

Advisory Committee on Head Start Research and Evaluation

Final Report

August 2012





Advisory Committee on Head Start Research and Evaluation: Final Report

Submitted to the Secretary of
the U.S. Department of Health and Human Services

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The findings of this report are those of the Advisory Committee on Head Start Research and Evaluation. They do not necessarily reflect the view of the U.S. Department of Health and Human Services.

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Foreword

THE ADVISORY COMMITTEE ON HEAD START RESEARCH AND EVALUATION: HISTORY AND PURPOSE

Congress first called for the Advisory Committee on Head Start Research and Evaluation (the “Committee”) in its 1998 reauthorization of the Head Start program, with a requirement that the Secretary of Health and Human Services convene a panel of experts to inform the Department about the design of a newly required national evaluation of the program. The Committee was first chartered in 1999 and produced a report with recommendations for the design of what came to be known as the Head Start Impact Study (HSIS), along with recommendations for considering the findings of this study in the context of other research. The Committee was then re-chartered several times during the design and implementation of the study, in order to provide the Department feedback on the study’s progress and findings (see Appendix B for details on the timing and membership of the Committee over the years).

The final Congressionally-required report from the HSIS was published in January 2010, generating a great deal of conversation about how to understand and interpret the findings. Secretary Kathleen Sebelius re-chartered the Committee in May 2010, and again in May 2012, with the goals of having the Committee comment on the study findings; identify research-based recommendations for improving Early Head Start (EHS) and Head Start practice, as well as early childhood practice more generally; and identify priorities for future research.

COMMITTEE MEMBERSHIP

The Committee charter called for 21 individual members and 6 ex-officio (federal) members. The membership was to include researchers with expertise in child development, early childhood education and development programs, research and evaluation, and methodology. Twenty-one individuals were invited to participate, and 19 of these individuals accepted. In addition, six ex-officio members were invited¹. Appendix B includes a list of all Committee members and the period of their membership.

¹ One Committee member resigned during the Committee’s tenure and another was added. In addition, there was some turnover in the ex-officio membership, due to individuals leaving federal service. See Appendix B for a list of all members and their tenure on the Committee.

MEETINGS AND SUBCOMMITTEES

The Committee met five times between January 2011 and January 2012 to discuss key aspects of their charge. Each of these meetings took place in the Washington DC area. All meetings were open to the public. In addition, the Committee formed five subcommittees focused on the following topics: 1) The Impact of Head Start and EHS on Children and Families; 2) Quality Teaching and Learning; 3) Parent, Family, and Community Engagement (PFCE); 4) Health and Mental Health; and 5) Cultural and Linguistic Responsiveness².

Each of the five meetings was two days in length. The first meeting focused on evidence related to the effectiveness of Head Start and EHS, including a detailed review and discussion of the HSIS, the Early Head Start Research and Evaluation Project (EHSREP), and other studies of the long-term effectiveness of these programs³. The Committee also heard presentations from experts related to the continuity of early childhood programs and their impacts. The next three meetings focused on the topical areas of Quality Teaching and Learning; PFCE; Health and Mental Health; and Cultural and Linguistic Responsiveness. In each of these discussions there was an initial presentation on current policy initiatives and the most recent Head Start data available within the relevant content area. This presentation was followed by a series of panels on which experts in the content area presented evidence on the state of the research and effective early childhood practices in that area.

The final meeting in January 2012 focused on Committee deliberations around proposed recommendations. At this meeting, each of the five subcommittees presented potential recommendations relevant to its content area. The Committee charged a sixth subcommittee with identifying a set of overarching themes that would serve as the Committee's primary recommendations.

COMMITTEE REPORT

The first chapter of this report presents the Committee's vision for Head Start and its recommendations for steps to achieve that vision. These three recommendations are overarching and cut across all component and topic areas of Head Start. These recommendations are supported by five topical chapters. The first presents the Committee's reflections on the impact of Head Start and EHS, based upon the findings of the HSIS and EHSREP, as well as the broader literature on the effectiveness of Head Start. The remaining four chapters describe the Committee's vision for each of the four content areas addressed in their work, and provide detail on priorities for the implementation of the Committee's recommendations within each of these four content areas.

² See Appendix C for subcommittee membership.

³ Agendas and presentations from the Committee meetings can be viewed at http://www.acf.hhs.gov/programs/opre/hs/advisory_com/.

Advisory Committee on Head Start Research and Evaluation

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Table of Contents

Acknowledgements	i
Foreword	iii
The Advisory Committee on Head Start Research and Evaluation: History and Purpose.....	iii
Committee Membership.....	iii
Meetings and Subcommittees	iv
Committee Report	iv
Advisory Committee on Head Start Research and Evaluation	v
Committee Members.....	v
Ex-Officio Members	vi
Chapter 1: Recommendations of the Advisory Committee on Head Start Research and Evaluation	1
Head Start History.....	1
The Current Policy Context for Early Childhood Programs	4
A More Informative Science Base	6
The Committee’s Vision for Head Start	8
Federal and Local Roles in Implementing the Vision	9
The Path Forward: Committee Recommendations	11
Discussion of Committee Recommendations.....	13
Chapter 2: Understanding the Impacts of Head Start and EHS	27
Overview.....	27
General Conclusions About the Impact Studies	29
The Path Forward: Further Specification of the Committee’s Recommendations.....	36

Chapter 3: Quality Teaching and Learning	43
Overview.....	43
Head Start Today: Quality Teaching and Learning.....	43
The Committee’s Vision For Quality Teaching and Learning	49
The Path Forward: Further Specification of the Committee’s Recommendations.....	49
Chapter 4: Parent, Family, and Community Engagement	61
Overview.....	61
Head Start Today: Parent, Family, and Community Engagement.....	62
The Committee’s Vision for Parent, Family, and Community Engagement	66
The Path Forward: Further Specification of the Committee’s Recommendations.....	67
Chapter 5: Health and Mental Health	77
Overview.....	77
Head Start Today: Health and Mental Health	78
The Committee’s Vision for Health and Mental Health.....	81
The Path Forward: Further Specification of the Committee’s Recommendations.....	83
Chapter 6: Cultural and Linguistic Responsiveness	95
Overview.....	95
Head Start Today: Cultural and Linguistic Responsiveness.....	96
The Committee’s Vision for Cultural and Linguistic Responsiveness	101
The Path Forward: Further Specification of the Committee’s Recommendations.....	102

Appendix A: Charter for the Advisory Committee on Head Start Research and Evaluation	A-1
Appendix B: Full List of Committee Members	B-1
Appendix C: Subcommittee Membership	C-1
Appendix D: Invited Presenters and Presentation Topics	D-1
Appendix E: Acronym List	E-1

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Chapter 1: Recommendations of the Advisory Committee on Head Start Research and Evaluation

This Report of the Advisory Committee on Head Start Research and Evaluation presents the Committee’s recommendations for improving Head Start program effectiveness based on the current research base and current thinking about best practices across multiple disciplines. These recommendations are also informed by changes that have occurred in the context of early childhood education (ECE) over the past decades. Much has changed in our nation and within Head Start in particular since 1965 when Head Start began, and even since 1995 when Early Head Start (EHS) was launched. There have been major changes in the population of children in the country, we have witnessed an intensified focus on school readiness, and there have been new efforts to build more coordinated systems of services for children from birth through age 8. Yet much remains the same. Head Start still serves the nation’s poorest and most at risk children during the early years when their brains are growing fastest and when they are most amenable to interventions to protect their development, and optimize their health, capacity for learning, social skills, and school readiness.

The Advisory Committee’s recommendations are based on an intensive review and extensive deliberation on the implications of Head Start’s history and unique features, the current and evolving policy context for early childhood programs, and our enriched body of knowledge on early childhood program interventions, including rigorous studies of Head Start and EHS.

HEAD START HISTORY

Any report intended to shape Head Start’s future must first acknowledge the developmental trajectory that has brought it to where it currently stands. Initiated as a part of President Johnson’s “War on Poverty,” Head Start was created out of concern for the well-being of children in low-income families—based on evidence that children who were raised in poverty were less likely than more advantaged children to complete school or to find stable employment, had more health and developmental challenges, and were more likely to be poor themselves in adulthood. As its name implies, the Head Start program was developed to enhance the experiences of children in low-income families prior to school entry, with the goal of alleviating the effects of growing up poor.

At its inception in 1965, Head Start was the only large-scale child development program in the United States. It was visionary then, and in many ways continues to lead the early education

community. For example, Head Start has been and continues to be a leader in its focus on family engagement and comprehensive services, on children with disabilities, and on children from diverse cultural and linguistic backgrounds; in its commitments to accountability for program quality; in its investments in the professional development of the ECE workforce; and in its commitment to and investment in research and evaluation to improve practice in all aspects of the program. In recent years, Head Start extended its focus to include the first three years of life through the EHS program.

From its inception, the Head Start program has been guided by the current research on child development. Its guiding principles of supporting the development of the “whole child” and providing support to families and communities built on evolving theories about the ecological systems that affect children’s long-term development^{i,ii,iii,iv,v}. From the beginning, Head Start emphasized the importance of a comprehensive program that would result in a well-rounded, socially competent child. Cognitive, language, social emotional, health, physical development—all were considered important.

As the program grew, it expanded opportunities for children to receive high-quality services in a number of ways. It transformed from an eight-week summer program to—most commonly—a part-day nine month program that serves children during the school year. Over time, Head Start grew to serving both 3- and 4-year-old children and was expanded to reach children in migrant and seasonal farm worker families, and American Indian and Alaska Native (AI/AN) children. In the early 1970s, Head Start was first required to ensure that 10 percent of the enrollment opportunities for children served nationally were reserved for children who had disabilities. In 1994, the EHS program was authorized to serve pregnant women and children from birth to 3 years of age.

At the same time as it was expanding its reach, the Head Start program was also building an infrastructure to support quality, an effort for which there was little precedent. Head Start published its first set of Program Performance Standards in 1974, along with implementation of a rigorous on-site monitoring process for ensuring that standards were being met. Head Start Program Performance Standards (Performance Standards) have been revised several times with an increasing emphasis on the quality of services for children and families. Head Start has also provided training and technical assistance (T/TA) to support programs in providing professional development to staff members and program managers, and in remedying deficiencies in quality. Further, Head Start has expanded accountability to include replacement of grantees that were unable or unwilling to provide high-quality services and sound management practices.

This increased emphasis on Performance Standards included an increased emphasis on teachers’ professional competencies. In 1972, Head Start initiated development of the Child Development Associate (CDA) credential, with the goal of increasing the competency of Head Start teachers. The CDA soon became a foundation for professional development in Head Start and in the ECE community at large. The CDA continues to serve as a valuable entry certification for early childhood

teachers, as Head Start has continued to raise the bar by requiring all teachers to possess associate and/or bachelor's degrees in child development or ECE.

The Head Start program has provided leadership to the early childhood field in many other ways. Begun at a time when most children in low-income families lacked health insurance, it was visionary in its recognition of the importance of the health of the children and families Head Start serves to children's development and academic performance^{vi,vii}. Even today, Head Start plays a critical role in supporting the health needs of low-income families and their children, for example by arranging for or providing dental care when many children in low-income families are unlikely to receive it. Head Start engagement of parents and families in supporting their children's learning, volunteering in classrooms, contributing to decision making, and enhancing their own educational and economic advancement is another early and continuing key component and model for the early childhood community.

Throughout its history, Head Start has also continued to sponsor and use research on ECE. Throughout its existence, the Head Start program has conducted numerous demonstration projects, accompanied by evaluations, to help identify effective methods for program improvement around quality, home visitation, enhanced transition approaches, assessment, mental health, and many other areas. There have been ongoing efforts to support research relationships between Head Start programs and universities to develop and evaluate innovations, and Head Start programs have opened their doors to a countless array of research and evaluation efforts. At the same time, there has been an increase in national data collection efforts to measure how well Head Start and EHS children and families are doing and the impact of the programs. Rigorous randomized control studies with follow up into elementary school have been conducted (and are discussed in greater detail in this report, see, particularly, Chapter 2), as have even longer range econometric studies that examine adult outcomes^{viii,ix,x,xi}.

Head Start is continuing to evolve and improve. Recently, the Office of Head Start (OHS) developed two new Outcomes Frameworks that describe the aspects of children's development and family well-being that programs must address, implemented new requirements for programs to establish school readiness goals and track progress toward them, and incorporated a reliable and valid measure of classroom quality (the Classroom Assessment Scoring System [CLASS]) into its program monitoring and professional development work. The OHS also recently announced a new system (the Designation Renewal System [DRS]) that will require programs to compete for their grants if they have not demonstrated that they are providing effective services through CLASS data, evidence about the development and use of local school readiness goals, and other criteria.

In sum, Head Start has a powerful legacy of innovation, and a strong identity as a nationwide program with uniform Performance Standards and significant cumulative impact on the early childhood field due to its accomplishments, scale, and reach into every State and most local

communities. These attributes equip Head Start well to respond to new challenges and opportunities present in today's policy context for early childhood programs.

THE CURRENT POLICY CONTEXT FOR EARLY CHILDHOOD PROGRAMS

As Head Start continues to build on its strengths and strives to improve program quality and outcomes, it faces a new context of expectations, a shifting and expanding population of young children in low-income families, and a new movement to improve the linkages and coordination among diverse programs for children birth through age 5, as well as with kindergarten through third grade education.

Early Childhood Program Goals: An Intensified Focus on School Readiness: Minimizing Achievement Disparities with More Diverse and Disadvantaged Children

Head Start is called on to respond to a new sense of urgency about preparing children in low-income families for school, based on the growing evidence of the early onset of achievement disparities between economically disadvantaged children and their more advantaged peers, and the awareness that early disparities are linked to long-term negative educational and economic outcomes. Young children from families with incomes at 200 percent of poverty and below are significantly behind their more advantaged peers in cognitive development at age 2, and by school entry children in low-income families are typically further behind their more advantaged peers. These disparities have been documented consistently in multiple studies and across multiple domains of development^{xii,xiii,xiv,xv}. Moreover, evidence is mounting that gaps widen as students progress through school^{xvi}. Children's readiness for kindergarten seems to define a trajectory for the future; children who are behind at school entry tend to remain behind and those in the lead tend to gain advantage^{xvii}. While this pattern may relate to the continued socioeconomic disadvantage experienced by children who enter school behind their more well-off peers, it also suggests the importance of efforts to alleviate this educational disadvantage as early as possible.

Increasingly Diverse Populations of Young Children

The increased priority placed on addressing disparities in early learning and school readiness is reinforced by the changing demographic characteristics of families with young children in America. Notably, after a period of decline, poverty rates are increasing for families with young children. In addition, increasing numbers of children entering kindergarten today are from homes where

English is not the primary language. According to 2011 Program Information Report (PIR) data, more than a third of children in Head Start are dual language learners (DLL). Dual language learning children have been found to be at particular risk in regards to school readiness and later school success. These risks most likely represent a combination of the lower average socioeconomic status of DLL and societal perspectives on second languages (learning two languages at once has been found in other circumstances to provide cognitive advantages)^{xviii,xix}. Yet these circumstances suggest that Head Start programs are in a unique position to support these children’s development early in their lives. This changing landscape has created an urgency to learn more (and quickly) about how to optimize outcomes prior to school entry for children both living in poverty and learning English.

A New Prenatal Through Eight System

Along with responding to a sharper focus on enhancing school readiness and serving a more diverse population, Head Start is working with a richer and more complex set of early care and education program partners. Head Start is no longer the primary or largest publicly-funded early care and education provider for children in low-income families in many States. All States sponsor child care services and programs for infants, toddlers, and preschool children with disabilities. The majority of States now sponsor prekindergarten (Pre-K) programs, with varying services. Most States are also adding or expanding home visiting programs for low-income families with young children.

As the landscape of publicly funded early childhood programs has grown, there are concerns about coordination across these programs and the need to build a more unified system that serves children and families prenatally through age 8. Many discussions by this Advisory Committee and others have focused on the need to develop greater alignment—in outcomes for children, standards for program quality, child assessment and program monitoring efforts, data systems, and professional development—across the disparate set of providers that serve young children and their families. Indeed, the Department of Education (ED) and the Department of Health and Human Services (HHS) have recently funded nine States in the Race to the Top – Early Learning Challenge program, which aims to support States in developing more coordinated systems that serve children prenatally through age 8. There have also been massive changes in the landscape of other human services programs that connect with Head Start, including the passage of the Affordable Care Act, changes in child welfare and mental health services and mandates, and changes in welfare and employment programs.

As Head Start moves towards its sixth decade, it faces new expectations for enhancing the school readiness of children in low-income families and minimizing early achievement disparities. This focus validates Head Start’s original mission but also signals a new level of expectation for documenting the outcomes of Head Start and other early education programs. At the same time, the

context of Head Start programs is changing, with increased numbers of children in low-income families and higher proportions of DLLs, and a larger and changing set of other early childhood programs with which Head Start programs must increasingly coordinate.

A MORE INFORMATIVE SCIENCE BASE

The Committee’s recommendations build on the Head Start we know today, considering the changing landscape of ECE practice and science, using the existing knowledge base about Head Start effectiveness as a starting point. Committee deliberations began with in-depth review and analyses of the Head Start Impact Study (HSIS) and the Early Head Start Research and Evaluation Project (EHSREP), in the context of other Head Start and early childhood intervention research^{xx,xxi,xxii}. Results of the Committee’s deliberations on these two rigorous studies of Head Start effectiveness are in Chapter 2 of this report.

From review and discussion of the HSIS and EHSREP reports, the Committee concludes that Head Start leads to short-term benefits across multiple areas of children’s well-being and school readiness. The Committee notes that other studies using rigorous, although non-experimental, approaches find long-term benefits for Head Start into adulthood, even if—as seen in the Head Start and EHS evaluations—benefits are not seen in elementary years. The long-term findings from the HSIS and EHSREP are still unclear, as these studies have not gone beyond third grade for HSIS and fifth grade for EHSREP, and therefore the Committee recommends low-cost, high-yield follow up after high school, as described in the Committee’s recommendations below.

The Committee concludes from reviewing Head Start and other research that there is potential to augment both short-term and longer-term outcomes of Head Start. That potential can be realized by (1) making quality and other improvements and optimizing dosage within Head Start and EHS, and by (2) improving the ways that gains are maintained and built upon in elementary school.

Indeed, since Head Start’s creation in the mid 1960s, we have learned even more about the potential of ECE programs to promote children’s capacity for learning and achievement, both as they enter elementary school and also through adulthood. A number of landmark studies in early childhood, including the Abecedarian, Perry Preschool, and Chicago Parent-Child Center program evaluations, have documented impressive effects of early childhood programs for promoting children’s development both initially and through adulthood^{xxiii}. More recently, studies of Pre-K programs have shown promise for enhancing the school readiness of children in low-income families^{xxiv,xxv}. Early childhood programs including Head Start can reduce achievement disparity typically by 20 to 50 percent^{xxvi}. Naturally, programs aspire to the higher end of this continuum and the Committee believes that rigorous approaches as recommended in this report can lead to greater improvements in readiness, depending on length of time in the program; quality of services and intensity, focus, and sequence of services; and other factors highlighted in this report^{xxvii}.

Research has helped to illuminate factors that can increase the effectiveness of early childhood programs. For instance, a growing literature documents the effectiveness of specific enhancement curricula, combined with professional development and progress monitoring, to support children's social-emotional, mathematical, and language and literacy development^{xxviii,xxix,xxx,xxxi,xxxii,xxxiii}. Likewise, our understanding of factors that promote quality programming, including effective approaches to teacher-child interaction, is expanding^{xxxiv,xxxv}. Strategies to support parenting and parent-child relationships, and methods for increasing children's health outcomes have also come a long way since the 1960s. In short, we know even more now about how important it is that disadvantaged children come to kindergarten able to compete with more advantaged peers, we know more about how preschool can help reduce disparities, and we know better how to optimize what happens in Head Start classrooms and throughout the program in order to address and begin to reduce achievement gaps and send children to kindergarten ready for school success. We do not know all that we need to know, but we know a great deal more than we did in 1965 when the program began. A new era is now possible in which programs leverage current knowledge about the critical interactions of classroom and instructional quality, family and community engagement, cultural and linguistic responsiveness, and child and family health to target more effectively the school readiness outcomes of the children they serve.

Head Start is at a critical juncture today—standing on a long and illustrious history while initiating new reforms, taking a clear look at its own effectiveness based on rigorous research; pursuing the reduction of achievement gaps despite the current worsening of underlying socioeconomic disparities; accommodating changing demographics; working in the context of local, state, and federal birth to 8 programs; and, finally, informed by a knowledge base that now offers promising leads for how to move forward. It is at the intersection of research, policy, and practice, with a sense of optimism for the challenging and compelling work ahead, that the Advisory Committee on Head Start Research and Evaluation, a group of scientists and leading practitioners, offers a science-based vision and recommendations for Head Start in the future. The recommendations address both areas where there is a significant body of research that can be used to inform practice, as well as areas in which new research is needed to fill the gaps in our knowledge about what practices to recommend. The Committee's recommendations aim to present a strategy for building greater connections between Head Start research and practice, using research and data to inform continuous improvement in practice at every level, local through federal.

In this chapter, we provide our vision for Head Start moving forward, followed by a set of recommendations that will help us achieve that vision. These recommendations are broadly focused and have implications for all core components of the Head Start program. This chapter is followed by a set of more focused chapters, in which we discuss the Committee's findings and vision within the key topical areas that were the focus of our meetings: the Impact of Head Start and EHS; Quality Teaching and Learning; Parent, Family, and Community Engagement (PFCE); Health and Mental Health; and Cultural and Linguistic Responsiveness. Within each of these chapters, we

further elaborate on the recommendations described in this chapter, presenting a set of priorities for implementing these recommendations within each of these four topical areas.

THE COMMITTEE'S VISION FOR HEAD START

The Committee envisions a Head Start program that is systematically and consistently focused on outcomes (particularly school readiness outcomes and others on which school readiness depends), guided by research and data, with collective ownership of results for children and families as well as a culture of innovation and improvement for reaching the goals in a variety of locally individualized ways.

Head Start has been successful in developing an infrastructure—including Performance Standards, monitoring, and regulatory guidance—to emphasize the importance of quality in its programs. At this juncture, however, it is important for the program to move from a culture of compliance to a culture of learning. This would be a culture in which the program—at all levels, from the Federal OHS, through the TA and monitoring systems, and to the level of grantees—makes decisions that are based on evidence and data, with information about children's school readiness being paramount. Indeed, Head Start is well positioned to move in this direction, with a considerable data and research portfolio and many examples of individual programs that use data effectively and partner with researchers to innovate and evaluate their efforts. Yet, there is inconsistency across the Head Start community, and there remain challenges at multiple levels with data quality; technological and staff capacity for collecting, analyzing, and interpreting research and data; and the timeliness of data collection. For example, Head Start lacks a national data system that can provide timely information on characteristics of children and programs.

This Committee encourages Head Start to take further steps in its growth as a Learning Organization¹, from top to bottom. An important first goal of this vision for Head Start should be to ensure that every Head Start grantee, and the Federal Head Start program writ large, becomes a Learning Organization where decisions about instructional practices and curricula, assessments, monitoring, professional development, and organizational development are integrally linked to each other and to school readiness and other key goals. A second goal is to expand the evidence base where it is insufficient, and to rely on existing evidence from research, evaluation, and ongoing monitoring of progress to develop and continually refine programs to ensure that they are systematic, intentional, and intensive enough to achieve their goals for children's school readiness and family well-being. A third goal is to continue to work across the ECE field in communities and at the federal level to further develop systems to serve children from before birth to age 8 in ways that support their optimal development.

¹ Learning in Action defines a Learning Organization as an organization skilled at creating, acquiring, interpreting, transferring and retaining knowledge, and at purposefully modifying its behavior to reflect new knowledge and insights^{lxixiii}.

The Committee notes that a number of its recommendations may be achieved by reprioritizing funding strategies, however, some will require new funds. For example, research funding for Head Start has been constant for nearly two decades, despite exciting new research tools and methods, opportunities, and challenges. An infusion of funding for research and data has the potential to help move the nation into a new era with enhanced effectiveness in serving the most disadvantaged children in the United States today. Priority topics for research are described throughout this chapter.

FEDERAL AND LOCAL ROLES IN IMPLEMENTING THE VISION

Implementing the vision advanced by the Committee has implications for all levels of Head Start. It will require systematic mechanisms for ongoing review, dissemination, and application of evidence. It will also require changes in the TA system to ensure that programs receive and understand this evidence; that programs then receive support in translating the evidence into practices that are implemented with high fidelity, while making necessary adaptations to local contexts and populations; and that they receive guidance on how to use data at the program level, as well as at the level of individual staff members (teachers and home visitors), to continually evaluate and improve their work with children and families. The Committee's vision includes:

- ▶ **Federal agencies** that use evidence and data to inform policy decisions and priorities and to ensure that they are achieving their goals.
- ▶ **Local programs** that focus on outcomes for children and families and build tightly connected systems of assessment and progress monitoring, curriculum, professional development, and organizational development to support those outcomes using the most effective practices and use their local resources to support the high-quality implementation of these practices.
- ▶ **Front-line staff and mid-managers** who effectively implement these practices and who use data on children and families to individualize learning opportunities to stimulate and support progress across all groups of children regardless of culture, language, or learning ability.
- ▶ **Communities** that encourage coordination across Head Start and other early childhood programs and track children's progress over time (from birth to school entry and into elementary school) to better support individual child growth and collective community efforts that support the outcomes of children and families.
- ▶ **Families** who engage in programs, offer and reflect on data, and work with the other levels of the Head Start system toward children's school readiness goals.

While the Committee is charged with making recommendations to the Secretary, improving children's school readiness requires practice changes at the local level, where children and families are served. Accordingly, the Committee recommends federal actions to generate optimal practices

at the local level, while describing what these desired practices will look like in grantees. It will be critical that local programs focus on effectively implementing those practices that will best support the well-being of their children and families. The Department should use data collected by local programs to enhance its understanding about the local conditions necessary for effectively selecting, implementing, and adapting evidence-based practices. Head Start at the federal level will also need to support these practice improvements with TA approaches and research and evaluation that are directly aligned to support these most effective practices.

In its deliberations, the Committee discussed the challenges and opportunities associated with the fact that Head Start is not a monolithic program. Head Start programs require a great deal of latitude to design and implement services in a way that is responsive to the local community context. Some Committee members had concerns about the efficiency and effectiveness of having local programs select their own school readiness goals or identify the most effective practices for promoting school readiness. Some Committee members were concerned that the goals would vary across communities or that the most effective practices would vary by population or context. In general, the Committee feels that it would benefit Head Start for the Federal Government to provide more guidance to local grantees about the school readiness goals they should be trying to achieve, how to measure them, and which practices and curricula are most effective for achieving these goals in different settings or with different populations, while acknowledging that practices have not been rigorously identified for all cultural groups. The Committee believes that further guidance could be provided without prescribing specific decisions; that guidance could inform local selection from among a set of the best available evidence-based approaches. Several of the recommendations emphasize a stronger role for the Federal Government in providing guidance and refocusing TA to better support practices that are linked to school readiness and other key outcomes. The recommendations to provide greater guidance to programs in their decision making seek to sustain local decision making while providing for a more efficient and informed process.

THE PATH FORWARD: COMMITTEE RECOMMENDATIONS

RECOMMENDATION I. DATA-DRIVEN FOCUS ON SCHOOL READINESS AND OTHER KEY OUTCOMES:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes within local programs, across federal components of the program, and from federal to local levels.

Toward achieving this recommendation, the Committee further recommends that the Secretary:

1. Develop federal guidance for local programs on how to define and measure: (1) children's progress toward school readiness in all five domains required by the DRS—for both English-speaking and DLLs—and identify the most appropriate assessment tools for measuring those goals; and (2) other key outcomes that contribute to readiness, including program quality, family health and well-being, and PFCE. This guidance should have a prenatal to age 5 focus and consider factors in early elementary school such as the state early learning and K-3 standards. The Secretary could develop this guidance by convening an expert panel, which should also make recommendations for the development of new assessments where gaps are identified, and recommend approaches that programs should use (or avoid) in analyzing progress toward school readiness goals.
2. Following the provision of federal guidance on readiness (see Recommendation I-1), help programs build assessment and data systems to track children's progress toward school readiness and other key program outcomes and use these data to guide and motivate continuous program improvement. Federal assistance to programs in this area could include T/TA, development of model systems and data elements, and facilitation of peer-to-peer learning.
3. Support and guide each program, considering its own unique population, in selecting effective practices to strengthen children's school readiness and family well-being (including child and classroom assessments, curricular and family engagement approaches, professional and organizational development, and TA) and then implementing those practices with fidelity and in an integrated way so that there are effective feedback loops (for example, with assessment results guiding practice improvements and targeted professional development).
4. Strengthen and streamline the focus of all components of the national Head Start Program—Performance Standards, TA systems, monitoring, and program data collections—to jointly drive toward the goals of improving children's school readiness and other key outcomes. Improve use of existing national data such as monitoring and PIR data to inform national policymaking, and develop improved national data systems to provide more comprehensive, timely information on Head Start children, families, and programs. The Committee recommends that federal data systems be reorganized so that, without additional burden, programs are collecting and reporting the information necessary for the OHS to make effective decisions about how the program is working, who it is serving, and what is needed in monitoring and TA.
5. The Committee recommends a federal cross-agency panel be established to develop a framework for identifying critical components of early childhood workforce preparation aimed at both higher education and non-credit bearing professional development for early education teachers, home visitors, and administrators. The interested agencies should provide funding for implementing and evaluating competency-based models in institutions of higher learning.

RECOMMENDATION II. USE OF EVIDENCE-BASED PRACTICES:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

Toward achieving this Recommendation, the Committee further recommends that the Secretary:

1. Working with other federal agencies, continually review, disseminate, and update the existing and emerging evidence related to effective practice, using a transparent system of evidence standards and review processes that recognizes the diversity of populations and settings within Head Start and translates the current evidence base in a way that is accessible to practitioners.
2. Focus the TA system on helping programs select and implement the strongest available evidence-based practices in all areas from classrooms and home visiting to health and family engagement practices. Ensure that these are integrated practices, not stand-alone pieces (curriculum, assessment, professional and organizational development; see Recommendation I) and that all TA is provided in an effective manner (e.g., offers up-to-date technology to support practitioners' use of evidence-based practices). Carefully monitor results of these efforts and subsequent information about these practices as they are implemented in the field more broadly.
3. Conduct strong evaluations of major new initiatives (such as the DRS and the Birth to Five pilot), and ensure that evaluation results are used for program improvement. Use administrative data to study program quality and effectiveness.
4. Build the research base to address gaps identified in the reviews of evidence-based practices. This research should also address questions of recruitment, engagement and practice for families with greatest risk, DLLs, Native Americans, and other groups where evidence gaps exist.

RECOMMENDATION III. CONTINUITY OF SERVICES:

Further improve continuity and coordination of early childhood services beginning during the prenatal period and continuing to age 8.

Toward achieving this recommendation, the Committee further recommends that the Secretary:

1. Provide guidance to local programs to help them optimize Head Start resources in communities to most efficiently and effectively provide services to children across ages prenatal to 8, including expanding EHS.
2. Guide and support local EHS and Head Start programs to coordinate with each other (e.g., so children do not experience gaps in services), with other early childhood providers (e.g., to minimize and make smooth transitions across the ECE day and over time), and with schools (e.g., coordinating with early grades in schools on curricula, assessments, and family engagement).
3. Improve alignment and linkages between Head Start and other early childhood standards, child assessments, program monitoring, data, professional development, and TA initiatives, including efforts to include Head Start children in state data systems. Steps toward improved alignment may include federal collaboration with States as well as federal encouragement for Head Start programs to collaborate with States.
4. Conduct research studies to: (1) better describe family, cultural, and demographic factors related to continuity in quality early care and education for children prenatal to age 8; (2) determine effects of multiple years of high-quality service on children's school readiness and continued school performance; and (3) learn what conditions following EHS, Head Start, or other early childhood care and education—including quantity and types of service and types of instruction, in combination with contextual variables—best support children's continued achievement and adjustment. Working across the government, increase funding for continuity studies and particularly including the less-studied prenatal to age 3 program sector.
5. Conduct follow-up and further analyses of the HSIS and EHSREP with low-cost, high-yield efforts that will illuminate how children and families have fared in the long run after participating in Head Start.

DISCUSSION OF COMMITTEE RECOMMENDATIONS

RECOMMENDATION I. DATA-DRIVEN FOCUS ON SCHOOL READINESS:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes within local programs, across federal components of the program, and from federal to local levels.

School readiness is the central goal toward which Head Start efforts drive. Following their theories of change, programs also track key outputs, such as classroom practices; and outcomes, such as family health, well-being, and engagement in the program. The Committee finds that in furthering the Head Start Learning Organization, programs will need guidance as to how readiness and other key outcomes can be measured and in how to use resulting data to improve practice. They need guidance on how to draw from the best available evidence and how to select and use assessments. There are indications that readiness goals are more likely to be achieved when all efforts are integrated and aligned towards the readiness focus. The Committee finds that there are many opportunities for programs to learn how to more tightly integrate goals, curricula, assessments, professional, and organizational development and for the Federal Head Start program to align policies around the goal of school readiness, ensuring a common message from federal to local levels.

Toward achieving Recommendation I, the Committee further recommends that the Secretary:

- 1. Develop federal guidance for local programs on how to define and measure: (1) children’s progress toward school readiness in all five domains required by the DRS—for both English-speaking and DLLs—and identify the most appropriate assessment tools for measuring those goals; and (2) other key outcomes that contribute to readiness, including program quality, family health and well-being, and PFCE. This guidance should have a prenatal to age 5 focus and consider factors in early elementary school such as the state early learning and K-3 standards. The Secretary could develop this guidance by convening an expert panel, which should also make recommendations for the development of new assessments where gaps are identified, and recommend approaches that programs should use (or avoid) in analyzing progress toward school readiness goals.**

The National Education Goals Panel (1995) has provided a broad definition of school readiness and has informed the development and revision of the Head Start Child Development and Early Learning Framework^{xxxvi}. Today, Head Start programs are tasked with setting school readiness goals and tracking children’s progress toward those goals. The Committee finds that programs need guidance in how to set these goals and measure readiness appropriately, particularly given the diverse populations they serve. There may be some measures that should be collected across all programs. It is beyond the scope of the Committee to make these specific recommendations but the Committee deems such further deliberation a high priority. Moreover, the Secretary should provide guidance about other important outcomes (in addition to readiness) on which to collect data, such as family health and well-being, family engagement, and classroom or home visiting quality. The Committee finds evidence that school readiness trajectories are established early so programs will need guidance in measurement for infants and toddlers, as well as for preschool-age children^{xxxvii}. The existing literature suggests that there are some gaps in the measures available today, especially in particular domains of development such as social-emotional development. The Committee suggests that Secretary identify the gaps and establish priorities and criteria for new measures for use in programs.

- 2. Following the provision of federal guidance on readiness (see Recommendation I-1), help programs build assessment and data systems to track children’s progress toward school readiness and other key program outcomes and use these data to guide and motivate continuous program improvement. Federal assistance to programs in this area could include T/TA, development of model systems and data elements, and facilitation of peer-to-peer learning.**

Some Head Start programs are systematically using data to inform their classroom practices, and the Committee applauds these efforts as examples of the implementation of its vision^{xxxviii}. The Committee also notes that most Head Start programs collect data today, however, data that will

best inform their progress toward readiness goals may require new investments in materials, training, reliability, certification, and analysis. The Department can support these programs through efforts such as providing TA around building data systems and using assessment, or providing targeted resources to help programs enhance their technological infrastructure or enhance staff capacity.

- 3. Support and guide each program, considering its own unique population, in selecting effective practices to strengthen children’s school readiness and family well-being (including child and classroom assessments, curricular and family engagement approaches, professional and organizational development, and TA) and then implementing those practices with fidelity and in an integrated way so that there are effective feedback loops (for example, with assessment results guiding practice improvements and targeted professional development).**

The Committee notes that programs showing impressive effects on the school readiness of children in low-income families feature thoroughly integrated systems of assessment, curriculum, and professional development^{xxxix, xl, xli, xlii, xliii, xliv}. Although these programs may focus on different content or skills, they share a tight integration of the curriculum and pedagogy with defined school readiness outcomes, integrated progress monitoring, and professional development. The Committee emphasized the need for TA efforts to be prioritized in helping programs build and implement these tightly integrated practices.

- 4. Strengthen and streamline the focus of all components of the national Head Start Program—Performance Standards, TA systems, monitoring, and program data collections—to jointly drive toward the goals of improving children’s school readiness and other key outcomes. Improve use of existing national data such as monitoring and PIR data to inform national policymaking, and develop improved national data systems to provide more comprehensive, timely information on Head Start children, families, and programs. The Committee recommends that federal data systems be reorganized so that, without additional burden, programs are collecting and reporting the information necessary for the OHS to make effective decisions about how the program is working, who it is serving, and what is needed in monitoring and TA.**

Head Start is a large and multifaceted program. To be most effective, its components need to be aligned and focused on the ultimate outcomes that the program aims to achieve: children’s school readiness and other key outcomes. Hence, the messages and methods coming from all the partners of the federal system—TA networks, monitoring, regional offices—need to support the focus on children’s school readiness and integrated practices across all components of programs to reach those goals. While Head Start has taken giant steps in aligning policies with the readiness goals (e.g., revised Head Start Outcomes Framework, the DRS), the Committee notes there could be even more alignment and streamlining of goals, policies, and data. The Committee acknowledges that the

Performance Standards could be restructured and made more efficient, which could also minimize the burden of data collection. Whenever appropriate, the OHS should share data with grantees in ways that are both useful and timely. This includes data from the Head Start PIR, the monitoring system, and CLASS observations.

- 5. The Committee recommends a federal cross-agency panel be established to develop a framework for identifying critical components of early childhood workforce preparation aimed at both higher education and non-credit bearing professional development for early education teachers, home visitors, and administrators. The interested agencies should provide funding for implementing and evaluating competency-based models in institutions of higher learning.**

In the U.S. today, many institutions of higher learning are providing ECE courses in preparation for degrees and certifications, but there is no systematic coordination or standardization of this workforce preparation. As a consequence, pre-service preparation is variable, the meaning of a bachelor's degree and professionalization of the workforce is uneven, and, more problematical, higher education cannot be relied upon for preparation of the teachers and other staff needed to implement the complex early childhood practices described in this report and required to ensure the future success of early childhood programs for children in low-income families. The Committee recognizes that many agencies within and outside the OHS have a stake in pre-service preparation of the early childhood workforce, and it encourages collaborative efforts across the Federal Government and in conjunction with institutions of higher learning to identify, develop, test and improve models of teacher, home visitor, and administrator preparation that are criterion- or performance-based in order to build a high-quality workforce for Head Start and other early childhood programs for the future.

RECOMMENDATION II. USE OF EVIDENCE-BASED PRACTICES:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

As noted, the evidence base for effective ECE practices has grown considerably in the past decade. The Committee notes the need to help programs stay abreast of this emerging evidence base in order to select the most promising practices for their specific populations, and to adjust their implementation as more information about these and newer practices becomes available. In addition, the Committee believes that innovation from programs, including innovation stimulated by local culture and context, should be encouraged, documented, and studied for potential broader application. Thus, the Committee recommends two types of new research related to the evidence base: systematic testing of promising local innovations and efforts to build the evidence base where evidence is lacking.

Toward achieving Recommendation II, the Committee further recommends that the Secretary:

- 1. Working with other federal agencies, continually review, disseminate, and update the existing and emerging evidence related to effective practice, using a transparent system of evidence standards and review processes that recognizes the diversity of populations and settings within Head Start and translates the current evidence base in a way that is accessible to practitioners.**

The Committee has serious concerns about whether many curricular materials and teaching methodologies currently used in most Head Start programs are those that are most effective in promoting school readiness outcomes. Rather, a growing research literature suggests that content-specific curricula that are tightly integrated with ongoing assessment and professional development systems are more effective in promoting specific outcomes than a more general curricular framework used alone^{xlv,xlvi,xlvii,xlviii,xlix,l}. Other studies show effectiveness in using specific literacy or math curricula in combination with a global curriculum^{li}. This suggests that the challenges implicit in implementing both types of curricula are not insurmountable. The Committee recommends improving the connection between evidence for effective practice and implementation of those practices by developing a system of reviews that will evaluate and translate the evidence on specific curricula for local programs. The Committee specifically recommends a joint effort among federal partners to study and build on existing models of evidence review such as the ED What Works Clearinghouse and the evidence review of home visiting

programs under the direction of HHS. Such reviews should describe not only those curricula with strong supporting evidence but should also include information about new efforts where findings are promising, and ongoing follow up information on how evidence-based practices are faring as they are scaled more broadly. These reviews should be careful to identify the populations and contexts for which evidence exists and does not, and should identify potential barriers to implementation at the local level. The evidence should include effective programs from birth through early elementary school and need not be limited to studies of Head Start. In addition to the Committee's concerns about the use of curricula that lack a solid evidence base, the need to identify and implement evidence-based and promising practices also applies to the areas of quality teaching and learning, health and mental health, and PFCE.

- 2. Focus the TA system on helping programs select and implement the strongest available evidence-based practices in all areas from classrooms and home visiting to health and family engagement practices. Ensure that these are integrated practices, not stand-alone pieces (curriculum, assessment, professional and organizational development; see Recommendation I) and that all TA is provided in an effective manner (e.g., offers up-to-date technology to support practitioners' use of evidence-based practices). Carefully monitor results of these efforts and subsequent information about these practices as they are implemented in the field more broadly.**

This recommendation follows from the previous one (II-1). Once evidence-based and promising practices have been identified, programs must select the best evidence-based practices for their own community context. TA providers can be very helpful in this process. This will likely be a two-step process wherein TA providers, together with program monitors, may help identify areas where practices being used are not evidence-based, when evidence-based practices relevant to local contexts and populations are available, or where local school readiness evidence suggests the need for more effective practices. TA providers will need to develop systems for working closely with programs to select and implement the evidence-based practices that are most effective within specific local programs. As we have noted, several recommendations are directed at the federal level to provide ongoing review of the evidence and to strengthen TA. Within this framework of accessible information about evidence and supports to translate the evidence into practice, we see the use of local dollars for TA and professional development as critical elements employed to translate evidence-based practices to local programs. TA should be specifically designed to support the high fidelity implementation of the evidence-based practices, while at the same time ensuring adequate adaptation to differences in local contexts and populations. Coaches and education coordinators need to be equipped to support the staff on an ongoing basis in implementing this integrated work.

It is important that the systems developed to support programs in their use of effective practices are themselves effective and, to the degree possible, supported by evidence. Within early childhood generally, there is overreliance on ineffective strategies for professional development such as one-

time trainings or workshops that are not explicitly linked to a program’s practices and services^{lii}. Instead, professional development must be linked to organizational development designed to spread and support the desired practice improvements across the entire program^{liii,liiv,lv}. In addition, science on coaching and mentoring has been steadily growing but more research and development of models of effective TA are needed^{lvi,lvii}. Research based on the rapidly developing field of implementation science—and the vast literature on adult education—can inform the process. The most successful models use coaches who observe practitioners in their daily work environment, provide models of positive practice for them in their work with children, and provide supportive feedback in helping practitioners manifest and maintain positive practices^{lviii,lvix}. The coaching focuses on the practitioners’ implementation of the program’s curriculum or desired practices and is intensive, focused, and sequenced. The coaches themselves receive mentoring and coaching as well as supervision (e.g., from state implementation teams or master coaches). Their efforts are informed by evaluations of effective coaching models and effective TA. Some coaching models successfully utilize video and distance methodologies both for direct coaching of classroom staff and for mentoring coaches^{lx}.

3. Conduct strong evaluations of major new initiatives (such as the DRS and the Birth to Five pilot), and ensure that evaluation results are used for program improvement. Use administrative data to study program quality and effectiveness.

The Department has implemented some major changes to Head Start in the past few years: including a new DRS, the widespread use of the CLASS instrument, new frameworks focused on school readiness and PFCE, a set of Mentor-Coaching grants, as well as a new TA system. It is critical, moving forward, that the Department commit resources to evaluating the implementation and effectiveness of its improvement efforts and to using the information from those evaluations to make additional improvements. Without systematic evaluation, it is difficult to know whether or how these efforts are helping Head Start achieve its objectives. Improved administrative data at the federal level would help the program monitor changes in grantee practices in the context of new initiatives and can also provide a foundation of information on which the Department can build more rigorous evaluations that are more timely and less costly.

4. Build the research base to address gaps identified in the reviews of evidence-based practices. This research should also address questions of recruitment, engagement and practice for families with greatest risk, DLLs, Native Americans, and other groups where evidence gaps exist.

This recommendation includes developing approaches for ensuring that populations with low levels of enrollment are able to access Head Start, recruiting populations into Head Start research that have not been included or have been studied separately in other research, developing and validating culturally relevant assessments and interventions, and examining dosage and other implementation variables and their relationship to children’s and families’ outcomes. This is

especially important in areas where the evidence base for practice has not been conclusive and where basic science can provide guidance for practice (e.g., neurolinguistic research on DLLs and developmental science studies on children with multiple risk factors).

The available evidence base for effective practices is not sufficiently robust to specify effective practices for use within certain contexts or with certain populations. In addition, some cultural and ethnic groups define and establish evidence differently, and uphold their own sets of ethical standards for research. There are several areas of research identified by the Committee as needing particular attention. These include research that: (1) highlights whether and how effective practices work across different contexts or settings; (2) identifies effective practices for different populations of children and families; (3) identifies, develops, tests, and improves adaptation processes; (4) studies optimizing recruitment strategies particularly for the families with the greatest needs; and (5) investigates varying levels of dosage for families with higher numbers of risk factors. For example, the Committee discussed whether it would be useful to study impacts from implementing a core set of goals, curricula, and monitoring tools in programs of varying contexts. On the other hand, it is important to identify, test, improve, and when warranted, disseminate innovative practices which often originate in local programs. The Committee notes a pressing need for more research related to measures, practices, recruitment, and dosage and for research building optimal practice for populations that have not been consistently included in research studies (e.g., AI/AN children, children of migrant and seasonal farm workers), where research approaches have not been culturally relevant and appropriate, or where research results have been inconclusive (e.g., children in families experiencing cumulative challenges)^{lxi}. Research on dosage should examine questions related to length of day, year-round services, and number of years of participation (see also III-4).

RECOMMENDATION III. CONTINUITY OF SERVICES:

Further improve continuity and coordination of early childhood services beginning during the prenatal period and continuing to age 8.

While the first two of the Committee's recommendations refer to enhancing integration and alignment within programs and the entire Head Start system, this recommendation refers to enhancing integration and alignment of early childhood programs within communities and States, and across the prenatal to age 8 range. Head Start exists today within a broader context of state and other federal efforts focused on school readiness (e.g., Race to the Top Early Learning Challenge, Promise Neighborhoods, Pre-K to grade three initiatives, Educare Head Start programs, state Quality Rating and Improvement Systems [QRIS]). The number and scope of such efforts across the nation create opportunities for Head Start to work with other programs to better leverage and coordinate resources to provide a continuum of services in communities for children in low-income families, from prenatal development into the elementary school years. In some communities this

may mean expanding services, especially for infants, toddlers, or 3-year-olds; and in others it may mean changes in which agencies serve which children in order to create that optimal continuum. For example, in some locales, Head Start may serve 3-year-olds and state-funded Pre-K might serve 4-year-old children. Recognizing the growing number of Head Start programs that combine multiple funding streams to provide services, the Committee believes it has become less meaningful to study Head Start as a single funding stream than to better understand how Head Start can effectively work with other community programs. Given a smaller research base in this area, most of the recommendations in this section are for research—research to learn more about how to build more effective programs and systems that support families from the prenatal period to age 8, and about how to maintain and build upon the gains that children realize from EHS, Head Start, and other early childhood programs.

To achieve this Recommendation, the Committee further recommends that the Secretary:

- 1. Provide guidance to local programs to help them optimize Head Start resources in communities to most efficiently and effectively provide services to children across ages prenatal to 8, including expanding EHS.**

Despite an increasing body of evidence showing the importance of the prenatal period and the years between birth and age 3, and the effectiveness of high-quality EHS programs during this period, the Committee is concerned about the small percentage of eligible expecting families and children served by EHS. In addition, noting uneven quality in programs serving infants and toddlers in low-income families, the Committee emphasizes that ensuring greater access to *quality* programs for children from prenatal through age 3 should be a priority for the Department^{lxii}. Programs need greater flexibility to serve younger children in their communities where other quality options exist for 4-year-olds, and they need support in ensuring they have proper staffing, training, and facilities to serve younger children. Moreover, although preliminary, the evidence to date suggests not only that EHS itself provides benefits to children and families as they enter school, but also that children benefit most when EHS is followed by participation in other quality center-based programs^{lxiii}. Hence, it is possible that—and worth studying whether—an expansion of EHS, coupled with greater coordination between EHS and Head Start or other preschool programs might lead to stronger and more sustained benefits for children and families.

- 2. Guide and support local EHS and Head Start programs to coordinate with each other (e.g., so children do not experience gaps in services), with other early childhood providers (e.g., to minimize and make smooth transitions across the ECE day and over time), and with schools (e.g., coordinating with early grades in schools on curricula, assessments, and family engagement).**

The Advisory Committee on Head Start Services for Families with Infants and Toddlers recommended that children completing EHS transition to Head Start or other follow-up quality

center-based programs^{lxiv}. In fact, children in the EHSREP who had these follow-up services were faring better at kindergarten entry than those who did not, but only about half of EHS study children did receive such services^{lxv}. The Committee emphasized the importance of continuity of children’s experience and the need to improve transition experiences. Despite a few studies about transitions of Head Start children into elementary schools, there is a relatively small research base to inform efforts to improve transitions^{lxvi}.

3. Improve alignment and linkages between Head Start and other early childhood standards, child assessments, program monitoring, data, professional development, and TA initiatives, including efforts to include Head Start children in state data systems. Steps toward improved alignment may include federal collaboration with States as well as federal encouragement for Head Start programs to collaborate with States.

Today, in States and communities, tremendous shifts are occurring across early childhood services. Such new initiatives as Race to the Top Early Learning Challenge Grants and QRIS are stimulating and responding to collaborations across programs with different funding. Head Start is and should be an active participant in the ongoing efforts to coordinate across the various early childhood programs. The Department should remove barriers to and promote this engagement in ways that do not sacrifice the quality of the Head Start programs and that retain developmentally differentiated criteria for standards, assessment, monitoring, and data across the prenatal to 8 age span. In two areas—QRIS and coordinated early childhood data systems—the Department should investigate how regulations, data requirements, and monitoring may enhance or impede coordination across systems and provide guidance to programs to facilitate participation. The Committee recommends that Head Start programs cooperate with efforts to assign unique identification numbers to children in state early childhood databases, while following approved procedures to protect the privacy and misuse of the data. Finally, the Committee strongly recommends that Head Start continue its efforts to work closely with ED to test new approaches to coordination between Head Start and elementary schools.

4. Conduct research studies to: (1) better describe family, cultural, and demographic factors related to continuity in quality early care and education for children prenatal to age 8; (2) determine effects of multiple years of high-quality service on children’s school readiness and continued school performance; and (3) learn what conditions following EHS, Head Start, or other early childhood care and education—including quantity and types of service and types of instruction, in combination with contextual variables—best support children’s continued achievement and adjustment. Working across the government, increase funding for continuity studies and particularly including the less-studied prenatal to age 3 program sector.

Head Start is rarely the only early childhood program that children experience, as many are in some form of child care prior to Head Start and they go into kindergarten in elementary school. As a

result it is important to understand the factors related to children’s attendance and engagement in quality early childhood programs throughout their early years. Likewise, the Committee notes that we have only limited information about the effects of receiving multiple years of high-quality services on children’s school readiness and adjustment in elementary school. Many Committee members and others have criticized the notion that Head Start or any other early childhood program can inoculate children against future problems, or against future experiences with the limitations of educational, health, and other services or the quality of their neighborhoods. It is possible that the benefits of attending higher quality programs accumulate with multiple years of such services. Finally, it is important to better understand what types of conditions following Head Start—both the nature and dosage of instruction and services children receive in elementary school (including services aimed at engagement of families), and conditions and experiences beyond school and family—are most conducive to sustaining gains made from early childhood programs. The Committee recommends that the Department work with other agencies to support these studies, while not losing sight of the prenatal to age 3 period as well.

5. Conduct follow-up and further analyses of the HSIS and EHSREP with low-cost, high-yield efforts that will illuminate how children and families have fared in the long run after participating in Head Start.

The Committee is not unanimous about whether the Department should invest resources in continuing to study the children in the HSIS and EHSREP because of competing needs for limited research dollars. However, these studies represent the most rigorous evaluations conducted to date of these programs, and the lack of impacts in the elementary grades detected by these studies does not preclude the possibility of longer term benefits. Both older and newer population studies show positive effects on long-term indicators (e.g., high school graduation rates) among participants in Head Start^{lxvii, lxviii, lxix, lxx, lxxi, lxxii}. Thus, the Committee recommends that the Department use lower-cost, higher-yield approaches to examine long-term impacts from these studies as children from the original samples move into adulthood, capitalizing on administrative data wherever possible. Special attention should be paid to understanding variables predicting benefits over the long term, such as program characteristics and quality, characteristics of families who benefit most, the role of dosage and attendance in EHS and Head Start, neighborhood characteristics, and the contribution of later school environments.

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Chapter 2: Understanding the Impacts of Head Start and EHS

OVERVIEW

Over its first two meetings, the Secretary’s Advisory Committee on Head Start Research and Evaluation reviewed and discussed the results of both the Head Start Impact Study (HSIS)ⁱ and the Early Head Start Research and Evaluation Project (EHSREP)^{ii,iii,iv}. These results are summarized here and, as recommended by previous advisory committees, are interpreted in the context of a substantial body of early childhood intervention research. This additional research includes new studies by economists that use the most rigorous nonexperimental statistical methods including regression discontinuity, difference-in-difference models, and sibling fixed-effect models^{v,vi,vii,viii}. In this chapter, following presentation and interpretation of the findings from the HSIS and EHSREP and other studies, the Committee presents its recommendations for research, policy, and practice.

The National Head Start Impact Study was a longitudinal study that involved approximately 5,000 3- and 4-year-old children across 84 nationally representative grantee/delegate agencies in communities where there were more eligible children and families than could be served by the program. Children were randomly selected from classrooms and randomly assigned to a treatment group (Head Start) or control group for one year. After that, the families of the 3-year-olds were free to participate in Head Start or not, and 4-year-olds generally transitioned to kindergarten. Thus, assignment to the treatment group involved eligibility for one year of Head Start as a 3- or 4-year-old, which may or may not have been followed by another year of participation in Head Start for the 3-year-olds at the families’ volition. A year of eligibility for Head Start involved participation in programs that generally ran for the academic year (approximately 9 months) and were often part-day programs. Data collection began in the fall of 2002. Children were assessed at the beginning and end of a Head Start year (3- and 4-year-olds), at the end of the year following Head Start (if they enrolled as 3-year-olds), at the end of kindergarten, and at the end of first grade. They were also assessed at the end of third grade but data from that assessment have not yet been reported.

HSIS found modest to moderate positive impacts after one year of the Head Start program for both 3- and 4-year-olds and across most child outcome areas assessed—language, early pre-reading skills, and health—and parenting, with some differences in patterns across the two cohorts (e.g., impacts on social-emotional skills in the 3-year-old cohort but not in the 4-year-old cohort and impacts on parental reading to children, provision of cultural enrichment activities and reduced spanking in the 3-year-old cohort as contrasted to a reduction in the use of time out by parents in

the 4-year-old cohort)¹. However, the effects found at the end of the Head Start year for the full sample largely disappeared by the end of first grade, with some exceptions. There were first grade social-emotional impacts in the 3-year-old cohort and health impacts in the 4-year-old cohort, with health impacts in the 3-year-old cohort in kindergarten. In addition, there were impacts at first grade for several subgroups of children. These include children who were dual language learners (DLL), entered Head Start with lower skill levels, had higher social risk, had special needs, had mothers who reported mild depressive symptoms, and lived in non-urban settings.

The Committee finds limitations but also strengths in the HSIS. Limitations are that: (1) HSIS analyzed the effects of only one year of Head Start, with no test of two years of enrollment, despite the fact that many children in Head Start today receive two years of services; (2) a majority of children in the control group received early childhood services so the study comparison was primarily between Head Start and other early childhood programs; (3) in the 3-year-old cohort 50 percent of the control children attended Head Start as 4-year-olds and only 63 percent of the Head Start children received two years of Head Start. It is difficult to interpret follow up findings for the age 3 cohort when many children in both groups attended Head Start for at least a year. Although crossovers (children randomly assigned to Head Start who did not attend Head Start and children who were assigned to the control group who attended Head Start during the treatment year) occurred during the study, Committee members stated that statistical analyses taking the crossovers into account did not change any conclusions about treatment impacts, suggesting the problem with crossovers does not change the findings. The Committee notes strengths in the HSIS. Unlike any other evaluation of an early childhood program, it included a nationally representative sample of programs and children combined with random assignment of children to treatment and control conditions. The study also included a rich set of baseline and outcome measures, and comprehensive reporting of all outcomes whether impacts were significant or not.

The Early Head Start Research and Evaluation Project enrolled 3,001 families in 1996 – 1998 in a randomized control trial in 17 of the first 128 EHS sites funded. Sites were purposively selected for rural/urban community status, region, race/ethnicity, and program model to reflect the composition of Early Head Start (EHS) at that time. Children and families were assessed when children were 14, 24, and 36 months old (when they completed the EHS program), the spring before kindergarten, and in fifth grade. Experimental (EHS vs. control group) and nonexperimental analyses (combinations of EHS ages 0-3 or not; prekindergarten [Pre-K] or other formal education programs at ages 3 – 5 or not; and enrollment in schools with compositions of fewer than 64 percent receiving free and reduced-price lunch or not) were conducted during follow-up periods.

The EHSREP also found modest impacts when children had completed the program, at age 3^{ix}. EHS children had significantly better social emotional, language, and cognitive development than the

¹ Specifically, Head Start children who enrolled as 3-year-olds and 4-year-olds had better language and literacy skills (effect sizes [ES] ranging from .09 to .35), math skills (ES = .15), fewer problem behaviors (ES of .14 to .21), and better dental and health outcomes (ES of .11 to .33). There was some evidence that parenting, especially for the 3-year-olds was enhanced, ES of .14 to .18.

control group children. They also were more likely to be immunized and to be receiving Part C services for children with disabilities. Parents offered more stimulating home environments; read more to children; were more supportive and less punitive; and had better self-sufficiency outcomes related to training, education, and employment². For EHS, there were persisting impacts two years after the children left the program in the areas of social-emotional development, special needs services, and parenting. Children were assessed again in fifth grade. By fifth grade, the impacts disappeared, with one exception: there was one overall trend effect on a composite of social-emotional functioning. There were some impacts in subgroups at fifth grade. There were sustained child and parenting effects through fifth grade for African- Americans and Whites and for children and families who had been in EHS home visiting programs.

The Committee finds the limitations of the EHSREP were that: (1) programs were evaluated shortly after EHS was begun so programs were not mature, and (2) the programs were selected from a pool of EHS programs funded in the first two years after EHS began but were not a representative sample. Although attempts were made to select programs typical for program types, race/ethnicity, and region, the programs were not selected at random; (3) attrition of sample was a limitation (54.4 percent of the original sample was assessed at fifth grade); however, the program and control groups remained statistically comparable throughout all data collection waves. Still, generalization of findings may be impaired. Strengths of the study were random assignment of children and families into treatment and control groups and, because the study was conducted when the program was just beginning, a supplementary study that assessed and quantified implementation was included³.

GENERAL CONCLUSIONS ABOUT THE IMPACT STUDIES

The Committee recommends interpreting both studies in the context of a large body of literature that includes 40 years of Head Start research, studies of other early childhood interventions, as well as studies of school reform and the achievement gap. It is also important to take into account the eligibility requirements for Head Start and EHS, which show that these programs generally serve a population in poverty, whereas other early childhood programs serve families with a broader range of demographic characteristics. The appropriate interpretation of the studies' findings in context is

² EHS children who received at least some intervention (91 percent of the treatment group) had better language and cognitive skills (ES = .12 to .13), fewer problem behaviors (ES of .11 to .14) and higher attention and engagement (ES of .16 to .20). Parenting was enhanced (ES of .10 to .15) and parents were more likely to be employed or in school (ES of .09 to .17).

³ The Head Start and EHS studies were similar in that both were randomized control trials but were very different in important ways: The HSIS studied a mature program and EHS was just beginning when studied; HSIS used a (modified) representative sample of all Head Start programs with a subsample randomized at each site, whereas EHS used a purposive sample; the HSIS had separate samples of children entering when ages 3 or 4 whereas EHS included a single sample of families enrolling during pregnancy or when infants were up to a year old; in the HSIS, the study only examined the effectiveness of being allowed one year of Head Start (as the control group children who were 3 at the study start were allowed to enroll in Head Start at age 4), whereas the EHS study examined the impact of the full three-year program (although in both studies there was variability in the dosage that Head Start or EHS children and families actually received). The HSIS reflects a cohort of enrolled children and families in 2002, whereas the EHSREP results reflect the experiences of families entering EHS in the mid- to late-1990s. EHS was a study of intervention for infants and toddlers whereas the HSIS focused on preschool age children. Given that populations, methodology, and interventions are different from each other, the Committee recommends against comparing the outcomes of these two studies.

that Head Start and EHS are improving family well-being and improving school readiness of children at or below the poverty line in the U.S. today. In addition, however, the studies illustrate ways that services for children can be improved. Overall, it is apparent that important questions have not been answered by these or any other studies and that additional research is needed. In addition, the Head Start and EHS programs evaluated were implemented prior to important improvements in both programs. Changes in Head Start have included the widespread use of observational measures of quality that focus on instructional quality as well as emotional support and classroom management, new requirements that establish thresholds of observed quality below which programs will be required to compete for renewal, and the introduction of a new technical assistance system for Head Start programs. EHS has also evolved since the evaluation of some of its earliest sites. For example, data from the Head Start Family and Child Experiences Study (FACES) focusing on EHS programs (referred to as the Baby FACES) indicates that increasingly more programs are offering a combination of home-based and center-based services. The Committee comes to several specific conclusions about the study findings and their meaning for the future of Head Start practice and research.

Head Start and EHS Have Many Significant Immediate Impacts

Compared to care at home by families and in the other early care and education settings available in communities experienced by control group members at the time of the evaluations, both Head Start and EHS result in statistically significant short term (by end of program) improvements in children’s functioning in important areas of cognitive-academic development, social-emotional development, approaches to learning, and health as well as improvements in parenting and—for EHS—in some parent self-sufficiency outcomes.

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Understanding HSIS and EHSREP end-of-program impacts in the context of other research and evaluation studies.

Questions about these impacts have been raised—especially within the past year in public discussion^{x,xi}. Some of these questions relate to the size of the impacts. The Committee consensus is that these impacts are in line with

the magnitude of findings from other scaled-up programs for infants and toddlers, with regard to the EHS findings^{xii} and center-based programs for preschoolers, with regard to the HSIS findings^{xiii,xiv}. Larger impacts may be possible, e.g., by increasing dosage in EHS and Head Start or improving instructional factors in Head Start. EHS, together with other scaled-up infant-toddler programs, reveals the difficulty in ensuring that all families receive an adequate dosage, especially within a home-visiting intervention^{xv}. Analyses with Head Start children show stronger developmental outcomes across domains for children who had attended two years vs. one year of

Head Start, taking into account the characteristics of children and families^{xvi}. A recent meta-analytic study shows greater impacts from preschool programs that incorporate more-intensive direct instruction by teachers^{xvii}. Another meta-analysis of early childhood education programs found that among those with added parent education, programming that includes opportunities for modeling and practice of parenting skills is associated with larger positive effects on cognitive outcomes than purely didactic parent education^{xviii}. Therefore, as can be seen in this report, the Committee also believes that if Head Start implements its focus on evidence-based quality improvement and both programs do more to ensure adequate dosage, instruction, and parent support for children, these efforts may well result in larger impacts.

Recent discussions have suggested that Pre-K programs may be more effective at improving the school readiness skills of children in low-income families than is Head Start^{xix,xx}. The Committee discussed this issue at length and concluded that several factors must be considered in this comparison. First, state Pre-K programs differ widely across the States. They vary widely in terms of the number of hours children attend, the requirements for teaching staff, and the observed quality. Studies suggest that some of the Pre-K programs with the longest hours and most qualified teachers are effective, and have shown larger effects than Head Start. A summary of the evaluations noted that the effect sizes ranged from .3 to .8 on academic outcomes for these programs^{xxi}. It is important, however, not to compare a nationally representative sample of Head Start programs with unrepresentative samples of Pre-K programs, particularly if there is reason to believe the latter include disproportionately strong programs. The 11-state Pre-K study revealed large differences in the quality and pre-post changes of the Pre-K programs^{xxii,xxiii}. In this study of state Pre-Ks that serve large numbers of children who were at least 5 years old, the overall effect sizes for child outcomes ranged from an ES of .16 for math and an ES of .26 for social skills, to ES of .33 for language, similar to those found for Head Start. Mean scores on classroom quality measures were not dissimilar to those reported in the recent 2006 FACES descriptive study of Head Start^{xxiv}. Thus, some States appear to have very effective programs and others do not. Hence, it is unclear whether a study that used a nationally representative sample of state-funded Pre-K programs would find smaller, larger, or comparable impacts to those found in the HSIS. Furthermore, state Pre-K programs likely provide less of a safety net given that some state programs appear to have been negatively affected by state budget deficits^{xxv}. In short, the great heterogeneity in state Pre-K programs and the rapid pace of change in these programs make any simple comparison unwarranted.

Other methodological issues also suggest that the HSIS may provide a more conservative test of the effectiveness of Head Start than the current Pre-K studies provide of Pre-K. These include the fact that many of the Pre-K studies are regression-discontinuity (not randomized control) studies, do not follow children beyond kindergarten, and with a few notable exceptions, typically examine only

a very small set of cognitive outcomes⁴. Moreover, the comparison group in Pre-K studies (children who did not meet the age cutoff for Pre-K) is less likely to have received alternative forms of center-based early childhood care than the control group in the HSIS. Finally, the fact that Head Start serves a more impoverished population than state Pre-Ks typically serve limits our ability to compare the findings across these programs, although researchers have attempted to control statistically for the differences.

Impacts Do Not Persist into Elementary School, but the Literature Suggests There Could Still Be Longer-Term Effects

In the overall samples, on most indices of cognitive-academic development and social-emotional development, the impacts of Head Start and EHS do not persist into elementary school (e.g., first grade for Head Start; fifth grade for EHS). On average, across children in the EHSREP and HSIS, when analyzed within the experimental design of the studies, the positive effects of program experiences dissipate early in elementary school for Head Start and by the end of elementary school for EHS^{5,6}.

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As a Committee appointed by the Secretary of the U.S. Department of Health and Human Services (HHS), it is important that we focus on these two major studies HHS has conducted. However, to fully understand the policy implications of the findings from these studies, the Committee believes it is essential to consider the broader research context. Unlike new programs, Head Start has been the subject of thousands of program evaluations, research syntheses, meta-analyses, and analyses of large databases that have included Head Start children. Unlike for the newer EHS program, investigators have been able to

⁴ Head Start and EHS programs seek to have impacts on children's social emotional as well as health outcomes. They also aim to affect parenting skills and, in some programs, aspects of parental self-sufficiency.

⁵ In this report, we emphasize end-of-program results (at age 3 for EHS and after one year of Head Start for Head Start) and the most recent follow up (first grade for Head Start and fifth Grade for EHS). However, there were intermediate data collections. For both Head Start and EHS, a number of the impacts were sustained after the program had ended—for Head Start, especially for children who had begun Head Start as 3-year-olds, there were sustained impacts a year later, and EHS showed sustained impacts in some areas two years after children finished the program.

HSIS children were followed up approximately a year after the experimental Head Start year. The children who had been in Head Start as 3-year-olds were rated more highly by their parents in emergent literacy (ES = .16) and had better phonologic processing (ES = .15). They also had better parent-reported approaches to learning (ES = .11), were more likely to receive dental care (ES = .20), and were more likely to receive care for injury (ES = .10). Parents were less often reported to be authoritarian (ES = -.14). Children who were in Head Start as 4-year-olds when followed up a year after the program (at the end of kindergarten) did not sustain cognitive, social-emotional, or parenting impacts, but were more likely to receive health insurance coverage (ES = .11) and to be reported as having health status that was excellent or good (ES = .13). EHS children were followed up the spring or summer before they entered kindergarten, two years after their eligibility for Head Start had ended. Just prior to kindergarten entry, EHS children had significantly fewer behavior problems (ES = -.12), more-positive approaches to learning (ES = .14), and better emotion regulation (ES = .09). Spanish-speaking children had better Spanish receptive vocabulary (ES = .29) and all children had fewer speech problems (ES = .09). Parents continued to more often read daily (ES = .10), provide more teaching activities (ES = .11), attend open house in the child's school (ES = .21), and report fewer depressive symptoms (ES = .12); and children less often lived with someone with an alcohol or drug problem (ES = -.08).

⁶ Further, the HSIS study provides limited potential for interpreting the persistence of positive effects within the 3-year-old cohort because the study was designed to test for one year of Head Start and about half of those who enrolled as 3-year-olds in the control group attended Head Start as 4-year-olds. There were larger impacts in this cohort at the end of the treatment year but it is not clear whether loss to follow up could be related to the Head Start experience of the control group.

address the central issue of the longer-term persistence of Head Start effects. Here we briefly review studies of Head Start completed by economists using rigorous methods applied to large, representative databases, which have shown Head Start effects in high school and adulthood. We report on four studies that conducted rigorous analyses of long-term outcomes in Head Start employing econometric methods designed to allow causal inferences from observational data^{xxvi,xxvii,xxviii, xxix}.

- ▶ A study by Garces and colleagues of long-term outcomes from Head Start showed that White attendees, relative to their siblings who did not attend Head Start, were more likely to graduate from high school, go to college, and earn more money as adults. African-American attendees did not show comparable long-term educational advantages, but they were less likely to have been involved in crime, an outcome not seen for Whites^{xxx}.
- ▶ Deming examined long-term outcomes in a sample of 3,698 Head Start attendees born to participants in the National Longitudinal Study of Youth. By comparing Head Start attendees with their siblings who “differentially participated in Head Start, other preschools, or no preschool,” Deming found Head Start to be associated with higher scores on a “composite index” of long-term outcomes (including high school graduation, college attendance, idleness, crime, teen parenthood, and health status)^{xxxi}.
- ▶ Ludwig and Miller found a beneficial effect of Head Start on educational attainment and health outcomes in their regression discontinuity study in counties receiving and not receiving Head Start in 1965^{xxxii}.
- ▶ Most recently, Johnson matched Panel Study of Income Dynamics (PSID) data from 1968-2007 to Head Start administrative data. Using difference-in-difference models as well as sibling comparisons, Johnson found beneficial effects of Head Start on educational attainment, grade repetition, adult health, annual incidence of incarceration (for Black males), and wages (for men)^{xxxiii}.

A number of studies of Head Start completed by economists using rigorous methods applied to large, representative databases have shown Head Start effects in high school and adulthood.

These nonexperimental studies of Head Start capitalizing on longitudinal data and employing rigorous econometric analyses suggest that Head Start does confer a long-term advantage in adolescence and early adulthood when young persons face new developmentally challenging tasks. Taken together, there is evidence of long-term positive outcomes for those who participated in Head Start in terms of high school completion, avoidance of problem behaviors, avoidance of entry into the criminal justice system, too-early family formation, avoidance of special education, and workforce attachment. These and other findings also point to economic benefits of Head Start over the initial costs of the program. At this time, these studies provide the strongest evidence of the long-term benefits of Head Start. Ten or more years from now, the children of the HSIS and EHSREP will be able to show whether the randomized trial demonstrates similar Head Start benefits. These

studies are complemented by other long-term follow-up studies of early childhood interventions similar to Head Start or EHS in which there was evidence of longer-term impacts even after shorter-term impacts diminished or disappeared^{xxxiv,xxxv,xxxvi}.

The challenge of interpreting “fade out” and the role of elementary school quality. The true nature of what is traditionally regarded as “fade out” is not well understood. It may include true “fade out” (reduction of the program group’s performance), “catch up” (greater gains in the control group due to an educational focus this group did not experience prior to kindergarten), or transformation and/or sleeper effects whereby positive gains in achievement and behavioral adaptation (perhaps transmitted through parenting effects), appear to fade but then reappear in longer-term outcomes that have cost-benefit implications.

The role of elementary school quality in supporting gains from intervention programs is not well understood either. Evidence from the nonexperimental analyses conducted within EHS suggests that the best outcomes in fifth grade were seen when children received EHS followed by Head Start or other formal care and education programs at ages 3 – 5, followed by being in schools with less-dense concentrations of children receiving free and reduced-price lunch (less than 64 percent, which was the mean percentage of children receiving free and reduced lunch in this sample)^{xxxvii}. Although the percentage of children receiving free and reduced-price lunch is not a direct marker of elementary school quality, these nonexperimental analyses raise the possibility that quality educational experiences that continue into elementary school contribute to maintaining positive outcomes. The previously cited study by Johnson, using multiple and more rigorous standards of school quality including per pupil spending, class size, teacher quality, and curriculum quality, found that Head Start impacts on educational attainment and men’s earnings were greater when children attended schools with higher per pupil spending during their adolescent years^{xxxviii}. One of the most important research, practice, and policy agendas of the next decade is to understand how elementary education for children in low-income families can be transformed not only to maintain but to build upon and expand the positive impacts of early interventions like EHS and Head Start.

Certain Subgroups Have Stronger Short Term Impacts and Persisting Positive Effects

Studying subgroups is consistent with the recommendation of an earlier Head Start Advisory Committee that studies of Head Start impacts investigate “for whom and under what conditions” Head Start is effective^{xxxix}. Both the EHSREP and HSIS provide evidence that certain subgroups of children, families, and communities may experience larger immediate impacts and persisting positive effects in some domains, although these findings are considered more preliminary given the number of analyses

Both the EHSREP and HSIS provide evidence that certain subgroups of children, families, and communities may experience larger immediate impacts and persisting positive effects in some domains.

conducted and small sample sizes with decreased statistical power to detect effects. Depending on the outcome domains assessed, some important and substantial impacts persisted for the lowest-academically performing Head Start children, and for African-American children both in Head Start (through first grade for the 4-year-old cohort only) and in EHS (through fifth grade). In EHS there was also evidence of some sustained effects for Whites and for children and families who enrolled in EHS home visiting models. The findings from subgroups suggest there are groups for which Head Start and/or EHS is particularly effective in both the short and longer term and others for which new strategies for intervention may be required (e.g., highest risk families in EHS). There are also subgroups for which impacts are more likely to fade out (e.g., Hispanics in EHS) but it is not known whether such fade out is related to the intervention or the environments children experience subsequently (or both). We need to understand more about the groups showing strong and persisting effects and those for whom effects do not persist or become manifest.

Appropriate and inappropriate interpretations of the HSIS and EHSREP. The Committee has concerns about the conclusions drawn in some media and policy arenas regarding the effectiveness of Head Start based on evaluations of other early childhood programs. The Committee contends that, particularly when considering the HSIS, there has never been another early childhood program subject to the same level of testing as the Head Start program. Interpretations of the results based on other studies are inappropriate when those studies differ in critical ways in independence of the evaluation, sample size and representativeness of programs, samples of families and children, and nature of comparison groups.

In particular, the Committee finds it to be inappropriate to make comparisons of the HSIS findings with those of small-scale, single-site demonstration studies, such as the Perry Preschool Program and the Abecedarian study. Unlike Head Start, these earlier programs were small demonstrations, were multi-year programs, took place in a time when there were few alternatives for early childhood care and education (that the control group could participate in), and researchers were actively involved in the program design and implementation. These were not tests of fully scaled-up, public programs.

As we have noted earlier in this report, the Committee does not consider it appropriate to compare results from Head Start studies to those of state Pre-K studies because Head Start and Pre-Ks are different types of programs and serve different populations, because the HSIS included a representative sample of all Head Start programs and Pre-K program studies for the most part have not been nationally representative (important because state Pre-K programs vary widely), and because studies have used different statistical methods for determining effects. It should be noted also that in some States, Pre-K and Head Start programs are offered collaboratively or even in the same programs. Thus, there is a need not for comparison of results across types of programs, but for studies that take collaborative structures of Head Start and Pre-K into account, examining program quality and effects on children in such programs. Preliminary data from the sampling frame for the National Survey of Early Care and Education underscores the importance of such

approaches, indicating that 23 percent of Head Start programs are co-located with Pre-K programs^{xl}.

Also as noted earlier, the Committee finds comparison of HSIS and EHS studies to be inappropriate given that the two programs serve different ages of children, and that the two impact studies were conducted very differently and at very different stages of program implementation.

The Committee questions comparing Head Start's impact on a variety of outcomes to the impact of programs that focus on one or two outcomes. Head Start, as is true for Pre-K programs, seeks to improve children's cognitive and academic school readiness, and the importance of such focus is central. But Head Start also seeks to effect changes in children's physical and mental health, social-emotional functioning and parenting, parent mental health and self-sufficiency. There is evidence that, in addition to achievement outcomes, some of these other outcomes are also mechanisms (e.g., social-emotional functioning and health) for long term success^{xli,xlii}. Head Start and EHS have, in fact, been shown to have a breadth of positive short-term effects and longer term effects on health and mental health. It is not clear, as yet, if effects into young adulthood indicated by nonexperimental analyses of Head Start participation are rooted in the range of domains on which short-term effects occur, or on selected outcomes that other early childhood programs do not target, such as child health, social-emotional development, or parent self-sufficiency^{xliii,xliv,xlv}.

THE PATH FORWARD: FURTHER SPECIFICATION OF THE COMMITTEE'S RECOMMENDATIONS

Altogether, the Committee concludes that the HSIS and EHSREP findings point to two major directions for Head Start practice and research in the future: (1) focus on improvements in Head Start to enhance short-term impacts; and (2) improve the way that gains are maintained and built upon following Head Start in elementary school (and following EHS in Head Start and other early childhood programs).

The following discussion elaborates on the Committee's three Recommendations, with a particular focus on priorities that emanate from our review of the HSIS and EHSREP and other studies of Head Start effectiveness. In particular, the discussions focus on the need for more research to better understand how programs can improve and to build upon both the short-term and longer-term impacts of Head Start and EHS.

RECOMMENDATION I:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes, within local programs, across federal components of the program, and from federal to local levels.

Impact Studies Priority 1: Develop and norm new outcome measures, including those used for progress monitoring, for Head Start populations to enhance Head Start's ability to assess critical areas of program emphases, including but not limited to health and executive functioning and outcomes for children, outcomes for DLLs, and outcomes for parents.

Both the HSIS and EHSREP used highly regarded, reliable, and valid outcome measures. Many local Head Start and EHS programs also use good measures. However, the field has an abundance of child outcome measures that do not possess adequate psychometric characteristics, or are inappropriate for use in progress monitoring. This is particularly true in certain outcome domains such as children's health and executive functioning, outcomes (in all areas, not only language and literacy) for DLLs, and measures of parenting and other adult parental behaviors.

In addition, much progress has been made by early childhood researchers in creating measures in these areas, although some need further testing, and all could benefit from systematic norming. If Head Start and EHS programs are to be able to rely on such measures for progress monitoring and developing strategies for program improvement, the Committee urges that strong, reliable measures be made available to all programs.

RECOMMENDATION II:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

Impact Studies Priority 2: Conduct new research—experimental to the extent feasible—aimed at improving Head Start and EHS practice through testing quality improvements in instructional practices and parent engagement, enhancements in supports for children’s social-emotional development and health, advances in progress monitoring, and implementation of evidence-based professional development strategies.

Program improvement is a crucial goal for both Head Start and EHS programs. Although many ideas for improving practice are put forward, few are tested to see if they really offer the promised enhancements and are significantly better than what programs are currently doing. The Committee urges the Secretary to support rigorous studies that will enable programs across the country to be successful while implementing program improvements.

Research aimed at improving practice often can provide strong evidence because it is frequently possible to conduct the studies as randomized control trials since no participants are denied services. Whenever a new, improved program practice (such as a curriculum to enhance literacy among DLLs, training to improve teachers’ instructional skills, or a program to increase parent engagement) has sufficient support and is clearly specified, it can be tested experimentally. Sometimes referred to as a planned-variation study, this research can be done by randomly assigning individual classrooms, centers, or even intact programs to receive the enhanced service, or not. Teachers in the “treatment” settings would receive the necessary training enabling them to implement the enhancement, while those in the control settings would not, but simply continue with their usual practices. Results from such studies would provide unambiguous evidence about the value of the program improvements being tested.

Impact Studies Priority 3: Conduct research aimed at improving practice by investigating program effects for policy-relevant subgroups, including children of families at different poverty levels, children at highest risk, Hispanic children, and DLLs.

Extensive subgroup analyses were conducted in both the HSIS and EHSREP. The report authors noted the importance of these analyses for informing policymakers about potential differential effectiveness of the programs for diverse constituencies. The Committee believes it is important to gather additional evidence for the particular policy-relevant groups identified in this priority. In some cases this may require only additional secondary analyses of the HSIS and EHSREP data sets. However, where feasible, new studies focusing on these subgroups in contemporary Head Start and EHS settings should be conducted.

RECOMMENDATION III:

Further improve continuity and coordination of early childhood services beginning during the prenatal period and continuing to age 8.

Impact Studies Priority 4: Find relatively low-cost, high-yield methods to extend follow-up studies of the EHSREP and HSIS samples into adolescence and early adulthood.

Discussion of nonexperimental, econometric analyses of the long-term effects of Head Start appear earlier in this chapter. (It is too soon for similar studies of the EHS sample to have been conducted.) Because those analyses were not based on randomized groups and used data collected for other purposes (as in the National Longitudinal Survey of Youth or PSID, for example), it is important that their conclusions be confirmed using the randomized samples of the HSIS and EHSREP.

Long-term follow-up studies can be expensive; therefore, the Committee suggests that the Secretary consider strategies that are relatively low cost. This could be done by checking on ways of accumulating administrative data that could include whether sample members graduated high school, their age of school drop-out (if not graduated), absenteeism, and standardized test scores. In addition, wherever possible, data on characteristics of the elementary, middle, and high schools attended by Head Start and EHS sample members should be obtained so that the long-range impacts of the programs can be judged in relation to children's post-program experiences.

Impact Studies Priority 5: Conduct new analyses of: (a) existing HSIS and EHSREP data to learn more about effects of variation in quality, dosage, and children's follow-up experiences; and (b) other national databases to learn about Head Start's and EHS' longer-term effectiveness.

Both the HSIS and EHSREP contractors carried out some nonexperimental analyses to examine ways in which variations in children's experiences while enrolled in their respective programs were associated with outcomes at the end of the program and at the follow-up points included in the reports published to date. Nevertheless, their reports necessarily focused on the experimental impact analyses. More such analyses could yield useful suggestive findings regarding the influences on child outcomes of such factors as the quality of Head Start classrooms sample children attended, duration and intensity of program services they participated in, and children's post-program experiences (such as the nature of preschool programs EHS children attended or characteristics of schools Head Start children enrolled in).

At the same time, more secondary analyses such as those cited in Chapter 1 could be carried out with additional large, national databases.

Impact Studies Priority 6: *The Committee suggests that the Secretaries of HHS and ED further identify important forms of alignment between early interventions and elementary education that can maintain and enhance the positive impacts of EHS and Head Start through elementary school. The Committee commends HHS and ED for their collaborative efforts toward achieving better alignment. Promising leads from research, practice, and policy on how to create such alignment can be expanded upon and scaled up.*

The Committee heard considerable testimony and had lengthy discussion about why short-term gains may not be sustained (while acknowledging the longer term gains seen in nonexperimental studies cited earlier). The reasons seem not to be simple and discussion focused on differences among fade out, catch up, cultures of learning (e.g., when a high proportion of poverty-level students attend a single school vs. a school with more socioeconomic diversity), need to support parents, and match of instruction to child abilities (e.g., when school instruction may better fit one group of children than another). Generally, the Committee agreed that a more concerted effort in both practice and research will be needed to better understand how best to support and maintain the gains that research has demonstrated occurring in Head Start and most pre-kindergarten programs. HHS and ED have embarked on a collaborative effort to better understand how to support preschool gains and optimize learning for children in low-income families, but the Committee noted that much more collaboration, focus, and study are needed as the puzzle regarding how to best maintain early gains is a long way from being solved.

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Chapter 3: Quality Teaching and Learning

OVERVIEW

As noted in Chapter 1, Head Start is at a critical point of opportunity for enhancing children’s development by promoting high-quality learning experiences and improving the quality of teaching practices, both in Head Start and Early Head Start (EHS) classrooms and home visits, and in supporting parents as children’s first teachers. The efforts undertaken through Head Start’s ambitious reform agenda take several steps toward improving practice in Quality Teaching and Learning by increasing the emphasis on children’s school readiness, implementing a Mentor-Coaching effort, restructuring the technical assistance (TA) system to focus on research-based practices¹, and monitoring programs on the quality of teacher-child interactions.

In its deliberations, the Committee examined information about how Head Start today addresses the key components of quality teaching and learning, including curriculum, assessment, and education and training of staff. In this chapter we present our summary of the state of Head Start at this juncture, followed by a vision for what the Committee would like to see in Head Start teaching and learning moving forward. Finally, the chapter provides priorities for implementing each of the Committee’s three recommendations within the area of quality teaching and learning.

HEAD START TODAY: QUALITY TEACHING AND LEARNING

All Head Start programs report using early childhood curricula, though the quality of those curricula and the quality of implementation is unknown.

The Head Start Program Performance Standards (Performance Standards) require programs to implement an early childhood curriculum (i.e., a written plan based on sound child development principles) that identifies goals for promoting learning and development across multiple domains and defines the experiences for children and roles of staff necessary for achieving those goals. According to the Program Information Report (PIR) and the Family and Child Experiences Study (FACES) 2006, virtually all programs report that they are using at least one curriculum¹.

¹ In 2011, the Office of Head Start funded the National Center on Quality Teaching and Learning in Head Start, at the University of Washington (working with six other universities), to implement targeted technical assistance and outreach training, research and evaluation in this area. For more information, please access the website at <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/>.

The Head Start Act of 2007 pushed Head Start further in its curriculum requirements, requiring that curricula be based on scientifically valid research, have standardized procedures for training and implementation, be comprehensive, and be linked to ongoing assessment. Programs exercise considerable autonomy in their approach to meeting these requirements, including selecting among any of the widely available “off the shelf” curricula or developing their own. In fact, despite the fact that there are no requirements for using a specific curriculum, or for choosing among a specific set, most Head Start programs use one of two curricula: 68 percent of center-based and 61 percent of home-based Head Start programs use Creative Curriculum, and another 16 percent use the High/Scope Curriculum in center-based classroomsⁱⁱ. Among EHS center-based programs, 87 percent use Creative Curriculum, as do about a fifth of home-based EHS programs. More common in home-based programs are Parents as Teachers (44 percent), and Partners for a Healthy Baby (41 percent)ⁱⁱⁱ.

Yet, there are also programs that choose alternative curricula, and some programs (five percent in Head Start) report that they have designed their own. However, the level of training and quality of implementation of any curricula in Head Start is not well known. While most Head Start teachers have received training in their curriculum at least once^{iv}, it is not clear whether they receive refresher training over time. Only 13 percent of EHS programs report that they provide annual curriculum training to their staff^v.

Head Start programs also screen children for developmental delays and use assessments to monitor children’s progress in the program, although—again—there are questions about the quality of the tools used and the effectiveness of their implementation.

Performance Standards require programs to screen all children to identify any concerns related to the child’s development that need referral for evaluation. Programs are also required to implement ongoing assessment procedures to continually monitor children’s developmental progress. All programs report having assessments in place^{vi,vii}.

Parallel to its components related to curricula, the Head Start Act of 2007 required programs to move toward more effective assessment, requiring that instruments used by programs be valid and reliable; administered by trained staff; and developmentally, linguistically, and culturally appropriate for the purpose and with the population with which they are implemented. In addition, recently published regulations related to the Head Start Designation Renewal System (DRS) further specify that programs must use child-level assessment data to individualize services for children and must aggregate and analyze these data at least three times a year to examine progress toward meeting program-level goals and for continuous quality improvement.

As with their choice for curriculum, programs have autonomy in selecting assessment instruments that meet these requirements, including the option of developing their own. The most commonly used assessments in Head Start are those associated with Creative Curriculum (previously the Creative Curriculum Developmental Continuum, which has now been replaced with the Teaching Strategies GOLD), which is used by nearly 40 percent of Head Start programs^{viii}. In EHS, the most commonly used tools are the Ages and Stages Questionnaire (used by about a third of programs) and Creative Curriculum Developmental Continuum (used by about a quarter of programs)^{ix,x}.

Again, the quality of implementation of these tools is largely unknown. Further, a sizeable percentage of Head Start and EHS programs reported using an assessment instrument they have designed (about 9 percent of Head Start programs and about a quarter of EHS programs)^{xi,xii}.

Head Start is meeting its mandates for teachers' education and hours of teachers' professional development, although there is little known about the quality of that professional development or whether it has led to improvements in teaching quality.

The Head Start Act of 2007 requires that Head Start teachers in center-based classrooms must have an associate, bachelor's or advanced degree in early childhood education (ECE) (or in a related field with related coursework and teaching experience or meet the Teach for America requirements). EHS teachers in center-based programs must have a minimum of a Child Development Associate (CDA) credential and have been trained or have equivalent coursework in age-appropriate ECE and child development. Nationally, at least 50 percent of all teachers in center-based programs (Head Start or EHS) must have at least a bachelor's degree by September 30, 2013 and all teaching assistants must have at least a CDA.

Head Start appears to be progressing towards meeting these requirements. While in 2001 only 17 percent of preschool classroom lead teachers in center-based programs had a bachelor's degree, according to the PIR, in 2011, 46 percent had a bachelor's degree and another 10 percent had advanced degrees. Among assistant teachers in Head Start classrooms, one percent had a bachelor's degree in 2001, while in 2011, seven percent had a bachelor's degree and one percent had advanced degrees^{xiii,xiv}. About a third of Head Start teachers in 2011 had an associate degree. Sixty-one percent of teaching assistants had a CDA. Teachers' education in EHS is lower. In 2011, 22 percent of infant and toddler classroom teachers in center-based programs had a bachelor's degree and another 2 percent had an advanced degree. EHS home visitors are more educated than EHS teachers, with 39 percent of home visitors having a bachelor's degree and another 6 percent having an advanced degree^{xv}.

While Head Start teachers must be provided with at least 15 hours of training or professional development each year, local programs have considerable autonomy in determining how best to

use their resources for training and technical assistance (T/TA) (which make up at least 50 percent of all national funding available for TA to Head Start). There is little information available regarding how local programs use those resources, although EHS teachers and home visitors are provided an average of 53 and 48 hours of professional development a year, respectively^{xvi}.

Head Start appears to have a solid foundation for quality teaching and learning, with programs meeting specific mandates for curricula, child assessment, and teacher education. Yet, there are still areas for improvement.

Overall, the Committee views these data as suggesting a high rate of program compliance with Head Start’s standards for quality teaching and learning. Programs are meeting basic requirements for education and having curricula and assessments in place in their programs. It is less clear, however, whether these mandates are being implemented in a way that results in high-quality early care and education. The evidence does not support the idea that simply having a curriculum or having a certain level of education is sufficient to ensure high-quality teaching and learning practices.

National data on Head Start and EHS children and programs suggest that there is variability in the quality of Head Start teaching and learning, and that—while children make meaningful progress during their time in Head Start—they still leave Head Start significantly behind their same age peers. More than 80 percent of Head Start and EHS programs fall in the minimal to good range on global ratings of the classroom environment, though very few are of inadequate quality^{xvii,xviii}. Data from the Classroom Assessment Scoring System (CLASS) Preschool version raises concerns, with a substantial percentage of Head Start classrooms falling in the low quality range on a summary rating of Instructional Support^{xix}. These findings are comparable to observational ratings of quality in other publicly funded programs, including those in a study of 11 state prekindergarten (Pre-K) programs^{xx}. Yet, they raise concern about the need to improve instructional practices in early childhood programs as a whole, and in Head Start programs in particular. These findings are of particular concern given that most Head Start and EHS children enter the program with skill levels well below national norms. While they do make progress toward norms during their time in the program, many still leave the program behind their same-age peers^{xxi,xxii}.

The broader early childhood literature suggests that instructional quality in general, and practices related specifically to the development of vocabulary and mathematics skills, are areas with the greatest need for support and improvement. Further, children’s early skills in these areas are among the most important predictors of subsequent academic achievement. In most early childhood programs, time spent in mathematics instruction is limited relative to time focused on other areas (e.g., language and literacy)^{xxiii}. While programs focus on language and literacy development, they need support in helping children build their vocabularies. The “whole child perspective” embraced within Head Start means that progress in instructional quality in general, and strengthening practices more specifically in such areas as building children’s vocabulary and

early math skills (and content areas now emerging in the research as potentially important, such as early science), will need to be balanced with the ongoing priorities placed on such areas as social-emotional development and health.

What Early Childhood Research Tells Us about Supporting Quality Teaching and Learning

There have been considerable advances in recent years in research demonstrating the potential for excellence in teaching and learning experiences in early childhood programs. Although this research suggests that the relationship between quality experiences and children’s outcomes is complicated and dynamic, it also provides an important foundation for improving the quality of teaching and learning in Head Start and EHS^{xxiv}. Some of the most important findings from research include the following:

The quality of early care and education programs matters for children’s development, although the nuances of what types of quality matter for which types of skills (and how much they matter) are complicated.

A review of the literature on quality along with a series of secondary analyses of early childhood data, funded by the Office of Planning, Research and Evaluation, suggest that children’s skill levels are influenced by the observed quality in classrooms. Consistent relationships were found between the quality of emotional support in teacher-child interactions and children’s social and emotional skills, while cognitive skills were more likely to be related to the instructional climate. Quality measures that focus on environmental supports in specific developmental domains (e.g., measures of the quality of language instruction or math instruction) show somewhat stronger prediction to children’s outcomes in aligned domains of development than for measures not aligned with domains. Further, there is some evidence that it is especially at higher levels of instructional and domain-specific quality that there are linkages between improved quality and improved child outcomes^{xxv,xxvi,xxvii}. Thus, there is a need to focus on more clearly identified and targeted approaches to promoting outcomes. There is also a need to help programs move out of the “moderate” range of quality into the higher range, and then to continue to improve quality within the higher range.

We have a growing body of evidence on how integrated systems of teaching and learning can promote school readiness. There is a growing body of research on the effectiveness of comprehensive, multi-component models for promoting early learning and development in Head Start classrooms. These models include focused, explicit curricula with scope and sequence; assessments linked to those curricula; and effective, responsive, and developmentally appropriate classroom practices directly aligned with the curricula and assessments^{xxviii,xxix,xxx,xxxi,xxxii,xxxiii}. Many of

these models also include intensive professional development (primarily mentor coaching) so the teacher can receive individualized support to more easily apply skills in the classroom. These curricula, used with coordinated assessments and professional development, have much larger impacts on school readiness skills than do the comprehensive curricula typically used in Head Start programs. The size of their effects across differing contexts, however, and the feasibility of taking them to scale are still uncertain. The Committee observed, however, that these models share common characteristics in their approaches to curricula, assessment, teaching practices, and professional development in that each component of the model is focused, intensive, and systematic, and the components are synergistic, with both the assessments and the professional development directly linked to curriculum and classroom practices.

We have more to learn in this area. While some programs have successfully combined a global and specific curriculum, little information exists to help programs improve teaching and learning across multiple areas of development simultaneously. Less is known about models appropriate for EHS and other settings serving infants and toddlers. While there are promising evaluations of some integrated curricula within Head Start, there is a clear need for further research on such approaches. Furthermore, while there are promising models of professional development, there is a clear need for further research on integrating curricula and professional development within Head Start programs^{xxxiv,xxxv}.

The dosage of high-quality teaching and learning experiences and the sequencing of experiences across the full period from infancy to school entry matters for children's development. The same research focusing on the consistency of relationships between measures of quality and child outcomes described above also looked at the dosage of participation in Head Start. This work found consistently stronger outcomes across domains of development for children who had participated in two years rather than one year of Head Start. In research following participants of EHS through school entry, those who participated first in EHS and then in formal early care and education (rather than parental care or home-based child care) had stronger early elementary school outcomes^{xxxvi}. There is thus an emerging body of evidence focusing on the dosage of Head Start and EHS participation as important to consider, along with the sequencing of high-quality early care and education and home visiting experiences spanning the infancy and toddler period and the preschool age period.

Gaps in the research indicate the need for systematic study to help inform quality teaching and learning practices.

As we consider quality teaching and learning, we need to consider the full period from birth to school entry. We need systematic study not only of what quality teaching and learning entails in each age period, but also of what sequencing and dosage of such experiences are most beneficial for children prior to school entry. We are at the point of needing to add the dimensions of time and

sequencing to the understanding of quality teaching and learning. In addition, there is little research to shed light on how to think about quality teaching and learning at the level of the program or system. That is, past research efforts have been designed to answer questions about the quality of Head Start classrooms and outcomes for the children in these classrooms, or to evaluate the effects of innovations or interventions in a limited number of local programs. Little information is available at the program level that examines the variability in the outcomes or effectiveness of the nearly 1600 local Head Start programs. It may be that all programs are similar in the progress and outcomes they generate for children and families. Or there may be programs that are consistently producing much higher or lower levels of growth on key outcomes. The Committee discussed the role of measurement of quality and outcomes at levels above that of the individual classroom (e.g., center, program), as well as the potentially important role of leadership and management in promoting a culture of effective teaching and learning.

THE COMMITTEE'S VISION FOR QUALITY TEACHING AND LEARNING

The Committee finds that Head Start programs have a number of the components for quality teaching and learning already in place. The Committee acknowledges the progress Head Start has made by a strategy geared to enforcement of compliance with standards, defined primarily in the form of inputs and procedures, such as the requirements for curricula and processes for aggregating data, combined with TA. Head Start's inter-locking system of Performance Standards, on-site program monitoring, T/TA, and the capacity to defund programs that are unable to remedy deficiencies in program quality has been a strong model of accountability in early care and education. The new initiative to require programs to be identified as low-performing and to compete for funding represents a significant expansion of this accountability strategy.

Moving forward, the overriding need for Head Start quality teaching and learning in the coming decade is not for more mandates, but rather to **implement** the best of what research tells us in each of the component areas, to **integrate** these components in order to meet very specific goals for children's school readiness and to **conduct further research** where there is more to learn about translation of research into practice or where the research is not definitive.

THE PATH FORWARD: FURTHER SPECIFICATION OF THE COMMITTEE'S RECOMMENDATIONS

The following discussion elaborates on the Committee's three Recommendations, with a particular focus on priorities in the area of Quality Teaching and Learning as they relate to each of these three

recommendations. The first two recommendations are linked as stated in the overview, and are discussed together.

RECOMMENDATION I:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes, within local programs, across federal components of the program, and from federal to local levels.

RECOMMENDATION II:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

Quality Teaching and Learning Priority 1: In addressing Overarching Recommendation I, the Committee sees a need for additional guidance to programs on how to define and assess the progress of children towards school readiness goals, how to achieve those goals through quality teaching and learning practices, and on how to define and assess other goals that may be contributing to readiness in specific programs.

Defining and assessing progress towards school readiness goals. Many Head Start programs are requesting assistance in selecting assessments, implementing them, and using data from assessments. Accordingly, the Committee recommends that the Secretary convene a panel of experts and leaders from early childhood and early elementary education to provide guidance to programs to help them better understand how to define and measure school readiness and prioritize constructs for assessment. We further suggest this expert panel review research on the relationship between children's progress and status on the indicators in the Head Start Child Development and Learning Framework and their success in kindergarten through third grade.

The panel should also examine the implications for Head Start’s school readiness goals of state early learning guidelines, state and local kindergarten readiness assessment initiatives, and other aspects of standards and assessments across the birth through age 8 continuum. This would make it possible to determine whether research supports defining a limited common set of school readiness goals for use by all local programs; then the panel could make recommendations regarding assessment instruments that provide the strongest measurement of the outcomes defined in those goals. It could also provide guidance on other aspects of defining and assessing progress towards school readiness goals, including approaches that provide evidence of children’s progress over time and provide feedback on the extent to which Head Start programs are narrowing the typical disparities between the trajectories of learning and development of children in low-income families and their same-aged peers.

In addition, the panel could examine the feasibility and benefits of collaborative efforts by programs in defining, assessing, and using data on school readiness goals, such as voluntary state-wide consortia of programs, groups of programs that are already using a common child assessment tool, or programs that share common characteristics such as those serving migrant and seasonal farmworker families or large proportions of English language learners. Such consortia could identify and provide the training needed for reliable and valid assessment on the selected assessment tools, develop and share software for entering and managing the results from the assessments into useable datasets, and assist teachers in understanding how to use the results from assessments to determine which children may need additional instruction on specific topics.

A related topic for the expert panel could be to define the evidence for alternative pathways towards school readiness: alternative routes by which program inputs, systematically and intentionally implemented, relate to outputs that in turn relate to child readiness outcomes. Some evidence exists that program impacts on parenting partially mediate program impacts on children^{xxxvii}. The expert panel could identify evidence for other pathways (e.g., improvements in health, mental health, self-sufficiency) and suggest constructs for programs to measure in relation to these further pathways.

Curriculum plan and coordinated professional development. To accomplish their school readiness goals, programs will need an overall curriculum plan. The Committee recommends that Head Start programs work towards plans with the following basic components.

- ▶ First, a curriculum plan should have a well defined *scope*. This scope identifies the targets for change specified by the program’s school readiness goals (or as noted above, common program-wide school readiness goals).
- ▶ Second, the curriculum should have a well-documented, evidence-based *sequence* of the targeted skills it aims for children to develop, and should provide sufficient opportunities for children to learn and practice each skill. For the major foci of the curriculum there should be empirically supported developmental progressions of each targeted skill in a manner that

ensures that the child has been taught the prerequisite skills before advancing in the progression.

- ▶ Third, the overall curriculum plan should demonstrate how children’s learning experiences are stimulated by well recognized *methods of effective early childhood pedagogy*. These methods would include, for example, the deliberate and varied use of large and small group instruction, interactive reading, and engaging and interactive center activities, considering also the intentional use of technology^{xxxviii}.
- ▶ Fourth, the selected curriculum or curricula should have *evidence that children’s skills improved* in studies conducted by evaluation teams without ties to the developer and, ideally, using random-assignment evaluation designs. Selection should be based on the magnitude of the effect sizes (differences between treatment and comparison groups), not the statistical significance levels.
- ▶ Finally, this plan should provide clear guidance through *adequate professional development* to both teachers and teacher assistants of how to apply, within these methods, the highest levels of emotional and instructional support to students as delineated by evidence-based, teacher-student interactions. The implementation and use of the CLASS data should be a key part of this plan.

The Committee concluded that programs need guidance in how to make use of curricula developed to address specific areas of content (such as early vocabulary development or mathematics) in combination with a “comprehensive” curriculum designed to guide teachers in all aspects of early learning and development. That is, early educators need support both in the processes of supportive and stimulating interactions that provide a foundation for content-specific curricula, and also in implementing content-specific, evidence-based curricula. For example, many grantees use both a comprehensive global curriculum and a specific focused language and literacy curriculum for which there is evidence of positive impacts on language and literacy skills, but report that considerable professional development is needed not only on the content-specific curriculum, but also on how to coordinate the global and specific curricula.

The Committee feels that it would be useful to conduct comparisons by independent researchers of the effectiveness of widely used curricula in order to inform decision making by programs. There is a need for research on effective integration of content-specific curricula in multiple domains (for example, combining an explicit focus on language and literacy, math, and social and emotional development). Much greater effort has gone towards developing curricula for preschool-age children than for infants and toddlers. Baby FACES studies show that Infant Toddler Environment Rating Scale-R scores in 223 EHS classrooms in 38 states average 3.9 out of 7 points possible^{xxxix}. “Good” quality is typically considered to be in the 5 – 7 range. These scores suggest that classrooms for infants and toddlers cannot be overlooked in the effort to develop curricular models.

Progress monitoring. The Committee urges that programs receive support in understanding and implementing progress monitoring. It also urges the development of further progress monitoring tools where there are gaps.

Progress monitoring involves frequent assessment of how individual children and groups of children are moving toward the programs' identified school readiness goals. It is an active use of information to guide program activities at all levels, including using information about individual children's progress for further individualizing learning opportunities, and using information from groups of children for planning at the classroom, center, or program level. Effective progress monitoring of school readiness requires both an evidence-based tool that can provide an accurate reflection of children's school readiness and progress over time, and the appropriate understanding and use of information from use of this tool to guide program efforts to support individual children and groups of children.

To accurately understand children's progress toward school readiness, programs need assessments that are reliable and valid for the populations with whom, and purposes for which, they are used. The Committee identified concerns about available progress monitoring tools overall, and those available especially for particular subgroups. There is less evidence for the reliability and validity of the ratings and portfolios that are often used in progress monitoring than for direct assessments^{xl}. There is a particular dearth of instruments that have been identified to be reliable and valid for assessing children's progress over time for use with dual language learners (DLL), children with special needs, and for infants and toddlers. The Committee recommends further research on the reliability and validity of progress monitoring tools in general, and research toward the development of appropriate tools especially for DLL, children with special needs, and for infants and toddlers.

Quality Teaching and Learning Priority 2: In addressing Overarching Recommendation II, the Committee emphasized the importance of a highly focused system and process of coaching and mentoring as critical for the implementation of evidence-based practices.

A growing body of evidence supports the conclusion that individualized professional development focused on the implementation of specific evidence-based practices directly in the setting of care and education can support improvements in program quality and in children's development and learning^{xli}. Complementing Head Start's increased emphasis on teacher educational attainment, we strongly recommend a carefully developed system for mentoring and coaching to assist early educators in actually implementing specific positive practices in interactions with children that are supported by the evidence. Our recommendation is not just for *more* mentoring and coaching, but for a system of mentoring and coaching that is closely coordinated and aligned with the designated priorities for children's school readiness, and the implementation of curricula for which there is

evidence that they support these specific aspects of school readiness, with child assessments used to monitor progress.

A scalable system of effective professional development must accomplish two overarching tasks. First, there must be evidence that the specific selected professional development approaches improve practice and children’s learning. Second, the professional development must be embedded in a state or regional system of incentives, management, and evaluation that enables high levels of participation across programs and fidelity of implementation within programs.

This more intensive approach to TA focuses on moving away from one-shot training on individual topics and moves toward developing a professional development infrastructure that includes, supports, and builds on existing educational management/coordination/specialist positions already in programs to achieve systematic changes in practices. Critical components that support this type of sustained and systemic implementation include the following: (a) implementation teams at both the state and local levels that actively coordinate implementation of evidence-based practice; (b) an organizational umbrella of T/TA supported by adequate funding and broad visibility; (c) a cadre of individuals who can provide coaching support for local implementation, a small group of individuals who can train teams on the practices and processes of evidence-based practice, and a system for ongoing evaluation; and (d) a small group of demonstration centers that can document the viability of the innovative approaches within the local context.

Without the two conditions of (a) a proven-effective model and (b) a system for scaling up the implementation of evidence-based models, ineffective, one-time experiences that have little hope of impact will remain the norm. Most program leaders know they need to move away from one-time workshops—the approach they have used for decades. Experience tells them that professional development should be sustained, intensive, and focused on content and practice. But where is the supply of proven-effective programs? Where would a program leader turn to identify programs that work?

A recent review of more than 1,300 studies of the impact of teacher professional development on K-12 student outcomes found only nine studies that met standards for “evidence without reservations” from the What Works Clearinghouse^{xliii}. These nine professional development programs consistently showed moderate effects on student achievement, and all involved elementary school teachers. One of the other most commonly deployed approaches to teacher professional development, accumulating course credits or advancing in terms of degree status (e.g., from bachelor’s to master’s), was found to have virtually no impact on student outcomes or teacher practice in the K-12 grades. This leads us to question the current emphasis in Head Start and other early childhood programs—through regulation and resources—on increasing the number of bachelor’s degrees required for teaching staff.

When considering the birth through school entry years, there is a need both for a review of the evidence to identify effective professional development models, and to continue in the development and evaluation of further models. However, in keeping with our earlier recommendation, we underscore the need for research focusing on identifying and developing further examples of integrated curriculum/professional development/assessment systems. It would be useful to have research comparing the effectiveness of more and less well-integrated systems in promoting child outcomes. This research would require the development of measures of integration. Such measures, in turn, would be useful tools for assessing integration of curriculum, professional development, and assessment at a systems level.

Quality Teaching and Learning Priority 3: Extend the research on evidence-based practices to focus specifically on elements that pertain to markers of quality used in the DRS.

Given the new regulations regarding competition of programs showing observed quality scores in specific ranges, it will be important to examine what approaches are effective in bringing about quality improvement in such programs. The Committee recommends a particular focus on identifying the supports that are effective in bringing about improvements in Instructional Quality on the CLASS that bring programs from below to above levels that can trigger the need to recompet. Examination also of programs scoring high on measures of quality, particularly in the area of Instructional Quality, can provide important information for quality improvement efforts in programs. There are further important questions for study as the DRS is implemented. These include whether programs required to compete are concentrated in certain geographical areas, among grantees with particular characteristics, or among programs utilizing particular approaches in terms of curricula, assessments, and professional development.

Quality Teaching and Learning Priority 4: Provide increased emphasis on supporting the skills, knowledge, and continuous availability of educational coordinators or managers and home visiting supervisors for selecting and implementing the most effective evidence-based approaches.

Throughout this chapter and this document, the Committee has emphasized the importance of ensuring that programs are using effective, integrated teaching and learning approaches that ensure that children make progress toward school readiness. Educational coordinators and managers and home visiting supervisors will be critical in this effort, as they are charged with developing and overseeing the educational component of programs.

Both education coordinators/managers and home visiting supervisors must have sufficient and intensive time dedicated to their roles as the educational leaders. Furthermore, there is not a clear articulation of the expected knowledge and skills for these roles or how best to prepare staff to be able to monitor and improve practices within the program.

Educational coordinators need further professional development aimed at helping them train and monitor teachers in using evidence-based teaching methods. They also need support in understanding how they can use data from child assessments, CLASS, and other classroom-level data, and information on children and families to identify professional development needs and to monitor how well the program is doing at achieving school readiness goals. In parallel, supervisors of home visiting staff need to be able to guide home visitors in how to identify and address areas in which families most urgently need support.

Quality Teaching and Learning Priority 5: Renew efforts by Head Start and EHS programs to engage parents and families from the range of diverse backgrounds as full partners in promoting children’s early learning. Continue to build the evidence on specific approaches to family engagement that augment other program efforts to support children’s learning and school readiness.

As noted in the Committee’s discussion on parent, family, and community engagement (PFCE), Head Start has long recognized that parents are children’s first teachers and viewed families as full partners in teaching and learning efforts. Moreover, there are many studies of parenting that illustrate variability in parenting that is predictive of children’s readiness and development (e.g., in language, cognitive, and social-emotional development)^{xliii,xliv}.

Parents and other family members need to know about children’s development and what children are learning in Head Start, and they need tools and skills that they can use to help promote the children’s development. Teachers need guidance in how to best convey information about children’s development and about ways parents can promote progress, as well support in viewing parents as sources of information and insights about children’s strengths, dispositions, relationships, and needs.

Many EHS programs deliver EHS services through home visiting. Home visiting programs tend to follow a theory of change whereby the program seeks to equip the parent as the child’s first teacher rather than providing direct services to the child^{xlv}. Programs are also expected to make specific efforts to prepare parents to continue to support their child’s learning as they transition between Head Start/EHS and other education programs, including public schools.

Head Start’s PFCE Framework provides a new outcomes-oriented approach to engaging all program staff members and managers in building positive, productive relationships with parents and families from the full range of diverse backgrounds. Stronger family engagement in supporting children’s learning must be viewed and supported as an integral element of Head Start’s approach to quality teaching and learning. The specific recommendation here is for continuing to build the evidence base on family engagement approaches in children’s learning that augment the effects of other program elements.

RECOMMENDATION III:

Further improve continuity and coordination of early childhood services beginning during the prenatal period and continuing to age 8.

Quality Teaching and Learning Priority 6: In providing further specification for Overarching Recommendation III, the Committee recommends research extending the research on the duration and sequencing of EHS and Head Start participation in order to guide efforts on continuity and coordination of early childhood services.

Currently, a greater percentage of 4-year-old children eligible for Head Start are served by Head Start than is true for eligible 3-year-olds, and vastly more 4-year-olds are served by Head Start than infants and toddlers by EHS. As noted earlier, the Committee recommends expansion of EHS and thoughtful realignment of resources in Head Start communities to serve more younger children and to maintain continuity of quality services once services have begun.

Initial studies point to longer participation in Head Start, and participation in EHS followed by formal early care and education programs (center-based child care, Head Start or Pre-K) as predictive of stronger developmental outcomes^{xlvi}. These initial results use nonexperimental approaches and consider associations, albeit taking rigorous approaches in controlling for selection.

We urge systematic study of more sustained exposure to Head Start and sequencing of EHS and Head Start. The methodology for such work is challenging. The Committee recommends convening a group to make recommendations for rigorous research on dosage and sequencing of exposure to quality teaching and learning. This research should consider developmental period(s) of such exposure, seeking to shed light on the features of quality that are of greatest importance in different periods. This research should also consider for which children (e.g., with which population characteristics) continuous EHS/Head Start service would be most beneficial, and for which children two years of Head Start would be most beneficial.

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Chapter 4: Parent, Family, and Community Engagement

OVERVIEW

Parent, family, and community engagement (PFCE) has been a cornerstone of Head Start since its inception in 1965. The developers of the Head Start program understood that to improve outcomes for children, the program needed to address all aspects of children’s development (i.e., cognition, health, social and emotional development) as well as the context of parent, family, and community within which children live. The primary goals of parent and family engagement in Head Start are to promote family and parent well-being and to strengthen parent-child relationships, which in turn promote children’s health, development, and school readiness. The Head Start Program Performance Standards (Performance Standards) require programs to involve parents in policymaking and opportunities, provide parents with opportunities to participate in the program (as volunteers or employees, including an emphasis on observing and interacting with children), provide parent involvement and education activities, be respectful of each family’s cultural and ethnic background, provide opportunities for parents to enhance parenting skills and knowledge, and be open to parents during all programs hours.

While programs are required to encourage parent participation and involvement, parents’ participation is voluntary. Standards also stipulate that programs collaborate with a wide range of community partners in order to ensure that children and families have access to needed services. These standards support strong program engagement with community agencies and institutions through periodic community assessments, linkages to services supporting family well-being, development of agreements with local school districts to improve the transition of Head Start children to kindergarten, and the establishment of Health Advisory Committees to involve medical and dental providers in supporting Head Start children and their families.

In its deliberations, the Committee examined information about how Head Start today addresses the critical area of PFCE. In this chapter we present our summary of the state of Head Start at this juncture, followed by a vision for what the Committee would like to see in Head Start’s efforts to engage parents, families, and communities moving forward. This is followed by priorities for implementing each of the Committee’s three recommendations within the area of PFCE.

HEAD START TODAY: PARENT, FAMILY, AND COMMUNITY ENGAGEMENT

There has been renewed focus on PFCE by the Office of Head Start (OHS). In 2010, the OHS initiated the National Center on Parent, Family, and Community Engagement (NCPFCE) to assist OHS and its technical assistance (TA) providers in the provision of support to programs and to benefit the larger early care and education community¹. The goals of the NCPFCE are to:

1. “Identify, develop and disseminate evidence-based practices that are positively associated with the development of children from prenatal-to-eight and the strengthening of families and communities;” and
2. “Uplift and refresh current practices and co-create new approaches that actively and intentionally engage parents, families, communities and programs in the development and learning of young children.”

In addition, in August 2011, OHS released the PFCE Frameworkⁱ. This Framework, developed by OHS and the NCPFCE with input from Head Start parents, Head Start staff, researchers, and policymakers, delineates seven specific family outcomes for PFCE: (1) family well-being, (2) positive parent-child relationships, (3) families as lifelong educators, (4) families as learners, (5) family engagement in transitions, (6) family connections to peers and community, and (7) families as advocates and leaders. The Framework provides guidance to help programs build the organizational level supports and systems they need in order to foster positive child and family outcomes. Over the coming years, support will be provided to help programs incorporate the Framework into their systems and use it to guide their provision of services.

Finally, OHS is also examining how to best support a high-quality family service worker (FSW) workforce. While the work of engaging families and communities is the responsibility of all Head Start staff (from bus drivers to Center Directors to teachers), FSWs’ primary purpose is to focus on the needs of parents and families. OHS has provided guidance to programs concerning preferred qualifications of FSW staff, and will next work with programs to develop the systems, organizational conditions and processes, including ongoing training and supervision, needed to support FSWs in their work, especially concerning implementation of the new framework.

Data from descriptive (Family and Child Experiences Study [FACES] and Baby FACES) and evaluation (EHSREP) studies and from the Program Information Report (PIR) provide a useful snapshot of who Head Start parents and families are, of their engagement with their children, of parents’ and families’ participation and engagement with Head Start, and of some of the benefits of

¹ For more information on the National Center on Parent, Family and Community Engagement, access the website at <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/center>.

parents' and families' engagement in Head Start and with their children. These data, however, do not provide information concerning the quality of interactions between staff and families or specifically what occurs within family and staff interactions.

Head Start families are diverse, representing a wide range of cultural and linguistic backgrounds, different family and household compositions, and a range of experiences with employment and public services receipt.

There is tremendous diversity in the cultural and linguistic backgrounds of Head Start parents. Specifically, FACES 2006 found that 35 percent of parents were Hispanic/Latino, 33 percent were African-American, 24 percent were White, and 8 percent were from mixed or other ethnic groups. In addition, from FACES 2000 to FACES 2009, the percentage of children living in households in which English is not the primary language spoken has increased from 17.9 to 25.9ⁱⁱ. In EHS, nearly one-fourth of parents were born outside of the United States, but almost all children in the Baby FACES study were born in the United Statesⁱⁱⁱ.

Head Start families also vary in household and family composition, employment patterns, and need and receipt for public services. According to the 2011 PIR, 57 percent of families were headed by a single parent, and in half of these families, that parent was not employed, while another 15 percent of these were in school or training^{iv}. In the majority of two-parent families, at least one parent is working, although in 19 percent of the two-parent families, neither parent worked.

Despite the fact that these families are poor, only small minorities receive public benefits, with the exception of Women, Infants, and Children (WIC). Sixteen percent of families receive Temporary Assistance for Needy Families benefits, 7 percent receive Supplemental Security Income benefits, and 58 percent receive WIC benefits.

Sizeable portions of families have various special needs, however. Four percent of families served by Head Start (44,242 children) are homeless. Approximately 15 percent of children have a disability, which is defined as having had a professional indicate that the child has a developmental problem, delay, or special need.

Levels of parent and family engagement within Head Start vary by the type of engagement and type of family, and there is some evidence that having access to Head Start and Early Head Start (EHS) can increase parents' engagement with their children.

Most parents in Head Start are at least somewhat engaged in the activities of the programs, although parents are more likely to have engaged in activities associated with the child's classroom

or learning than in efforts to engage parents in governance, parental education, or social activities. According to the 2006 FACES data, 85 percent of parents reported having met with their child's Head Start teacher, 60 percent reported having volunteered in their child's classroom, and 72 percent reported having observed their child's classroom. A lower percentage of parents reported participating in Policy Council (25 percent), attending Head Start social events (50 percent), or attending parent education activities (49 percent)^v.

Both the Early Head Start Research and Evaluation Project (EHSREP) and the Head Start Impact Study (HSIS) found evidence of impacts of Head Start and EHS on parents' engagement and relationships with their children. The HSIS found that parents with 3-year-olds in Head Start were more likely to have read to their children after a year in Head Start than parents who were assigned to the control group and showed more positive parent-child relationships in first grade^{vi}. Likewise, the EHSREP found a number of statistically significant positive outcomes, including that children and parents who participated in EHS were more likely to be well-engaged with their child when the child was age 3 than were children and parents randomly assigned to the control group. Children were less negative towards their parents, and parents were more supportive than control group parents. As in the HSIS, EHS parents were more likely to read to their children than parents in the control group. Finally, EHS parents were more likely than control group parents to report having a wider repertoire of discipline tactics to draw from, and less likely than control group parents to spank their children^{vii}.

The EHSREP also found that EHS had impacts on parental outcomes and that impacts on parenting and parent outcomes were more favorable for some groups of parents than for others. For instance, EHS parents were more likely than control group parents to have participated in education and job training activities, or to have a job when the program ended^{viii}. EHSREP found that program impact variation was associated with the number of demographic risk factors a family had (i.e., being a single parent, receiving public assistance, being neither employed nor in school or job training, being a teen parent at the child's birth, lacking a high school diploma or GED). Specifically, EHSREP found that EHS had a few impacts on families that had fewer than three risk factors, many favorable impacts on families with three risk factors, and unfavorable or no impacts on families with more than three risk factors, suggesting that the programs are successful in meeting families' needs when families have a moderate number of risk factors but need new strategies for families with a high number of cumulative risks^{ix,x}.

An explicit theory of change in EHS home-based programs is that program investments in parenting and parents will lead to improvements in child development. While the literature on the importance of parents to children's development is quite extensive, there is less data available on the impact of program enhancements of parenting on child outcomes^{xi,xii}. In mediated analyses, the EHSREP found that about 25 percent of EHS program impacts on children at 3 years of age were mediated by impacts on parents when their children were 2 years old^{xiii}.

We know little about the quality of community engagement in Head Start, although Head Start programs have many formal agreements with community organizations.

In terms of community engagement, the PIR reports on the number of collaborative agreements that Head Start programs have with local organizations. Specifically, in 2010-2011, there were 17,974 local education agencies (LEAs) in programs' service areas; 14,086 LEA Agreements to Coordinate Disabilities Services; 12,961 LEA Agreements to Coordinate Transition Services; 10,946 Pre-kindergarten Collaboration and Resource Sharing Agreements; and 6,107 Part C Agreements to Coordinate Disabilities Services. Beyond this, though, not much is known. Existing datasets such as the HSIS contain information that could be used to examine the community context in which Head Start families and children live. However, to date, these data have not been analyzed.

Little is known about Head Start staff that are charged with working with families.

As mentioned earlier, while all Head Start staff are expected to contribute to encouraging parent and family engagement, the FSWs usually are the staff whose primary responsibility is to work with families to set goals and to provide supports (if needed) so that families can reach those goals. Head Start is unique among early childhood education (ECE) settings in its dedication of a relatively large percentage of staff to working directly with and focusing specifically on parents and families. According to the 2010-2011 PIR, programs employed 21,608 Family Workers and 3,920 Family and Community Partnership Supervisors to serve nearly one million families^{xiv}. Head Start invests more resources in family engagement than other mainstream early care and education programs.

Information on the FSW workforce is limited primarily to PIR data on FSWs' educational backgrounds and years of experience. Specifically, the PIR shows that 42 percent of the FSWs employed in 2010-2011 had a Baccalaureate or advanced degree, whereas 37 percent had only a high school diploma. In addition, the 2008-2009 PIR reported that 8,667 Family Workers had five or more years of experience, while 2,777 had less than one year of experience^{xv}. Beyond this basic information, though, there is no systematically collected data that describes the FSW workforce's day-to-day responsibilities, activities or compensation. Anecdotally, it appears that there is tremendous variability in the tasks that FSWs perform within a program and in the size of their caseloads. In addition, it is important to keep in mind that FSWs' responsibilities are not one-dimensional, but instead range across all aspects of child development and family need, including health, disabilities, and economic self-sufficiency. There is also little information about how these workers interact with Head Start teachers, parents, and others to build families' engagement in children's learning and preparation for the transition to school.

In sum, while there are considerable data on Head Start families and Head Start program efforts in PFCE, more attention has been paid over the years to child outcomes than to parent or family outcomes. While national studies like the Head Start FACES have collected some information about parents, families, and communities, these data have not been analyzed to the extent the data on child outcomes have.

In addition, there are relatively few high-quality measures and assessments of family engagement in early care and education, making it difficult to reliably collect valid data in this area. Recognizing the need in the ECE field for measurement of family engagement, the Administration for Children and Families is currently funding the Family-Provider Relationship Quality project, the purpose of which is to develop a well-tested and psychometrically sound measure of the quality of relationships between families and early care and education providers. The project focuses on measuring family-provider relationship quality, since strong relationships between families and ECE providers are an important ingredient in family engagement, as well as for other family and child outcomes.

THE COMMITTEE’S VISION FOR PARENT, FAMILY, AND COMMUNITY ENGAGEMENT

As a two-generation program, Head Start has a long history of supporting PFCE; of promulgating Performance Standards focused on program practices designed to engage parents; and of supporting the collection of considerable data on the characteristics of families’ and programs’ efforts to implement these standards. Some programs have strong PFCE work that can be lifted up for further examination, research and dissemination to other programs. Building on this strong foundation, the new Head Start PFCE Framework is increasing the visibility of this core element in Head Start’s overall strategy to enhance children’s school readiness and ongoing success in school and in life. The Framework provides a more explicit, outcomes-based approach to strengthen Head Start efforts in this area.

The Committee applauds the new Framework and offers a series of specifications of the overarching recommendations for using it as a catalyst for a next generation of Head Start PFCE efforts and research. The Committee’s recommendations place Head Start and EHS’ efforts in the context of a prenatal to age 8 continuum of early childhood and family engagement opportunities, and are complementary to those seen in other chapters (and expressed in Chapter 1 of this document). As stated in this chapter, the Committee recognizes that there are many activities (some involving the use of existing and new research) necessary for implementing, testing, and improving the Framework. These include: identifying and measuring outcomes data in order to track progress, developing new program demonstrations and new tools, acquiring more knowledge regarding staff and professional support for staffing, and obtaining information about how approaches to

supporting PFCE account for the differential levels of need across families as well as families' cultural and linguistic backgrounds. The Committee also recognizes that this is an opportunity for Head Start to use all of its new accountability investments and tools to build a culture of learning, continuous improvement, and accountability for PFCE within Head Start.

THE PATH FORWARD: FURTHER SPECIFICATION OF THE COMMITTEE'S RECOMMENDATIONS

The following discussion elaborates on the Committee's three recommendations, with a particular focus on priorities in the area of PFCE as they relate to these recommendations.

RECOMMENDATION I:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes, within local programs, across federal components of the program, and from federal to local levels.

Parent, Family, and Community Engagement Priority 1: Use a data-driven, continuous improvement model vs. a compliance model for Parent Family Community Engagement.

The Committee suggests that Head Start expand the focus on implementing PFCE-related Performance Standards to include building program capacity for using data for continuous improvement and progress on the seven outcomes defined in the PFCE Framework. To provide leadership in this direction, HHS could: (a) define a set of PFCE indicators for the seven PFCE outcomes to complement its Child Development and Early Learning Framework; (b) identify or develop program-friendly measures to track the progress of families; (c) provide TA and resources to help programs use data to track and make sense of the progress of families and children as a part of their program self-assessment and continuous improvement efforts.

To this end, the OHS can draw on research experts and program leaders from Head Start/Early Head Start and from other early childhood, human service, and education efforts working with

families with low incomes. These include early childhood projects such as Educare, as well as family literacy, home visitation, parent education, employment training, adult education, and family strengthening efforts. Each of these program communities, and the research and evaluation experts that study them, can contribute models, tools, and lessons from their experience to inform the design of PFCE indicators, help to make determinations on the state of the art in tools for assessment of parent and family progress towards outcomes, and contribute approaches to building local program capacity to understand and use data on family outcomes in continuous improvement efforts.

OHS can consider the benefits and feasibility of developing a uniform, consistent strategy for documenting family progress and outcomes, including the ability to aggregate information from all local programs, as well as the benefits of providing flexibility for local programs in setting priorities among different outcomes and determining how best to measure family progress. The Committee also suggests consultation with program and research experts on how to define data elements and on how to set ambitious but achievable targets for progress, given the diversity of families and the typical level of intensity of services, depth of relationships, and duration of participation in EHS and Head Start programs. The Committee notes that local programs will need TA and the internal staffing resources to implement this recommendation.

Parent, Family, and Community Engagement Priority 2: Learn more about relations between PFCE and child outcomes in Head Start by conducting analyses using existing datasets.

The Committee suggests more extensive, cross-cutting (examining findings across as well as within datasets) and fine-grained data analysis using *existing data sources* (such as HSIS, EHSREP, FACES, Baby FACES, and Early Childhood Longitudinal Studies Birth and Kindergarten) to test and illuminate the relationships between program and parent/family outcomes, between parent/family and child school readiness outcomes, and with parent/family outcomes as mediators of program effects on school readiness, and the relations of organizational practices to key outcomes.

The Committee finds that little has been explicated about parent/family outcomes as mediators in two-generation programs, particularly in two-generation programs for 3- to 5-year-olds. A little more is known about program impacts on parents of infants and toddlers and about these impacts as mediators of child outcomes^{xvi}. However, studies linking effects on parents to effects of programs on children are sparse in every age category. Theories of change about parent and family engagement within two-generation programs, including within home visiting programs, have not been explicated. However, the Committee finds that more parent and family data exist than have been analyzed, that family data collected in two-generation programs have been under analyzed and under reported, and recommends beginning with new analyses of extant data. What are the pathways of improvements in family self-sufficiency, mental health or parenting skills, and the seven family engagement outcome areas as outcomes and mediators of child development?

Parent, Family, and Community Engagement Priority 3: Initiate new research to study PFCE pathways to child outcomes.

The Committee suggests that OHS and the researchers it supports become more explicit about identifying and testing theories and approaches for organizational-level improvements and promising program practices related to pathways for achieving outcomes in the Framework's seven family outcome areas, especially pathways that ultimately lead to child school readiness outcomes. There is a need to know more about Head Start effects on parent and family outcomes and how and to what extent they in turn lead to child outcomes.

This recommendation has several components. OHS can (1) identify promising practices that researchers can test systematically; (2) theorize and operationalize links between program practices and outcomes in the seven areas of the framework; (3) develop, implement, and evaluate new program demonstrations to investigate these links, and (4) investigate the links between Head Start's approaches to achieving parent outcomes of different types and children's development. Finally, this process should focus on informing programs, supporting continuous program improvement and capacity building, and generating new theories for researchers and programs to test in areas where theories are lacking or inadequate. While there are some findings on small scale demonstrations and models, there is a need to learn more about how to bring them to scale, and to adapt them to diverse Head Start contexts.

Parent, Family, and Community Engagement Priority 4: Align all PFCE data collection efforts with one another and with the PFCE framework.

The Committee suggests an effort to align the Framework outcomes, strategies, and systems with the Performance Standards and with the approach to collecting data on PFCE through the PIR, OHS program monitoring efforts, FACES, and other research and data systems. The goal of this direction is to ensure that high-quality and appropriate data on key aspects of PFCE services and outcomes are routinely collected and used to guide improvement efforts at the national, state, and local levels. This alignment effort should also identify opportunities to reduce the burden of data collection on programs and eliminate duplication in reporting requirements, while improving Head Start's ability to address critical questions regarding PFCE.

As noted previously, the Committee believes it is important to gain a clearer understanding of what parent engagement looks like, how practices vary across Head Start, how FSWs spend their time, the contributions of teaching staff to family engagement, and how families participate in and benefit from this engagement. The Committee recommends that HHS dedicate resources to collecting more and more detailed and better aligned data, whether through its surveys or its administrative management system, to better understand Head Start practices in these areas. This Committee also seeks to tighten the focus and alignment across content and timing of multiple data sources: Are Performance Standards in the area of parent engagement being met? Are there critical Performance

Standards for attaining the outcomes identified by the Parent Engagement Framework and can progress on these Performance Standards be better tracked through PIR and FACES data? The Department should also seek opportunities to simplify current documentation and reporting requirements.

RECOMMENDATION II:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

Parent, Family, and Community Engagement Priority 5: Develop a strategic plan and dedicate resources to implementing the new PFCE Framework.

The Committee suggests that the OHS develop a strategic plan and dedicate resources to implementation of the new PFCE Framework. This includes policy, training and technical assistance, research and evaluation studies, and partnerships.

The new PFCE Framework offers a conceptual framework for understanding the links among program organizational elements, family outcomes, and child outcomes. The literature on the importance of parents to children's development is quite conclusive^{xvii}. Head Start has long recognized the importance of parents in its two-generation focus. However, the many dimensions of working with parents have not previously been as explicit as they are in the Framework. The Framework now offers the opportunity to systematically link and implement all program elements to target family outcomes, and through them, child outcomes. Previously, there has been more focus on operationalizing the classroom activities of Head Start. Now there is a chance to develop theories and practices to achieve desired parent and family outcomes. The Framework offers a new chance to leverage this potential of Head Start.

Parent, Family, and Community Engagement Priority 6: Study PFCE staffing and consider standards for training and credentialing these staff.

The Committee suggests systematic study of the roles and activities of FSWs parent involvement staff, and teaching and other staff in programs who are working with parents, and of the organizational supports for their work. The Committee is interested in knowing about staff with specific family involvement and engagement responsibilities, including FSWs, teachers, and other staff, including their credentials, ratios, caseloads, health and well-being, responsibilities, ongoing

professional development, and related supports. Effective strategies for ongoing professional development also need to be identified and/or developed, and tested. The Committee recommends that the Department collect data from every Head Start program, supplemented by qualitative studies to understand how programs have structured family services and engagement to achieve the seven family outcomes. Based on these studies, the Administration for Children and Families should consider whether to set minimum standards for staffing, for training or credentialing of family workers, for maximum caseloads, and specific recommendations to programs for ongoing professional development.

Parent, Family, and Community Engagement Priority 7: Refine and implement findings about cultural responsiveness and its relation to children’s outcomes.

The subcommittee on PFCE suggests the development of logic models, constructs using new or recently developed culturally sensitive measures that would allow for research on the effects of program cultural responsiveness on PFCE and child and family outcomes, for evaluation of interventions intended to increase program cultural responsiveness and make linkages to PFCE and ultimately child outcomes.

For parents to participate fully in their children’s education, bridges across cultures must be built. For children to participate fully in their own education, they must know that these bridges are being built so that they are not torn between conflicting loyalties, and so that they do not feel they must choose one culture—the family’s or the school’s—at the risk of alienating the other^{xviii,xix}. Building bridges across cultures in Head Start requires a systemic approach across program foundations and impact areas—leadership, program environment, professional development, continuous improvement, teaching and learning, and family and community partnerships. Yet we know little about how to measure success in building these bridges, success that would correlate with parents’ greater engagement in their children’s schools, and children’s greater ease in crossing the bridge between school and home. The Committee does find that considerable work has been completed testing the reliability and validity of many recently developed or revised measures for different race/ethnic groups and recommends that this work be harvested for the new research suggested by this recommendation, and that older measures that do not meet these criteria be dropped from reporting in existing data collection and reporting, and from future research.

Parent, Family, and Community Engagement Priority 8: Develop new models and strategies for serving families with multiple risk factors, especially in EHS.

The Committee suggests greater attention be given to families with multiple risk factors, including more research to better understand optimal timing of enrollment (e.g., before birth, in infancy, or later), types (content) of models and strategies, individualized tailoring, duration of program services (e.g., years of service), level of family engagement, asset-based assessment, and how these risk factors and services connect to outcomes.

Studies show that a portion of EHS families, as many as 25 percent, have more than 3 risk factors. The EHSREP showed that when children were age 3, the program had not been successful with this group (see data from the EHSREP above), although there were positive impacts with other groups. Head Start for 3- and 4-year-olds showed greater but variable success with the families with the highest risks. The Committee believes the EHS findings should signal a priority for prenatal to 3 programs, and possibly all programs, to receive more programmatic support and research to understand better how to work with young parents with multiple demographic risks. The Committee recommends new research to better understand the families with the highest risks and program variance in serving them. This research should identify family strengths that may be moderators of program effects, track family engagement and outcomes longitudinally, as well as attempt to understand the engagement from the family's perspective to better develop strategies to successfully engage families in a way that supports children's development (e.g., mixed methods). For example, EHS found positive effects for families of infants in families with highest risks when parents were highly engaged^{xv}. Other studies of single, teen mothers with limited formal education and their children might focus on variation in father engagement and other supports in these mothers' and children's lives, over time, and about how programs can help mothers cultivate long-term supports for themselves and their children. Still another EHS nonexperimental finding showed that children in families with highest demographic risk benefited more if they attended Head Start after EHS, compared to children in other forms of care and education during the 3 – 5 years, including those who were not enrolled in formal programs^{xvi}. Such a finding suggests further investigation of the additive effects of EHS and Head Start for the families with highest risk.

Parent, Family, and Community Engagement Priority 9: Learn more about the importance of community variation and delivery of services and outcomes.

In the area of community engagement, the Committee recommends consultation with other fields and analyses of other data sources to expand Head Start's approach to theory, research, and practice. Such consultation and analyses are recommended to better understand the role of community variation in parent engagement with links to children's learning, as well as the role of community variation in family and child outcomes. The Committee recommends beginning by linking HSIS, EHSREP, FACES, and Baby FACES with other data sources (e.g., Census, Head Start spending) in order to examine relations between community resources and parent engagement and to examine Head Start spending in parent and family engagement as a function of community resources.

The Committee recommends that Head Start join forces with other fields in evolving conceptions of community engagement. Community engagement is being redefined in the fields of public health, community psychology, and others, as well as in ECE. New opportunities for theory building and for research on community engagement are being generated through the application of a range of theoretical frameworks and associated methodologies in areas such as social networks, complex systems, and emergent phenomena, and constructs such as community collective efficacy and

community resilience. Further, the Committee recommends research to unpack the question of how much available community resources affect Head Start capacity to achieve its outcomes. Ethnographic work demonstrates that program ability to affect outcomes is related to community resources. Studies in Chicago have demonstrated that neighborhood context and formal support enabled improved child outcomes but when a critical mass of debilitation is reached, it is difficult to have an impact^{xxii}. Not only does neighborhood disadvantage matter (percentage poor, unemployed, single mothers) but so does a sense of collective efficacy in neighborhoods^{xxiii,xxiv}. The Committee recommends collecting data on resources in communities, or linking with administrative data. Relevant data would illuminate the ways in which communities where Head Start centers are embedded differ with respect to the resources and social cohesion that are available within them (e.g., pediatric clinics, mental health services, libraries, parks, playgrounds, child care services including for profit centers, prekindergarten, and other not for profit centers). Other community context variables can also be assessed using administrative data (e.g., crime rates, number of fast food restaurants, immunization rates, lead cases, and others). Census tract data provide an idea of the density of poor families as well as of single mothers, residential stability, and so on. All of these contribute to the community context. The Committee recommends using HSIS, FACES, Baby FACES, and the EHSREP data to examine community variables to tell whether, as a whole, programs are more or less effective in resource rich vs. resource poor communities, as well as how community factors influence parent engagement.

Parent, Family, and Community Engagement Priority 10: Conduct research on links among community engagement, program organizational factors, Head Start spending, services, and outcomes.

The Committee suggests descriptive and micro studies of community engagement, linked to and interpreted in relation to organizational factors and local Head Start spending associated with the ability of programs to achieve desired child outcomes^{xxv,xxvi}. The purpose of such studies is to learn about varying factors in communities that relate to services, and about how programs mobilize resources, organizations, and services in varying community contexts. Such work can lead to new hypotheses and knowledge about ways varying community context factors can be addressed and about how program organization and resources can be varied to achieve optimal parent and child outcomes.

As noted throughout this report, community context matters but how programs can optimize outcomes under varying community contexts is not objectively understood. There exist a large number of program standards that relate to community engagement, but there is also enormous flexibility in how these are carried out, for good reasons, the most important of which is that individual programs must be designed to be responsive to local community factors. Each community is unique and each program should be designed to meet the standards in ways that the program determines work best in its own context, based on local resources, needs and dynamics.

The problems with this flexibility are that there is little guidance for programs and that less is known about how local context affects individual program's community engagement efforts, parents, families, and the ultimate outcomes Head Start seeks to effect. Community factors also may play a role in how a Head Start program expands its resources and obtains other community resources available for children's services. This is important, given that expenditures are linked to children's outcomes^{xxvii}. Today, studies involving multiple sources of densely layered quantitative data about communities, such as described in the previous recommendation, new techniques such as asset mapping and qualitative work are possible using mixed methods design to answer key questions about community engagement. The Committee proposes examining how community factors are linked to resources expended for program services and to the organizational structures of programs^{xxviii}.

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Chapter 5: Health and Mental Health

OVERVIEW

The health of young children in low-income families was incorporated into the comprehensive nature of Head Start from its inception as evidenced in the Cooke memo of 1965, which provided recommendations for Head Start’s role in supporting the health of children and families, including the provision of medical and dental screenings and exams, ensuring children were immunized and had access to health services, and providing children with nutritious mealsⁱ. These initial recommendations and the comprehensive, integrative nature of health programming and services in Head Start were visionary, and—indeed—Head Start has always been and continues to be unique among early childhood programs in its emphasis on health services for children and families.

Head Start programs are required to meet 179 different Head Start Program Performance Standards (Performance Standards) related to Health, Nutrition, Mental Health, and Safety. These standards include identifying children’s access to ongoing sources of continuous, accessible, health care; tracking children’s immunization, well-child, and other preventive and primary health care services and interventions and providing case management for health services; screening children for medical and developmental needs and ensuring that further diagnostic testing, examination, and treatment are received where needed; obtaining dental examinations and treatment where needed; and enhancing awareness of and securing services for mental health needs. The overall requirements of the Health Component include the provision of a comprehensive program of health services to assist each child in attaining maximum physical, emotional, cognitive, and social development; the promotion of preventive health services and early intervention; and the provision of families with the skills, insights, and linkages needed to obtain ongoing health care so that children will continue to receive comprehensive health care after they leave the Head Start program.

Head Start has long had a special focus on the needs of children who are living with disabilities. Since 1972, before the enactment of the federal special education law now known as the Individual with Disabilities Education Act (IDEA), Head Start programs have been required to reserve at least 10 percent of their enrollment opportunities for children with disabilities. In 2010, Head Start and Early Head Start (EHS) programs provided services to more than 112,000 young children living with disabilities (about 11 percent of the total Head Start enrollment). Head Start and EHS programs actively recruit children with previously identified disabilities, in coordination with their special education and early intervention partners. Further, Head Start’s emphasis on providing developmental and health screenings help to identify disabilities in children who have not yet been

identified. Head Start’s comprehensive child development model often provides the first opportunity to identify a disability or health condition affecting a young child’s development.

In its deliberations, the Committee examined information about how Head Start today addresses the critical area of health and mental health. In this chapter we present our summary of the state of Head Start at this juncture, followed by a vision for what the Committee would like to see in Head Start’s efforts to enhance the health and mental health of those it serves moving forward. This is followed by priorities for implementing each of the Committee’s three recommendations within the areas of health and mental health.

HEAD START TODAY: HEALTH AND MENTAL HEALTH

The context of health care in the United States has changed dramatically since the Cooke report was published in 1965, and many more children in low-income families have health insurance and receive basic preventive health services.

In both the Head Start Impact Study (HSIS) and Early Head Start Research and Evaluation Project (EHSREP), the vast majority of children and pregnant women (about 90 percent)—regardless of their enrollment in Head Start—had health insurance during the study^{ii,iii}. This reflects the expansion of access to health care, including Medicaid and the State Children’s Health Insurance Program, nationally for low-income families and their children since Head Start’s beginning.

Yet, while health insurance coverage is quite high for children in low-income families, access to and use of dental services is less common^{iv}. In the HSIS, only a little more than half of children in the control group had received dental care in the prior year (measured at the spring of the first year of the study). Indeed, this study found that Head Start had one of its largest impacts on children’s receipt of dental care, increasing the likelihood that children had received dental care in the prior year by 15 to 17 percentage points. Further, despite relatively high rates of health insurance during preschool years, Head Start increased the likelihood that children had health insurance in their early years of elementary school. While health insurance rates were about 90 percent for both 3- and 4-year olds (control and Head Start group) during their preschool years, these rates dropped for control group members when children entered kindergarten and first grade, particularly for the group that applied to Head Start at age 4, whereas they remained level for Head Start children even after leaving Head Start^v.

Data from the Program Information Report (PIR) also suggests that the majority of Head Start children (about 91 percent) are up-to-date on their immunizations. Indeed, the EHSREP found that EHS increased the likelihood that children had received their immunizations^{vi}. Further, about three-quarters of parents enrolled in EHS report that their children have received the appropriate

number of well child visits by age one^{vii}. Further, according to the PIR, about 97 percent of Head Start children have a medical home and about 90 percent have a dental home.

While most children in Head Start have health insurance and are receiving key preventive services such as immunizations and dental examinations, the evidence regarding the health of Head Start children is more mixed.

More than three-quarters of parents of Head Start children report that their children are in very good or excellent health, as do nearly 80 percent of parents of children in EHS. Levels of premature birth or low birth weight in EHS are comparable to national norms^{viii}.

At the same time, children in both Head Start and EHS have very high rates of obesity and overweight. Well over a third of children in Head Start entered the program obese or overweight in 2006, compared to a national survey that found about a quarter of preschoolers were obese or overweight nationally in 2003 through 2004^{ix}. Rates of obesity or overweight for 2-year olds in EHS were also high, with 16 percent of children overweight and 17 percent obese. These rates are comparable to those found for a nationally representative sample of 2-year olds who were born in 2001^x.

As would be expected given Head Start's emphasis on enrollment of children with disabilities, as well as the fact that Head Start serves an economically disadvantaged population, there are also a significant number of children in Head Start and EHS who have developmental and health needs. According to both the Family and Child Experiences Study (FACES) and PIR data, about 15 percent of Head Start children have been identified by a professional as having a developmental problem, delay, or special need. For the majority of those identified in FACES as having such a need (80 percent), the delay was related to the children's speech or language^{xi}. Data on 1-year-olds in EHS suggests that they score slightly below national norms on a measure of personal-social development, and more than a third of children score in an "at risk" category on a developmental screener, particularly in the areas of problem solving and fine motor development^{xii}.

Thus, while Head Start children are receiving medical and dental services at fairly high rates, they still show many areas of developmental need that suggest that the developmental, health, and mental health components of Head Start are critical needs for this population. Further, while Head Start has been visionary in its approach to addressing these needs among low-income families, there is room for further improvements as low-income families and their children continue to face heightened health and developmental challenges.

These challenges are particularly concerning, given the prevalence of health disparities in the U.S., with minority children showing particular health needs and more limited access to services than White children. Of particular concern in Head Start are the needs of children in Migrant and

Seasonal farm worker families, American Indian and Alaska Native children, and children in rural communities, all of whom face greater challenges in access to health care services.

Head Start has launched several efforts to address children’s health.

Indeed, Head Start has initiated an array of health programming and technical assistance (TA) to aid grantees in meeting the challenges they face. Most recently, in September of 2011, the Office of Head Start (OHS) awarded a cooperative agreement to the American Academy of Pediatrics¹ to operate the National Center on Health. The Center will showcase evidence-based practices to ensure all Head Start and EHS agencies have access to the same level of high-quality information, training and technical assistance(T/TA) in order to produce the best possible outcomes for children. The National Center on Health will focus on health, oral health, mental health, safety and nutrition for pregnant women and children birth to five as well as their families.

The Department has also funded many new initiatives in this area, including efforts related to oral health, health literacy, obesity and nutrition, emergency preparedness, and mental health. For example, the Department launched a dental homes initiative with the goal of developing a network of quality dental homes for Head Start and EHS grantees. This work is ongoing and will be overseen by the National Center on Health. Further, in 2006, the Department invested approximately \$2 million in grants to 52 Head Start and EHS programs to develop, implement, and disseminate culturally sensitive, innovative, and empirically based best practice models addressing access to oral health services, oral health education in the classroom and in the home, and community partnerships/capacity building related to oral health. Finally, the Department has launched several efforts to address the high rates of obesity and overweight among children in low-income families in the United States, and Head Start children in particular. These include Head Start Body Start, which provides resources—including play space enhancement grants to Head Start programs—to help early childhood professionals, caregivers, and communities create dynamic play/learning environments and promote physical activity for young children. It also included training grantees in I Am Moving, I am Learning, which seeks to increase daily moderate to vigorous physical activity in programs, improve the quality of movement activities intentionally planned and facilitated by adults, and promote healthy food choices. There is also an effort to increase the quality of information on the health component of Head Start within Head Start research studies. For instance, the Department recently launched a Health Managers Descriptive survey, designed to fill gaps in information about Health Managers and related staff in Head Start programs, as well as gain

¹ The center will include the following partners: Education Development Center, Inc.; Georgetown University's Department of Pediatrics' Center for Child and Human Development; Georgetown University's Health Policy Institutes' National Maternal and Child Oral Health Resource Center in collaboration with the Association of State and Territorial Dental Directors; the Health Care Institute at the University of California, Los Angeles; Anderson School of Management; and the National Training Institute for Child Care Health Consultants at the University of North Carolina at Chapel Hill. For more information on the National Center on Health, access the website at <http://eclkc.ohs.acf.hhs.gov/hslc/ta-system/health/center>.

information about how health initiatives are prioritized, implemented, and sustained in Head Start programs nationwide.

THE COMMITTEE'S VISION FOR HEALTH AND MENTAL HEALTH

Since its inception, Head Start has recognized the importance of health, nutrition, and mental health—for expectant mothers and from the very beginning of life—to children's school readiness and overall outcomes. This prescient position has been strengthened by subsequent research, for example, on the effects of health, nutrition, and mental health during pregnancy and early childhood on fetal programming, epigenetics, and fetal, and early brain development—all of which in turn can affect lifelong health, mental health, and productivity outcomes^{xiii,xiv,xv}. The National Scientific Council on the Developing Child and the National Forum on Early Childhood Policy and Programs published this summary from the *Foundations-of-Lifelong Health are Built in Early Childhood* 2010 report: “A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—beginning with the future mother's well-being before she becomes pregnant—lays the groundwork for a lifetime of vitality. When developing biological systems are strengthened by positive early experiences, children are more likely to thrive and grow up to be healthy adults. Sound health also provides a foundation for the construction of sturdy brain architecture and the achievement of a broad range of skills and learning capacities^{xvi}.” Quality outcomes are more likely to be achieved when the ongoing health and mental health of the child and family are maximized^{xvii,xviii,xix,xx}.

Today, the Committee finds that Head Start/Early Head Start (HS/EHS) has many systems, procedures and expectations in place for positively affecting health and mental health outcomes. Typically this has been a two-prong approach. When necessary, actual health services, oral health services and mental health services are provided. In addition, a coordinated system that includes Health Services Managers and sometimes medical and mental health professionals ensure healthy and safe practices within the HS/EHS setting, help promote access to and use of effective medical and dental homes, coordinate the early identification of developmental and behavioral delays, help ensure the provision of community interventions, and generally raise the health literacy of staff and families. Head Start is commended for its national leadership in introducing comprehensive, integrated health services in an early childhood education program context. However, after hearing about the many programmatic approaches to health and about children's health outcomes documented in FACES and Baby FACES studies, the Committee's central finding is that, despite a significant focus on children's health in Head Start, the health of Head Start children is still of concern^{xxi,xxii}. Even though Head Start children have better health outcomes than control group children (e.g., dental health, health insurance, immunizations, emergency room use), many children in Head Start still have health problems and needs, as is true for many of their parents. Hence there

is still work to be done to further promote health and well-being of the children and families in Head Start. The Committee has identified four broad overarching approaches achieving this goal of better health and mental health for Head Start children and families:

- ▶ New efforts to connect and coordinate timely, follow-up services for all children, especially for children with special health, mental health, and developmental needs.
- ▶ More reliance on and standardization of training and procedures using evidence-based practices which emphasize collaboration with the health professions organizations and health professionals within the community.
- ▶ Careful description of the variety of ways that programs are meeting different health, nutrition, and mental health requirements; linking the approaches to educational, health and mental health outcomes; and using these descriptions to develop new tools that programs can use for formative evaluation.
- ▶ Increased collaboration among all Head Start stakeholders, including professional organizations, to better leverage local resources, and to improve the consistency of messages and services for the local Head Start programs.

The Committee finds that Head Start does a good job in providing health screening for all children and in making referrals to Part B and Part C, but, the Committee directs OHS to focus on follow-up services after the screening and or the medical/dental exam. Specifically, the Committee would like to direct OHS efforts to the following: enhancing the referral and evaluation process by focusing on timing and follow through for Part B and Part C; services for other children who have special health needs that do not yet qualify for Part B or Part C; and collaborating with state and local organizations to improve follow up services for children in communities with limited resources.

The Committee recognizes that Head Start is not a provider of health care for children but rather a facilitator of health services to ensure the needs of enrolled children are met. In turn, the Committee recommends a more coordinated and intensive relationship with each child's medical home, and efforts within the community to find a medical home when a child does not already have this. To meet this recommendation, the Committee recommends that the Department could engage in a collaborative effort with the national health community in order to ensure high standards for health professionals working with and within Head Start programs. One outcome of the collaborative work between the OHS and the national health community would be more intensive T/TA related to health and nutrition for Head Start staff.

To do this work, the Committee also suggests development of new health outcome measures that can be used by the Federal Government as well as formatively by local programs so that programs can track their own progress in linking their health services to health outcomes.

THE PATH FORWARD: FURTHER SPECIFICATION OF THE COMMITTEE'S RECOMMENDATIONS

The following discussion elaborates on the Committee's three Recommendations, with a particular focus on priorities in the area of Health and Mental Health as they relate to these recommendations.

RECOMMENDATION I:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes, within local programs, across federal components of the program, and from federal to local levels.

Health and Mental Health Priority 1: To focus on the role of health/mental health in the Head Start Learning Organization, the Committee suggests that the OHS work towards improving the quality of descriptive and health/mental health data that are regularly collected by programs, including those collected at both the federal level and in local Head Start programs, in order to learn more about services and child and family outcomes in the health component (including health literacy and behavioral health).

Currently, the Health Managers Survey will collect descriptive data to better understand the variation in Head Start health services, and potential reasons why variations exist. It is important to collect data on how health and mental health consultation standards are met, about training of health managers and consultants and in a future study to link different health management models of providing such services to outcomes. Such information can become a baseline for the study of the health component and should either be collected periodically (e.g., every five years) or routinely through management programs to tell local programs whether they are providing health services in alignment with best practices and, importantly, as a stepping stone towards understanding whether health and mental health services are improving health and mental health outcomes. To the end of linking processes to outcomes at the program and federal levels, critical data fields may eventually include new child and family health and safety outcomes, health literacy, data about frontline workers' health and health literacy, questions about health consultation/health manager staffing,

about how data are shared with local health systems and other providers. Such data collection could also include enhanced descriptive data about specific health problems such as asthma and weight/obesity. Critical new data fields for local or federal management systems could also emerge from research focused on variables found to make a difference in health outcomes.

Health and Mental Health Priority 2: The Committee sees a need for new and more measures of health/nutrition/mental health outcomes both for programs to use in formative assessment and for outcomes in national descriptive and impact studies.

The Committee finds that the mechanisms for potential Head Start impacts on health are many: children in Head Start receive more access to health care, nurse/mental health/nutritionists are embedded in Head Start, and there is greater effort to increase health literacy of staff and parents. The Committee hypothesizes that the health effects may be underestimated given current measures of health available for large studies today and calls for new and improved measures to better capture the inputs as well as outcomes in the health and mental health area. In addition, child educational and long-term outcomes need to be linked to these health and mental health program practices and efforts.

Health and Mental Health Priority 3: The Committee suggests OHS enhance the capacity of local programs to ensure timely follow-up on the results of developmental and health screenings.

Head Start is relatively successful in ensuring that children receive health and developmental screening within 45 days of entry and within 90 days for medical and dental exams. The Committee recognizes that programs are currently expected to follow up with additional services when a screening or exam indicates a need for health or development services. However, for various reasons, including timely and appropriate evaluations by Head Start Staff and the professionals contracted to provide these services, lack of a definitive diagnosis, lack of health resources in some communities, or lack of parent follow through, some programs are challenged in this task. Programs are also responsible for establishing partnerships with agencies in these communities in order to serve the needs of children beyond those that the programs themselves are qualified to serve. However, the reality is that in many communities sufficient and adequate treatment resources simply do not exist. In remote, sparsely populated rural communities, dental, medical, and developmental specialists are often entirely absent and, when recruited, are often difficult to retain. While some conditions require only one or a few treatments, for example many dental and medical procedures, others such as chronic diseases and most developmental disorders require repeated interventions over time.

The challenges of providing medical, dental, developmental, and mental health care to children in remote, rural areas are not significantly different from those for adults in those areas. Moreover, in

densely populated urban settings specialists may be abundant but there may be unacceptably long wait times for their services, difficulties with access related to Medicaid, or difficulties in finding a provider who is culturally and linguistically appropriate, for either screening or follow-up services. In addition these services may be of variable quality, and in some cases, disproportionately lower quality when available to children living in poverty. The promise of early identification and early intervention for better outcomes at reduced costs cannot be fulfilled by Head Start's timely screenings alone. Timely follow-up services are needed and these often depend on health care resources beyond the control of Head Start programs.

Although it would not solve the health care resource shortage, Head Start programs may need enhanced T/TA on strategies for communicating with parents about children's special health needs. For example, the information about a borderline or failed screening needs to be sensitively communicated in a culturally relevant way, with suggestions for what should happen next. There is a need for increased attention to promoting skills in communication about borderline screenings to both parents and teachers, and about referral for further testing if screening identifies that need. In these instances, an intensive developmental plan should be put in place while the program waits for an Individualized Family Support Plan or an Individualized Education Plan or if the child is not referred or does not qualify. Such situations are made more complicated when parents do not understand or agree with the program's view of the problem, or when they are unable to keep appointments for needed treatment services, which is often the case for parents living in poverty with little flexibility in their work schedules. The Committee stresses the link with the medical home as part of the solution to these problems, particularly those of a medical nature, so that unrealistic expectations are not placed on Head Start programs and so that health care professionals are appropriately engaged immediately after the screening process.

The Committee suggests a data system be developed that would allow programs to report their efforts to identify such resources, gaps in their efforts to do so, time lapse from referral to Part C or Part B until services begin, and other gaps in existing resources in their communities. Although this will not immediately solve the problem, such data will more clearly and specifically define and localize the unfulfilled treatment needs of Head Start children, and will help mobilize the resources necessary to fill these gaps. This assessment should include an examination of the extent to which access to services varies for different populations served by Head Start. The Committee recommends that OHS health TA providers be consulted in this process.

Health and Mental Health Priority 4: *The Committee suggests expanding follow up and individualizing services to include children with special health and developmental needs (e.g., developmental delays not yet diagnosed as a condition, high risk situations that predispose to poor health or delays such as being born premature, significant oral health problems, chronic health problems and some mental health-related problems)².*

While Head Start mandates serving 10 percent special needs children who qualify for Part C or Part B, studies of U.S. children show 14 percent or more have special health needs and/or developmental delays³ and many others have temporary medical conditions that affect their ability to learn, although all may not qualify for Part B or Part C. Moreover, rates for children in low-income families are higher. Sometimes children will eventually meet criteria for a diagnosis that will qualify them for Part B or Part C services, but until that happens, they still would benefit from targeted interventions. Early intervention for developmental delays can actually resolve the delays, but left unaddressed the delays can hamper health and learning^{xxiii}. There is also a need to broaden individualized approaches to meet the needs of children who do not qualify for these special services but who need intensive supports. There may be community or state resources that programs can collaborate with, such as better integration with medical homes, use of Neurodevelopmental Birth to Three Centers, or use of education approaches such as Response to Intervention that supplement services for children. Teachers and home visitors need tools for, and training in, monitoring the progress of children with developmental delays and on instructional strategies for addressing their individual developmental and learning needs. In addition, the health and mental health consultants for Head Start and EHS need to be facile in providing this support and coordinating early intervention.

RECOMMENDATION II:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

² Some Head Start and other early childhood programs use a tiered approach to providing services. Children who qualify for Part B or Part C may be considered as being on one end of the tiered continuum; those who have special health or developmental needs but do not qualify for special education services may be considered in a middle group requiring additional services beyond those of typical children in a classroom. The third group would be comprised of children who are developing typically. Another approach would be to develop a specialized definition (e.g., referred to as special health and developmental needs). However, such definition may be difficult to implement or interpret, given the definition of special needs in the IDEA that already exists.

³ National Survey of Children with Special Health Care Needs, 2005-2006, screened 364,841 children for special health care needs^{xxxx}.

Health and Mental Health Priority 5: *The Committee suggests that the OHS continue to prioritize and implement when possible the evidence-based best practices as recommended by health professional organizations for providing health, mental health, oral health, and professional nutrition support for programs. Training and background of the professionals who currently provide these services, once documented, will help OHS institute an evidence-based system of training and ongoing TA. This training and flow of information should be standardized from the federal, regional, state and local level.*

Much is now known about *how* to improve health in early learning settings, *how* to improve the health literacy of children and families, and *how* to improve overall health and mental health outcomes in children^{xxiv}. Programs emphasize meeting the health-related Performance Standards and coordinating that process. Each program employs a health services manager. Beyond the health manager, programs rely to a greater or lesser extent on health, mental health, and nutrition consultants from the community, when available, to fulfill the requirements of the Performance Standards. The Performance Standards indicate specific requirements for Head Start health managers, as well as nutrition and mental health managers or consultants (depending on how this is configured locally). OHS should uphold these requirements to programs, focus on helping programs in hiring health managers with the training needed, and ensure continual T/TA for health managers so that they are versed in evidence-based practices. Where outside consultation is sought, it is important for Head Start to ensure that the most effective system of health and mental health consultation is used and that the consultants have access to the most effective means to deliver their information and support^{xxv,4}. Programs located in rural areas and those addressing cultural differences are particularly challenged. In addition, the Committee encourages OHS to seek counsel from the American Academy of Pediatrics and other health partners to assist in characterizing the current system and help to begin planning for maximizing alignment with professional health evidence-based strategies. Finally, there is a need to standardize monitoring in the health area and to provide designated leadership in federal regional offices in order to standardize health guidance.

⁴ Many States are currently encouraging health consultation in multiple early childhood settings. Consistent with Head Start's leadership in providing health-related services in early childhood education, the approaches for orienting and training health and mental health consultants should be systematized and these resources should be shared with States as they endeavor to improve health-related consultation in all early learning settings. States or Head Start working in collaboration with States may consider other ideas proposed by the Committee such as a system of graduate training for the health and mental health consultants that would improve the overall preparation and training of consultants. For example, the National Training Institute for Child Care Health Consultants has a nationwide system of train-the-trainer programs to improve health consultation, and such an approach would be important in the implementation of improved health consultation in Head Start and the early childhood field. Researchers at Georgetown University also have developed a system to improve mental health consultation^{xxxxi,xxxxii}.

Health and Mental Health Priority 6: The Committee suggests continuing to include staff members in health T/TA. Health trainings should occur regularly and encourage best practices related to promotion of health, development, social-emotional health, and include working with families on health issues.

The Committee has identified two areas of T/TA that extend beyond the role of the local Head Start health manager addressed in the previous recommendation. First, the Committee suggests specific training for teachers and family service workers in order to emphasize health and nutrition education, together with all domains of typical development, in classrooms and in other family-related venues. The training should also include how to engage and work with families around health topics. The Committee recognizes that this is happening within Head Start today but suggests intensifying it and notes a need for standardization of best health-promoting services and practices including standardizing health-related professional development and guidance from the regions (see Health Priority 4).

It is likely that all of these TA strategies can be developed with the guidance of the OHS health T/TA providers. Many opportunities in a program involve staff beyond health coordinators and consultants, that if used can help foster positive health-related outcomes for children. For example, as teachers design learning experiences in the classroom or in their work with parents through home visiting, they can use those opportunities to incorporate content about nutrition and physical activity that reinforces healthy living habits^{xxvi,xxvii}. Family support staff can also use their time with parents to explore the ways in which current living conditions may affect their own and their child's health status (physical and mental). Providing these non-medically trained staff with the tools, resources, and support to help prevent negative outcomes (e.g., childhood obesity, dental caries, mild developmental delays, etc.) is a vital part of having a comprehensive strategy to promote optimal health and mental health^{xxviii}.

Health and Mental Health Priority 7: The Committee suggests a concerted focus on mental health in Head Start and EHS, including working towards better characterization and documentation of children's, parents', and staff mental health needs; developing and promoting the use of screening measures, new models of consultation and service delivery and evidence-based strategies to employ, particularly in rural areas where there are shortages of mental health services (e.g., systematic use of teleconferencing models).

There is evidence from the EHSREP that rates of depressive symptoms are about 50 percent among EHS mothers with children under a year of age; depressive symptom rates of mothers of older EHS children range from 16 to 23^{xxix}. Similarly, the EHSREP found relatively high rates of reported parental stress and family conflict^{xxx}. As noted earlier, 19 percent of Head Start parents reported either moderate or severe depressive symptoms during Head Start^{xxxi}. These rates were somewhat

reduced by involvement in EHS and Head Start but programs remain challenged to deal with mental health issues among Head Start parents and their children. While acknowledging challenges such as scarce mental health resources in rural and poor urban communities, the Committee encourages uptake of promising practices such as early screening for depressive symptoms, adoption of culturally sensitive models for delivering mental health services showing promising results^{xxxii}, and tele-mental health models showing success for service delivery in sparsely populated rural communities^{xxxiii}. The Committee also encourages focus on staff mental health. In the FACES study, teacher mental health was measured using the short form of the Center for Epidemiologic Studies Depression scale^{xxxiv}. Four percent of teachers report symptoms of severe depression and 6 percent, moderate depression^{xxxv}.

There is evidence that EHS and Head Start programming contributes to positive mental health of parents and positive child social-emotional development, likely by promoting positive parent-child interactions, through classroom and home visiting approaches that stress child social and emotional development, and through efforts to improve parental education and self-sufficiency that promote parental efficacy, empowerment and social connectedness, and healthy family functioning^{xxxvi,xxxvii}. Yet, direct impacts on parent mental health symptoms present challenges and seem to take time (e.g., EHS did not have an effect on reducing parental depressive symptoms until children reached 5 years of age), although there was an impact on reducing depression at age 3 among mothers who were identified as depressed at enrollment^{xxxviii}. Thus, intervention needs to be early, focused, and continuous. Families with serious mental health issues may need priority for Head Start services following EHS to create a longer treatment period.

Health and Mental Health Priority 8: The Committee suggests that the OHS study multi-component obesity prevention initiatives that are tailored for children and families from diverse backgrounds and with diverse resources. The obesity intervention efforts need to be in concert with other Federal agencies, public health, and other entities, and should include intensification of prenatal through age 2 obesity prevention, and data collection and analysis to maximize cultural and linguistic appropriateness.

The Committee notes that the Performance Standards pertaining to nutrition are appropriate but that programs still struggle with what they need to do, about how to involve parents, with what foods they actually serve to children, and in determining if what they are doing is appropriate for the communities they serve. Given the prevalence of obesity among Head Start children, the Committee finds there needs to be a coordinated effort that also looks to the health professions for recommendations for more fine-grained nutrition-related and physical activity data collection for Head Start studies, including for FACES and Baby FACES.

Health and Mental Health Priority 9: The Committee suggests more research to identify effective strategies for addressing health and mental health issues within the particular context of Head Start.

In order to close the gap between what and how health services are offered and health outcomes, the Committee suggests a health research agenda that includes a number of types of studies relating inputs to outcomes. Optimally, these would include: studies of the effectiveness of various forms and systems of health/mental health consultation (e.g., in-house, registered nurse consultation, health educator) as they relate to overall quality of program and child/family health outcomes; compliance with Performance Standards and relations to outcomes; child/family health literacy linked to educational and health outcomes; studies of dosage of health services and outcomes; and evaluations of specific health interventions (e.g., obesity prevention, smoking cessation, and effects of third hand smoke). Given documented health disparities by race/ethnicity and family language, as data related to effectiveness are collected, analyses by race/ethnicity, and family language, as well as in the aggregate, need to be conducted. These data are vital to understand the interplay of race/ethnicity and family language with quality early learning programs.

New, more scalable approaches to children’s health, mental health, and oral health that can be carried out within Head Start programs are needed. Prevention and health promotion will be the primary areas in which nonmedical professionals will be able to improve children’s health and mental health, while reducing health care costs and human suffering. The Committee suggests that funding be appropriated and prioritized for the research and development of such approaches. Examples include evidence-based programs addressing child, parent, and Head Start program staff health and nutrition literacy, particularly those that amplify their impact through peer network strategies. Additionally, research and development of classroom-based programs to promote healthy development and help to prevent and provide treatment or intervention for developmental delays and disorders, new and existing, are also needed.

RECOMMENDATION III:

Further improve continuity and coordination of early childhood services beginning during the prenatal period and continuing to age 8.

***Health and Mental Health Priority 10:** The Committee recommends new efforts to ensure that every child has a medical/dental home⁵. To facilitate this, the Committee suggests coordination with national health/dental health professional agencies, Centers for Medicare & Medicaid Services, and state Medicaid to provide guidance for coordination between Head Start and Medicaid locally. OHS, with guidance from the National Center on Health, can convey best practices for connecting children to a medical home and best practices for programs to use in collaborating with the medical home to leverage interventions in the community, especially when services are difficult to find and best practices for working with parents, communicating the need for a robust, ongoing medical home.*

Children who receive health care in a medical home (accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective) have improved health indicators, and HS/EHS have access to a partner that can help marshal community interventions when health, mental health, and oral health concerns for the child or family are identified^{xxxix}.

Sometimes, children do not receive health care in the context of this expanded definition of a medical home. It may be that there are no primary care clinics practicing in this comprehensive, collaborative way, or they may not be taking patients, particularly covered by Medicaid reimbursement. Sometimes the child's family does not choose to receive their health care in the context of a relationship, preferring intermittent, acute care through emergency rooms, after-hours clinics, or convenience clinics. Head Start can collaborate with federal and state agencies to explore best practices to overcoming each of these barriers, in a localized, systematic way.

Currently, the Performance Standards require programs to identify a source of continuous, accessible care for each child/family and having a medical home is documented in the PIR. However, the Committee notes that needing a medical home, specifically, is not specified in the Performance Standards and that standards for definition of medical home are broader than what is measured in the PIR, so a first step could be for programs to document the components of a broader definition. Following this broader definition of medical home would mean that programs would have a better understanding of what constitutes a medical home. In turn, programs can work with parents on the benefits and appropriate use of a medical home (when available).

⁵ The PIR inquires whether families have a medical home. The Performance Standards refer to the need for continuous and accessible care. Thus, programs report high rates of compliance but the full extent of services may not be realized, particularly beyond screenings (which occur within 45 days of enrollment and 30 days of enrollment within Migrant programs).

Programs can improve coordination with and reliance on the medical home provider, particularly in cases where the child has a special health, mental health, or developmental need. Head Start programs working together with the medical home can multiply the educational, developmental, and health benefits of all interventions. In addition, there is a need to explore overcoming some parents' reluctance to engaging a medical home for their child's health care. The Committee encourages OHS to look to health professional associations and Medicaid agencies to help explain the comprehensive nature of the medical home to programs but also to encourage local providers to provide Medicaid services to Head Start programs and families, to follow the lead of physicians who provide comprehensive, family-centered care following health evidence-based practices for Medicaid recipients, and who simultaneously work in partnership with Head Start programs. Parallel procedures are recommended around supporting dental homes. In each case the Committee recognizes that a series of conversations with professional associations and Medicaid agencies may be useful in order to promote the reciprocal nature of this recommendation. The best practices would then need to be shared among all the regions and the local programs in a systematic way.

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Chapter 6: Cultural and Linguistic Responsiveness

OVERVIEW

Head Start today serves a very different population than the Head Start of 1965. The nation is far more diverse culturally and linguistically than it was then, due to policy and demographic shifts. For example, 1965 marked the most important federal legislation concerning immigration of the past 50 years, the Hart-Celler Act, which opened up the United States to new waves of immigration from Latin America, Asia, the Caribbean, and Africa. By the 1970s, the historic African-Americans' migration to the urban North ebbed, as the manufacturing economies of the Rust Belt and the Northeast shrank. By the 2000s, a substantial proportion of Black Americans had moved back South, as that region's economic fortunes expanded.

Despite these enormous changes in cultural, racial, ethnic and linguistic diversity, rates of poverty have remained stubbornly high, with economic inequality increasing substantially during the past 30 years. Recent evidence shows, for example, that family incomes doubled across all income quintiles from 1958 to 1978, while only the top quintile's incomes rose by this amount between 1978 and 2008. Economic inequality in the United States thus grew substantially during the 1980s, 1990s and 2000sⁱⁱ. This means that the role of Head Start in providing educational opportunities for children in low-income families remains, if anything, more important than at any time in its history.

The emphasis on “maximum feasible [community] participation” in Head Start, established as a bedrock principle of it as well as other War on Poverty programs, has placed responsiveness to the diversity of local communities at the center of Head Start's theory of change since 1965ⁱⁱⁱ. This responsiveness is represented through local governance and oversight in Head Start programs, including parent council representation in decision making. Head Start programs are expected to serve the children and families in their communities who are most in need, and ensure that they are serving them in ways that are most culturally appropriate given the population of that community. The Community Assessments that Head Start programs conduct allow them to examine how local populations and their needs change over time and, ideally, to select the program design and services to be responsive to those needs and most effective for those communities. In this way, the cultural and linguistic make-up of a Head Start program is at the heart of the program, and evidence of this should be found across all aspects of the design and operation of each program.

This important emphasis is clear in Head Start’s long history of supporting children and families from different language and cultural backgrounds. For instance, Head Start distributed bilingual and bicultural curriculum models back in 1976. The emphasis also was highlighted by the publication of the document, *Multicultural Principles for Head Start Programs* in 1991 (updated in 2010) which has become integral to the values and philosophy of Head Start. The initial document outlined ten principles that Head Start programs should follow to support cultural and linguistic responsiveness in their programs, ranging from discarding stereotypes and treating children as individuals, selecting curricula with consideration of cultural relevance, supporting children’s home language while helping them acquire English, to ensuring that culturally relevant and diverse programming and practices are represented throughout the components and services in a Head Start program.

In its deliberations, the Committee examined information about how Head Start today addresses the critical area of cultural and linguistic responsiveness. In this chapter we present our summary of the state of Head Start at this juncture, followed by the Committee’s vision for Head Start’s efforts to ensure that the program is being responsive and supportive of the evidence base and cultural and linguistic diversity represented in the children and families it serves. This is followed by priorities for each of the Committee’s recommendations within the areas of cultural and linguistic responsiveness.

HEAD START TODAY: CULTURAL AND LINGUISTIC RESPONSIVENESS

Head Start continues to support efforts to improve the cultural and linguistic responsiveness of its practices, with an increasing emphasis on the growing population of Dual Language Learners (DLLs). In addition to expecting programs and staff to thoughtfully and intentionally respond to demographic changes in the communities served, Head Start Program Performance Standards (Performance Standards) include many specific regulations that pertain to culture and language and that require programs to accommodate the increasing linguistic diversity within the target population. For example, regulations require that local agencies’ approaches to child development and education be developmentally and linguistically appropriate, recognizing differences in languages and cultural backgrounds, and “provide an environment of acceptance that supports and respects... culture, language, and ethnicity,” among other experiences and characteristics (45 Code of Federal Regulations 1304.21(a)(1)(i & iii)) in the area of children’s social and emotional development, local agencies must “(encourage) development which enhances each child’s strengths by... supporting and respecting the home language, culture, and family composition of each child” (45 CFR 1304.21(a)(3)(i)(E)). In terms of parents, “Communication with parents must be carried out in the parents’ primary or preferred language or through an interpreter, to the extent feasible” (45 CFR 1304.51(c)(2)). And, as a final example, staffing regulations specify that “When a majority

of children speak the same language, at least one classroom staff member or home visitor interacting regularly with the children must speak their language” (45 CFR 1304.52(g)(2)). In addition, the 2007 Head Start Act enhanced requirements for programs serving children and families who speak languages other than English, including requiring that children make “progress toward acquisition of the English language while making meaningful progress in attaining the knowledge, skills, abilities, and development described in clauses (i) through (ix), including progress made through the use of culturally and linguistically appropriate instructional services.”¹

Head Start has taken several actions in recent years to realize the goals of cultural and linguistic responsiveness, including introducing changes in terminology and new resources for technical assistance and professional development. The term “dual language learners” has been adopted and promoted by Head Start to highlight and encourage the linguistic assets of children and families who speak languages other than English^{iv}. In 2008, the Office of Head Start (OHS) National Dual Language Institute: A Time for Action assembled program directors and managers, teacher and parent leaders, and other staff from Head Start, Early Head Start (EHS), Migrant and Seasonal Head Start (MSHS), and American Indian/Alaska Native (AI/AN) Head Start programs to discuss the importance of dual language learning and to present practice strategies, tools, applied research, innovative collaborations, and responsive policies. The Institute and a series of professional development webinars/webcasts that followed focused on common questions and critical issues identified by programs in their efforts to embrace linguistic diversity and to improve their support for the healthy development and learning of DLLs.

As part of revisions to the Head Start Training and Technical Assistance System, in 2010 the OHS awarded a cooperative agreement to Bank Street College to operate the National Center on Cultural and Linguistic Responsiveness². This center was established to provide the Head Start community with research-based information, practices, and strategies to ensure optimal academic and social progress for linguistically and culturally diverse children and their families. Through user-friendly materials and training, the center promotes strong language and literacy skills in children’s home language and in English, local program planning that is culturally responsive, and development of family resources that are linguistically appropriate. Among these materials, the center has developed a catalogue of resources concerning native and heritage language preservation, revitalization, and maintenance, including program workbooks, dictionaries, and curricula^v.

As another guide for programs and staff, the recently published Head Start Child Development and Early Learning Framework clearly emphasizes the importance of gaining an understanding of what children who are DLLs know and can do across all domains of the framework, regardless of language spoken, as well as an emphasis on English language development.

¹ These clauses describe the range of outcomes that children must develop and demonstrate in Head Start. These include language and literacy skills, social and emotional development, approaches to learning, and physical development.

² For more information on the National Center on Cultural and Linguistic Responsiveness, access the website at <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/cultural-linguistic/center>.

The Head Start population is diverse and continues to change over time.

A large percentage of our nation's children lived in poverty in 2010 (22 percent, up from 18 percent in 2007). This pattern is due in large part to the effects of the Great Recession of 2008-2009. Not surprisingly, the demographic characteristics of children in poverty are reflected in enrollments in Head Start and EHS. The distribution of child poverty in the U.S. is historically uneven, and data from recent years show no respite from these longstanding patterns. Nationally, 39 percent of African-American children were living in poverty in 2010, with the corresponding rates for Hispanic and White children at 35 percent and 12 percent, respectively^{vi}. In terms of numbers of children living in poverty, in 2010, the largest number of children in poverty by panethnic group were Hispanic (6.1 million), followed by White (5.0 million), and African-American (4.4 million).

According to administrative data from the 2009-2010 program year, 40 percent of children enrolled in Head Start programs (i.e., collapsed across Head Start and EHS) were identified by parents as White, 36 percent of children were of Hispanic or Latino ethnicity, 29 percent were African-American, approximately 8 percent were bi- or multi-racial, 4 percent AI/AN, 2 percent Asian, and less than 1 percent were Native Hawaiian/Pacific Islander^{vii}. The remaining 17 percent of children were identified by parents as "Other" or unspecified race.

There are differences in the types of Head Start services received by children from different racial, ethnic, and cultural backgrounds.

The proportions of children of Hispanic or Latino ethnicity are similar across EHS and Head Start programs. However, proportions identified in different racial groupings are slightly different, with fewer Black or African-American children served by EHS (25 percent) than Head Start (31 percent), and more White children in EHS (43 percent) than in Head Start (39 percent). The proportion of children in Head Start who are identified as Hispanic has nearly doubled over the last three decades, increasing from 19 percent in 1980 to 36 percent in 2010^{viii}.

In EHS, program service approaches vary significantly by race/ethnicity of mothers^{ix}. White families are more likely to be served by home-based programs (66 percent) than African-American families (2 percent) and Hispanic families (27 percent) are. African-American families are much more likely to be served by center-based programs (44 percent) than in any other service model. Hispanic families are more evenly distributed across service approaches and are somewhat more likely than White or African-American families to be in programs offering both home- and center-based services (or multiple options).

In Head Start, the timing of entry and amount of services received appears to vary by race/ethnicity. The Head Start Impact Study (HSIS) found that children from Hispanic families were less likely to receive an early year of Head Start (i.e., enter at 3 years of age) than children from

White or Black families (24 percent of Hispanic vs. 29 percent of White and 46 percent of Black children)^x. In addition, the likelihood that children returned for a second year of Head Start varied by racial, ethnic, and immigration characteristics. Namely, children from Hispanic families were more likely than children from Black or White families to return for a second year of Head Start and children from Black families were less likely to return for a second year than children in the other two race/ethnicity groups. Likewise, children from families in which mothers were recent immigrants, and Spanish was the household language, were significantly more likely to return for a second year of Head Start.

There are a sizeable, and increasing, proportion of Head Start children who are DLLs³, and these children bring a variety of cultural backgrounds and experiences to Head Start.

Nearly one out of three children enrolled in Head Start come from homes in which a language other than English (LOTE) is spoken. DLLs comprise 28 percent of children enrolled in Head Start, 26 percent of children in EHS, and 89 percent of children in MSHS programs^{xi}. Only 14 percent of Head Start programs reported serving exclusively English speaking families in 2010. For most DLLs in Head Start, Spanish is the primary language spoken at home (83 percent of DLLs in Head Start, 84 percent of DLLs in EHS). The other LOTEs among families in Head Start and EHS include Asian languages, African languages, European/Slavic languages, Pacific Island languages, and Native North American/Alaska Native languages^{xii}.

Other experiences related to DLL status. In the Head Start context and within the U.S., the label “dual language learner”, in fact, overlaps substantially with other significant characteristics and experiences. The majority of children who are DLLs in Head Start and EHS programs are children of immigrants or are immigrants themselves. Ninety-two percent of DLLs entering Head Start in fall 2006 were born in the U.S., while most of their parents (86 percent of mothers and 90 percent of fathers) were born outside the U.S. Eighty-two percent of DLLs entering Head Start had two parents born outside the U.S. Two-thirds of 1-year-old DLLs in EHS in spring 2009 had foreign-born mothers and three-fourths had foreign-born fathers^{xiii}. Sixty-four percent of DLLs in EHS had two parents born outside the U.S.^{xiv}.

³ **Dual language learners.** The Office of Head Start uses the term “dual language learners” (DLLs) to refer to children who are learning two (or more) languages at the same time or are learning a second language (English) while continuing to develop their first (or home) language. This term encompasses other frequently used terms for children who speak a language other than English (LOTE) in the U.S., including “limited English proficient” (LEP), as defined in the Head Start Act, “English language learner,” “children for whom English is a second language,” “language minority,” and “bilingual”^{lxix}. In contrast, dual language programs (also known as dual immersion, two-way immersion, or two-way bilingual programs) are programs designed to serve both language minority and language majority students concurrently by combining language groups and providing instruction in two languages, with the goal of supporting bi-literacy and cross-cultural understanding^{lxxii,lxxiii}.

Head Start also has a significant proportion of programs that serve unique cultural populations, such as migrant and seasonal farm workers and AI/AN programs.

Approximately four percent of the children served by Head Start are enrolled in MSHS programs^{xv}. While the vast majority of families served by MSHS programs are Hispanic or Latino (98 percent), the remaining two percent include AI/AN, Asian, Black or African-American, and Native Hawaiian/Pacific Islander families. As noted above, the majority of families served by MSHS programs primarily speak a LOTE at home, with Spanish being the most common (96 percent of DLLs) followed by native Central American, South American, or Caribbean languages (three percent of DLLs).

MSHS (Region 12) programs have more flexibility than other Head Start programs to structure services differently to serve the families in their communities, resulting in a much wider range of program variations. For example, MSHS programs coordinate enrollment periods and length of program year with the local agricultural seasons. Also in response to the particular needs of the communities served, the majority of children in MSHS receive center-based services five days per week and for eight hours or more per day, while a small percentage of children are served in family child care settings (five percent)^{xvi}. Half of the children enrolled in MSHS programs are infants and toddlers (i.e., 0 to 2 years old). More than half of the children continue for two or more years. More than a third of children do not re-enroll after a year, and slightly more than 10 percent of children are enrolled for less than 45 days. MSHS programs are challenged by shorter periods of enrollment/attendance among the children and families served, but also recognize that children are in centers and experiencing Head Start more intensively while enrolled.

Within Head Start, there are many programs operated by federally recognized AI/AN tribes, consortia, or corporations, and are commonly referred to as AI/AN programs (Region 11). These programs reflect the diversity of languages and traditions that exist in AI/AN cultures. Currently, less than 5 percent of children in AI/AN programs speak a native language at home, compared to 16 percent of children in 2001. Hence, many programs are integrating strategies and initiatives to support native language preservation and revitalization within their communities. There are many children from AI/AN families served by programs not operated by AI/AN tribes.

Head Start staff reflects the diversity of the children and families served.

Overall, the racial and ethnic backgrounds of staff look similar to those of the children served by Head Start, with similar distributions across race/ethnicity groupings. A substantial proportion of children who are DLLs in EHS and Head Start are cared for by teachers who are Hispanic—half of 1-year-old DLLs in EHS classrooms in spring 2009 had teachers who were Hispanic and nearly half of DLLs who entered Head Start in fall 2006 had lead teachers who were Hispanic^{xvii}. Most DLLs are

also hearing their home language used during home visits and in programs. In EHS, 69 percent of infants/toddlers who are DLLs had a lead teacher who spoke a LOTE in the classroom^{xviii}. In Head Start, 85 percent of DLLs who entered in fall 2006 were in programs in which staff members speaking the child's home language were available^{xix}.

THE COMMITTEE'S VISION FOR CULTURAL AND LINGUISTIC RESPONSIVENESS

One of the unique strengths of the United States derives from its capacity to welcome the richness of the cultures of the many diverse peoples who have built and continue to build it. In early childhood, when parents transmit cultural and developmental goals through values, expectations, and aspirations through native language and culturally rooted behaviors to their children, the children are better protected from psychological derailment that can interfere with education, employment, and civic engagement later in life^{xx,xxi,xxii}.

Recent evidence shows a remarkable unanimity in diverse parents' early goals for their children's learning and achievement—one study showed that mothers of a variety of Latino, Asian, and African-American ethnic and linguistic groups endorsed goals related to child learning (solicited in an open-ended way) at high and indistinguishable rates. In contrast, their goals for children's behavioral development did differ across groups^{xxiii}. Thus, there is evidence for both unity and diversity in the goals of racially and ethnically diverse parents of young children in the U.S.

Historically, educational institutions have not always been successful in sustaining or reinforcing children's identifications with their cultures of origin, but many Head Start programs have led the way in showing how this can be done. For example, innovations such as Abriendo Puertas, which provides a structured curriculum on language stimulation, health, socio-emotional development, and parent engagement and advocacy for Latino parents, have been welcomed by Head Start and EHS programs nationwide^{xxiv}.

For children from immigrant families, the resiliency conferred by close ties to their families and their cultures depends on learning their home languages. Recent neurolinguistic findings demonstrate that dual language or multi language learning from the beginning of life provides children with enhanced cognitive functioning, as well as executive function skills, enriched neurological development, positive language and social development, as well as the long term health benefit of decreasing the risk of Alzheimer's disease^{xxv,xxvi}. Head Start has the opportunity to study, refine, and optimize children's language learning in multiple languages and ethnic groups in the future, building on current research and practice. To do this, programs will need to: (1) be intentional about language and cultural policies and practices, building on Performance Standards proactively; (2) intensify strategies for reaching language objectives; (3) identify new assessments

that provide culturally appropriate formative assessment data that can be used to design individualized instruction for the unique language learning needs of young DLLs; and (4) be supported by a new generation of program evaluation and research to learn about successful classroom, program, and family engagement strategies for diverse language and cultural groups. The Committee envisions deepening Head Start's long-standing commitment to cultural sensitivity by systematically learning about and disseminating strategies that affirm and maintain cultural identity while strengthening family and child functioning.

THE PATH FORWARD: FURTHER SPECIFICATION OF THE COMMITTEE'S RECOMMENDATIONS

The following discussion elaborates on the Committee's three Recommendations, with a particular focus on priorities in the area of Cultural and Linguistic Responsiveness as they relate to each of the recommendations.

RECOMMENDATION I:

With school readiness and other key outcomes as beacons, strengthen Head Start as a Learning Organization that: (1) is characterized by a commitment to using data for continuous improvement to further strengthen outcomes; (2) develops appropriate assessments and helps programs use their results to guide practice; and (3) integrates and aligns all practices, policies, and supports toward achieving these outcomes, within local programs, across federal components of the program, and from federal to local levels.

Cultural and Linguistic Responsiveness Priority 1: New assessment instruments and methods are needed for assessing the abilities of DLLs and their environments.

The assessments that have been validated for DLLs and are available for programs serving DLLs are limited. Given the centrality of assessment in good teaching and learning practice, it is critical that we identify and/or promote the development of effective instruments, and ensure that they are being well implemented and the information is being used correctly.

Assessments practices for DLLs must include determination of language dominance and proficiency at program entry as well as progress monitoring in both languages while children are acquiring

English language proficiency. Although few standardized measures are appropriate for young DLLs, it is still recommended that DLL children be assessed in both their home language and English whenever possible, while taking into account participant burden. One reason is that while a child is learning English, he may show greater initial progress in the home language and limited progress in the second language. Another reason is that research shows that when the child's achievements are examined in the home language, teachers can also make fairly accurate predictions about the child's potential for learning in the second language^{xxvii}. If the DLL child is able to learn age-appropriate concepts in the home language, it is probable she will be able to transfer this knowledge to English-language learning.

As there is much variability in the amount and quality of English exposure as well as home language development, DLL children will show uneven progress between the two languages, depending on the language tasks. For example, a child may be proficient in one language for one task (e.g., letter naming, simple vocabulary) but not for another (e.g., listening comprehension)^{xxviii}. Another child may be able to hold a simple conversation in English but not be able to answer questions about a story or a sequence of pictures^{xxix}. Because of this variability and the fact that knowledge is mediated by language, it is almost impossible to obtain an accurate measure of progress without examining development in the two languages.

Informal, indirect methods of observing DLL children's interactions and language usage can provide important information on the child's level of language proficiency. Research has shown that teachers can be highly reliable in estimating a child's level of proficiency and English usage based on their observations of the child^{xxx}. Observations and insights from other staff who speak the child's home language and have contact with the child, such as bus drivers and family or health specialists, also can be collected through the use of standardized forms^{xxxi,xxxii}. When assessing DLL infants' language, social, and conceptual development in EHS programs, it is critical that assessors have an understanding of how first and second languages typically develop, how they interact and influence each other, and the quantity and quality of language exposure the child is receiving. Knowing who is talking to the child, in which language, and for what purposes is essential knowledge when determining if the child is making typical progress in mastering the normal language milestones. To determine the DLL child's progress in each language, it is necessary to gather information from the parents/family members, collect observational data on the child's language usage patterns in multiple contexts, as well as administer more formal language tests.

Cultural and Linguistic Responsiveness Priority 2: Research is needed to help us better understand normative developmental trajectories for DLLs in both their home language(s) and in English.

There is a remarkable shortage of information on normative development for young DLLs in the United States. Most normed assessment instruments lack information specific to DLLs. This makes it difficult for programs and researchers to understand how DLLs are progressing in their

development and whether they are within the range of normative development or in need of additional supports. For instance, one of the most commonly used normed Spanish tests of vocabulary, the Test de Vocabulario en Imágenes Peabody, or TVIP, is normed on a monolingual Spanish-speaking population. As a result, practitioners have little information to help them understand whether children who are learning both English and Spanish are making normative progress. For some children, this might result in being mischaracterized as having a language delay when in fact their language development is normal. For others, it may lead practitioners and teachers to miss actual language delays because of inaccurate assumptions about normative development for DLLs.

The Committee suggests that the normative development of diverse subgroups of Head Start children be studied in ongoing studies such as Head Start Family and Child Experiences Study (FACES) and in control groups of experiments such as the Early Head Start Research and Evaluation Project or the HSIS, the latter through secondary analyses of the existing databases. These opportunities are rich for longitudinal examination of trajectories of diverse subgroups in the Head Start population. Future large-scale studies, moreover, should incorporate groups such as AI/AN or MSHS children, who were not included in these national studies.

RECOMMENDATION II:

Implement the strongest and most current evidence-based practices that either: (1) benefit all children; or (2) are tailored for population subgroups. Continue to develop and test new refinements, particularly for specific subgroups, thereby further building the evidence.

***Cultural and Linguistic Responsiveness Priority 3:** The Committee recommends supporting children’s home language development while increasing their English language skills, by both explicitly valuing the child’s home language and by seeking ways to support its continuation through specific instructional practices and an explicit language policy.*

The research base in the field of early language development indicates the importance of supporting young DLLs’ home language development in early childhood education (ECE) settings, while also increasing their English language skills. Maintaining and progressing in their home language can be important for DLLs’ neurolinguistic development, their long term-relationships with their families, their personal identity and sense of self, their community and culture, as well as for their adult competitiveness in the job market. Current research has also documented cognitive and neurolinguistic benefits for native English speakers when they learn a second language. While

the exact relationships among home language maintenance and English language development for preschoolers are not known at this time, certain aspects of home language proficiency, (e.g., phonological awareness, grammatical knowledge, narrative abilities, listening comprehension) have been shown to transfer to English language learning and facilitate acquisition of early English literacy skills^{xxxiii}. Thus, it is important in Head Start classrooms to focus on vocabulary (expressive as well as receptive), listening comprehension, narrative production, and oral language skills, as well as decoding, to ensure that children develop the language skills they will need to achieve high levels of academic success^{xxxiv}.

One of the most important ways that programs can help support children's home language development is by encouraging their parents to continue to use their home language when speaking with their child. Programs often report that parents are concerned about their children's progress in learning the English language, and therefore are frequently hesitant to continue to speak the home language with their children, thinking that it might limit their English language learning. Yet, because Head Start is a two generational program that helps parents understand how their children learn and how they can contribute to it, correcting this serious misunderstanding should be a standard of Head Start practice.

It is important for programs to make their goals for DLLs explicit with regard to both English and home language development. Thereafter it is important that the program be intentional in implementing the goals. These goals should govern the policies of the program, the governance and administrative structures, professional development, and practices with families. For instance, if a program has an explicit goal of promoting children's home language development (along with English language development) within its classrooms or home visits, it must ensure that its instructional and teaching strategies are not "subtractive" (i.e., only bilingual until sufficient English has been achieved)^{xxxv}. Or as another example, a program could also choose to be intentional about bridging strategies that bridge between the program and parents' language in the home. The particulars of any program's language policy and plans may differ depending upon the specific make-up of the program staff, the children and families it serves, and the local community, but the science is clear about the benefits to children's cognitive development of maintaining and developing the home language while developing English language proficiency.

Cultural and Linguistic Responsiveness Priority 4: New research is needed that tests the translation or adaptation of evidence-based methods for different cultural or language groups.

Like language background, culture presents a context that must be understood and recognized when working with families. There are tensions between consistency, standards, and tailoring of efforts, and between adopting evidence-based practice and adaptation of these practices. Yet, practices that are not culturally responsive and appropriate are unlikely to be met or implemented with enthusiasm and may fail. New evidence-based practices have rarely been tested with the range

of populations served by Head Start nationally. There is a tension between understanding the heterogeneity in programs' effectiveness and the need for federal approaches that can identify the "common denominator" of what is important for all children. There is often limited research to help programs understand what aspects of evidence-based practice can be tailored or modified to meet specific language and cultural contexts at the local level without sacrificing the core components of the practice.

The Committee believes that there is a middle ground whereby research systematically studies effects of practices and policies and their components in such a way that take-up and experiences, as well as impacts, are investigated in a cultural context. Such research should use a variety of methods (e.g., mixed qualitative/quantitative methods) for studying both program impacts as well as for interpreting how implementation occurs and is perceived in varied cultural contexts. Recent advances in impact evaluation that integrate qualitative approaches to assessing meaning making of participants provide models for such work in Head Start^{xxxvi,xxxvii}. In addition further research is needed to identify the core components of evidence-based practices that must be preserved while undertaking adaptations of these practices across different cultural contexts.

Cultural and Linguistic Responsiveness Priority 5: More program-level research is needed on practices for supporting DLLs, both more descriptive studies to understand what is currently being used as well as information on what strategies work, for which populations, and in which settings.

The school readiness and later achievement disparities between DLL and English speaking peers among children in low-income families are of great concern. Such disparities in reading and math skills are of moderate size at the beginning of kindergarten^{xxxviii,xxxix}. However, there is compelling research showing that DLL children can achieve increases that exceed those of native English-speaking children^{xl}. However, large gaps between these children's skills and national norms persisted at age 11 in the oral language skills, such as expressive vocabulary^{xli}. Thus, there is a need to support the early language development of DLLs that goes beyond alphabetic knowledge and decoding skills to include oral language skills which form the early roots of reading comprehension.

There is also encouraging data from evaluation studies in early childhood care and education that DLLs can benefit even more from such interventions than their native-speaker peers^{xlii,xliii}. For example, the HSIS found somewhat more sustained and wide-ranging positive effects among DLLs than among the native English speakers in the sample^{xliv}. Recent studies of prekindergarten in Tulsa and Boston found that Latino children and DLL children benefit more from preschool education programs than their native English-speaking peers^{xlv,xlvi}. In the case of the Boston study, the gaps in both reading and math school readiness in kindergarten between Latino and White children, for example, and between DLLs and native speakers were largely eliminated through the implementation of evidence-based reading and math curricula at scale. However, we should be cautious about the long-term impacts of single years of high-quality early childhood intervention.

DLLs in the U.S., for example, are at higher risk of experiencing lower-quality kindergarten and primary school environments than their majority-culture peers. To prolong the benefits of preschool education of high instructional and classroom quality, this quality must be sustained through the primary grades. Aligning curricula is a crucial step in this process^{xlvii}. When the quality of school environments is high and maintained over time, Spanish-speaking DLLs are particularly likely to benefit^{xlviii}.

Cultural and Linguistic Responsiveness Priority 6: Efforts to raise awareness of the “Multicultural Principles for Head Start Programs” should be increased and efforts to put these principles into practice supported.

The Committee affirms the principles expressed in the *Multicultural Principles for Head Start Programs* and recognizes Head Start for being a leader in the early childhood field in supporting cultural and linguistic responsiveness^{xlix}. It is unclear from existing data, however, to what extent Head Start programs nationwide are aware of these principles and are using them to guide the design and delivery of their services and programs. There is likely substantial variability at the grantee and center levels in applying these principles in practice. Thus, the Committee recommends that the Secretary continue efforts to promote this work, with an emphasis on ensuring that these principles are being represented in Head Start practice throughout the country. The National Center on Cultural and Linguistic Responsiveness is a key resource for helping the Department move in this direction, and can be a leader in developing practical tools for helping programs assess their cultural and linguistic responsiveness and ensure that they are meeting the needs of the diverse communities they serve. In particular, the Committee recommends an emphasis on ethnically diverse and immigrant populations and helping programs ensure that they are adapting their practices as their communities are changing over time. There is growing evidence suggesting that Hispanic families, in particular, tend to be underrepresented in early childhood programs^l. The data are not clear as to whether this is also a problem in Head Start, but the pattern points to the need to ensure that local programs understand how their communities are changing and adapt to ensure that their services remain appropriate for these new populations.

Cultural and Linguistic Responsiveness Priority 7: The Committee finds that programs’ capacities to recruit, enroll, and be responsive to the range of immigrant populations in their communities should be strengthened.

The share of America’s children with at least one foreign-born parent grew from 13 percent in 1990 to 23 percent in 2009^{li}. Children of immigrants were responsible for nearly 60 percent of the growth in the U.S. child population in the 1990s, and virtually all of the growth during the 2000s. Immigration tends to select for qualities such as persistence, resilience, and commitment to the country that has been actively chosen. These qualities may help to explain the unique strengths of a nation built from generations of immigrants. Yet children with immigrant backgrounds are at risk today. Children of immigrants in 2010 overall had a poverty rate of 39 percent, compared to 31

percent for children of native-born parents^{lii}. In 2010, the number of Latino children in poverty surpassed the number of White children in poverty for the first time in U.S. history^{liii}. Children of Asian immigrants are also growing rapidly in numbers—this group is diverse, and includes many who are at economic risk as well. Much of the migration to the U.S. is concentrated in traditional gateway States like California, Florida, New York, Illinois, and Texas; but in the last decade immigration and consequently the numbers of children in immigrant families have surged in the Southeast and in the Midwest. For example, North Carolina, Georgia, Nevada, Arkansas, and Tennessee led the nation in the percentage growth in immigrants between 1990 and 2009^{liv}.

The rapid growth in children of immigrants nationwide has posed opportunities as well as challenges for Head Start and EHS. Head Start and EHS are among the most trusted community programs among immigrant parents^{lv}. The unprecedented diversity in languages and cultures represents opportunities for professional development of teachers and family service workers. However, newcomer families may require additional support in that they are usually less familiar with the resources available to help support child rearing in their communities^{lvi}. In addition, in many communities services are simply less available in the languages that immigrant parents speak or fitting the daily routines of these parents, many of whom work long or non-standard hours.

Head Start, EHS, and other early childhood programs are especially effective in improving the cognitive school readiness of Latino children^{lvii,lviii,lix}. Yet preschool enrollment of children of Latino families remains low compared to other groups^{lx}. Enrollment, for example, of Mexican origin children in the U.S. in preschool currently lags far behind their peers in Mexico, who have benefited from a national policy mandating preschool education for 4-year-olds^{lxi}. Enrollment barriers in Head Start among immigrant families are likely not due to parent values—by preschool age, virtually all parents regardless of immigration status, desire preschool education for their children^{lxii}. It is likely that the gap in enrollment among Latino children is partially due to the large increases in recent years in unauthorized migration to the U.S, together with access and affordability. There are currently 4.5 million citizen children with at least one undocumented parent, for example, with virtually all of these children in low-income families eligible for Head Start and EHS (91 percent of children younger than age 6 with an undocumented parent are U.S. citizens)^{lxiii}. Parental undocumented status poses a developmental risk for children in early childhood, with cognitive skills particularly likely to be affected. This is partly because children of undocumented parents are enrolled in center-based care and preschools at lower rates than their peers of documented parents, even adjusting for indicators of socioeconomic status^{lxiv}. Undocumented parents often perceive a choice between risking deportation by providing paperwork to enroll their citizen children and providing them with learning opportunities such as preschool education.

In addition, families with refugee status experience unique stressors and traumas that deserve attention in Head Start and EHS programs. Experiences of family separation, extended exposure to armed conflict and deprivation, and stints sometimes lasting years in refugee camps can strain

family resources and functioning. Parents of young children are often simultaneously coping with these severe stressors as well as all the experiences of newly arrived families adjusting to new communities. Head Start and EHS programs can play a vital role in welcoming and supporting such families^{lxv}.

Given the rapid increases in immigrant families in the U.S., particularly from Latin America; East, South, Central, and Southeast Asia; Africa; Eastern Europe; the Middle East; and the Balkan nations, it is critical that programs are aware that they should pay as much attention to country of origin in families as to language, race, and ethnicity. There is wide variability in the cultures of people who share any given language based on their country of origin. Programs must not assume that all non-English-speaking children are the same, or that all children who speak the same language are the same, just as they do not assume all English-speaking children are the same. Refugee populations or unauthorized populations, for example, often come to the U.S. with unique and severe emotional and physical stressors from experiences before migration. In countries of origin, parents or children may have experienced discrimination or social exclusion based on race, ethnicity, indigenous status, secondary migration, or other factors. If programs are unaware of these aspects of their families' origins, they will be providing services based on incomplete information. Culturally responsive practices thus require an understanding of families' unique cultural and migration circumstances, and practices that go beyond such understanding to structuring responsive services and family and community engagement. The Department can support programs by helping them understand how immigration experiences relate to culture and how the cultures of groups of individuals who might share a language, race, or ethnicity can vary. Programs themselves can first encourage a stance of curiosity and desire to understand the cultural and related histories of their families, among all staff. Integration of this new knowledge into the structure and content of Head Start services is then required, to build and improve upon culturally responsive practice.

Cultural and Linguistic Responsiveness Priority 8: Head Start research should make greater attempts to understand and document the characteristics and experiences of groups of children and families, including children in immigrant families.

Achievement and opportunity disparities are important reasons for understanding the importance of addressing issues related to race, ethnicity, language, culture, and economic circumstances in early childhood. Such disparities can exist both across and within programs. However, disparities are often documented only across very broad, panethnic categories such as "African-American," "Latino" or "Hispanic," "Asian" and "White." Within each of these categories are many different groups, and they may have little in common with each other beyond the language they speak or the color of their skin. Research findings that detail the different experiences of such broad categories of racial and ethnic groups are difficult to interpret without understanding the differences among groups within these panethnic categories. Head Start research would be better served by

attempting to disentangle the experiences of race, ethnicity, culture, immigration experiences; and country of origin, language, and economic circumstances to provide more “actionable” information for programs. At minimum, Head Start research should pay attention to the larger populations being served by the Head Start program and attempt to represent and understand the experiences of these groups, either through smaller scale focused studies or by oversampling the groups in national studies. For example, while national Head Start studies typically have large enough samples to examine DLLs as a separate category—given their prevalence in Head Start programs—they are rarely able to look within the relatively large group of Spanish-speaking DLLs to examine differences by country of origin, acculturation or incorporation, experiences of discrimination, or culture. Each of these has unique and important associations with family and child functioning. Likewise, there have only been limited attempts to examine the experiences of children in immigrant families in these studies to date. The program and broader field would be well-served by having a more explicit focus on the experiences of large cultural and language groups to better understand their strengths and needs. This should include attempts to understand the degree to which differences across groups represent cultural differences, rather than differences related to economic circumstances, geographic location, political, or historical experiences or other factors.

Within this frame, the Committee suggests that researchers working with Head Start populations identify ethnic, language and immigrant groups within their potential samples and, prior to commencing studies, integrate research questions and constructs related to family, program, and child characteristics that may be specific to the primary groups represented^{lxvi}. In this way, the research literature on Head Start experiences can be expanded and integrated in feasible ways into practice and policy at local and national levels.

In addition, the Committee suggests further analysis of the impact studies of Head Start and EHS to better understand differential patterns of impacts by race, ethnicity, and language. Each of the studies found some differences in impacts for groups as defined by race and ethnicity and/or language, but little follow-up research has been conducted to understand these differences^{lxvii, lxviii, lxix}. It is important to further investigate these differential impacts in order to better understand them and to glean potential lessons for policy and practice. For example, mechanisms of impacts may differ for particular groups and recent methods advances for the study of variation in mechanisms within studies across groups and could be applied to these studies^{lxx}. “Fade out” or “catch up” processes might differ in longer-term effects across groups, in part because different racial, ethnic, language, or immigrant groups vary in their school, neighborhood, and family experiences after Head Start.

The Committee also recommends further investigation into the differential representation of cultural and linguistic groups in different years of Head Start. There is evidence that DLLs are more prevalent in older cohorts of Head Start children. The FACES study has found that the cohort entering Head Start at age 4 includes a greater percentage of DLLs than the cohort that enters at age 3. Further, there appears to be greater representation of DLLs within Head Start than EHS. It is


important to better understand these differences, particularly in light of research suggesting that Hispanic children tend to be underrepresented in ECE programs.

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Appendix A:
Charter for the Advisory
Committee on Head Start
Research and Evaluation

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2010 Original Charter

Authority

42 U.S.C. 9844(g), Section 649(g)(1) of Head Start Act, as amended. The Committee is governed by the provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the information and use of advisory committees.

Objective and Scope of Activities

The purpose of the Advisory Committee on Head Start Research and Evaluation (“the Committee”) is to review and make recommendations on the design of the study or studies that provide a national analysis of the impact of Head Start programs. The Committee will also advise the Secretary of Health and Human Services (“the Secretary”) regarding the progress of the study.

Description of Duties

The Committee will maintain and advise the Secretary and Assistant Secretary for Children and Families (“the Assistant Secretary”) regarding the progress of research that is providing a national analysis of the impact of Head Start programs. The Committee will also comment; if the Committee so desires, on the interim and final reports regarding such research to be submitted to the Committee on Education and Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.

Agency or Official to Whom the Committee Reports

The Committee provides advice to the Secretary of Health and Human Services (HHS) and the Assistant Secretary for Children and Families.

Support

Coordination, management, and operational services shall be provided by the Administration for Children and Families, Department of Health and Human Services (HHS).

Estimated Annual Operating Costs and Staff Years

The estimated annual cost for operating the Committee, including compensation and travel expenses for members but excluding staff support, is \$257,162. The estimated annual person-years of staff support required is .10FTE, at an estimated annual cost of \$15,320.00.

Designated Federal Officer

ACF will select a full-time or permanent part-time Federal employee to serve as the Designated Federal Officer (DFO) to attend each Committee meeting and ensure that all procedures are within applicable statutory, regulatory, and HHS General Administration Manual directives. The DFO will approve and prepare all meetings agendas, in consultation with the Chair, call all of the Committee and subcommittee meetings, adjourn any meeting when the DFO determines adjournment to be in the public interest, and chair meetings when directed to do so by the official to whom the Committee reports. The DFO or his/her designee shall be present at all meeting of the full committee and subcommittees.

Estimated Number and Frequency of Meetings

Meetings shall be held up to three (3) times per year. Meetings shall be open to the public except as determined by the Secretary or other official to whom the authority has been delegated in accordance with the Government in the Sunshine Act (5 U.S.C. 552b (c)) and the Federal Advisory Committee Act (FACA). Notice of meetings shall be given to the public. Meetings shall be conducted, and records of the proceedings kept as required by applicable laws and Departmental regulations.

Duration

Continuing

Termination

Unless renewed by the appropriate action prior to its expiration, the Advisory Committee on Head Start Research and Evaluation will terminate two years from the date the charter is filed.

Membership and Designation

The Committee shall consist of 21 members appointed by the Secretary. Members shall be experts in evaluation and research, education, and early childhood programs. The Committee shall also

consist of six ex-officio members representing the Administration for Children and Families; the Office of the Assistant Secretary for Planning and Evaluation; the Department of Education; and the Government Accountability Office.

Members shall be invited to serve for four-year terms; such terms are contingent upon the renewal of the Committee by appropriate action prior to its termination. The members for this committee will be special government employees.

Subcommittees

Subcommittee may be established with the approval of the Secretary or designee. Subcommittee members may be composed of the parent committee. The subcommittee shall make recommendations to be deliberated by the parent committee. The Department Committee Management Officer will be notified upon establishment of each Subcommittee and will be provided information on its name, membership, function, and estimated frequency of meetings.

Recordkeeping

The records of the Council, established subcommittees, or other subgroups of the Committee shall be managed in accordance with General Records Schedule 26, Item 2 or other approved agency records disposition schedule. These records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C.552.

Filing Date

Approved:

 MAY 12 2010

Date



Secretary

2012 Re-Charter

Authority

42 U.S.C. 9844(g), Section 649(g)(1) of Head Start Act, as amended. The Committee is governed by the provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the information and use of advisory committees.

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The purpose of the Advisory Committee on Head Start Research and Evaluation ("the Committee") is to review and make recommendations on the design of the study or studies that provide a national analysis of the impact of Head Start programs. The Committee will also advise the Secretary of Health and Human Services ("the Secretary") regarding the progress of the study.

Description of Duties

The Committee will maintain and advise the Secretary and Assistant Secretary for Children and Families ("the Assistant Secretary") regarding the progress of research that is providing a national analysis of the impact of Head Start programs. The Committee will also comment; if the Committee so desires, on the interim and final reports regarding such research to be submitted to the Committee on Education and Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.

Agency or Official to Whom the Committee Reports

The Committee provides advice to the Secretary of Health and Human Services (HHS) and the Assistant Secretary for Children and Families.

Support

Coordination, management, and operational services shall be provided by the Administration for Children and Families, Department of Health and Human Services (HHS).

Estimated Annual Operating Costs and Staff Years

The estimated annual cost for operating the Committee, including compensation and travel expenses for members but excluding staff support, is \$257,162. The estimated annual person-years of staff support required is .20FTE, at an estimated annual cost of \$28,000.

Designated Federal Officer

ACF will select a full-time or permanent part-time Federal employee to serve as the Designated Federal Officer (DFO) to attend each Committee meeting and ensure that all procedures are within applicable statutory, regulatory, and HHS General Administration Manual directives. The DFO will approve and prepare all meetings agendas, in consultation with the Chair, call all of the Committee and subcommittee meetings, adjourn any meeting when the DFO determines adjournment to be in the public interest, and chair meetings when directed to do so by the official to whom the Committee reports. The DFO or his/her designee shall be present at all meeting of the full committee and subcommittees.

Estimated Number and Frequency of Meetings

Meetings shall be held up to three (3) times per year. Meetings shall be open to the public except as determined by the Secretary or other official to whom the authority has been delegated in accordance with the Government in the Sunshine Act (5 U.S.C. 552b (c)) and the Federal Advisory Committee Act (FACA). Notice of meetings shall be given to the public. Meetings shall be conducted, and records of the proceedings kept as required by applicable laws and Departmental regulations.

Duration

Continuing

Termination

Unless renewed by the appropriate action prior to its expiration, the Advisory Committee on Head Start Research and Evaluation will terminate three months from the date the charter is filed.

Membership and Designation

The Committee shall consist of 21 members appointed by the Secretary. Members shall be experts in evaluation and research, education, and early childhood programs. The Committee shall also

consist of six ex-officio members representing the Administration for Children and Families; the Office of the Assistant Secretary for Planning and Evaluation; the Department of Education; and the Government Accountability Office.

Members shall be invited to serve for four-year terms; such terms are contingent upon the renewal of the Committee by appropriate action prior to its termination. The members for this committee will be special government employees.

Subcommittees

Subcommittee may be established with the approval of the Secretary or designee. Subcommittee members may be composed of the parent committee. The subcommittee shall make recommendations to be deliberated by the parent committee. The Department Committee Management Officer will be notified upon establishment of each Subcommittee and will be provided information on its name, membership, function, and estimated frequency of meetings.

Recordkeeping

The records of the Council, established subcommittees, or other subgroups of the Committee shall be managed in accordance with General Records Schedule 26, Item 2 or other approved agency records disposition schedule. These records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C.552.

Filing Date

May 12, 2012

Approved:

MAY - 9 2012
Date



Secretary



Appendix B: Full List of Committee Members

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Appendix B: Full List of Committee Members

Full List of Committee Members throughout Charter Period

Committee Members (date of appointment)

J. Lawrence Aber, New York University
(January 2011)

Jeanne Brooks-Gunn, Columbia University
(April 2011)

Margaret Burchinal, University of North Carolina at Chapel Hill (January 2011)

Judith Carta, University of Kansas (January 2011)

Thomas Cook, Northwestern University
(January 2011)

Gayle Cunningham, Jefferson County Committee for Economic Opportunity
(January 2011)

Jerlean Daniel, National Association for the Education of Young Children (January 2011)

Linda Espinosa, University of Missouri-Columbia – Retired (January 2011)

John Fantuzzo, University of Pennsylvania
(January 2011)

Danette Glassy, American Academy of Pediatrics (January 2011)

Whitcomb Hayslip, Los Angeles Unified School District – Retired (January 2011)

John Love, Ashland Institute for Early Childhood Science and Policy (January 2011)

Tammy Mann, The Campagna Center
(January 2011)

Robert Pianta, University of Virginia
(January 2011)

Thomas Schultz, The Council of Chief State School Officers (January 2011)

Joshua Sparrow, Harvard University
(January 2011)

Heather Weiss, Harvard University (January 2011)

Hirokazu Yoshikawa, Harvard University
(January 2011)

Martha Zaslow, Society for Research in Child Development (January 2011)

Edward Zigler, Yale University (January 2011, resigned from Committee)

Current and Former Ex Officio Members

Current Members

Sherry Glied, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Jacqueline Jones, Senior Advisor to the Secretary for Early Learning, U.S. Department of Education

Yvette Sanchez Fuentes, Director, Office of Head Start, Administration for Children and Families, U.S. Department of Health and Human Services

George Sheldon, Acting Assistant Secretary, Administration for Children and Families, U.S. Department of Health and Human Services

Linda Smith, Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services

Michael Yudin, Acting Assistant Secretary for the Office of Elementary and Secondary Education, U.S. Department of Education

Former Members

David Hansell, Acting Assistant Secretary, Administration for Children and Families, U.S. Department of Health and Human Services

David Harris, Deputy Assistant Secretary for Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services

Joan Lombardi, Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development, Administration for Children and Families, U.S. Dept. of Health and Human Services

Thelma Meléndez de Santa Ana, Assistant Secretary for Elementary and Secondary Education, U.S. Department of Education



Appendix C: Subcommittee Membership

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Appendix C: Subcommittee Membership

Overarching Recommendations

Margaret Burchinal
Judith Carta
Linda Espinosa
Tammy Mann
Robert Pianta
Thomas Schultz
Joshua Sparrow
Martha Zaslow

Quality Teaching and Learning

Margaret Burchinal
Judith Carta
Gayle Cunningham
Jerlean Daniel
Linda Espinosa
John Fantuzzo
Whitcomb Hayslip
Robert Pianta
Thomas Schultz
Heather Weiss
Martha Zaslow

Health and Mental Health

Lawrence Aber
Judith Carta
Thomas Cook
Danette Glassy
Tammy Mann
Joshua Sparrow
Martha Zaslow

Impact Studies of Head Start and Early Head Start

Lawrence Aber
Jeanne Brooks-Gunn
Margaret Burchinal
Linda Espinosa
John Love
Martha Zaslow

Parent, Family and Community Engagement

Jeanne Brooks-Gunn
Gayle Cunningham
Danette Glassy
Thomas Schultz
Joshua Sparrow
Heather Weiss

Cultural and Linguistic Responsiveness

Gayle Cunningham
Linda Espinosa
Whitcomb Hayslip
Tammy Mann
Joshua Sparrow
Hirokazu Yoshikawa

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Appendix D:
Invited Presenters and
Presentation Topics

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Appendix D: Invited Presenters and Presentation Topics

January 25 – 26, 2011 Invited Presenters

Stephen Bell

Abt Associates
Co-Presenter with Jennifer Brooks, Ronna Cook, Andrew Mashburn, Michael Puma, “Head Start Impact Study Design and Findings and 3rd Grade Follow-up Plans”

Jennifer Brooks

Office of Planning, Research and Evaluation
Co-Presenter with Stephen Bell, Ronna Cook, Andrew Mashburn, and Michael Puma, “Head Start Impact Study Design and Findings and 3rd Grade Follow-up Plans”

Ronna Cook

Ronna Cook Associates
Co-Presenter with Stephen Bell, Jennifer Brooks, Andrew Mashburn, and Michael Puma, “Head Start Impact Study Design and Findings and 3rd Grade Follow-up Plans”

Thomas Cook

Northwestern University
Committee Member
Discussant on “Commentary on Head Start Impact Study: What Does It Tell Us about the Program and about Future Research Needs?”

Gayle Cunningham

Jefferson County Committee for Economic Opportunity
Committee Member
Discussant on “Commentary on Head Start Impact Study: What Does It Tell Us about the Program and about Future Research Needs?”

Naomi Goldstein

Director, Office of Planning, Research, and Evaluation
“Head Start and Early Childhood Research at the Administration for Children and Families”

Robert Granger

W.T. Grant Foundation
Discussant on “Commentary on Head Start Impact Study: What Does It Tell Us about the Program and about Future Research Needs?”

Jens Ludwig

University of Chicago
“Beyond the Head Start Impact Study: Context from Other Studies”

Katherine Magnuson

University of Wisconsin
“The Persistence of Head Start Program Effects: What Role Does Subsequent Schooling Play?”

Andrew Mashburn

University of Virginia
Co-Presenter with Stephen Bell, Jennifer Brooks, Ronna Cook, and Michael Puma
“Head Start Impact Study Design and Findings and 3rd Grade Follow-up Plans”

Robert Pianta

University of Virginia
Committee Member
“Experiences In and Impacts of Classrooms K-3: Implications for Head Start”

Michael Puma

Chesapeake Research Associates, LLC
Co-Presenter with Stephen Bell, Jennifer Brooks, Ronna Cook, and Andrew Mashburn,
“Head Start Impact Study Design and Findings and 3rd Grade Follow-up Plans”

Yvette Sanchez Fuentes

Director, Office of Head Start
“Advisory Committee on Head Start Research and Evaluation: Office of Head Start”

Deborah Stipek

Stanford University
“Effective Instruction for Young Children”

Louisa Tarullo

Mathematica Policy Research
“The Children and Families of Head Start: National Data from FACES 2006”

April 12 – 13, 2011 Invited Presenters

Karen Bierman

The Pennsylvania State University
“Thinking Across Broad Domains: Integrating Curricula and Instruction”

Susan Bredekamp

Independent Consultant
“Effective Instructional Practices and the Role of Assessment”

Margaret Burchinal

University of North Carolina – Chapel Hill
Committee Member
“Dosage Effects in Early Care and Education: Evidence from Secondary Data Analysis”
“Testing the threshold in associations between child care quality and child outcomes”
“What is Educare?”

Rachel Chazan Cohen

George Mason University
Co-presenter with Helen Raikes, “Short and Long Term Impacts of Early Head Start”

Doug Clements

State University of New York
“Math Lessons’ from Research”

Susan Dickstein

Brown University
“Instructional Practices: Role of Assessment”

Linda Espinosa

University of Missouri – Columbia (Retired)
Committee Member
Co-presenter with Whitcomb Hayslip,
“Improving Instruction for Young Dual Language Learners: Strengths and Limitations of Current Research”

John Fantuzzo

University of Pennsylvania
Committee Member
“Achieving a Common Purpose in the Real World of Head Start”

Whitcomb Hayslip

Los Angeles Unified School District (Retired)
Committee Member
Co-presenter with Linda Espinosa,
“Improving Instruction for Young Dual Language Learners: Strengths and Limitations of Current Research”

Mary Louise Hemmeter

Vanderbilt University
“Supporting Professional Development to Ensure Effective Instruction”

Laura Justice

The Ohio State University
“Supporting Professional Development to Ensure Effective Instruction”

Helen Raikes

University of Nebraska – Lincoln
Co-presenter with Rachel Chazan Cohen,
“Short and Long Term Impacts of Early Head Start”

June 7 – 8, 2011 Invited Presenters

Catherine Ayoub

Brazelton Touchpoints Center, Harvard Medical School
“Family Well Being: Addressing Parental Depression and Related Adversity”

Jeanne Brooks-Gunn

Columbia University
Committee Member
Discussant for “Programs for Parents Focused on Post-Secondary Education”

Amanda Bryans

Office of Head Start
“Office of Head Start: Head Start Today”

Yvette Sanchez Fuentes

Director, Office of Head Start
“Head Start Today: Quality Teaching and Learning”

Louisa Tarullo

Mathematica Policy Research
“Learning Environments in Head Start: National Data from FACES”

Barbara Wasik

Temple University
“Language and Literacy: What Research Tells Us about Improving Outcomes for Young Children”

Martha Zaslow

Society for Research in Child Development
Committee Member
Discussant for “Themes and Recommendations Regarding Early Head Start and Dosage”
Presenter on “Emerging Issues in Early Childhood Professional Development”

Rachel Chazan Cohen

George Mason University
“Reaching Families in Early Head Start: Data from Baby FACES”

Jerlean Daniel

National Association for the Education of Young Children
Committee Member
Discussant for “Competencies and Preparation of Family Engagement Professionals”

Anne Duggan

Johns Hopkins University
“Lessons to Guide Future Head Start Research and Evaluation”

Carl Dunst

Orelena Hawks Puckett Institute
“Family-Centered Practices, Parent Engagement, and Parent and Family Functioning”

Vivian Gadsden

University of Pennsylvania
“The Family Engagement Transaction: Learnings from EPIC’s Home Connections and Head Start”

Christine McWayne

Tufts University
“Family Engagement during Preschool: A Multidimensional Look across Diverse Measures, Cultural Groups & Head Start Sites”

Toni Porter

Bank Street College of Education
“Defining Parent and Family Engagement: Recent Efforts to Define and Measure Family-Provider Relationships”

Kyle Pruett

Yale University
“Resilient Context of Positive Paternal Engagement: RCT of Child/Family outcomes with special focus on Hispanic cohort”

Lori Roggman

Utah State University
“Parent Engagement in Early Head Start Home Visits: Home Visitor Strategies & Training”

Joshua Sparrow

Brazelton Touchpoints Center, Harvard Medical School
Committee Member
Presenter on “Relationships: The Heart of Engagement”
Discussant for “Professional Development to Support Positive Relationships”

Paul Spicer

University of Oklahoma
“Engaging Native Families”

Louisa Tarullo

Mathematica Policy Research
“Head Start Families’ Engagement with Programs: Data from FACES”

Heather Weiss

Harvard University
Committee Member
“Head Start Research, Demonstration and Evaluation Strategies: The Case of Family and Community Engagement”

Martha Zaslow

Society for Research in Child Development
Committee Member
Discussant for “Impacts on Families and Parents”

September 21 – 22, 2011 Invited Presenters

Nikki Aikens

Mathematica Policy Research
“Linguistic and Cultural Diversity of Head Start Children and Families: Data from FACES 2006”

George Askew

Administration for Children and Families
“The Role of Head Start in a Changing Health System: Health Disparities”

Marco Beltran

Office of Head Start
“Implementation and Evaluation of Office of Head Start Oral Health Initiative”

Charlotte Brantley

Clayton Early Learning
“Example of Program Language Policy in Action”

Judith Carta

University of Kansas
Committee Member
Co-facilitator for Guided Discussion and Recommendations
Presenter on “School Readiness for Young Children with Disabilities: What Do We Know? What Do We Need to Know?”

Linda Espinosa

University of Missouri – Columbia (Retired)
Committee Member
Co-facilitator for Guided Discussion
Co-presenter with Whitcomb Hayslip,
“Instructional Programs and Practices for Young Dual Language Learners: Home Language Maintenance and English Acquisition – Is It Either/Or or Both and More?”

Eugene Garcia

Arizona State University
“Immigration and Early Education: An Account of Family Engagement and Academic Gap Reductions”

Danette Glassy

American Academy of Pediatrics
Committee Member
“Health, Early Learning and Care: Update on Emerging Policies”

Bernard Guyer

Johns Hopkins University
“Promoting Child Health and School Readiness in Early Life: Life Course Perspective”

Whitcomb Hayslip

Los Angeles Unified School District (Retired)
Committee Member
Co-facilitator for Guided Discussion
Co-presenter with Linda Espinosa,
“Instructional Programs and Practices for Young Dual Language Learners: Home Language Maintenance and English Acquisition – Is It Either/Or or Both and More?”

Ariella Herman

University of California Los Angeles
“Health Care Institute: Research to Practice – Empowering Parents, Benefiting Children, Creating Strong Foundations for Healthy Families”

Elizabeth Macgruder

Los Angeles Unified School District
“Intentional Planning for Oral Language and Vocabulary Instruction”

Deborah Perry

Georgetown University
“The Role of Mental Health Consultation in Head Start”

Yvette Sanchez Fuentes

Director, Office of Head Start
“Head Start Today: A Look at Demographics and Culture and Linguistic Responsiveness”
“Head Start Today: Health”

Joshua Sparrow

Brazelton Touchpoints Center, Harvard Medical School
Committee Member
“Culture, Community, and Complex Systems: Touchpoints in Intervention Adaptation and Co-construction”

Louisa Tarullo

Mathematica Policy Research
“Health and Developmental Status of Head Start Children: Data from FACES 2006”

Yasmina Vinci

National Head Start Association

Cheri Vogel

Mathematica Policy Research
“Cultural and Linguistic Diversity of Early Head Start Children at Age 1 Baby FACES”
“Health and Development Status of Early Head Start Children: Baby FACES”

Hirokazu Yoshikawa

Harvard University
Co-facilitator for Guided Discussion and Recommendations

January 18 – 19, 2012 Invited Presenters

Yvette Sanchez Fuentes

Director, Office of Head Start
“System for Designation Renewal of Head Start and Early Head Start Grantees”



Appendix E: Acronym List

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Appendix E: Acronym List

The following terms and/or acronyms appear at least once in the draft chapters of the Secretary’s Advisory Committee (SAC) Head Start Research and Evaluation Report. The American Psychological Association (APA) editorial rule for acronym usage appears at the end of the list.

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)

A [Back](#)

Administration for Children and Families (**ACF**)
American Academy of Pediatrics (**AAP**)
American Indian/Alaska Native (**AI/AN**)

B [Back](#)

C [Back](#)

Child Development Associate (**CDA**)
Classroom Assessment Scoring System (**CLASS**)

D [Back](#)

Designation Renewal System (**DRS**)
Dual Language Learners (**DLL**)

E [Back](#)

Early Childhood Education (**ECE**)
Early Childhood Longitudinal Study (**ECLS**)
Early Head Start (**EHS**)
Early Head Start Research and Evaluation Project (**EHSREP**)
[U.S. Department of] Education (**ED**)

F [Back](#)

[Head Start] Family and Child Experiences Study (**FACES**)
Family service worker (**FSW**)

G [Back](#)

H

[Back](#)

Head Start/Early Head Start **(HS/EHS)**

Head Start Family and Child Experiences Study **(FACES)**

Head Start Impact Study **(HSIS)**

Head Start Program Information Report **(PIR)**

Head Start Program Performance Standards **(Performance Standards)**

[U.S. Department of] Health and Human Services **(HHS)**

I

[Back](#)

Individuals with Disabilities Education Act **(IDEA)**

J

[Back](#)

K

[Back](#)

L

[Back](#)

Language other than English **(LOTE)**

Local Education Agency **(LEA)**

M

[Back](#)

Migrant and Seasonal Head Start **(MSHS)**

N

[Back](#)

National Association for the Education of Young Children **(NAEYC)**

National Center on Parent, Family, and Community Engagement **(NCPFCE)**

O

[Back](#)

Office of Head Start **(OHS)**

P

[Back](#)

Panel Study of Income Dynamics **(PSID)**

Parent, Family, and Community Engagement **(PFCE)**

Prekindergarten **(Pre-K)**

[Head Start] Program Information Report **(PIR)**

Q [Back](#)

Quality Rating and Improvement Systems (**QRIS**)

R [Back](#)

S [Back](#)

T [Back](#)

Technical Assistance (**TA**)

Test de Vocabulario en Imagenes Peabody [Spanish Vocabulary Assessment] (**TVIP**)

Training and Technical Assistance (**T/TA**)

U [Back](#)

U.S. Department of Education (**ED**)

U.S. Department of Health and Human Services (**HHS**)

V [Back](#)

W [Back](#)

Women, Infants, and Children (**WIC**)

X [Back](#)

Y [Back](#)

Z [Back](#)