



**Leading the Way:
Characteristics and Early Experiences
of Selected Early Head Start Programs**

Volume II: Program Profiles

December 1999

The Commissioner's Office of Research and Evaluation
And the Head Start Bureau
Administration on Children, Youth and Families
Department of Health and Human Services

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.*

This report was prepared for the Administration on Children, Youth and Families, U.S. Department of Health and Human Services (DHHS), under contract HHS-105-95-1936. The contents of this report do not necessarily reflect the views or policies of DHHS, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

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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.

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

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.

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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

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 (NWTTHS) 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. NWTTHS 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. NWTTHS 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. NWTTHS 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

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)

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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

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.

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.

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.

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

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

¹At 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

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

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

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

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.

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

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,

