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Lessons Learned from the Early Head Start Program

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Introduction

Early Head Start (EHS) is a federal, two-generation program to enhance children's development and families' functioning. It serves low-income pregnant women and families with infants from birth to age 3 in the United States. EHS began in 1995 and in 2010, the American Reinvestment and Recovery Act of 2009 allocated $1.1 billion (U.S.) for it, allowing the program to add 50,000 enrollment slots in fiscal year 2009-2010.[1] In 2014, Congress appropriated a half a billion dollars to expand EHS slots through Early Head Start—Child Care Partnerships (EHS-CCP) grants. By 2017, funded EHS slots increased to more than 150,000.[2] Even so, EHS serves less than 10 percent of eligible children.[2]

Programs are charged with providing high quality, comprehensive, developmentally enriching services to children and services to parents that support them in their role as primary caregivers and encourage self sufficiency. These comprehensive services include core early education and child development, health, oral health, mental health, nutrition, family support, and family and community engagement services (per the revised Head Start Program Performance Standards[3]). Programs help ensure that families receive needed services by acting as a bridge to the

community to link families to services. Service integration is built into the model because of its two-generation focus and emphasis on providing comprehensive services. Programs must work to establish ongoing collaborative relationships with community organizations to promote access to services.[3]

Subject

It is expected that families need supports beyond the child and family development services provided through home visits and center-based care, and no single program will likely meet all needs. To create comprehensive integrated services, the performance standards require programs to facilitate communication and cooperation among community providers and document their own efforts to establish partnerships.[3] These partnerships are meant to promote service integration, coordination and seamless access to services.

Problems/Issues

Programs face a number of challenges in providing comprehensive integrated services. Making the services available is necessary but not sufficient; there may be a need to follow up to ensure appointments are kept or to provide other supports (such as transportation). Providing specialized services may be challenging if there are few such providers in the community. Further, programs that partner with community child care providers must ensure that partners also meet Early Head Start quality standards. Another challenge to service provision is the prevalence of non-English/non-Spanish languages in many programs, which can make it difficult to provide services in the languages families speak. Moreover, current immigration policy, presents challenges for some programs that serve immigrants. These programs must combat lack of trust that could prevent families from taking up needed services.

When children reach 2½ years of age, programs plan for their transition from EHS. Transition planning fosters service integration by identifying appropriate placements, then establishing lines of communication, sharing records and communicating the progress and needs of the child and family to the new provider. Ideally, other services also continue after transitions, again depending on service availability and families' continued eligibility (they must re-qualify financially for Head Start, which can be a barrier to entry).

Research Context

EHS has been studied extensively, in terms of its effects on children and families and its implementation. The early work of the Early Head Start Research and Evaluation Project (EHSREP) showed that children and families in the 17 original research programs benefitted from EHS in numerous domains and that benefits in some domains (for example, children's social-emotional development), found at age 2 extended to ages 3 and 5, two years after program eligibility ended.[4,5,6] Implementation studies of the early program showed progress in establishing community partnerships that increased the availability of services for families. Accordingly, impacts were stronger impacts for programs that were fully implemented early in the study.[5,7]

The Survey of Early Head Start Programs (SEHSP)[8] conducted a national survey of program directors to examine program organization (including use of partnerships). More recently, a study of a nationally representative sample of EHS programs, the Early Head Start Family and Child Experiences Survey (Baby FACES 2009),[a] included a census of nearly 1,000 children in two birthday windows (prenatal/newborns or about 1 year old) and followed children and families until age 3 or until they left the program. The study collected information on partnerships, documented service receipt and referrals, tracked program exit, and assessed program quality and parent involvement.[9,10] As part of Baby FACES 2009, the provision and receipt of core child development services in home-based or center-based options were tracked on a weekly basis by program staff. Currently, another national descriptive study of EHS (Baby FACES 2018) is underway to extend the lessons learned from Baby FACES 2009. It focuses on the processes in EHS programs (classrooms in particular) that support infant/toddler growth and development in the context of nurturing, responsive relationships.a Also underway is the study of Early Head Start—Child Care Partnerships (EHS-CCP) that will document the characteristics and features of EHS-CCP partnerships and activities.[b]

Key Research Questions

We know much about the services that programs offer and families actually receive but less about how EHS programs engage with community partners to provide services and how programs integrate services. Understanding how partnerships work in practice and the barriers to full collaboration could spark similar work to help programs become more effective partners and leaders. Also less clear is how programs support responsive relationships between: teachers and children, teachers/home visitors and parents, and parents and children to affect child and family outcomes. Unpacking the black box of program processes would help support teachers and home

visitors and improve professional development and quality of services to better meet families' needs.

Recent Research Results

With regard to services provided through partnerships, Baby FACES 2009 found:

1. Nearly all programs (98 to 100%) offered a variety of services to support family self-sufficiency, typically through referral, including financial counseling, education or job training, and employment assistance.
2. Nearly all programs (95% to 98%) offered key child and adult health care services, mostly through referral.
3. Most programs (77%) offered mental health screenings to families and offered therapy services through referral or by a community partner on site.
4. 93% of programs had a formal written partnership with a Part C provider.[c]
5. More than one-third of programs maintained at least one formal partnership with a child care provider, and about 25 percent of children in these programs were served through these partners.

With regard to services families received, Baby FACES 2009 found:

1. The rates of service take-up for core child and family development services (home visit completion and center attendance) are fairly high on average. Families in the home-based option for a full year completed about three-quarters of the home visits offered. Children who are in the center-based option for a full year attended about 85 percent of center days offered.
2. Most mothers of newborns (80%) reported receiving services provided by EHS during their pregnancies, most frequently receiving pregnancy-related information, on topics such as breastfeeding, nutrition, or how to take care of themselves or babies.
3. Apart from services specifically related to pregnancy, families reported receiving a range of services from EHS or from community agencies referred by EHS, including health services, finding good child care, financial support, help with job search or job training, with more than 10% to 20% of families receiving these services. Relatively few families received

transportation assistance, help with a job search or job training, financial supports, mental health services, or a variety of other services.

4. About 70% of families received at least one referral in one year—those who received at least one referral averaged six a year. Families who did not receive a referral were more likely to be African American and a single-parent household, and have a mother who is employed, but less likely to have a child who is a dual language learner.

In sum, we know about common types and basic features of partnerships and how they are used in practice but much less about how programs actually work to support and promote responsive relationships (for example, through professional development, use of data, and service coordination and referrals).

Research Gaps

Research on how services are integrated and whether services match family needs is lacking. In Baby FACES 2009, 35% of families left the program before their eligibility ended.[11] Families with higher risk levels were less likely to be rated as highly involved in the program compared to families with lower risks. Receipt of services while enrolled varied and service use was also associated with risk level. Higher-risk families received fewer services, likely because they were more difficult to engage and serve.[5,7,11] Apart from risk, family involvement in the program may predict early program exit. However, even with the information collected in Baby FACES 2009, we still do not fully understand the circumstances related to early exit and what programs can do to keep children enrolled. We also know less about the uptake of services other than core child and family development services.

Baby FACES 2018 focuses on program processes and functioning, classroom features and practices, and home visit processes. The findings will add to our understanding of how EHS programs support responsive relationships to promote infant/toddler growth and development.

Conclusions

EHS has shown positive effects for the families and children it serves. Service integration seems relevant to the positive effects of the program in that positive impacts were found both for fully implemented programs (which included establishing partnerships to integrate services) and for those that provided both center and home-based services (giving families access to whichever

was more appropriate for their needs).[5,6]

Programs have clear practice guidelines in the revised Head Start Program Performance Standards, and evidence suggests that they are successful in establishing community partnerships to offer an extensive menu of services. Many facilitate families' access to services by providing them at the program site. Moreover, most families received core child development services as well as a wide range of other services from EHS or from other community agencies through referrals. Nonetheless, we know little about whether services match families' needs and about gaps in service provision. These gaps are not necessarily a shortcoming of the EHS program, but may be related to the availability of services in the community. Further hampering understanding is that programs do not use a standard management information system (MIS) to collect data on service use.[8] Although nearly 90% of programs reported using an MIS,[8] individual programs vary greatly in terms of the types of data stored and staff members' technical skills to use them. Hence, there is no readily available national family-level information at this time, although Baby FACES 2018 and a planned Baby FACES 2020 will begin to address this gap.

Implications

Research to find ways of collecting standardized data about service use would help programs to identify any gaps and any families who need more support to take up needed services. Programs that do collect these data might require support to use them effectively.

At a national level, findings on service receipt at the individual family level from Baby FACES 2009 helped identify the characteristics of families and programs associated with higher and lower use of services and with particular types of services used. Such data might suggest strategies for identifying and engaging these families sooner and more effectively. With more findings coming in from Baby FACES 2018, it would be helpful to find ways to add to what we know and make findings accessible to wider audiences so that they can be used by practitioners and the research community.

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Notes:

[a] See Early Head Start Family and Child Experiences Study (Baby FACES), 2007-2020. Office of Planning, Research and Evaluation Web Site. https://www.acf.hhs.gov/opre/research/project/early-head-start-family-and-child-experiences-study-baby-faces. Accessed May 1, 2018.

[b] See the Study of Early Head Start-Child Care Partnerships, 2013-2018. Office of Planning, Research and Evaluation Web Site. https://www.acf.hhs.gov/opre/research/project/early-head-start-child-care-partnerships-study. Accessed May 1, 2018.

[c] Part C of the Individuals with Disabilities Education Act (IDEA) is a federal grant program. It provides funds to help states operate comprehensive statewide early intervention services for infants and toddlers with disabilities from birth through age 2 and for their families.