source of the most referrals to the program.

Enrollment. The CHS EHS program was originally funded to provide services to 120 families, 80 of whom would participate in the research. Families that are not in the research are those with children between 6 and 18 month old and those that previously participated in CCDP. At the time of the site visit, the program was serving 122 families, 92 of which are participating in the evaluation research. Of the 92 program

COMMUNITY PROFILE

South King County has a growing population spread over a sprawling area. Manufacturing jobs in companies such as Boeing traditionally have dominated this area's economy. Manufacturing jobs are becoming scarcer, however, and lower-paying service jobs (generally without health benefits) are becoming the typical form of employment. Unemployment rates for South King County were not readily available, but the unemployment rate for King County as a whole was about eight percent at the time of the site visit. South King County is predominantly white, although its newest residents are more likely to be members of racial/ethnic minority groups--African Americans, Asian Americans (especially Southeast Asian refugees), Native Americans (concentrated on the Muckleshoot Reservation in the town of Auburn), and Ukrainians.

The three cities the CHS EHS program serves--Auburn (population approximately 33,000), Kent (population approximately 37,000), and Renton (population approximately 41,000)-- are among the poorest in South King County. In 1989, approximately 12 percent of Auburn's children, approximately 10 percent of Kent's children, and approximately 7 percent of Renton's children lived in poverty. Each of these three cities is approximately 85 percent white and 8 percent Asian American, with the rest of the population made up of African Americans, Hispanic Americans, and Native Americans.

South King County has high rates of teenage pregnancy, infant mortality, and poverty. Approximately 12 percent of all births in Auburn are to 10 to 17 year-olds; in Kent and Renton, the rates of births to 10 to 17 year-olds are approximately eight percent and seven percent, respectively. The infant mortality rates in Auburn, Kent, and Renton are approximately 1.2 percent in each town. In each of the three towns, approximately 25 percent of the preschool (ages 0 to 4) population receives Medicaid and approximately 7 percent of the preschool population is uninsured. Between 1985 and 1992, the robbery rate in Kent increased 136 percent.

Affordable housing is increasingly scarce, and homelessness is a growing problem. The community lacks east-west public transportation. Buses run north and south between South King County cities and Seattle-Tacoma. Residents are more likely to need to go between towns within South King County, however, and this is difficult to do without a car. Affordable high-quality child care is also scarce. There was a long wait for state-subsidized child care spaces in King County at the time of the site visit.

South King County has many social service agencies that work hard to collaborate and integrate services. Major community-based service organizations (in addition to the CHS) are the Seattle-King County Department of Public Health, Catholic Community Services, the state Department of Social and Health Services (DSHS), and the Puget Sound Educational Service District (which includes Head Start).

families in the research sample, however, 29 had dropped out of program services for one or more of the following reasons: (1) moving away/the program is no longer convenient, (2) an overwhelming degree of life stress and chaos interfering with the ability to take advantage of program services, and/or (3) an expressed need for fewer or different services than EHS offers. When families drop out of program services, the program tries to stay in touch with them. Frequently, this involves sending notices only about enjoyable CHS events and activities to those families dealing with overwhelming life stress. If families who have moved away return, they are offered the opportunity to enroll again. The program director reported struggling between holding program slots open for very mobile and/or chaotic families (especially those that are research families) and opening these slots to new families. At the time of the site visit, both strategies were being pursued simultaneously.

CHILD DEVELOPMENT CORNERSTONE

Child development services include home visits, center-based child care, and parenting services. This program's approach to child development also overlaps considerably with its approach to family development. Specifically, the centerpiece of this EHS program is the "family resource team." Every family resource team includes a minimum of three people: the parent, a home visitor, and a public health home visiting nurse. Depending on the parent's situation and needs, others (for example, the other parent or a mental health specialist) may be part of the family resource team for a temporary or enduring period.

The family resource team works to create and follow the individual family service plan (referred to as a "family action plan") in which the child and family's needs, goals, and service plans are specified. The home visitor leads the family resource team. The entire family resource team meets approximately once every three months to evaluate and update the family action plan.

Home Visits. Prior to the first meeting of the family resource team, the home visitor and public health nurse concentrate on assessing the needs of the child and parent. The public health nurse administers the *Denver Developmental Screening Test* and the *Region X Assessments* (including completing grids documenting child growth). The public health nurse also completes several observations from the *Nursing Child Assessment Satellite Tool* (NCAST), which is an assessment battery developed by the local researcher partners). For example, as part of the NCAST, the public health nurse may conduct an observational assessment of the mother feeding her infant. The home visitor administers the *Hawaii Early Learning Profile* (HELP) and also collects data for the local research team (for example, data on parenting stress). Collecting these data helps the home visitor assess the child's situation.

As services are implemented, the first priority of the home visitor is to monitor and enhance early infant development. The HELP is used continually both to assess infants' progress on developmental milestones and as a source of activities for the parent and infant. For example, if the infant is lagging in motor skills and/or the parent has identified motor development as an area of concern or interest, the home visitor will draw on the HELP's proposed activities for promoting motor development.

The program's approach to child development focuses on building supportive relationships, especially between parents and children. The child's attachment to the parent is anticipated to serve as a springboard for children's subsequent development. A positive relationship between the home visitor and the parent is anticipated to counter a parent's history of negative close relationships, facilitate parents' participation in EHS services, and serve as a model for the infant-parent relationship. The program also emphasizes relationships between staff and children.

Home visitors give the parents ideas and activities to implement between visits, and they frequently lend parents toys and materials.

In addition to the family action plan and the HELP, the home visitors also administer the local researchers' *Interactional Coaching Curriculum*, which is designed to enhance the infant-parent relationship. Specific activities from this curriculum include working with expectant mothers to make gift baskets for the infant and to create a "psychological space" in the mother's mind for the infant (for example, to think about life with a child and to enlist the support of family and friends). After the child is born, the *Interactional Coaching Curriculum* continues by having the home visitors videotape interactions between the mother and her baby. The home visitor and parent then view and discuss the taped interactions. Many EHS parents have experienced discomfort in viewing themselves on videotape. (The local

researchers speculated that a lack of self-esteem underlies this discomfort.) For these families, videotaping is introduced especially gently and gradually.

Although the principal activities of the home visitors consist of coordinating the family action plan and administering the various curricula, another important part of the home visitors' work is the way in which these activities are implemented. The home visitors' most important task is the development of a trusting, supportive relationship with the parent. The program emphasizes the relationship between the home visitor and the parent as a gateway to enhancing the parent's development, the parent-child relationship, and the child's subsequent development.

Home visits typically last from an hour to an hour and a half. Each home visitor carries a caseload of 12 to 15 families. All EHS families whose children are enrolled in CHS child care receive home visits at least once a month. Those whose children are not enrolled in CHS child care receive weekly home visits. Home visitors are required to have a bachelor's degree in early childhood development or a related field and five years of experience.

Group Child Development Activities.

In addition to home visits, the CHS EHS program offers group parenting services. During the year prior to the site visit, the CHS hired a parent education coordinator and implemented two kinds of parenting services. The first, called Infant-Toddler Takeover, is a parent education class. The goal is to have the children take over the class and for this to be a completely child-centered time. This class involves parent educators demonstrating and encouraging developmentally appropriate and enjoyable child-parent activities such as sitting on the

floor and singing. This class is open to all EHS families and is offered once a week at the Kent CHS center. Transportation and child care for siblings is provided as necessary.

The second type of parenting services, called Playworks, is a parent education class for infant-parent pairs who are experiencing attachment difficulties. The goal is to increase infants' experiences of sensitive and responsive caregiving while working with parents to enhance their skills in this area (for example, teaching infant cue-reading and encouraging holding with eye contact). Playworks is a 10-week set of services that can accommodate up to eight parent-infant pairs or families at a time. There are three half-day sessions per week at the CHS Kent facilities. The parent(s) attend at least one of these three sessions, with transportation provided by the CHS as necessary. Parents participating in Playworks are also given activities to practice at home. These activities are carefully coordinated with the home visitors' work.

In addition to the parenting services just described, which are specifically for EHS parents, the CHS operates four other parenting education programs at various community locations. These classes are open to the public, and child care is provided. EHS parents are made aware of these services and referred to them as necessary. At the time of the site visit, 38 EHS parents had availed themselves of these services.

Center-Based Child Development Services. In addition to providing home visiting services, the CHS operates and provides access to several child care facilities. At the time of the site visit,

approximately half of the program children were receiving child care services.

Since the previous site visit, the CHS had opened a new multiclassroom toddler and preschool center--the Green River Community College Child Care Center. This center accepts children from 18 months through four years of age. The two toddler classrooms can accommodate up to 12 children at a time, and half of the child care slots are reserved for EHS children. At the time of the site visit, the CHS EHS program was in the process of opening an infant-toddler center at the General Services Administration (a federal agency). Again, half of these slots will be reserved for EHS children.

Depending on the parents' needs, EHS children in CHS child care attend between three half-day sessions (12 hours per week) and five full-day sessions (up to 50 hours per week).

CHS child care services follow several sets of guidelines and curricula. A lead teacher, a teacher, and one or two student interns staff each classroom. Child care staff must have an associate's degree in early childhood education degree or a child development associate (CDA) credential, or they must complete CDA certification within one year of joining the staff. Lead teachers must have a bachelor's degree in early childhood education plus five years of experience.

Children are assigned to primary caregivers. Infants are cared for in groups of up to six infants, with a child-staff ratio of up to 3 to 1. Toddlers are cared for in groups of up to 12 toddlers, with a child-staff ratio of 4 to 1. EHS child care services emphasize socioemotional development and

COMMUNITY CHILD CARE

At the time of the site visit, half of the EHS families were using child care. Most children were receiving care in the program's centers, but a few were receiving care in other settings.

Although the quality of child care in South King County in general is perceived to be better than adequate, the supply of high-quality child care, especially for infants and toddlers and for children of parents who need child care during nonstandard hours, is not sufficient to meet the need for it. In addition, state child care subsidies for infants and toddlers cover only two-thirds of the price of formal child care. Because of these constraints, as well as concerns about entrusting the care of infants to unfamiliar people or child care centers, families relying on subsidies tend to use in-home care by neighbors, friends, and relatives.

At the time of the site visit, CHS EHS staff members and community members anticipated that existing child care slots would not be sufficient to meet the increased demand for child care resulting from the new welfare reform requirements. At that time, however, the community had not yet mobilized to address this concern.

self-help skills. Activities are planned based on National Association for the Education of Young Children (NAEYC) standards, *Learning Activities for Infants, Ones, and Twos*, and the *Anti-Bias* curriculum. Teaching children to label their emotions and working to make child-parent separations easier are two specific sets of child care activities. CHS child care services also emphasize sensitivity to cultural diversity: different ethnic foods are served, and various types of holidays are celebrated. Finally, CHS child care services emphasize parental involvement and parent-staff relationships. Parents are encouraged to become involved in classroom activities, even tangentially (for example, by sharing a favorite recipe with the cook). The children's primary teacher visits the family at home four times per year.

Other Child Care Services. If a parent wants child care but chooses not to have her

child participate in a CHS child care program, EHS staff members work with the parent to help her find a high-quality arrangement for her child. This includes assessing child care programs/situations with standard assessment tools such as the *Infant Toddler Environment Rating Scale*. In some cases, child care costs will be covered. If a parent's child care selection does not meet CHS standards, however, costs will not be covered and home visits typically are increased. Finally, respite child care is also available at several CHS facilities.

Child Development Assessments. As noted earlier, the program conducts an initial child assessment using the *Denver Developmental Screening Test, Region X Assessments*, the *Nursing Child Assessment Satellite Tool*, and the *Hawaii Early Learning Profile*. Ongoing assessments are

conducted using the *Hawaii Early Learning Profile*.

Health Services. In addition to participating on the family resource team, the public health visiting nurse provides a comprehensive set of health and safety services and assessments. This includes providing information about breast-feeding, infant nutrition, and infant development and completing the *Home Observation Measure of the Environment* (HOME). Each public health home visiting nurse carries a caseload of 40 to 50 families. The public health nurses visit each parent at least once a month for 45 to 60 minutes.

The public health home visiting nurses are responsible for making sure that each EHS child has a medical home. They work with mothers to develop and maintain family health plans that identify primary health and dental providers, record immunization schedules, and ensure that family members receive needed health care.

Services for Children with Disabilities. The CHS has an interagency agreement with the Washington State Division of Developmental Disabilities, the local agency for Part C. If an EHS infant is identified as having a disability, the family will be referred to a Child Therapy Center for children ages 0 to 3, or staff members from that center will come to a CHS facility. The child's disability services become an explicit part of the family action plan. Specific services provided include respite and therapeutic support for families, in-home chore services, parent education and groups, and staff training. At 30 months, the child becomes eligible for special services provided through the public school system. The CHS encourages parents to link with to public school services as early as possible, to gain experience and confidence in working

with the school system. At the time of the site visit, approximately 12 percent of the EHS program children had suspected or diagnosed disabilities.

Transitions. At the time of the site visit, the program was planning to facilitate children's transitions into Head Start by arranging visits to Head Start classrooms and meetings with teachers. For children in South King County, the program was planning to seek special dispensation for moving 3-year-old children into Head Start, which serves mostly 4-year-old children. The program had not yet made plans for facilitating children's transitions to other programs.

FAMILY DEVELOPMENT CORNERSTONE

Needs Assessment and Service Planning. The family resource team works with parents to create and follow a family action plan. To develop the plan, the family resource team conducts a card-sorting activity in which the parent prioritizes her needs and concerns in five areas: (1) basic needs, (2) economic development, (3) physical health, (4) mental health, and (5) child development and parenting. For each area parents sort activity cards into three piles: (1) what I do now, (2) what I want to do, and (3) what I don't do now OR what doesn't apply. The parent then contracts with the home visitor on steps to pursue her most pressing goals. The home visitor and the parent complete a set of forms documenting the parents' goals, the steps she will take to accomplish her goals, and the time frame in which she will complete her plan. The goal of this system is to promote parents' taking responsibility for designing, as well as for following, their service plans.

The CHS EHS program's approach to the family development cornerstone involves building on family strengths to support parents' well-being. The program focuses on self-development, positive relationships, and long-term self-sufficiency. Family development services are highly individualized; they also promote maximum parental participation in the design and maintenance of service plans.

Case Management. When other services are needed, the home visitor will help connect the parent with these services, either within the CHS or in the larger community. When referring parents to other CHS services, staff emphasize parental responsibility. For example, if a mother needs clothes for herself or her children, she is referred to the CHS clothing bank. To receive clothing, however, the mother must agree to do volunteer work at the clothing bank or make a donation to the clothing bank (provide a "clothing exchange").

In addition to the home visitors and the public health home visiting nurses, key staff members who contribute to the family resource team and family development cornerstone are the family advocate, the economic development coordinator, and the mental health specialist. The family advocate coordinates emergency services and services for families' basic needs (such as housing or food). The economic development coordinator meets with all parents within six months of enrollment to assess initial employability and to formulate an individual training plan. Thereafter, the economic development coordinator is available to work with parents--principally

through referral--on goals related to literacy, education, job training, and employment. The mental health specialist is a psychotherapist (psychiatric nurse practitioner) for the CHS whose first priority is counseling EHS participants on an as-needed basis. Mental health concerns in this population include maternal depression, the lingering effects of mothers' childhood traumas (for example, maltreatment, especially sexual abuse), and life skills (for example, anger management).

Father Involvement. The CHS EHS program works with both fathers and mothers and encourages the father-child relationship as well as the mother-child relationship. The program has taken several special steps to encourage fathers' involvement in program services, including holding a "Dad to Dad" class for fathers and their children, sponsoring "Dad's night out" field trips to ball games, sponsoring a father's fishing trip, and holding special work parties to make repairs at the program site.

Parent Involvement in the Program. Given that the CHS EHS services are delivered directly to parents, parent involvement is a built-in component of this program. In addition, parents are recruited to volunteer at the program's clothing bank and at special events (such as a "back-to-school" fair). Parent council meetings are held, although participation at these meetings is not consistent. The program director described many parents as being intimidated by the idea of participating on the council. To counter this, more willing participants are asked to recruit other parents, and minutes of the parent council meetings are sent to all parents. Social events for parents (for example, potluck dinners) are also offered. Finally, the CHS has a history of involving its program

participants on its regional advisory boards and agencywide board of trustees.

STAFF DEVELOPMENT CORNERSTONE

The CHS EHS program follows a comprehensive staff development plan. The staff development plan is organized according to the CHS South King County Strategic Plan and the four EHS cornerstones. The agency's Strategic Plan requires it to "offer a work environment that is highly motivating, supportive, provides for individual responsibility, [and] recognizes and rewards both team and individual staff performance." The program's staff development objectives are to (1) recruit staff that have the knowledge, skills, and experience to provide high-quality, comprehensive, culturally appropriate, and family-centered services; (2) develop an effective model for ongoing staff training and mentoring; and (3) offer competitive salaries, compensation, and career advancement.

Training. The program's Staff Development and Training Plan consists of five training modules: (1) child development, (2) family development and self-sufficiency, (3) community building, (4) staff development, and (5) continuous improvement. Each training module, in turn, consists of a number of specific training objectives. Home visitors and child care providers attend a series of workshops on parent-child interactions and also receive special training in working with children with special needs. In addition, the local research partners have trained the public health nurses and home visitors in the NCAST and *Interactional Coaching Curriculum*. Staff members described this training as extremely valuable. For the

family development cornerstone, the program conducted several preservice, all-staff training sessions on such topics as family support principles and practices and family empowerment.

Ongoing staff training opportunities include periodic reviews of assessment tools; regular meetings on the mission, values, and goals of the agency; statewide management and supervision training workshops; and special within-program workshops offered on an as-needed basis (for example, on fetal alcohol syndrome and developmental disabilities). The program uses staff action plans to monitor staff development.

Supervision and Support. The CHS EHS program holds numerous regular staff meetings. All-staff meetings are held quarterly. The leadership team, which includes the program director, home visitor coordinator, parenting education coordinator, and child care director, meets weekly. Home visitors meet weekly for approximately two hours; these meetings provide a context for informal training (sharing of ideas, problems, and solutions) and for social support. Child care staff members also meet weekly, as do the family advocates. In addition, staff members meet as needed to conduct case conferences on specific families.

Many direct service staff consider the staff salaries paid by the CHS program to be low.

Staff Turnover. The program had experienced a fair degree of staff turnover during the year prior to the site visit. Two people working for the management and financial arm of CHS's South King County

WELFARE REFORM

Seventy percent of EHS families are estimated to be eligible for Temporary Assistance for Needy Families (TANF), and about half were receiving cash assistance when they enrolled in the program. At the time of the site visit, the Washington State TANF program, called WorkFirst, was about to begin operating (November 1, 1997). The WorkFirst program specifies that, after two years of welfare receipt, recipients must participate in work activities. These activities include paid employment, job training, community service, and vocational education training (for up to 12 months). Families may not receive cash assistance for more than five years over their lifetime. New parents are exempt from WorkFirst for 12 months. By June 1999, however, this exemption will be cut to 12 weeks. To remain eligible for benefits, unmarried minor parents and unmarried pregnant minor applicants must live in the most appropriate living situation as determined by the DSHS. Minors must be actively working toward a high school diploma or GED.

EHS staff members, as well as other community social service providers, were anticipating that welfare reform would result in a huge increase in families' need for child care. In the meantime, EHS staff members described parents as highly unaware of changes in the welfare system. Staff members expressed concern that the welfare reform requirements are too demanding and that, by forcing poor young parents into dead-end, low-skill jobs, the requirements will prevent these parents from becoming fully self-sufficient.

DSHS staff members will serve as case managers for families trying to arrange work activities. The EHS program director voiced concern that these staff members will not receive appropriate training to prepare them for their case management role. This concern motivated the EHS program director and economic development coordinator to devise a plan to work closely with both families and the DSHS on job training and job placement activities. Families will be instructed to contact the economic development coordinator as soon as they receive notice of specific TANF requirements. At this point, the economic development coordinator will help the parent prepare a special dossier illustrating past work experience, skills, current family situation, and any other pertinent information that will help the DSHS caseworker make the parent's transition from welfare to work easier.

office resigned. Several home visitors resigned; one was hired away by a better-paying EHS program in Seattle. The home visitor coordinator took maternity leave. Finally, at the time of the site visit, the program director was seeking to hire another program director so that she could focus more on the directorship of the CHS South King County region as a whole.

COMMUNITY BUILDING CORNERSTONE

Program Collaborations. The CHS has 25 interagency contracts and 17 informal interagency agreements with other community service providers. The three agreements that affect EHS families most directly are (1) a contract with the Seattle-

King County Department of Public Health, which provides public health home visiting nurses; (2) a contract with the King County Work Training Program, which provides the economic development coordinator; and (3) a contract with Catholic Community Services to allow EHS participants access to its Emergency Assistance Program, which provides emergency food, shelter, and cash grants.

Interagency Collaboration. South King County is a service-rich region characterized by an unusual degree of collaboration and coordination among service providers. The application for and receipt of the EHS grant led to even more collaboration. Specifically, contracts for services and interagency agreements have increased. In addition, service plan agreements have been made within a "community planning consortium," an interagency collaborative group. These agreements specify that EHS children must have a single case manager and single service plan; the purpose is to make unified and integrated service delivery easier and to avoid service duplication or contradiction. The program views each of these steps as important achievements under the community development cornerstone.

Community Building. Community development is also expected to be addressed indirectly--through the child development, family development, and staff development cornerstones. The EHS program is anticipated to enhance the development of this community's youngest citizens; eventually, this should enhance the quality of the community as a whole. As EHS services increase parents' knowledge (for example, knowledge of early development and of high-quality services) and self-sufficiency, they also should become more productive citizens, role

models, advocates (for example, in the public school system, in other social service agencies), and community leaders. The newly formed parent policy council should link EHS parents in new ways. Finally, staff members believe that the existence of EHS services has already raised community awareness of the importance of very early (ages 0 to 3) development.

CONTINUOUS IMPROVEMENT AND LOCAL RESEARCH

Early Program Support. The program director has participated in conference calls with other regional EHS programs set up by the Technical Assistance Support Center (TASC) to address general program administration issues. The program seeks training or technical assistance from its TASC or Resource Access Project (RAP) through conference calls. The program received a site visit from the Zero to Three national technical assistance team and its federal project officer and has maintained contact for clarifications.

Continuous Program Improvement. The CHS EHS program works closely on continuous program improvement with its local research team, which includes several researchers from the University of Washington Department of Child and Family Nursing. The researchers have expertise in early childhood socioemotional development (especially attachment theory and research), child care, early intervention, and program evaluation. The program director also worked with this local research team on the CCDP project.

Continuous program improvement efforts focus on understanding families' characteristics and needs, families' engagement in program services (especially

as it relates to staff-family relationships), and tailoring program services to families' needs. Data for continuous program improvement and local research will be collected by the CHS staff members and by local research staff in child and mother assessments conducted when the child is 3, 14, 15, 24, 25, 36, and 37 months old. The local researchers will also create quarterly case summaries of 12 to 14 cases followed from pregnancy through the child's third year. Finally, the ethnographer from the CCDP project will sit in on staff meetings and observe the child care centers in order to contribute to continuous improvement. The implementation of the Playworks parenting education classes was a direct response to concerns the local researchers raised about some infants' developing attachments.

Local Research. The local research focuses on close relationships, especially the role of the mothers' early attachments in how involved they get in EHS services and subsequent child and family outcomes. The central outcome domains include family functioning, child development, and family-staff relationships. Particular attention will be focused on child-mother attachment security, child language development, and child-staff and mother-staff relationships processes. The quality of child-mother, parent-child, parent-staff, and child-staff interaction is being assessed when children are 15, 24, and 36 months old.

The research will also examine the effects of the *Interactional Coaching Curriculum*, focusing on the associations between mothers' attachment security and their participation in this program component, the influence of the *Interactional Coaching Curriculum* on the child-mother attachment and the child's language development, and the associations between mothers' participation in the

curriculum and their participation in other EHS services.

PROGRAM SUMMARY

In the CHS EHS program, a family resources team provides child and family development services to families in home visits, weekly, or, if the child receives care in a CHS child care center, monthly. At the time of the site visit, CHS was opening a new infant-toddler center and increasing the child care slots available to EHS families. CHS was also anticipating the appointment of a new EHS program director to enable the current program director to focus on CHS management as a whole.

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