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On Track with Phoenix Early Head Start

Final Evaluation Report

by

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and

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with assistance from
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Phoenix Early Head Start
Executive Summary

Phoenix Early Head Start (EHS) is a program for first-time teen parents and their families. The 1999-2000 project year was the fifth and final year of a research and demonstration grant for EHS and concluded the fourth full year of program implementation. The program was originally funded in 1995 by the Administration for Children, Youth, and Families as part of a national initiative to provide services for low-income pregnant women and families with children ages birth to three. Early Head Start is a family-centered program designed to provide early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children.

Phoenix Early Head Start is operated by Southwest Human Development (SWHD), a non-profit human services organization providing comprehensive services to young children and families who are at-risk or have special needs. Southwest Human Development contracted with the Morrison Institute for Public Policy at Arizona State University to conduct a formative, continuous program improvement evaluation to assist EHS in refining program practices on an ongoing basis.

A description and analysis of the program's structure and planning phase during Year One, and research findings and analysis from Years Two, Three, and Four, are available in previous project evaluation reports (Sandler & Heffernon, 1998, 1999, 2000; Sandler & Kleinschmidt, 1996). In addition, case studies that followed the stories of 12 families throughout their participation in EHS have been recounted in a series of three publications (Heffernon & Sandler, 1998, 1999, 2000). The current document is the final evaluation report for Phoenix Early Head Start and provides a five-year perspective on program process and outcomes for children, families, staff, and the community.

Program Description

Phoenix Early Head Start recruits low-income teens, ages 13 to 19 years, in central/south Phoenix who are pregnant with their first child or who have an infant under six months of age. The program operates out of two sites: 1) Hamilton Elementary School in southwest Phoenix, and 2) the Southwest Human Development Good Fit Center in central Phoenix. The program is designed to assist 120 families with services provided through a three-pronged approach: weekly home visits, site-based group activities, and "brokered" services linking families with high-quality community resources. Male involvement is also a major EHS program focus, with outreach efforts to engage young fathers with their children and to support that ongoing relationship.

Program services are delivered by a primary staff of 12 family support specialists, guided by two site supervisors and overseen by a full-time project manager. Their services are enhanced by a resource staff that includes a male involvement specialist, a family services coordinator, registered nurses, child development/disabilities specialists, mental health professionals, and a

consulting nutritionist. Transportation services are provided by a full-time van driver and part-time bus driver. Program components are designed to address the four original nation Early Head Start cornerstones — child development, family development, staff development, and community building.

Child development is supported through ongoing home visits by the family support specialists, weekly parent-child play groups that encourage positive parent-child interactions, and monthly site-based socialization activities centered around child-development related themes. The child development/disabilities specialists provide additional child development support as they consult with families and staff, facilitate play groups, and coordinate services for children with special needs. Positive child outcomes are also advanced through the program nurses, who assess children's developmental and physical progress during semiannual home visits, facilitate health related site- based activities, and consult with EHS families and program staff.

Family development services are coordinated by the family support specialists who develop supportive alliances with families to assist them in achieving their goals, and who work with parents on improving health care practices, family planning, education, and employment. Many families also receive assistance from the male involvement specialist, who helps engage fathers in the program and in the lives of their children, provides assistance with immigration, housing, and jobs, and coordinates monthly father activities and special events. A part-time family services coordinator oversees and facilitates site-based activities and parent meetings. Program nurses conduct classes for EHS teens on childbirth, child care training, and CPR/First Aid training, and offer consultation on adolescent health and development. Mental health specialists provide assessments, direct services, and community referrals, and facilitate support groups where parents can discuss commonly-shared issues and concerns. Family development is enhanced during family-centered socialization activities and special events. Leadership opportunities are also offered to parents through participation on the EHS parent committee and the Head Start Parent Policy Council, and through attendance at local, state, and national conferences.

Staff development is accomplished through a multi-disciplinary staff training approach that is reinforced through a relationship-based model of supervision. Training is provided both by outside trainers and by EHS resource staff, and is aligned with the desired program outcomes for children and families. An expanded child development training agenda in 1999 established several ongoing training opportunities including monthly videotape reviews and "brown-bag" lunch/workshops on child development, quarterly child development training sessions, more frequent interaction with the child development specialists, and training in developmentally-based curricula. EHS management staff also have opportunities to focus on child development in a quarterly child study group established for SWHD program managers and supervisors of child development staff across the agency. To further augment staff training, a half-time EHS "training specialist" position was created during the past year to provide new family support specialists with one-on-one guidance during their beginning weeks on the job.

Community building and collaboration is pursued programmatically through linkages and collaborations that expand the breadth of services for program families, and more broadly through actions to increase community capacity to serve young families and move the birth-to-three policy agenda forward. Community relationships have fluctuated. An original partnership plan between EHS and the City of Phoenix Head Start ultimately dissolved; at the same time collaboration with other city initiatives grew (e.g., the Step-Up program for young fathers, and the Young Fathers Network). Connections and relationships with educational institutions and

quality child care resources have also shifted over time; both areas are an ongoing focus for EHS community-building efforts. In addition to linkages and collaboration, administrative level activities encourage broader-based coalitions, such as a SWHD agency partnership to develop a public-private model to support families and their children birth to three.

Program Outcomes

The continuous program improvement evaluation of Phoenix Early Head Start was designed to answer questions about program services, child and family development, staff development, and community building, and to address policy outcomes of local interest. The evaluation examined the effectiveness of program components and identified successes and challenges in achieving program objectives. A primary intention of the evaluation was to provide EHS managers and administrators with ongoing analysis and feedback to enable them to make adjustments as the program evolved.

Children and Families

Child and family development issues have been the predominant focus during EHS home visits, with additional assistance for children and parents provided in parent-child play groups, site-based socialization activities, and parent support groups. Program services appear to have had a positive effect: most indicators reflect improvement in parents' knowledge of child development, parent-child relationships, and family development. Many parents have gained knowledge about raising infants and toddlers, and have engaged in higher quality interactions with their children over time. Most EHS children are growing up in nurturing and supportive home environments, and several families have exhibited improvements in their home environment over the course of the program. Despite their increased knowledge, some parents have had difficulty with their children's transition from infant to toddler. Several parents held inappropriate developmental expectations for their toddlers, and many used inappropriate discipline strategies when faced with noncompliant behavior.

Many parents have maintained relatively positive mental health in the face of continuing life stressors. Parents reportedly have continued to utilize a moderate level of positive coping skills over time, with some increase in their use of higher level coping strategies; their stress related to parenting has decreased slightly over time, and has continued to be low to moderate overall; and, their sense of self-esteem and self-efficacy has grown. Both parents and staff believe that EHS program services have served as "protective" factors in contributing to parents' emotional well-being.

Personal health care practices and efforts towards self-sufficiency have continued to show some signs of progress. More parents are using birth control consistently; more are practicing appropriate health prevention and treatment for themselves and their children; and more parents are using appropriate safety practices at home and in cars. Many EHS parents have exhibited progress towards self-sufficiency by holding jobs or attending school; several program participants have graduated from high school or earned their GED. There are, however, some remaining areas of concern. Many parents who enrolled in education or training programs did not complete them, low literacy levels continued to present challenges for several parents, and salaries for most working parents remained low. With regard to health care, some parents still did not get perinatal care, and some families were still without a medical home.

Staff Development

In recent years staff training has centered primarily on child development and parent-child relationships; an expanded training agenda and adoption of a child development curriculum in 1999 provided staff with more focused, hands-on training opportunities. Results of these efforts have been mixed. While their knowledge in these domains improved, family support specialists have continued to struggle with the higher-level conceptual issues that can assist them in their work with families. Many of the results from assessments of staff training have continued to reflect the impact of ongoing staff turnover: staff with longer EHS employment (and thus more training) have generally scored higher than their less experienced, less trained colleagues on both objective and subjective measures. One ongoing challenge associated with staff turnover — new employee orientation — was addressed during the past year with the appointment of a half-time staff training specialist to work with new family support specialists.

The emphasis on child development and parent-child relationships has resulted in other training areas receiving less attention, particularly strategies for working with teen parents. And while most indicators show that staff have continued to work well with their families, many family support specialists want more training on understanding and working with adolescents.

Community Building

During the past five years EHS community linkages and collaborations have ebbed and flowed, a course that can be expected in any multi-faceted, multi-year program. Despite these fluctuating relationships, some progress has occurred in program activities that help create a community environment supportive of young children and families. EHS partnerships with the City of Phoenix Step-Up program for young fathers and the Young Fathers Network have helped enhance services for this group of parents. Program relationships with City of Phoenix delegate agencies became more firmly established last year as more EHS children turned three and began to transition into Head Start; SWHD/EHS developed a solid child care linkage with Crisis Nursery and has initiated actions to expand that relationship; and SWHD has continued with plans to operate its own child care center in the future. Although collaboration regarding education has a long way to go, efforts in this area have been ongoing and program administrators have expressed hope for revitalized relationships with some of their education partners.

Phoenix Early Head Start's community building efforts were validated in a survey of community leaders, who indicated that knowledge gained through EHS had influenced their decision-making. Administrative level activities have also continued to pursue development of comprehensive, integrated services over the years. Most notably, SWHD took a leadership role in Smart Beginnings, a system development effort that culminated in the November 2000 "Healthy Children, Healthy Families" ballot initiative.

Summary and Recommendations

Family-centered programs like Phoenix Early Head Start are called upon to provide a wide range of services. The challenge for EHS is complex: it requires balancing the program's primary focus on child development with the needs of the teen parents, and it requires attention towards helping parents move towards long-term economic stability. EHS has accomplished a great deal over the past several years and has learned much that can help improve services for families in future years. To build on that foundation, the following program recommendations are offered.

Program Recommendations

- Adopt a child development instrument to determine the effects of program services on EHS children.
- Allocate resources to address employment/training issues for program parents.
- Take action to retain staff.
- Maintain an intensive, ongoing staff training agenda in child development at all program levels — and regularly review its effectiveness.
- Get the word out about "lessons learned" from EHS.

In addition to providing quality services to children and families, programs such as EHS should also be viewed as an opportunity for continued learning about what it takes to help children 0-3 and their teen parents. The experiences of Phoenix Early Head Start during the past five years suggest that state and local decision-makers must take actions that champion a broad spectrum of family support initiatives:

Policy Recommendations

- Develop and fund a statewide system of services for teen parents.
- Expand programs that help young fathers.
- Invest in comprehensive, ongoing child development training for people who work with very young children.
- Provide financial incentives that encourage development of high-quality child care facilities and reward providers who deliver these services.

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Acknowledgments

This report marks the end of a five-year partnership to implement a continuous improvement evaluation for the Phoenix Early Head Start program. The collaborative effort brought together evaluators and program stakeholders who worked to make the EHS continuous improvement program evaluation a dynamic, ongoing process to inform decisions and encourage program evolvement. EHS managers and administrators have been fully engaged in the process, using evaluation data as a basis for rethinking and "retooling" some aspects of their original program plan. Family support specialists assumed responsibility for data collection in addition to their direct service tasks, and data managers worked persistently to align program data with the needs of the evaluation. This work was not always easy, but we believe it has been an interesting and rewarding journey.

To our EHS/SWHD partners — thank you. Thank you to the family support specialists and supervisors, both past and present. Thank you, Janice Mohr and Tina Sykes, for overseeing the programmatic details associated with data collection. Thank you, Gloria Tufo and Kevin Vaughan-Brubaker, for helping meet all of the data challenges. Thank you, EHS parents, for sharing your thoughts with us. Thank you also to the SWHD administrators and managers who provided ongoing guidance through their participation in the EHS evaluation subgroup, and to Kathy Doucette-Edwards for being a good partner during earlier years of the collaboration.

Continuous improvement evaluation can work only if there is commitment, support, and engagement from program administrators. The initial vision and commitment of Jan Martner, and the continued support and engagement of Sandy Foreman, have been essential to the success of this collaborative venture. We thank you.

The contributions of colleagues at Arizona State University and Morrison Institute are also greatly appreciated. Bob Weigand, Director of the Arizona State University Child Study Laboratories, has played a pivotal role throughout this evaluation. His expertise in early childhood development has guided the interpretation of the child and family data; his knowledge and insights have also been invaluable in addressing staff development outcomes and issues. Celeste Minzikah provided much-appreciated translating skills for Spanish-speaking parents in interviews and focus groups over the course of the evaluation. Cherylene Schick designed and produced all of the EHS evaluation reports during the past five years — tasks she has completed with both patience and good humor. Finally, our thanks to the Morrison Institute graduate student assistants who have been associated with EHS over the years. Kim Malone, Alia Sheety, and Anne Kleinschmidt provided the data management and research assistance that is so important to the success of any evaluation project.

Introduction

Background

Early Head Start began in 1995 in response to the growing awareness of a "quiet crisis" that was threatening the well-being of the nation's youngest children and their families. A report by the Carnegie Corporation showed that indicators contributing to risk such as poverty, inadequate prenatal care, insufficient child care, and parents with little social support, were often placing families on a downward spiral (Carnegie Task Force on Meeting the Needs of Young Children, 1994). This report came at the same time that Head Start services were being reorganized and expanded in several ways, including service to more families with infants and toddlers.

Early Head Start is part of the 1994 Head Start Reauthorization, funded through the Administration for Children, Youth, and Families (ACYF). It is intended to enhance children's physical, social, emotional, and cognitive development, enable parents to be better caregivers and teachers to their children, and help parents meet their own goals, including economic independence. The Early Head Start goals are to:

- Promote the physical, cognitive, social, and emotional growth of infants and toddlers and prepare them for future growth and development
- Support parents — mothers, fathers, and guardians — in their role as primary caregivers and educators of their children, and in meeting family goals and achieving self-sufficiency across a wide variety of domains
- Strengthen community supports for families with young children
- Develop highly-trained, caring, and adequately-compensated program staff

(*Federal Register*, March 17, 1995)

Drawing upon three decades of research in early childhood development and family support, and building on a large body of literature and practice, Early Head Start is family-focused and centers on four cornerstones considered essential to high-quality programs: child development, family development, staff development, and community building. The intent is to provide early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children (Advisory Committee on Services for Families with Infants and Toddlers, 1994).

The program cornerstones have been integrated into the revised Head Start Performance Standards that went into effect January 1998 and guide the services for all Early Head Start and Head Start programs. While the performance standards define the scope of services to be offered, they leave the design of the services to local programs based on local community needs (*Federal Register*, November 5, 1996).

Initial funding for Early Head Start was through a special initiative setting aside 3 percent of the national Head Start appropriation in 1995. Over the years, funding for Early Head Start has steadily increased, to 8 percent of the Head Start budget in 2000, and 10 percent in 2001 and 2002. More than 500 Early Head Start programs across the country have been providing services to infants and toddlers and their families, and new programs are continuing to be added (Mathematica Policy Research, 1999).

Since its inception in 1995, Early Head Start has unfolded within the context of ongoing social change, including welfare reform, brain research that has increased our understanding of the importance of early development, and growing attention to the role of fathers. These developments, along with research about how to improve outcomes for young children and families, have contributed to the evolution of Early Head Start programs over the last five years.

Project Overview

Phoenix Early Head Start (EHS) was one of the first 68 programs funded in 1995 by ACYF to provide services for low-income pregnant women and families with children ages birth to three. The program is operated by Southwest Human Development (SWHD), a nonprofit human services organization providing comprehensive services to young children and families who are at-risk or have special needs. SWHD offers a wide range of programs and services including Head Start preschool programs, the Maricopa County Healthy Families Program, and the agency's Good Fit Center, designed to provide infant mental health services and programs.

To assist Phoenix Early Head Start in refining program practices on an ongoing basis, Southwest Human Development contracted with the Morrison Institute for Public Policy, School of Public Affairs, Arizona State University, to conduct a formative, continuous program improvement evaluation. The evaluation recognizes the importance of program context, incorporating the perceptions of key stakeholders and involving program administrators and staff as partners.

The 1999–2000 project year (October 1, 1999 to September 30, 2000) was the fifth and final year of a research and demonstration grant for Phoenix Early Head Start and concluded the fourth full year of program implementation. Previous project reports provide a description and analysis of the program's structure and planning phase during Year One, and detailed program descriptions, methodology, and research findings from Years Two, Three, and Four (Sandler & Heffernon, 1998, 1999, 2000; Sandler & Kleinschmidt, 1996). In addition, case studies have followed the stories of 12 families throughout their participation in EHS. These "family stories" have been documented in a series of three publications (Heffernon & Sandler, 1998, 1999, 2000). The current report is the final evaluation document for Phoenix Early Head Start and provides a five-year perspective on program processes and outcomes for children, families, staff, and the community.

Research Context

The conceptual underpinnings for Phoenix Early Head Start come from several arenas. Recent years have witnessed growing support for the idea that providing prevention and intervention services for very young children and their families is a good investment (Carnegie Task Force on Meeting the Needs of Young Children, 1994; Advisory Committee on Services for Families with Infants and Toddlers, 1994; Center for the Future of Children, 1995, 1997; Zigler & Styfco, 1996). Increasing evidence about infant brain development has also heightened public awareness of the importance of improving opportunities for development during these very early years (*Newsweek,* 1997), and resulted in a 1997 White House Conference on Early Childhood Development.

Phoenix Early Head Start is a multidimensional program, incorporating research and knowledge from several domains to address the needs of at-risk infants and toddlers and their

teen parents. Grounded in research on infant and early childhood development, "two-generation" interventions, and home visiting, the EHS program reflects an ecological or transactional approach that suggests that developmental outcomes for young children result from interactions among a variety of individual, family, and community factors (Bronfenbrenner, 1979; Sameroff & Fiese, 1990). This perspective frames the problems affecting children in a broader context, and moves programs in the direction of multiple intervention strategies (Garbarino, 1990; Barnard & Morisset, 1995).

In analyzing interventions for very young children, Emde (1996) highlighted the need for programs that foster early socio-emotional development, which is critical to building strengths that can serve as protective factors throughout childhood. Such early socio-emotional development, he suggested, "will buffer against disorders not only of this age period but also against disorders of later ages that involve school engagement, social relatedness, conduct, and mood" (p.11). This key element in the Early Head Start initiative is supported through the nurturing of strong child-caregiver relationships.

The interconnectedness of children, families, and communities is one of the premises for a group of services generally identified as "family support," described by Kagan (1996) as programs that "seek to build on family strengths and to empower families, converting the focus from one in which *clients* receive services to one in which families are *partners* in designing and constructing services" (p. 157). The provision of comprehensive, flexible, and responsive services that deal with a child as an individual and as part of a family, and with the family as part of a community, has also been found to be a common characteristic of successful programs (Schorr, 1988, 1998; Schorr & Both, 1991). A decade review of early interventions with disadvantaged and disabled children similarly identified a holistic approach to addressing the needs of vulnerable children and their families, concluding that "for children whose social and economic environments threaten their development, intervention should focus more directly on those environments themselves: job training for parents…parental support groups, and groups that empower parents rather than disenfranchise them" (Farran, 1990, p. 533).

Research on high risk youth is also relevant to the Phoenix Early Head Start intervention. Low-income neighborhoods like those served through the program are characterized by conditions such as violence, drug sales, and school failure — circumstances that are more likely to place young people at risk. Research on adolescent risk and resiliency (Dryfoos, 1998) has identified common characteristics of resilient youth that can help counter some of these conditions, including attachment to a caring adult, independence and competence, and high aspirations — all elements that factor into EHS's work with teen parents.

Many researchers and practitioners believe that impoverished families benefit from two-generation programs designed to address the needs of children *and* their parents. By helping parents meet basic needs, gain some control over their lives, and develop good parenting skills, these types of interventions are believed to help establish children and families on a positive life course (Layzer & St. Pierre, 1996; Zigler & Styfco, 1996; Schorr & Both, 1991). Home visiting programs are one way to respond to these "two-generation" needs. Research evidence also suggests that the relationship between the home visitor and the program participant is an important determinant of a mother's receptiveness to intervention activities, affecting whether she becomes a "taker" or "non-taker" of program services (Osofsky, Culp, & Ware, 1988). There is growing consensus that effective intervention is based on participant-home visitor relationships that are, at the most general level, supportive, nonjudgmental, and empathic (Schrag Fenichel & Eggbeer, 1990; Ware, Osofsky, Eberhart-Wright, & Leichtman, 1987).

There is some research evidence linking home visiting programs for infants and their parents with positive outcomes such as reduced child abuse and juvenile crime prevention (Sherman, 1996), improved outcomes for pregnant women, improved quality of parental caregiving, improved home-rearing environments for children, improved childhood safety, and increased parent participation in the labor force (Kitzman, *et al.*, 1997, 2000; Olds, 1997). However, a recent analysis of evaluations of several key home visiting programs indicated variability in the benefits of such programs across populations, raising questions about the generalizability of program results (David and Lucille Packard Foundation, Spring/Summer, 1999). As a result, policymakers and practitioners are advised to view home visiting programs as part of a range of services offered to families with young children, rather than the definitive solution for achieving positive child and family outcomes. The analysis also emphasizes, however, that young children and families continue to need support, signaling the need to strengthen existing services and craft new approaches to meet their needs (Gomby, Culross, & Behrman, 1999).

Program Description

Phoenix Early Head Start recruits low-income teenagers 13 to 19 years old living primarily in central/south Phoenix who are pregnant with their first child or who have an infant less than six months of age. The program is offered through two sites: 1) Hamilton Elementary School in southwest Phoenix, and 2) the Southwest Human Development Good Fit Center in central Phoenix. Services to families are provided through three main program components: weekly home visits, site-based group activities, and "brokered" services linking families with high-quality community resources. Male involvement is also a major focus of the EHS program, with concentrated outreach efforts to engage young fathers with their children and to support that ongoing relationship. Parents are also afforded opportunities to develop leadership and decision-making skills through participation in the EHS parent policy committee as well as the larger and more comprehensive Head Start Parent Policy Council.

Phoenix Early Head Start is designed to serve 120 families, with a primary staff of 12 family support specialists, guided by two site supervisors and overseen by a full-time project manager. Program services are further supported by a resource staff that includes a male involvement specialist, two registered nurses, two half-time child development/disabilities specialists, a half-time family services coordinator, and a consulting nutritionist. Mental health resource staff members include a licensed psychologist who provides supervision and coordinates mental health referrals, a mental health specialist, and clinical psychology interns. A full-time van driver and part-time bus driver comprise the rest of the program's resource staff.

Phoenix Early Head Start became part of the SWHD Head Start Department on October 1, 1999; prior to this, EHS was managed through the agency's Family Health and Wellness Department. The program's current status as part of Head Start aligns it with federal guidelines for Early Head Start programs across the nation. With the receipt of additional funding earmarked for EHS as part of SWHD's annual allocation for Head Start, EHS program services will continue after the five-year demonstration cycle ends.

Early Head Start Program Components

Phoenix Early Head Start is designed to provide program participants with comprehensive early childhood development and family development services by facilitating positive parent-child relationships, improving infant-toddler developmental outcomes, helping ensure access to appropriate health care and child care services, fostering parent self-sufficiency, and actively

engaging fathers with their children. Program components are intended to generate outcomes in the four domains that comprise the original national Early Head Start cornerstones — child development, family development, staff development, and community building.

Child development is promoted through weekly home visits by the family support specialists who assist parents in planning developmentally appropriate activities for their children. Healthy parent-child interactions are also supported through monthly site-based socialization activities, several of which are centered around child development-related themes. Parent-child play groups offer additional child development support and encourage positive parent-child interaction. The initial play group offering geared for infants expanded to include a second group for toddlers as the need arose. During the 1999–2000 year, the EHS toddler play group merged with one of SWHD's Early Intervention toddler play groups for children with disabilities, and the new group has been co-facilitated by EHS and Early Intervention staff. An evening parent-child play group was also added during the past year to accommodate parents who work and/or attend school during the day.

Child development support is provided by the EHS child development/disabilities specialists. The addition of a second child development/disabilities specialist early in the program provided each EHS program site with half-time services. These specialists consult with families and staff on child development issues, facilitate the play groups, coordinate services for children with special needs, and administer developmental assessments. Children identified with developmental delays or disabilities are referred for further assessment as needed. The developmental and physical status of each child is also assessed during semiannual home visits by the program nurses. In addition, the nurses facilitate health-related site-based activities and consult with EHS families and program staff as needed.

Family development includes an array of program services delivered primarily through the family support specialists, with additional support provided by the EHS resource staff. Family support specialists work with a relatively small caseload of 10 families each to enable them to develop effective, supportive relationships with the family and provide the necessary mix of intensive and comprehensive services. One of the key program strategies employed to help parents develop healthy relationships with their children is the ongoing use of videotaping. Tapes made during home visits provide a tool for parents and family support specialists to review and discuss the parent's interactions with their children. The family support specialists also work with parents on personal development issues including health care practices, family planning, education, and employment.

Family development in EHS is also fostered through the activities of the male involvement specialist, who tries to engage hard-to-reach fathers in the program and in the lives of their children. As part of this endeavor, the male involvement specialist coordinates monthly "Dad's Night Out" activities and special events for fathers. In an ongoing effort to provide a balance of activities that will engage fathers in the program and also help them learn how to be good parents, some changes have occurred in the content and format for the father-focused activities. During the past year, Dad's Night Out was redesigned to regularly allow time for a social activity, dinner, and a discussion topic, and one of the EHS mental health staff members began co-facilitating these activities along with the male involvement specialist. Father-child activities were also included as part of the Dad's Night Out schedule on a quarterly basis. Meanwhile, the male involvement specialist has continued to provide information and referral services to families, particularly in the areas of immigration, housing, and jobs. Over the course of the program he has also become increasingly involved in local community collaboration activities, and he has facilitated male involvement workshops, both in-state and out-of-state.

The family development component is enhanced through a part-time family services coordinator, whose responsibilities include planning and facilitating parent committee meetings, support groups, and site-based activities. These activities, plus some additional management responsibilities, had previously been carried out by a full-time family services manager. The current coordinator position is filled by an EHS family support specialist, who continues to work with several families during the remaining half of her time.

Additional services for EHS families are provided by the program's nurses and mental health specialists. The nurses conduct childbirth classes for EHS teens, as well as classes for CPR/First Aid training and child care training. They also offer ongoing consultation on adolescent health and development. The mental health specialists provide assessments, direct services, and community referrals and coordination of service delivery to Phoenix Early Head Start families. Support groups facilitated by the mental health specialists continue to offer a forum in which parents can discuss commonly-shared issues and concerns. The availability of targeted support groups (*e.g.*, for Spanish-speakers or for fathers) and the frequency of meetings has varied over the course of the project. While the Spanish-speaking mom's group stopped meeting due to low attendance during the past year, an English-speaking mom's support group has been meeting three times a month, structured as an "open-entry, open-exit" process. The structure *within* the support group this year has also been expanded; parents now meet with the facilitators, and they are asked to identify the individual goals they want to work on in the group.

Other activities that facilitate family development include the monthly site-based socialization activities and special events such as a weekend family picnic, held again this year at a local park. A van and full-time driver, along with a 30-passenger bus and half-time driver, assist parents with the transportation needs associated with the various program activities.

Family development is also enhanced through the leadership and decision-making opportunities available to parents through their participation in the EHS parent committee and the more comprehensive Head Start Parent Policy Council. Participation in these groups has solidified over the course of the project. A total of 12 parents (six from each site) serve on the EHS parent policy committee and eight parents (four from each site) are representatives to the Head Start Parent Policy Council. Several EHS Council members are given the opportunity to attend national, regional, and state conferences each year.

Staff development occurs through a multi-disciplinary approach to staff training and is reinforced through a relationship-based model of supervision. Staff training is aligned with the desired program outcomes for children and families and covers a wide range of subjects, including areas specific to the EHS program intervention as well as to the larger SWHD agency. Training is provided by outside trainers as well as by Phoenix Early Head Start resource staff. Training topics during these sessions include areas such as discipline, CPR and first aid, health and safety, and the program's philosophy of male involvement.

An expanded child development training agenda in 1999 resulted in the establishment of several ongoing training opportunities, including monthly videotape reviews and "brown-bag" lunch/workshops on child development, quarterly child development training sessions, more frequent interaction with the child development specialists, and training in developmentally-based curricula. The concentrated focus on child development extends to management staff as well. During the past year, the EHS manager and site supervisors began participating in a monthly child development study group (along with supervisors from other SWHD programs), to refine their own understanding and use that knowledge in their supervisory roles.

An addition to the staff development component during the past year was to provide additional support for new family support specialists. A half-time "training specialist" position — filled by an experienced family support specialist who has been with EHS from its start — was created to facilitate the orientation of new family support specialists and provide them with one-on-one guidance and assistance during their beginning weeks on the job.

Community building and collaboration to help provide comprehensive, integrated services to EHS families is an integral part of the program's design. Phoenix Early Head Start was originally conceived as a partnership between SWHD and the City of Phoenix (primarily with the City's Head Start program and the Step-Up program for young fathers). Since EHS families are recruited from an area served by both entities, this approach made sense for a program dedicated to creating a coherent system of services for its participants. The partnership was originally operationalized through an EHS technical team that included SWHD/EHS managers and staff along with City of Phoenix Head Start and Step-Up representatives. The group's charge was to help with big-picture problem-solving and guidance. After experiencing declining attendance and increasing uncertainty about the team's purpose over the course of the first two program years, the technical team became inactive. At the same time, however, collaboration has continued between EHS and the Step-Up program, and additional connections have been made with the City's Human Services Department. During the past year, EHS has also established direct connections with City of Phoenix Head Start delegate agencies as well as other Head Start and Early Head Start programs, in order to facilitate program transitions for EHS families. In addition, EHS continues to link with a variety of other family-focused initiatives and resources.

Phoenix Early Head Start focuses on strengthening community support for families with young children at both a programmatic and administrative level. Program-specific linkages that directly assist EHS families continue to be initiated and supported, such as a partnership with Crisis Nursery for quality child care services. At the same time, a variety of broader-based administrative and management level activities are intended to help increase community capacity for serving vulnerable children and families and to move the larger community policy agenda forward. These types of actions include implementing strategies to enhance the breadth and scope of male involvement programs throughout the community, and participating in the "Smart Beginnings" partnership to develop a public-private model to support families and their children birth to three — which culminated in the development of proposed legislation to fund recommended services.

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Methods

Southwest Human Development contracted with the Morrison Institute for Public Policy at Arizona State University to conduct a continuous improvement evaluation of the Phoenix Early Head Start program. The purpose of this evaluation was to provide EHS managers and administrators with ongoing feedback to help them analyze program processes and outcomes in a timely fashion, thus enabling them to make adjustments as the program evolved. The evaluation was designed to answer questions about program services, child development, family development, staff development, and community building. (See Appendix A for the complete evaluation design, Appendix B for a full description of the evaluation methodology, and Appendix C for a brief summary of each evaluation instrument.)

Instruments and Data Collection

Both qualitative and quantitative data sets were included in the evaluation, with a large part of the data collection carried out by program staff. Some child and family assessment data were used both programmatically and evaluatively. Data about parents and children came from a number of sources. Parents were assessed at program enrollment and at subsequent six-month intervals, using assessment batteries composed of several different instruments. Annual parent surveys and focus group discussions provided information about program implementation. Case studies ("Family Stories") followed 12 families throughout their tenure in EHS. Child screening and assessment instruments monitored the development of individual children as they progressed through the program.

Evaluation of the staff training component of EHS incorporated a variety of approaches. Annual video-clip analysis assessed whether staff training made a difference in the way family support specialists worked with families. Focus groups, staff and supervisor surveys, and staff self-assessments also provided a variety of information about staff training efforts. Annual interviews with key stakeholders and ongoing evaluator observations of program meetings and activities generated insights about overall program process and implementation. A community survey implemented in the 1999–2000 program year provided feedback about efforts to build community capacity to support young families.

This report analyzes data collected from October 1995 through July 2000. Quantitative data were collected through March 31, 2000; qualitative data collection took place through July 31, 2000.

Participants

The participants in this study included 218 teen parents (215 mothers; 3 fathers) who were enrolled in EHS as of March 31, 2000 and identified as primary caregivers.[1] Evaluation data are

[1] A total of 252 participants have actually been enrolled in EHS since the program's inception. The 218 study participants are those people for whom both participation and assessment data are available. Demographic and enrollment data are reported for this group. The number of participants included in individual trend analyses varies, however, depending on the number of people for whom "matched" data are available at any two specific assessment points.

Figure 1

Parent Age at Enrollment

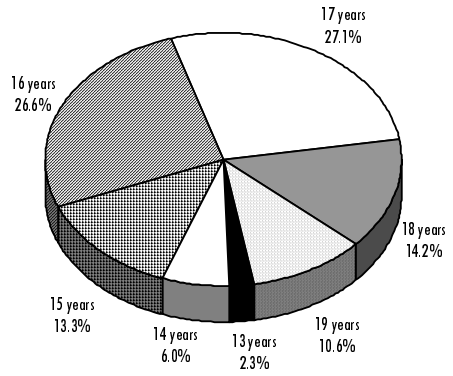


Figure 2

Parent Ethnicity

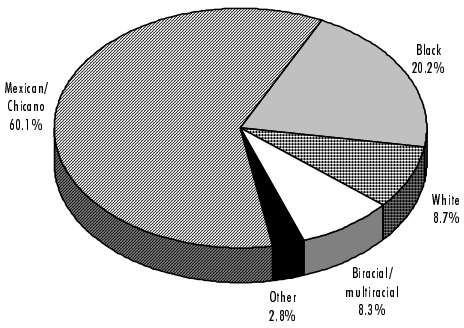
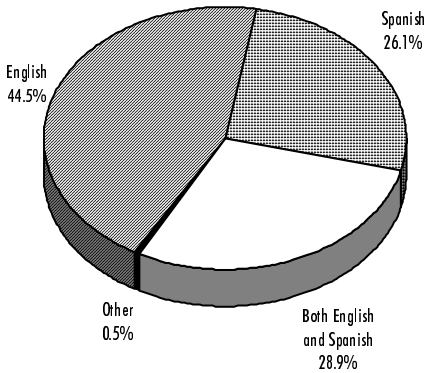


Figure 3

Language Spoken at Home



reported for this group of participants and their firstborn child (the "focus child"). An important component of the EHS program strategy is to encourage fathers to become involved with their children and participate in program activities. Therefore, participation data for fathers (*e.g.*, site-based activities, "Dad's Night Out," and father-child activities) have been included when appropriate and noted in the report.

While the EHS program is designed to serve 120 families, the number of participants enrolled at any one time varies. Participants leave the program for many reasons (participant disenrollment is addressed later in this section), and replacement of families is ongoing. Analyses for this evaluation include all participants for whom data were available, whether or not the participants subsequently disenrolled. Data reporting can be affected by a number of factors. For example: families cycle in and out of the program; parent assessments occur based on a participant's time in the program; and, parents sometimes miss an assessment occasion. Therefore, the data sets available for individual analyses vary in size. Accordingly, readers are cautioned against over-interpreting results of individual data analyses discussed in the report.

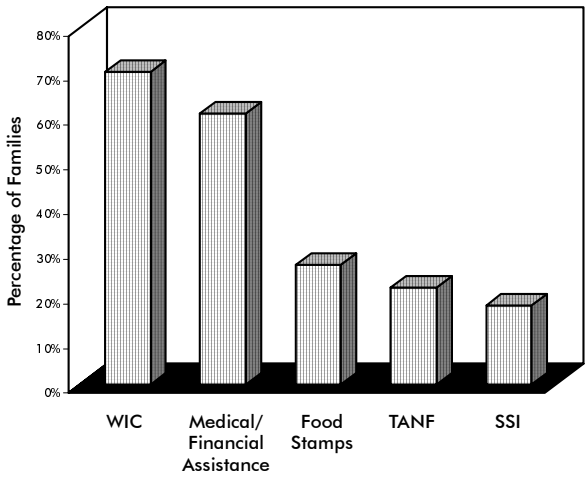
Demographic and background information is provided by participants at program enrollment. Since many EHS participants are living at home with *their* parents and siblings, the information that follows for participants' families refers to this extended family unit when appropriate.

When they enrolled in Phoenix Early Head Start, participants were between 13 and 19 years old. More than half the parents (54 percent) were 16 or 17 years old at enrollment, and more than 20 percent were 15 years or younger. At enrollment, 8 percent of participants (17 people) were married; 92 percent were single. Sixty percent of the parents described themselves as Mexican/ Chicano, and 20 percent identified themselves as Black. The remainder of participants were reported as 9 percent White, 8 percent biracial/multiracial, and 3 percent Vietnamese, Central American, or American Indian. English was the primary language reported in 45 percent of homes, and Spanish was identified as the primary language in 26 percent of the homes. Nearly 29 percent of participants said both languages were spoken in their homes, while less than 1 percent specified some 'other" primary language (Figures 1-3).

When they entered EHS, the most frequent source of public assistance reported by parents was the WIC program (Women, Infants, and Children), with 71 percent of families enrolled. Parents also reported that 62 percent of their families received medical financial assistance such as AHCCCS or Medicare. In addition, 26 percent of families said they were receiving food stamps at program enrollment, 21 percent were receiving TANF (Temporary Assistance to Needy Families), and 18 percent were receiving SSI (Supplemental Security Income) (Figure 4).

Figure 4

Public Assistance Snapshot: Family Status at Enrollment*



*Includes participants and the family members with whom they live (*e.g., their* parents)

When they enrolled in the program, participants were also asked to rate the adequacy of their resources to meet 21 basic needs such as housing, medical care, and transportation. Parents reported an average of three areas each for which their family did not have adequate resources, with a range from 0 to 17. The five problems cited most frequently are listed in Table 1.

Table 1

Percentage of Families with Inadequate Resources: Top Five Problems

Area of Need	% of Families
Job for self or spouse/partner	32.7%
Dental care for family	32.1%
Opportunities to participate in community groups	25.8%
Dependable transportation	21.1%
Medical care	21.1%

Participant Disenrollment

Considerable participant turnover has occurred since EHS first began providing services. Some of this is attributed to "completion" — 17 percent of enrolled participants (37 people) exited the program when they met their goals and no longer needed (or had time for) program services, and/or their children turned three and they were referred to another early childhood program. Another 44 percent of parents were disenrolled when it was determined they were not participating in the basic program services (*e.g.*, they continually missed home visits), or when they asked to be disenrolled for various reasons. Other families were disenrolled because they moved out of the program service area (7 percent), or because Child Protective Services removed the child from the home (2 percent). In total, 70 percent of the participants (152 people) originally included in this study had disenrolled from the program by March 31, 2000 (*i.e.*, they left the program some time during the previous three-and-a-half years).

While program turnover was considerable, it did not result in substantial changes in the overall demographic profile of EHS participants. In general, the distribution of parents' age and

ethnic background remained similar over time. There was, however, a noticeable shift in the primary language spoken at home. The percentage of EHS parents who lived in homes in which they identified Spanish as the primary language decreased 38 percent between 1997 and 2000. At the same time, the percentage of homes with both English and Spanish spoken more than doubled.

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Family Services and Outcomes

Family services in Phoenix Early Head Start are designed to support parents in their role as primary caregivers and educators of their children, help them become self-sufficient, and move them towards economic stability. Family services are coordinated by family support specialists, who develop supportive alliances with parents to assist them in working towards their goals. Many families also receive services from the male involvement specialist, who helps engage fathers in the program and in the lives of their children. Additional services are provided by EHS resource staff.

Multiple program activities are designed to address the comprehensive goals and desired outcomes for EHS families. Family support services are primarily delivered through home visits and reinforced through monthly site-based events that combine a variety of socialization and educational activities, parent-child play groups, parent support groups, and parent committees and councils. A family services coordinator plans and monitors the specific details necessary to support these activities. This is currently a half-time position, and is staffed by a family support specialist who also has responsibility for a small caseload of families.

Working together, parents and their family support specialist develop a "family partnership agreement" (FPA) which helps them assess their individual strengths and needs. The FPA then serves as a guide to help each family work towards achieving their goals. A family's progress is followed through multi-disciplinary team (MDT) reviews conducted at six-month intervals. This process forms the basis for ongoing planning by bringing together family support specialists, resource staff, and program supervisors to assess a family's status and identify any appropriate "next steps." It also helps ensure that families receive appropriate assistance as their needs change throughout their participation in EHS. On average, parents have participated in EHS for 17 months before leaving the program. Over half remained in the program for more than a year, and more than a quarter of parents participated for more than two years. (This information is based on EHS participants who had disenrolled from the program prior to April 1, 2000: N=152.)

The central program intervention strategy for supporting families is regular home visits. Because each family's needs are different and families demonstrate different levels of "compliance" or willingness to participate in program activities, the extent of services to each family varies. The average number of visits per family per month[2] has held relatively steady over the course of the program, with a slight decline registered during the first half of the 1999–2000 program year. There has typically been a wide range in the number of visits to individual families each month; however, the range appears to have narrowed somewhat in 1999–2000 (Figure 5; Table 2).

The degree or "intensity" of service delivery also varies for different categories of services that are addressed during a family's visits. The greatest focus of home visits throughout EHS has been on child and family development, with more than half the issues discussed during visits included in these two categories (Table 3).

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[2] This calculation is based on participants who were enrolled in EHS as of March 31, 2000 and those who left the program during the year for one of the following reasons: a) the family met their goals; b) the child was age-eligible to transition to a preschool/Head Start setting. Participants who were disenrolled from the program during the year for other reasons were excluded from this calculation, since these parents are often "missing in action" for several months prior to their disenrollment — during which time they would register *no* visits.

Table 2

Home Visits: 1996-2000

	Average # Home Visits Per Family Per Month	Range of Home Visits Per Family Per Month
1996-1997	2.6	<1.0 - 7.5
1997-1998	2.9	<1.0 - 6.6
1998-1999	2.8	<1.0 - 8.0
1999-2000*	2.4	<1.0 - 4.7

*Based on data from October 1, 1999-March 31, 2000.

Table 3

Percentage of Contacts* by Service Category per Visit: 1999-2000**

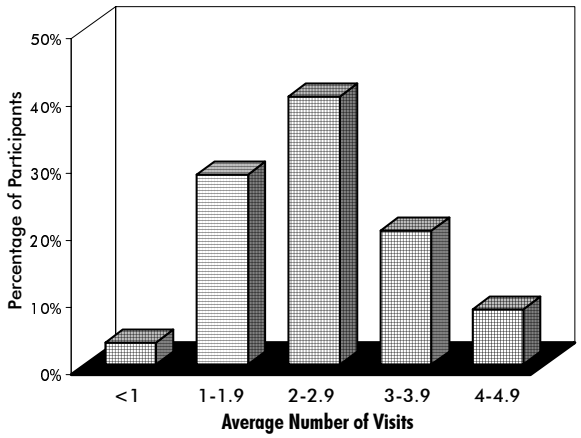
Service Category	% of Contacts Addressing These Issues
Child and family development	53.7%
Education and employment	18.5%
Medical	13.8%
Social services	8.3%
Child care	4.9%
Emergency	0.8%

*Percentage of time these issues were addressed
**Based on data from October 1, 1999 - March 31, 2000

Note: Each service category includes several topics/issues. Therefore, each category can be addressed more than once during the same visit.

Figure 5

Average Number of Visits Per Family Per Month: 1999-2000*



*Based on data from October 1, 1999 - March 31, 2000.

In addition to home visits, parents have also been encouraged to participate in group activities, including site-based socialization activities and parent support groups. These activities provide social support as well as information related to parenting, child care, health, education, and employment. Available data indicate that EHS participants generally attended an average of four of the monthly socialization activities per year, with individual attendance ranging between 1 and 12 activities. An apparent "core group" of participants — between 15 percent and 20 percent each year — attended these activities on a regular basis. These parents generally attended seven or more socialization activities over the course of a year. A large percentage of enrolled mothers (*e.g.*, 85 percent in 1998–1999) attended at least one of the monthly activities each year.

While parents have generally enjoyed the socialization activities and learned new things, some parents in 1999–2000 voiced their desire for changes. Several parents felt that too much "talking" and teaching occurred at the activities; they wanted to do more social things. Others said they wanted more time to ask questions after a learning activity. Some parents did not realize that the EHS parent committee was responsible for the agenda at the socialization activities, and therefore they could offer suggestions.

Parent support groups have continued to provide participants with a forum for sharing personal concerns and a safe environment in which to exchange ideas with their peers. Between 25 percent and 30 percent of mothers usually attended at least one mom's support group meeting during the course of a year. Through the years, support group offerings expanded and attendance increased.

While many participants attended only one session, a small core group of parents attended with some regularity, typically going to an average of four sessions in 1997–1998, seven sessions in 1998–1999, and 12 sessions in 1999–2000.

Satisfaction with the parent support group was a common theme among parents in the 1999–2000 focus groups. As in past years, mothers characterized the support group as a helpful outlet where they could talk about issues they didn't feel comfortable discussing at home. They appreciated the confidential, trusting environment. As one mother said, the group "is good…we can lay out everything." Another mother noted "feeling acceptance if you cry and voice concerns about your child." Fathers also had some opportunity for peer support through Dad's Night Out activities. One father at the parent focus group said that, in addition to discussing sports activities, they also talked about their kids and the stresses in their lives. He commented, "[It] helps us express ourselves…By the time I go home, I feel relieved, feel cleansed."

Male involvement has been a major focus of the EHS intervention, with the goal of engaging more fathers in the program and in their children's lives. Available participation data for the first half of the 1999–2000 program year is generally similar to previous years. Thirty-eight fathers participated in at least one home visit, with most present for a total of two. Three fathers, however, were present for 10 or more home visits each. In addition, 16 fathers participated in other program activities during the first half of the year: 11 of these attended at least one of the monthly site-based socialization activities, while nine participated in at least one Dad's Night Out.

Dad's Night Out activities were more structured during 1999–2000 than previously, a change that was viewed positively by program managers and supervisors. The group, which is co-facilitated by the male involvement specialist and the mental health specialist, reportedly placed more emphasis on parent-child relationships. The male involvement specialist also devoted much time to addressing issues of immigration and employment with program families, and continued to play a very active role in the community vis-à-vis young father issues. As in past years, however, staff concerns and questions still existed regarding how the male component integrates into the everyday reality of program service delivery.

Phoenix Early Head Start also provided opportunities for parents to develop leadership skills through serving on the program's parent committee or the SWHD Head Start Policy Council. Other opportunities for personal development frequently arose as well. During the past year, for example, four parents participated in presentations at national conferences, and four were members of interview teams responsible for hiring new EHS staff.

Adult-Child Relationships

One of the primary goals in EHS is to help parents recognize and understand their children's needs at different developmental stages and to respond to these needs in appropriate ways. Therefore, program services are intended to help parents form realistic expectations for their children's behavior and use effective parenting skills within the context of those expectations. Parent progress in developing positive relationships with their children has been followed using instruments adapted from the national Early Head Start evaluation and through locally developed measures.

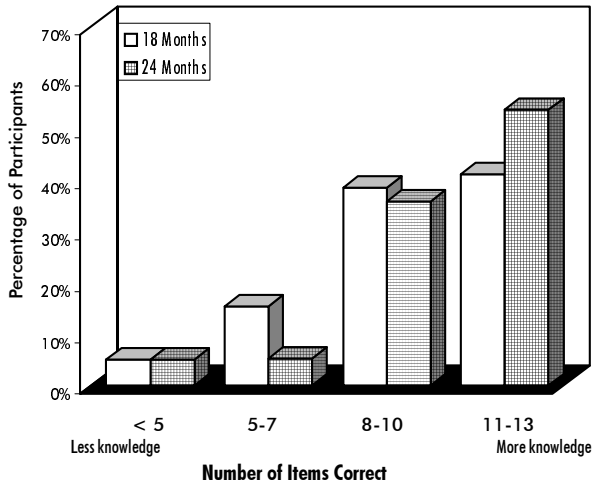
In order for parents to form realistic expectations for their children they first need to understand how children typically develop. Parent knowledge of child development has been assessed using two instruments that measure general understanding of infant and toddler norms and milestones, developmental processes, and caregiving strategies. Knowledge of infant development has been

measured using a nine-item instrument, *Raising a Baby*, with a higher score indicating better understanding of infant development and positive parenting practices. A second, 13-item instrument, *Raising a Child*, was given to parents who had been in EHS for 18 months or longer, and it included questions aligned to the development of toddlers.

Parents have demonstrated improvement in their knowledge of both infant and toddler development over time. They showed a statistically significant increase in their knowledge of raising a baby between program enrollment and 12 months of program participation. Parents assessed about their knowledge of raising a child after 18 months in the program and again after 24 months of program participation also showed a small, statistically significant improvement. The distribution of scores after 18 months and 24 months of participation is illustrated in Figure 6.

Figure 6

Knowledge of Raising a Child After 18 Months and 24 Months of Program Participation

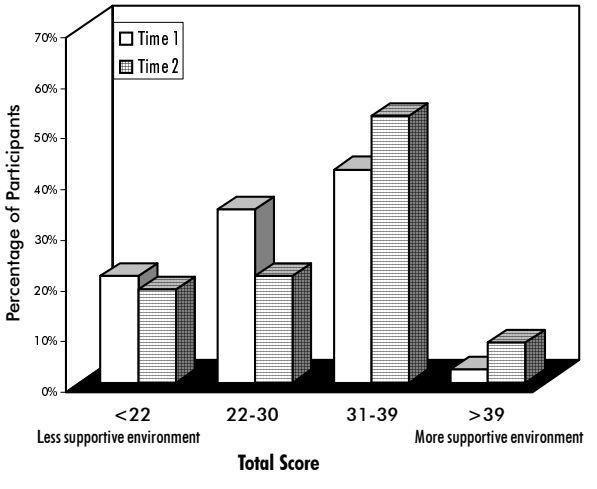


Information about adult-child relationships has also been obtained through assessments of the home environment that examine interactions between children and parents. This information was gathered through two different instruments: the *Infant/Toddler Home Inventory (HOME)*, which is completed by EHS nurses; and the *Home Assessment*, which is completed by family support specialists.

The 45-item *HOME* inventory was completed periodically for each family by EHS nurses. Items receive one point if the specified behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment. The data indicate that most EHS children live in supportive home environments, and that in many families the home environment showed a statistically significant improvement over time (Figure 7). Six families showed considerable improvement in their *HOME* scores over time, and four of eight families who were of concern on their first *HOME* inventory subsequently improved enough to move them out of that category.

Figure 7

Home Environment: 1997-2000



Family support specialists complete the *Home Assessment* — a subset of questions adapted from the Infant/Toddler Home Inventory — as part of the parent assessment battery administered at six-month intervals throughout the program. The questions are designed to appraise the quality of stimulation and emotional supportiveness in EHS homes: items focus on interactions such as parents' emotional tone and their verbal responses to their child's vocalizations.

Available data from the *Home Assessment* for families after 18 months in EHS and again after 24 months in the program corroborate the previous conclusion that most children continue to live in nurturing home environments, though there was a slight decline in scores between the two assessment periods. More than half these participants had scores in the "most nurturing" range at both assessment times. Preliminary data at 30 months into the program appears to be supporting these trends. Two contrary items, however, are notable: at 24 months into the program half of these parents did not provide toys for their child during the home visit, and nearly one third of them shouted at their child during the visit.

Additional information about parent-child relationships in EHS families comes from the *Parent-Child Activities* survey, which is included in the parent assessment battery. Mothers were asked how often they had engaged in specific activities with their child during the previous month. For those families where the father was also involved, questions were asked about his activities with the child as well. As a group, EHS mothers reported increased rates of parent-child activities at each six-month assessment occasion. Moreover, a group of parents for whom scores were available after 18 months and again after 24 months in the program reported high levels of engagement in parent-child activities at both times (Table 4). And preliminary information for some of these families after 30 months in the program suggests that these high activity levels were being maintained.

Table 4

Mother-Child Activities

Activity	Average Score: After 18 Months in EHS	Average Score: After 24 Months in EHS
Play with toys	4.6	4.5
Sing songs	4.1	3.9
Read stories	3.1	3.2
Play outside	3.9	3.9
Tease to get him/her to laugh	4.5	4.3
Overall Score	4.0	3.9

0 = not at all
1 = rarely
2 = a few times a month
3 = a few times a week
4 = about once a day
5 = more than once a day

Fathers who have been involved in their children's lives also appear to interact with their infants and toddlers in positive ways. Over time, mothers have consistently reported moderate to frequent occurrences of specific father-child activities. Frequencies for individual father-child activities at 24 months into the program are displayed in Table 5. One item of note, however, is that nearly one-third of fathers reportedly do not read to their children or tell them stories.

Another source of information about parent-child relationships comes from staff observations of family interactions over time. The *Parent-Child Observation Checklist* is a locally designed observation instrument that is completed by family support specialists for each family at six-month intervals. Observations are made in areas that include developmentally appropriate play, verbal interaction, discipline, and health care. The checklist is designed to record the family support specialist's assessment of parent-child relationships over an extended period of time. While reported parent-child relationships cover the spectrum of interactions from lower quality to higher quality,

Table 5

Father-Child Activities*

Activity	Frequency					
	Several Times a Week	Once a Week	A Few Times a Month	Several Times a Year	Once or Twice in Child's Life	Not at All
Reading or telling stories	24%	20%	24%	—	8%	24%
Feeding	54%	25%	18%	—	—	4%
Eating a meal together	61%	18%	14%	—	—	7%
Going to the playground or for a walk outside	54%	19%	12%	4%	—	12%
Playing at home	68%	11%	14%	4%	—	4%

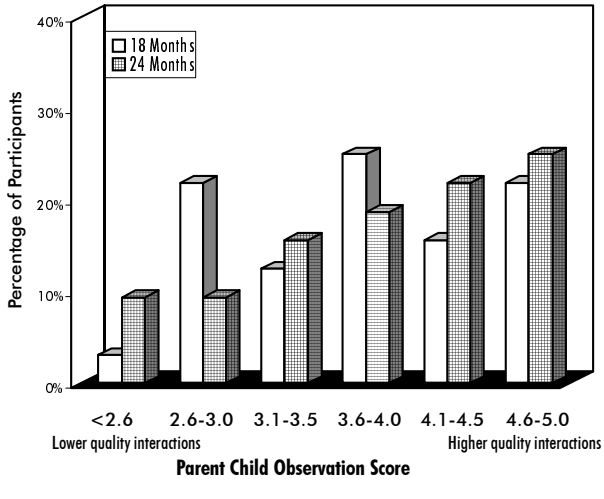
*As reported by the mother on the 24-month assessment
Totals may not equal 100% due to rounding
(N=28)

the majority of relationships fall into the middle and upper end of the distribution (Figure 8). Staff also reported observing higher quality parent-child relationships for families who had been participating in EHS for a longer time.

As part of their ongoing semiannual assessments, parents have been asked how they would discipline their children in different situations, and whether they had recently spanked their child. While most parents have consistently indicated the use of appropriate responses to some aspects of their children's behavior, they have also indicated that they were disciplining (or would be likely to discipline) other aspects of their children's noncompliance in ways considered counterproductive to long-term healthy development. Specifically, the percentage of parents with an inappropriate response to dealing with their children's tantrums worsened over time, and a majority of parents said they had spanked their child within the previous week. Because of these trends, discipline scores have declined over time. It is noteworthy that only a small percentage of parents report that they are "a person who has some trouble being a parent."

Figure 8

Parent-Child Interactions After 18 Months and 24 Months in Program



Parents participating in focus groups have continued to indicate that one of the most important aspects of EHS was learning how to be a good parent. One mother stated that EHS taught her "what to do to be a good mom." Other parents said they had become more patient with their children by learning how to cope and stay calm. Several parents agreed with a father who said the program helped him bond and "be more involved with my daughter's life." Some parents also said that parent-child playgroups had helped their

families to interact with other children and to see the differences and similarities among them. In addition, the playgroups had provided additional opportunities and experiences to families with limited books and toys at home.

Parent Mental Health

Program services in EHS are designed to promote parents' social and emotional development in order to support them in their role as their child's primary caregiver. Program activities help parents improve their decision-making skills, use effective coping strategies in stressful situations, and develop positive relationships. Parent social and emotional well-being has been assessed using established measures and EHS program data.

Many EHS parents face a variety of stressful life circumstances. To gain some understanding of participants' life circumstances, a *General Life Events* measure (adapted from Sandler, Reynolds, & Ramirez, 1986) was administered when parents enrolled in the program, and annually thereafter. Parents were presented with 20 stressful life events and asked to indicate which of them had occurred during the previous month.

Parents typically reported experiencing five stressful life events during the prior month, with a wide range in the actual number of stressful events for individual participants. About one-quarter of parents at each assessment occasion reported seven or more stressful events during the previous month, while approximately 15 percent reported one or no stressful events during that time.

Financial concerns were a continuing problem for many EHS participants, with around half the teens indicating their parents had talked about having serious money troubles, and also indicating their parents had acted very worried, upset, or sad. Two other stressful life events appear to occur frequently for many EHS families: around 30 percent of program participants typically reported that a close family member or someone they lived with had committed a crime, gotten in trouble with the law, or was sent to jail during the previous month; and around one-third said that a close family member or friend had died in the past month (see Appendix D for response rates for individual stressful life events for parents at 24 months into the program).

One way parents can help buffer the negative effects of some of the stressful circumstances in their lives is by using positive coping strategies. To help assess this aspect of their mental health, parents periodically completed a *Coping Strategies* instrument (Preventive Intervention Research Center, 1992). The items represent young people's use of positive coping strategies, such as active problem-solving and positive thinking, to deal with stressful life situations.

Many participants appeared to enter EHS with a moderate level of positive coping strategies, a characteristic that persisted among groups of participants who were assessed at subsequent points in the program. Moreover, available trend data for parents assessed at enrollment and again after 24 months in the program indicate an increase in the percentage of parents with more frequent use of positive coping skills (Figure 9).

In addition to the stressful events that frequently characterize their lives, teen parents can also be affected by the stresses associated with parenting. These stressors are important because, in addition to the effect they have on psychological functioning, they can also affect the quality of parenting. As part of their semiannual assessment battery, EHS parents completed a *Parenting Stress Index (PSI)*, an instrument that reflects the degree of parental distress and dysfunctional parent-child interactions.

Stress related to parenting has typically been low to moderate for participants over the course of the program. Between their first and second year of program involvement, parents also registered a small decrease in parenting stress (Figure 10; Table 6). Limited available data suggest that this pattern has continued into the third year of program participation. Parents have been most stressed about their inability to handle things and their reduced ability to do things they enjoy. They also often felt trapped by their responsibilities as parents.

Table 6

Parenting Stress Index: Mean Scores at 12 Months, 18 Months, and 24 Months in Program

Time in Program		Mean Score*
12 Months		1.85
18 Months	Range of Possible Scores: 1.0 = Low Stress 5.0 = High Stress	1.76
24 Months		1.61

*Statistically significant improvement from 12 months to 24 months and from 18 months to 24 months.

Figure 9

Positive Coping Strategies at Enrollment and After 24 Months of Program Participation

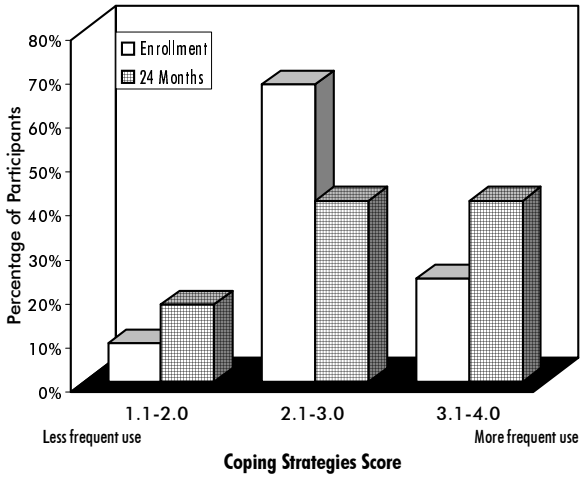
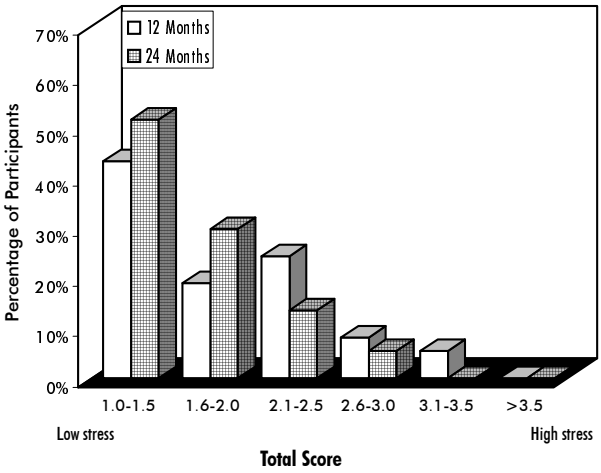


Figure 10

Parenting Stress After 12 Months and 24 Months of Program Participation



People can often deal with stress in more positive ways if they feel they have some control over, and responsibility for, the things that happen in their lives. Parents' sense of control has been assessed using a *Self-Efficacy Scale* (Mastery Scale, Pearlin, 1978, 1981). In this instrument, they were asked to react to statements such as "Sometimes I feel that I'm being pushed around in life," and "What happens to me in the future mostly depends on me."

Parents who enrolled in EHS generally had a moderate sense of control over their lives. This sense of self-efficacy continued to rise, with a small but statistically significant increase during their participation in the program. Moreover, there has also been a steady, appreciable increase over the course of the program in the percentage of parents registering a strong sense of efficacy (Figure 11).

Another personal characteristic that contributes to positive mental health and helps people deal with stressful life situations is self-esteem. Along with a moderate sense of self-efficacy, parents typically have also entered EHS with moderately high self-esteem. And as with self-efficacy, parents' self-esteem has progressively increased over the course of their participation in the program (Figure 12).

Program data and parents' personal comments provide added information related to parent mental health. Family support specialists indicated that over the course of the program, the majority of EHS parents were "engaging in appropriate social interaction" and were "not using illegal drugs to the point where it interfered with jobs, parenting, school, or relationships." Furthermore, the percentage of parents included in these two categories after 30 months of program participation (82 percent and 97 percent, respectively) represents a rise from earlier years. Additional information gathered through the program's semiannual multi-disciplinary (MDT) reviews indicates that several parents were referred for mental health services during the course of the program. According to available MDT data for participants after 30 months in EHS, six of nine parents referred for services during the previous six months had followed through to some degree.

Figure 11

Self-Efficacy at Enrollment, 12 Months and 24 Months of Program Participation

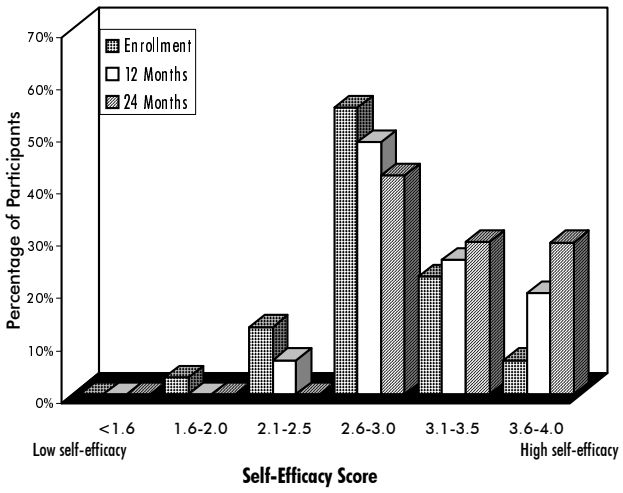
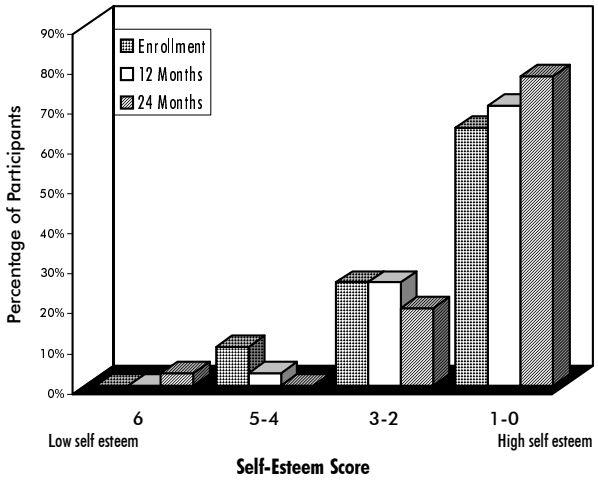


Figure 12

Self-Esteem at Enrollment, 12 Months, and 24 Months of Program Participation



The stressors and everyday reality of participants' lives were emphasized in a focus group discussion with family support specialists. They said that parents' circumstances — the fact that the majority are poor, and many are dealing with issues such as domestic violence and abuse — underscores the importance of the consistent relationships and social support that parents receive through EHS. The high value of EHS's social and emotional support was also articulated by parents over the years. Mothers at a parent focus group agreed that EHS helped them in resolving problems at home or with family and relatives. As one mother put it, "They support you in everything they can."

Parent Mental Health and Parent-Child Relationships

Some interesting correlations were found between indicators of parent mental health and parent-child relationships after 12 months of EHS program participation. At 24 months, however, a diminished sample size greatly reduced the ability to detect such effects as the program progressed. After 12 months, lower parental stress correlated to higher knowledge of raising a baby and observations of more positive interactions with children (statistically significant relations that also held for parents who had been in the program for 18 months). Also at 12 months, more frequent use of positive coping correlated with more knowledge of raising a baby and with reports of more frequent parent-child activities. More knowledge of raising a baby correlated with more frequent parent-child activities, and higher self-efficacy and higher self-esteem also exhibited small but statistically significant correlations with more knowledge of raising a baby.

Statistically significant relations *among* indicators of parent mental health were discernible across participants' time in the program. More frequent use of positive coping skills was correlated with higher self-efficacy, higher self-esteem, and lower stress at both 12 months and 24 months. And parents with higher self-esteem and higher self-efficacy indicated lower levels of stress at both assessment occasions. The ability to detect these relations at 24 months, despite the small sample size, is likely due to the fact that these are more robust relations that are consistent across time.

Again, parents' comments provide further insights. One mother remarked, "Now that I have two children, it's harder. I try not to despair, and really I know now so much more than before, so I can handle my baby better than I could before with my older one." Other parents concurred with the mother who said that she and her baby no longer stayed at home all day because EHS had helped her realize how important it was for both of them to get out of the house and have a variety of experiences.

Personal Health Care Practices

To promote and support family health and wellness, EHS program activities have included ongoing monitoring of health issues during home visits, site-based activities, and linkages to community health care providers. The desired outcome of these program services is for EHS parents to make progress in areas such as routine and preventive health care practices, appropriate perinatal care, and family planning.

Available data from parents' 30-month program reviews have continued to reflect earlier trends regarding personal health care practices. Nearly three-quarters of the parents had utilized preventive health care services (*e.g.*, well-woman exams) during the previous six months, and had reportedly sought appropriate care for health problems. While data are limited, the overall percentage of mothers with a medical home (*i.e.*, a regular source of health care) appears to have improved somewhat over time. In addition, available data indicate that six of 12 mothers who had no medical home 24 months into the program, reported a regular source of health care after 30 months of program participation.

Information about perinatal care continued to be mixed. Of seven parents, five reportedly obtained adequate prenatal care, while two parents did not. And two of four parents had not received timely postnatal care. In the area of family planning, nearly two-thirds of parents reported use of some form of birth control *consistently*, with Depo-Provera shots the most frequently utilized method. Over the course of the program, 27 of the teen parents (12.5 percent) have had second children; some were planned, while many reportedly were not. EHS managers and staff have identified this as one of the areas in which they feel the program has had the least impact.

Overall, parents have been very positive about the program support they received regarding matters of personal health care. They have continued to appreciate the assistance of EHS nurses, something that was strongly articulated during the most recent parent focus groups. In terms of their health care issues, several parents said that the EHS nurse was "better than going to the doctor." They indicated that most doctors didn't seem to have time to answer their questions, and most felt that the AHCCCS doctors were not responsive to them. Several parents agreed with the parent who stated, "The nurse has lots of impact on our lives."

Educational and Economic Self-Sufficiency

One of the goals of EHS is to help families move towards self-sufficiency. The strategy for doing this includes a focus on education as well as employment, since many of the teen parents are at risk of not completing their education. In fact, half the parents who enrolled in EHS had already dropped out of school. One program strategy for helping parents develop the foundation for long-term economic independence is to help facilitate education opportunities and/or the acquisition of job skills.

Progress in the area of education has been mixed. Many parents have participated in some type of education or job training experience during their time in EHS; for several, however, this has been an "on again, off again" experience. According to available data from the semiannual MDT program reviews, between a quarter and a third of participants had participated in some type of education or job training experience (*e.g.*, high school, GED program, community college, job training program) sometime during the six months preceding each of the reviews. While some of these people ultimately dropped out within the six-month period, several progressed to the next grade level and others successfully completed their course of study. Program administrators reported that 36 EHS participants graduated from high school or received their GED during their time in the program.

An increasing proportion of EHS participants have been choosing employment instead of, or in addition to, education. Sixty-seven percent of people for whom data were available after 30 months in the program had reportedly been employed full time or part time during the prior six-month period, while 30 percent had attended school or job training some time during that same period. The general pattern related to job stability remained consistent over time. Half the parents for whom data were available at their 30-month MDT review were still working at the same job throughout the six-month period, while nearly a quarter had changed jobs. The remainder had stopped working. Six of 15 people (40 percent) for whom salary information was reported said they earned $5.50/hour or less; at the higher end of the scale, five people reported hourly wages between $7.50 and $9.50.

Employment-related information was available for a small group of parents at 24 months and again after 30 months of program participation. Salaries increased for five of 12 parents and remained the same for the other seven. Over the same period of time some shifts also occurred in employment status. Two of seven part-time workers moved to full-time employment, while the other five remained in part-time jobs. Of 13 full-time workers at 24 months, two moved to part-time work, seven remained full-time, and four had stopped working by their 30-month program review.

Dependable and reliable transportation, and reliable child care, are important factors in facilitating an individual's ability to work. Available data, though limited, suggest that parents' access to these services has increased somewhat over time. Nevertheless, approximately one-third of parents at their 30-month MDT review reportedly still did not have access to reliable transportation or child care. Of

those parents who *had been* working, more than half had access to a car and nearly 30 percent used the bus. Reports about child care for those parents who were working indicated that more than two-thirds had a relative who took care of their child, while 20 percent used a child care center.

Employment and child care, and other indicators such as adequate housing and effective household management and budgeting skills, all contribute to parents' ability to move towards long-term self-sufficiency. The status of EHS parents with respect to these indicators after 30 months in the program is presented in Table 7.

Literacy is also associated with a person's ability to become economically self-sufficient. Throughout the course of the program, staff and administrators have identified English literacy as a problem for several EHS participants. Although staff have reportedly discussed and included literacy goals in family partnership agreements when appropriate, there has been little follow-through. Nearly one-quarter of parents entering EHS described their English-speaking reading and writing skills as "somewhat adequate" to "inadequate." This generally corresponds to assessments by the family support specialists. On 30-month MDT reviews, family support specialists identified 7 of 26 parents (27 percent) as needing literacy classes. Of these seven, however, only one parent reportedly attended a literacy program during the previous six months.

Table 7

Selected Indicators of Self-Sufficiency: Participant Status at 30 Months in Program*

Indicator	% of Participants
Employed part-time	33%
Employed full-time	36%
Living in adequate housing	97%
Access to and utilization of reliable child care	64%
Using effective household management and budgeting skills	80%

(N=33)
*Based on staff report with parent input.

Focus group data offer additional perspectives about program support for educational and economic self-sufficiency. Several parents commented on the assistance they received from EHS staff in pursuing educational goals and in finding jobs, while others mentioned help with housing and with emergency assistance (*e.g.*, food boxes) when necessary. While several family support specialists remarked that EHS had helped families make progress in these areas, some were ambivalent about the level of assistance the program provided. A few people questioned whether some parents were becoming too dependent on program staff, and others indicated that, while educational progress was a program goal, it was not always a personal goal for families.

For many of the Spanish-speaking parents, immigration status was a key issue related to their prospects for self-sufficiency. Parents at the focus group said that immigration requirements, and the onerous paperwork related to it, created an impasse for them in continuing their education and finding and maintaining employment. They also commented favorably on the assistance they received from the EHS male involvement specialist in finding legal help and getting through the paperwork. One parent summed up EHS assistance in moving Spanish-speaking parents toward self-sufficiency this way: "[EHS staff] help me a lot because the more I learn, the better able I am to defend myself and don't need to have them constantly there wherever I go. So, they can help other families that may need an interpreter more than me. I'd prefer that they help other people now that I can get out there on my own and speak English better."

Feelings of self-sufficiency and being able to handle change also came into play as families approached the time to transition out of the program. Initially, the transition process appeared to be difficult for parents and fraught with tension, but many of these early problems were attributable to a lack of coherent, well-articulated policies. After these issues were addressed, parents appeared to handle the transition process better. Several who participated in 1999-2000 focus groups said they felt comfortable with their upcoming transition out of EHS, and indicated they had been well prepared by their family support specialists in terms of understanding how the process would occur.

Summary

EHS parents continued to strengthen their understanding of child development over time. Their knowledge of raising a baby registered a statistically significant increase between enrollment and one year in the program, and their knowledge of raising a toddler showed significant improvement between 18 months and 24 months of program participation. Parent-child relationships also improved over time according to most indicators. Most EHS children enjoyed nurturing and supportive home environments, and, several families with home situations that were previously "of concern" subsequently showed improvement. Overall, mothers reported increases in activities they do with their children, and also reported moderate to high rates of positive parent-child activities for the fathers who are involved in their children's lives. In addition, family support specialists placed nearly half of EHS families in the category of "higher quality parent-child interactions," and they reported an overall increase in the quality of parent-child relationships over time. Parents also continued to say that their participation in EHS had helped them become better parents.

Not all parenting indicators, however, were as encouraging. Many parents continued to exhibit some developmentally inappropriate expectations for their toddlers. Half of them did not provide toys during a visit at 24 months, and nearly one-third shouted at their child during the visit. Also at 24 months, mothers reported that nearly one-third of involved fathers did not read to their children or tell them stories. Further difficulties were related to discipline. The percentage of parents reporting inappropriate responses to their children's tantrums worsened over time, and many reportedly used spanking as a discipline method.

The lives of EHS parents were characterized by a relatively high number of stressful life events, but with no apparent effects on their mental health. On surveys, parents typically reported an average of five stressful events in the prior month, including a high percentage of financial concerns, a high percentage of parents who were worried, upset, or sad, and a high percentage of close family members or friends who were in trouble with the law or who had died. Nevertheless, parents appeared to be relatively well adjusted on most measures of mental health. They reportedly maintained a moderate level of positive coping skills while in the program, with some increase in their use of positive coping strategies over time; they generally displayed low to moderate levels of stress related to parenting, with a small decline in parenting stress over time; their sense of control, or self-efficacy rose during their time in the program, with a steady increase in the percentage of parents registering a strong sense of self-efficacy; and their self esteem increased. Family support specialists underscored the stressors that are the everyday reality of participants' lives, and articulated their belief that EHS services and support have been important factors in parents' emotional well-being. Parents agreed, expressing appreciation of the social and emotional support they received.

Several positive correlations were found between parent mental health and parent-child relationships after parents had been in EHS for 12 months; however, a greatly diminished sample size reduced the ability to detect these types of effects as the program progressed. Nonetheless,

some significant relations among the indicators of parent mental health continued over time. At both 12 months and 24 months of program participation, higher self-esteem and self-efficacy among parents correlated with lower stress levels and more frequent use of positive coping skills, while more frequent use of positive coping skills correlated with lower parental stress.

Parents' personal health care practices and efforts towards self-sufficiency continued to show some positive signs. At their 30-month program review, nearly three-quarters of parents had used preventive health care services during the previous six months, and nearly two-thirds reported using birth control consistently. Nearly three-quarters of parents had also obtained appropriate care for health problems. Data, though limited, also indicated an overall increase in the percentage of mothers with a regular source of health care (*i.e.*, a "medical home"). Furthermore, 6 of 12 mothers with no medical home at 24 months in the program had been connected with a regular source of health care by their 30-month program review. Also at 30-month reviews, nearly one-third of parents had attended school or job training during the prior six months, and more than two-thirds were employed. Overall, an increasing percentage of EHS parents had been choosing to work. But many parents also participated in some type of education or training and, according to program administrators, 36 EHS participants have graduated from high school or received their GED.

A few signs remained troubling. Some parents still did not get prenatal or postnatal care, and some families were still without a medical home. Many parents who enrolled in education or training programs did not complete them, and the salaries reported for most working parents remained low. English literacy also continued to challenge several EHS parents. While approximately one-quarter of EHS parents were identified with poor literacy skills, few attended literacy classes.

One issue that presented difficulties in the past showed considerable improvement. In 1998–1999, the first families scheduled to transition out of EHS expressed confusion and dismay about the process. By the middle of 1999–2000, many of the early concerns related to the transition process were addressed, and families transitioning out of the program said they felt well-prepared and comfortable about it.

■ ■ ■

Family Stories: Case Study Results

To develop some of the rich background information that can only come from the stories of program participants themselves, case studies were undertaken with 12 families who were representative of all EHS program participants. Each of the 12 families was followed throughout their participation in the program, and their "stories" were updated as they unfolded from one year to the next.[3] Some of their background information was integrated into a broad composite sketch, below, that helps explain who these families are.

Family Composite

Case study families entering EHS consisted of at least one teen parent who was the primary caregiver. The mother was considered the primary caregiver in 11 of the 12 families, the father in one family. At the time of the final interview cycle in August 1999 (which included eight of the original families still enrolled in the program), three of the mothers were married to the father of their children.

By program design, EHS has focused efforts on engaging fathers with their young children. In the final interview cycle, five fathers were "involved" (loosely defined as having relatively frequent contact) with their children, while children in three families had limited or no contact with their fathers.

Many of the teens in the case study came from troubled, disrupted families. Several had been living with extended families in situations that involved complicated familial relationships and included children of other relatives. In some cases, severely strained relationships had occurred between the teen parents and their parents or relatives. While several of the teens experienced upheavals in their living situation, the living arrangements for some families had improved by their final interview. Positive changes included some teens who set up independent households and other families who moved to larger houses or more stable living situations.

Some of the teen parents initially voiced ambivalent feelings about their impending parenthood. Two mothers said they seriously considered an abortion to avoid the responsibilities of parenting. One father threatened to abandon the soon-to-be-mother of his child when he found out she was pregnant and wouldn't have an abortion. All three eventually changed their minds and expressed satisfaction with their decisions to accept the role of parent.

For several families, drug and alcohol abuse had been a problem. These abuses were characteristic of some of the teen parents themselves, their parents and relatives, or boyfriends. Many of the families had contact with the criminal justice system. At the time of the first interviews, one primary caregiving parent was on probation and at least two non-primary

[3] The sections that follow were excerpted from a companion document to this evaluation report (*Phoenix Early Head Start: Twelve Family Stories, Final Chapter)*, which contains each family's individual story.

caregiving parents were in detention. One teen parent's father died in prison and another's uncle was serving a prison sentence. Domestic violence, rape, or prostitution had also been reported in the background of three of the families.

Many of the teen parents experienced difficulty completing their education. Prior to their enrollment in EHS, more than three-quarters of the case study parents had dropped out of junior high or high school, and one parent reportedly had never attended any school at all. Over the course of the three years of the case study, several parents were in and out of school, and others continued to talk about plans to attend GED classes. At the time of the final interview, three of the parents had graduated from high school (with one subsequently enrolling in college), while five parents were not attending either school or GED classes.

Several parents faced special problems because they were undocumented immigrants, and therefore had to manage their lives under a different set of conditions than legal residents. Among the difficulties, illegal residents were not eligible for some types of public assistance. In one family, an illegally documented parent applied for health care through AHCCCS (Arizona's health care system for indigent people) but when illegal documents were discovered during the application process, the spouse of this parent lost his job — and the family's only source of income. Another parent without legal status, although successful in graduating from high school, encountered trouble in obtaining a college scholarship to continue her education. Nonetheless, several parents with undocumented status have been able to find and maintain employment.

Some of the children in EHS families also faced problems. During the first year of the program, staff expressed concern about two babies that had exhibited poor health or failure to thrive. In addition, one family was investigated by Child Protective Services after their baby was injured. As the case study unfolded, some children were diagnosed with speech and language delays and, at or subsequent to the time of the final interview cycle, two of these children had been pre-enrolled in Head Start programs with special services, while the family of another child had been connected with services through the state's Developmental Disabilities Division (DDD). Several of the children also faced competition from a sibling: over the course of the three years of the case study, seven of the 12 parents had second babies.

Common Themes

As their children neared their third birthday, transition out of EHS became an issue for all eight families remaining in the case study in 1999. While several parents understandably voiced sadness and regret at the prospect of leaving EHS, they articulated positive feelings that suggested a generally good experience with the transition process. Most of them talked about their experiences in EHS with some sense of accomplishment at becoming better parents, and some said they were looking forward to their children's next experiences in Head Start or preschool.

In the final interview cycle, several families displayed greater stability in their housing situations, and some showed limited economic progress. While some parents had steady employment, however, the tenuous nature of economic self-sufficiency for these families was also apparent. Occurrences such as an automobile breakdown or loss of employment income due to health problems, precipitated financial difficulties for a few case study families. And while several parents talked philosophically about going back to school, in practice they tended to seek the more immediate financial gratification of employment.

Over the course of the case study, several parents described "busier lives" that left them less time to engage in group socialization activities. Many parents talked about jobs, school, and second children, as factors that made it increasingly difficult for them to attend the monthly site-based program offerings.

After three years of case study, it was apparent that each family has followed its individual path, affected in part by particular strengths, needs, program participation, and family backgrounds. Some parents seemed to be strong program "takers," while others engaged in program activities to lesser degrees. All, however, appeared to have gained from their experiences. The family stories taken as a whole, and particularly with respect to EHS program experiences, were consistent in exhibiting several distinct themes. The most prominent of these themes follow:

Assistance from caring staff — Parents talked about their family support specialists and other EHS staff as people who cared about them and who provided them with assistance in many specific areas of their lives. They also said that their family support specialists helped them with their problems and relationships, and provided a crucial sounding board for their concerns because otherwise they felt they "don't have anybody that they can talk to." Many of the families mentioned they received emotional support from program staff, particularly in helping them deal with personal stresses. They felt valued as a result of EHS staff's belief in them, leading several parents to talk about their increased self-confidence.

Half the families interviewed in 1999 had to adjust to more than one family support specialist over the course of the case study due to staff turnover. While one parent expressed negative feelings about the experience, the others continued to feel supported. Families who maintained the same family support specialist throughout their time in EHS underscored the supportive nature of the relationship, expressing the feeling "[We] can talk about a lot of things...about the family, how it's doing, about...whatever."

Reassurance from home visits and child development — Parents said they received a great deal of information during their home visits, and articulated a growing sense of knowledge and understanding of their children's development. Home visits gave them regular opportunities to discuss problems, get information about specific topics they needed help with, and find out about their children's progress. The EHS nurses were a stable source of information and support to the families, providing periodic assessments of the children and support and assistance to parents with medical problems. Developmental assessments by EHS staff helped reassure parents about their children's well-being, and parents appreciated the individual guidance and assistance they received when they encountered specific problems. Ongoing discussions about maintaining their children's health and safety continued to keep parents' attention focused on these issues. EHS staff also connected parents with needed medical and psychological assistance when necessary.

Help in becoming good parents — Case study participants strongly credited the EHS program with helping them understand their children and become better parents. Nearly all of them talked about dealing with the stresses of parenting — learning patience, learning to control their anger, and learning positive discipline techniques. Several of them also mentioned the parent-child playgroups as a place where they learned good parenting skills, and where their children had positive experiences. Parents valued the information about child development, health, nutrition, and safety they received from the family support specialists, nurses, and child development specialists. They also appreciated the positive reinforcement they received from

EHS staff regarding their role as parents, expressing the feeling that "…just the fact that [the staff] have been telling me I am…a good parent has helped."

Help with personal goals — EHS helped parents try to stay on track and move ahead with their lives. Most parents talked about regularly "revisiting" their personal goals with their family support specialist, discussing where they wanted to go with their lives, and thinking through the steps necessary to get there. Their family support specialists provided assistance in helping them reach their goals in a variety of ways. They mentioned ongoing encouragement to stay in or return to school, with support in exploring programs and completing necessary paperwork. Other assistance was provided in locating and applying for jobs, completing and filing papers to obtain legal status, developing a budget and plan for savings, and connecting them with family planning services.

Help with daily life — Over the course of the case study many parents said they were better able to manage some of the activities of daily life. In the final interview cycle, this was particularly true for families who now owned cars, and those who had jobs and a steady source of income. Conversely, those families without a reliable source of transportation and with sporadic income needed—and received— program assistance in keeping medical appointments, looking for work, and help in obtaining food and household items. Program staff also guided families through government and medical systems. Parents were assisted in obtaining services through DDD, filing papers to gain legal status, enrolling in AHCCCS, and navigating the medical community.

Socialization opportunities for children and parents — While overall, parents in the final interview cycle were busier and had less time to attend EHS activities than in previous years, several parents mentioned the play groups as providing good opportunities for their children to socialize with other kids and participate in a variety of play activities. Those parents who said they had attended some of the monthly socialization activities continued to enjoy talking and learning about different topics in a group setting. A few of the parents also continued to serve on the parent policy committee. But several of the parents said they had less time to attend the socialization activities than in the past, and some expressed regret that they were not available to participate because their lives were so busy.

Summary

Overall, most case study families made progress during the study, though to widely differing degrees. The eight families still enrolled in the program at the end of the case study all faced transition out of Early Head Start, but generally appeared ready to move on with their lives. Although somewhat apprehensive about life without the "safety net" of EHS, they seemed much more confident than earlier. They had some knowledge and understanding of their children and themselves, and had articulated — and taken some steps towards achieving — personal and family goals.

Child Services and Outcomes

Phoenix Early Head Start program services are designed to help ensure that infants and toddlers grow up in a safe, stable, and supportive environment, and that they are provided with enhanced opportunities for long-term intellectual, social, emotional, and physical development. Through EHS services and activities, parents are encouraged to provide developmentally appropriate experiences for their young children. During home visits, family support specialists use modeling and coaching techniques to help parents learn to interact with their children using developmentally appropriate strategies. EHS has adopted the Portage child development curriculum to provide guidance to parents as they support and facilitate their children's healthy development. Monthly site-based socialization activities frequently include opportunities for parents to learn about different aspects of early childhood development and to participate in developmentally appropriate group activities with their children. Weekly infant and toddler play groups facilitated by the child development/disabilities specialists also offer experiences through which children and parents focus on play skills, language, and developmental sequencing. A new play group initiated in 1999–2000 brings together parents and children from EHS and the SWHD Early Intervention Program, and is facilitated by staff from both programs.

Support for positive child outcomes is also provided through additional services and activities carried out by the EHS nurses and child development/disabilities specialists. The nurses assess the physical and developmental status of each child at least twice a year during home visits, and they attend the monthly site-based activities where they are available to talk with parents about child health issues and periodically facilitate specific site-based activities (*e.g.*, nutrition). The child development/disabilities specialists facilitate parent-child play groups, consult with families and/or the family support specialists, and coordinate community resources when other intervention services are needed. They also provide support for children with special needs. Children with suspected or confirmed developmental delays are encouraged to participate in the weekly infant/toddler play groups, and special needs families receive home visits from the disabilities specialist until their referrals to outside community services are in place.

The major focus of the EHS intervention strategy is on child and family development. These issues, as mentioned earlier, accounted for 54 percent of the services provided during visits with families. This level of emphasis on child and family development has been characteristic of home visits throughout the course of the program; more than half the activities during home visits have typically focused on these areas. A variety of topics and issues fall within the child/family domain, therefore these categories can be addressed more than once during a single home visit. On average, child and family issues were addressed 2.4 times during each home visit during the first half of the 1999–2000 program year, slightly less than in previous years.

Parent-child play groups have continued to provide additional opportunities for encouraging and supporting healthy child development and parent-child relationships. Attendance of mothers and children at infant and toddler play groups has risen. During the first half of the 1999–2000 year, half the parents enrolled in EHS attended at least one play group session, with an average attendance of four sessions each over the six-month period. This represents a perceptible increase from the previous year.

Phoenix Early Head Start goals and desired outcomes for children extend across four domains: infant-toddler development, developmental delays or disabilities, healthy parent-child relationships, and infant-toddler health. The status and/or progress of children in these areas are presented below.

Infant-Toddler Development

Child development services addressed through EHS are categorized within six areas: cognitive, speech and language, social/emotional, gross motor, fine motor, and self help. Infants and toddlers who do not have developmental delays or disabilities are expected to demonstrate age-appropriate development in all areas.

Program staff use the *Infant-Toddler Developmental Assessment* (IDA) as one way to help them appraise children's developmental status. This instrument has also been used for evaluative purposes: a total "developmental risk score" is calculated for each child, with higher scores indicating higher functioning (maximum score = 6). The program schedule for administering the IDA changed over time, resulting in a wide range of data collection points.[4] Overall, average scores on the IDA have been in the "higher functioning" range between 4 and 5. In general, more than half the children screened at each assessment occasion have been identified with needs and concerns, typically in one or two developmental areas. While needs and concerns are registered in each developmental category, speech and language difficulties predominate.

Analysis of data for children between 24 months old and 36 months old (N=34) indicated an average IDA score of 4.8, with individual scores ranging from 1 to 6. Needs and concerns were identified for 18 of the 34 children (53 percent), with most registering speech and language difficulties.

Programmatically, concerns identified on the IDA should evoke attention on the family partnership agreement, and thus prompt the family's receipt of more intense services in that specific domain. That connection (between concerns and service intensity) occurred. Families of children with speech and language concerns had a greater proportion of their home visits focused on speech/language issues than did families with children screened as "competent" in this area (67 percent and 59 percent, respectively). This expected "balance" of needs/concerns with service intensity has been present in two of the three prior evaluation years as well.

Throughout the course of the program, parents have consistently talked about how EHS has helped their child's development. Parent focus group discussion this year again underscored the value of the play groups in helping their children's interactions and independence. One mother felt that interaction with other children helped her daughter "be more open-minded to a lot of things" and improved her communication skills, while another parent said her child used to be afraid to be around other children — but that was no longer true. EHS mangers and staff concurred with these positive assessments, and indicated their belief that the program's concentrated focus on child development, particularly during the past few years, has contributed to children's growth and positive parent-child relationships.

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[4] The IDA is currently scheduled to be administered when the child is 18 months old and again at 30 months. It was previously administered at 12 months, 24 months, and 36 months, with the Denver II administered at interim occasions. Program managers subsequently concluded that reversing the times for administering the IDA and Denver screenings would be beneficial both developmentally and programmatically.

Developmental Delays or Disabilities

Infants and toddlers in EHS who are identified with potential developmental delays or disabilities are expected to be referred to and receive appropriate intervention services, and to show developmental progress over time. The *Denver II*, administered by the EHS nurses, is one of the instruments used by the program to identify children with developmental concerns. Results are reported in three categories: "within normal limits," "suspect," or "untestable." A child identified as "suspect" will be referred for further testing or retested, depending on the degree of suspicion. Children reported as "untestable" are those who do not cooperate with the testing process. The program schedule for administering the screening has changed over time; currently, it is given when a baby is 45 days old, then again around 6 months, 12 months, 24 months, and 36 months.

Overall, the *Denver II* did not identify many children as "suspect"; as might be expected, though, the percentage of children with possible developmental delays increases slightly as they get older. Of infants screened between four and eight months old (N=123), 8 percent were identified as "suspect," with 92 percent considered within normal limits. Of a group of children screened at 19-39 months (N=37), five (14 percent) were considered "suspect," four children were untestable, and the rest were within normal limits.

There are a few factors that might account for the small number of children identified with developmental delays. First, the *Denver II* is generally considered to have very low sensitivity — it tends to identify only those children who have obvious developmental delays (Meisels & Wasik, 1990). In addition, the screening was not administered to children who had already been diagnosed with developmental delays — therefore, these children are not included in the percentage reported.

Children with possible developmental delays are also identified by the family support specialists. These children are referred to the EHS child development/disabilities specialists, and they may eventually be linked with other community services outside the program. According to information from the 30-month MDT reviews, five of six families who had children with suspected or diagnosed disabilities and were provided with referrals, had followed up on the referral. And according to family support specialists, five children with previously suspected or diagnosed disabilities all showed developmental progress during the six-month period prior to this MDT review.

Healthy Parent-Child Relationships

A primary desired outcome for the EHS intervention is that infants and toddlers in the program develop healthy relationships with their parents. Parental beliefs, attitudes, and behaviors associated with healthy parent-child relationships were reviewed in the earlier discussion of adult-child relationships. This section focuses on specific parent-child interactions, child behavior, and assessment of the overall quality of these relationships.

Parent-child relationships are periodically assessed by family support specialists, who are asked to draw on their observations over time to gauge the overall quality of parent-child relationships for each of their families. Data collected for a group of families after 18 months in the program, a group of families after 24 months, and a group of families after 30 months[5], offer family

[5] While the data available at 30 months are limited, the information is offered as a preliminary indication of ongoing trends.

support specialists' perceptions of parent-child interactions at each of these stages of program involvement. There was some fluctuation across these three assessment occasions. Families assessed at 24 months were described as exhibiting more positive overall parent-child relationships than the families assessed at 18 months, but ratings were slightly lower for the families assessed at 30 months. In general, the overall quality of the relationship between the parent and child was rated as "average" or "above average" for around 75 percent of families at all three of these stages of program involvement (18 months, 24 months, and 30 months).

Family support specialists were also asked to characterize the emotional tone of the parent-child relationship for each of their families. A larger percentage (77 percent) of families who had been in the program for 30 months were described as having "supportive/positive" relationships than families who had been in the program for 24 months or 18 months (74 percent and 59 percent, respectively). At the same time, the percentage of parent-child relationships characterized as "anxious/intrusive" decreased (from 22 percent of families at 18 months of program participation to 8 percent at 24 and 30 months), and the percentage of those described as "hostile/ambivalent" generally remained the same (15 -18 percent).

At all three stages of program involvement, family support specialists "agreed" or "strongly agreed" that more than three-quarters of the children were "using positive strategies to seek out their parents." At the same time, they believed that slightly fewer parent-child interactions were effective at 24 months than at 18 months, but then perceived an increase in effective parent-child interactions at 30 months. Family support specialists felt that 63 percent of parents at 18 months into the program "supportively responded to their child's calls for attention." This decreased to 59 percent of parents assessed at 24 months, and then increased to 77 percent of parents assessed at 30 months.

The differences in the ratings of parent-child relationships for the groups of families described at 18 months, 24 months, and 30 months into the program are hard to interpret. As discussed in previous reports, these differences might reflect actual changes in the quality of parent-child relationships, but it is also possible that the differences are due to staff turnover or individual differences in exposure to staff training. Recently hired staff might not have the same degree of training on the assessment tool as the people they replaced, thereby affecting the comparability of what is largely observation data.

Infant-Toddler Health

EHS services and activities are designed to help ensure that infants and toddlers in the program are physically healthy and safe. Available program data for families who had been in EHS for 30 months indicate that a large majority of families followed through with health promotion and treatment activities designed to keep their children healthy (Table 8). The 30-month data, though limited, suggest a positive trend — an increase from past MDT review occasions in the percentage of children who received scheduled immunizations. However, the compliance rates for well-baby/well

Table 8

Child Health Care: 30-month Family Review

Health Care Activity	% of Children
Receiving scheduled immunizations	92%
Receiving scheduled well-baby/well-child checkups	83%
Receiving appropriate treatment for health problems	76%

N=33

child checkups and for children receiving appropriate treatment for health problems indicate room for improvement, as they did at earlier MDT review occasions.

Interestingly, there appears to be a decline in the status of child health care practices at the time of families' 24-month MDT reviews. Data for this time period indicated less compliance with recommended health maintenance schedules than at the other reviews: considerably fewer children had received well-child checkups, and there was a decline in the percentage of children with up-to-date immunizations. With the 30-month family review, however, compliance levels seemed to improve again.

Information related to children's safety is mixed. Family support specialists have continued to raise concerns about child safety issues over the course of the program (and therefore, as children get older). According to available data for groups of families appraised at MDT reviews at all stages of program participation, family support specialists identified approximately 40 percent of families with home safety concerns. In addition, MDT data for a subset of parents for whom comparable information was available at 24 months and again after 30 months raise some concerns. Of 11 participants with home safety concerns at 24 months, seven were still of concern at their 30-month MDT review. Family support specialists also reported that six participants with a safe home environment at 24 months *were not* providing a safe home environment at 30 months.
Parent self-reports in general, however, have been more positive.

Data about parent knowledge and self-reported use of safety precautions is gathered as part of the semiannual parent assessment battery. In general, these data suggest that, up through 24 months of program participation, parents' knowledge and self-reported use of safety measures has improved over the course of their time in the program. In addition, a subset of parents for whom comparable data were available at assessment points throughout the program (12 months, 18 months, and 24 months) showed some positive changes over time (Table 9). For example, over this period of time nearly all parents said they used car seats or other appropriate child restraints. And, over this same time period, the percentage of parents who knew whom to call if their child ingested something poisonous also increased. An anomaly, however,

Table 9

Safety

	12 Month Assessment	18 Month Assessment	24 Month Assessment
If you had to get the phone number of the poison control center in an emergency, do you know how to find it?			
Yes	91.7%	94.4%	94.4%
What would you do?			
Call 911	39.4%	38.2%	44.1%
Look it up	9.1%	16.8%	11.8%
Have available	30.3%	38.2%	38.2%
Search for number	3.0%	—	—
Other	18.2%	11.8%	5.9%
Do you have covers on all your electrical outlets that don't have plugs in them?			
Yes	50.0%	55.6%	44.4%
Does your home have smoke alarms?			
Yes	69.4%	77.8%	72.2%
When you take your child in the car, what kind of child restraints do you use?			
Car seat	91.7%	86.1%	82.9%
Parent's lap	5.6%	8.3%	—
No restraint	—	2.8%	2.9%
Seat Belt	2.8%	2.8%	11.4%
Booster seat	N/A	N/A	2.9%

began to appear in parents' 30-month self-reports related to safety. While available data are limited, a *smaller* percentage of parents at 30 months into the program said they knew the appropriate telephone number to call if their child ingested poison.

An area of ongoing concern is parents' use of safety precautions involving electrical outlets. At all the assessment times, a large percentage of parents said they did not have covers on their unused electrical outlets — despite the fact that their children are at ages and stages where they are mobile and curious.

Additional information about program encouragement and support related to child health came from EHS parents. Focus group participants were unanimous in articulating their belief that the EHS nurses greatly assisted them with all aspects of their children's health. Several parents said they wished the nurse could visit them more often than twice a year, and some wanted to be able to consult with the nurse during monthly activities.

Summary

Child development and healthy parent-child relationships have been the central focus of EHS home visits and play groups over the course of the program; more than half of home visit activities have focused on these domains while, at the same time, mothers' attendance at parent-child play groups has steadily grown. According to EHS staff the program's stepped-up concentration on child development during the past two years has had a positive influence on children's growth and parent-child relationships. Parents, too, have continued to express positive feelings about EHS's impact on their child's development, particularly in helping them be open to new experiences and encouraging their positive interaction with other children.

Mixed results appear on developmental assessments of children. Overall, EHS children fell into the "higher functioning" range on assessments of infant/toddler development during the course of the program. Typically, however, more than half the children had some needs or concerns, predominantly in the area of speech and language. In 1999–2000, families with these children received more frequent attention to issues of speech and language during home visits than did other families. This connection between identified concerns and service intensity did not always occur in previous years. On a developmental screening, the overwhelming majority of children were considered within normal limits but, as would be expected, the percentage of suspected delays increased slightly as they got older. At families' 30-month MDT reviews, children previously identified with delays or disabilities all showed developmental progress during the prior six months, according to family support specialists. And when developmental concerns were identified and children referred for further services, all but one family reportedly followed through — an improvement from past years.

Most children in EHS have experienced supportive and positive relationships with their parents, according to family support specialists. Moreover, for families who remained in the program longer, the percentage of higher quality relationships ("supportive/positive") increased while the percentage of lower quality relationships ("anxious/intrusive or "hostile/ambivalent") showed a substantial decline. Family support specialists have also continued to report that a large majority of children use positive strategies to seek out their parents.

The area of child health has been a continuing concern, but some of the trend data are encouraging. Most families at 30 months into the program followed through with appropriate health promotion and treatment for their children. The 30-month data, though limited, also indicate an increase in the percentage of children who received scheduled immunizations. But

while many children reportedly received recommended checkups and appropriate treatment for health problems, there is still some room for improvement.

Child safety has also been a source of concern through the years. Results have been mixed. Parents' knowledge and self-reported use of safety measures improved between 12 months and 24 months of program participation, with increases in the percentage of parents who used car seats or other appropriate child restrains for their children, as well as increases in the percentage of parents who knew where to call in case of a poisoning emergency. Limited data from 30-month assessments, however, indicated a decline in the percentage of parents who knew where to call if their child ingested something poisonous. Family support specialists, also, have continued to raise home safety concerns. While data are limited, their reports indicate that several parents with home safety concerns at 24 months into the program showed no improvement after 30 months. Furthermore, home safety reports worsened for other families between these two periods as well. One area has been a continuing source of concern: over all assessment times, parents have shown little improvement in taking steps to protect their children from the dangers of electrical outlets.

■ ■ ■

Staff Training and Outcomes

The nature and quality of staff training has been identified as an important factor contributing to the effectiveness of early intervention programs serving families with very young children (Jerald, 1997; Advisory Committee on Services for Families with Infants and Toddlers, 1994; Schrag Fenichel & Eggbeer, 1990). Staff development has been an important focus of the Phoenix Early Head Start Program. Desired outcomes for staff address knowledge and skills in four domains:

- child development and parent-child relationships
- supportive alliances with families
- appropriate strategies for working with adolescent parents
- "core" knowledge necessary to implement EHS program services

Family support specialists attended trainings in all key staff development areas. Outcome data on staff training effectiveness were collected by means of assessments of staff knowledge and skills, surveys, interviews, focus group discussions, and review of program documents. Staff were also asked to complete a brief evaluation of each individual training session they attended and rate the training's "usefulness."

For the purposes of this report, ratings have been analyzed only for those trainings that addressed one of the four staff training goal areas and also received evaluations from two or more family support specialists. Ratings from other EHS staff (supervisors, nurses, support personnel) have not been analyzed because of the wide differences in their backgrounds, experiences, and knowledge. Trainings that addressed issues outside the four key goal areas have also not been analyzed.

The following subsections summarize staff training activities and data in each of the four key areas. They present the most recent outcomes from the first half of the 1999–2000 program year, and also show, where possible, comparisons across multiple program years. Most of these comparisons, however, have been affected by staff turnover (i.e., the same staff are not always being compared year-to-year). As of midway through the 1999–2000 program year, only one of the original family support specialists remained on staff. Moreover, the turnover among family support specialists has been continual, with up to five departing in a given year, so that as of June 2000, only three family support specialists had been employed with EHS for one year or more. In addition, two of the original site supervisors and the original program manager had left the program.

In response to growing concerns about staff turnover and comments that newly hired staff through the years hadn't received adequate orientation, program managers established a half-time training specialist position in October 1999 to provide new family support specialists with one-on-one guidance and assistance during their first weeks on the job. This position has been filled by an experienced family support specialist who has also maintained a small caseload of families. Staff comments from focus groups indicate that this action has been well received and has given new employees more confidence as well as a readily available source of support. As of September 2000, the training specialist had worked with seven new staff members and was expecting to begin work with two more, each new employee requiring three to six weeks of

assistance. The time and intensity of assistance varied depending on the employee's prior experience working in family-centered programs.

Child Development and Parent-Child Relationships

The quality of the parent-child relationship is considered to be a critical factor in child development, because parents provide much of the emotional support, engagement, and continuity considered necessary for an infant's healthy growth and acquisition of skills (Advisory Committee on Services for Families with Infants and Toddlers, 1994). In order to serve families with very young children, staff need to have knowledge of early childhood development and parent-child relationships (Schrag Fenichel & Eggbeer, 1990; Roberts, Wasik, Casto, & Ramey, 1991). Phoenix Early Head Start has identified this area as a priority of staff training.

Staff assessments conducted as part of the program evaluation for the 1997–1998 year (Sandler & Heffernon, 1999) identified gaps in family support specialists' knowledge of child development and parent-child relationships. These results were consistent with anecdotal data from focus groups and interviews with EHS staff and managers. In response, program managers expanded training efforts on these topics in a more systematic and structured manner. Beginning in January 1999, the changes took several approaches:

- ***Quarterly child development training sessions*** led by the director of Child Study Laboratories at Arizona State University
- ***Monthly videotape reviews*** held during team meetings, led by site supervisors with additional input from the child development/disabilities specialists and program nurses
- ***Monthly "brown bag" lunch sessions*** on child development led by EHS child development/ disabilities specialists
- ***Increased interaction with child development/disabilities specialists*** during play groups and site-based activities
- ***Training on specific developmentally-based curricula*** such as the Portage child development curriculum and the MacArthur speech and language assessment

Also in response to evaluation findings, SWHD established a quarterly "child study group" for program managers and supervisors of child development staff throughout the agency. Participants of this study group have identified a core of theoretical and conceptual issues that are essential to work with children and families and that are fundamental to staff training and supervision. The study group also provides program managers and supervisors with additional training in child development and parent-child relationships.

As a result of the increased focus on child development and parent-child relationships, staff development offerings in this category more than tripled from 1997–1998 to 1998–1999 (from 9 to 29 trainings). The first half of 1999–2000 reflected continued emphasis on this area as staff were offered 11 trainings in this category, of which five were rated by two or more family support specialists. On a five-point scale in which 5.0 signifies staff "strongly agree" that the training was useful (*i.e.*, that it was worthwhile, they learned from it, and they will use what they learned), all of the trainings earned a high rating (Table 10), generally consistent with a pattern of high ratings through the years. Among the most highly rated trainings in 1999–2000 were sessions on the Portage curriculum, on parental responsiveness, and on parent-child observations.

How well did staff recall information presented during child development trainings? To find out, the *Staff Knowledge Assessment* has been administered to family support specialists each year 1997–1998 to 1999–2000. Questions were based on an annual SWHD child development course attended by family support specialists. Ten questions on child development were used consistently all three years. Family support specialists generally scored highest each year on questions that addressed ways to use observation with families, cues from overstimulated babies, elements of language acquisition in babies, and developmental milestones for infants and toddlers.

Table 10

Staff Training: Child Development/Parent-Child Relationships

Training Session	N	Training Was Useful*
Activities Related to Portage Curriculum	4	4.9
Portage Training	9	4.4
Quarterly Child Development:		
Parent/Child Observations	6	4.7
Parental Responsiveness	8	4.8
Parent/Child Interaction	7	4.6

*Training was worthwhile; staff learned from training; will use what was learned.

Ratings: Scale ranges from 5=Strongly Agree to 1=Strongly Disagree

Comparing scores on those 10 questions over three years (Table 11) shows overall improvement among all staff, but a much greater improvement among staff who had both taken the child development course and been employed with EHS for at least one year. Results, however, must be viewed in light of the following caveats: 1) among those staff each year who had both taken the child development course and been employed by EHS for at least one year, the family support specialists being compared were not the same in all cases due to staff turnover; 2) the number of staff with greater than one year of experience is relatively small.

Table 11

Staff Knowledge Assessment Scores*: 1997-1998 to 1999-2000

	97-98	98-99	99-00	% Change 97-98 to 99-00
All Staff	7.7 (N=10)	8.1 (N=10)	8.8 (N=9)	14.3%
Staff employed ≧ 1 year and attended class	7.4 (N=5)	8.7 (N=5)	9.3 (N=2)	25.7%

*Maximum score = 10

To find out if staff knowledge made a difference in the way family support specialists worked with families, the Phoenix Early Head Start *Staff Video-clip Analysis* was developed by EHS/SWHD managers and child development specialists, in collaboration with program evaluators, to evaluate staff knowledge and skills in understanding child development and parent-child interactions. Family support specialists were assessed using this instrument each year from 1997–1998 to 1999–2000.

For the assessment, family support specialists were shown two videotaped examples of actual parent-child interactions: a mother and her infant, and a mother and her toddler. After each video-clip, the family support specialists were asked to consider two key areas — parent-child interactions and child development — and for each area to identify critical strengths, critical concerns, and items needing further assessment. Responses were compared to an answer key developed by EHS/SWHD managers and child development specialists in collaboration with program evaluators.

Family support specialists received two scores for each video-clip. The "exemplar" score totals the number of correct *examples* of a concept or key issue that the family support specialist was able to identify. The "conceptual" score totals the number of times the family support specialist named the *actual concept* involved, which requires a higher level analysis. Combining these two scores creates a third score called "total hits." Results and comparisons shown in Table 12 are reported only for those family support specialists who had been employed with EHS for three months or longer prior to the assessment.

Table 12

Staff Video-clip Analysis — Child Development and Parent-Child Interactions: 1997-1998 to 1999-2000

	% Total Hits*			% Conceptual Hits**		
	1997-98	1998-99	1999-00	1997-98	1998-99	1999-00
Clip 1: Infant[1]						
staff employed ≧ 3 months-12 months	42.6%	39.1%	63.7%	7.4%	10.3%	11.9%
staff employed > 12 months	60.0%	42.1%	53.6%	11.1%	13.8%	17.9%
Clip 2: Toddler[2]						
staff employed ≧ 3 months-12 months	63.3%	61.1%	58.3%	14.2%	15.3%	11.9%
staff employed > 12 months	58.7%	58.3%	61.9%	16.0%	24.2%	16.7%

*percentage of issues identified by either example or concept
**percentage of issues identified by concept only
[1]97-98 clip: 9-month-old; 98-99 clip: 11-month-old; 99-00 clip: 5-month-old
[2]97-98 clip: 18-month-old; 98-99 clip: 24-month-old; 99-00 clip: 17-month-old
staff employed ≧ 3 months - 12 months: 97-98 (N=4); 98-99 (N=3); 99-00 (N=6)
staff employed >12 months: 97-98 (N=5); 98-99 (N=5); 99-00 (N=3)

Results from the staff video-clip analysis over the three years indicate that family support specialists, overall, have continued to struggle with key child development constructs and conceptual issues, and are not able to consistently incorporate them into their observations of young children and parent-child interactions. And while results seem to suggest that staff who have been with the program for at least one year perform better than more recently hired staff, this conclusion must be interpreted with caution because of the small sample size.

In surveys, interviews, and focus group discussions over the years, EHS staff have talked about the training sessions they attended related to child development and parent-child relationships. Initially they expressed dissatisfaction with the number and substance of these trainings, and felt the overall training agenda required better organization. In more recent years, as the training agenda became more systematic, they characterized trainings as both ample and extremely helpful. For example, they commented that the reorganized and expanded training agenda had been responsive to their input, both in style (e.g., more "hands-on" and practical) and in breadth (e.g., a child development curriculum was adopted in response to their requests). They also said that staff training had, for the most part, given them the tools they needed to work with families. Site supervisors have agreed with family support specialists about their knowledge and skills. The supervisors also commented that the newly instituted child study group (for SWHD supervisory personnel) would likely give them the background to help family support specialists work better with families.

Staff turnover challenges the effectiveness of any training strategy because new personnel must be hired, typically without the experience or training of longer-term personnel. Through the years, both family support specialists and supervisors have indicated their belief that this situation affects the delivery of services to families. Staff surveys underscore the effects of turnover on staff knowledge. On self-assessments of their knowledge, recently hired family support specialists (less than three months experience) have, over the last three years, generally ranked themselves as having less knowledge of child development issues than have staff with at least one year of experience. At the same time, overall staff self-ratings on knowledge of child development declined moderately from 1997–1998 to 1999–2000.

Supportive Alliances With Families

Establishing a positive relationship between provider and parent is considered one of the key factors in achieving a successful intervention for infants or young children. Provider-parent relationships that strengthen a parent's feelings of acceptance and appreciation can, in turn, lead to parent-child relationships that are more positive (Kalmanson & Seligman, 1992).

While family support specialists did not receive training during the first half of 1999–2000 related to developing supportive alliances with families, and while they also had relatively few training sessions in this area over three previous years (annual average from 3-4), their supervisors felt they had been effective in working with families. On surveys regarding their staff, the supervisors have rated family support specialists highly each year on most of the specific skills related to building supportive alliances. Staff surveys of knowledge have supported this perception: on items related to supportive alliances, they most often "agreed" or "strongly agreed" with key characteristics considered important for working with families (e.g., collaborative planning). One difficulty related to supportive alliances that surfaced earlier in the program — the setting of appropriate boundaries — was apparently resolved through training and supervision. Parents have also agreed with the perception that family support specialists are succeeding in establishing supportive alliances with their families. On annual parent survey items addressing the quality of the parent-family relationship, parent responses have been highly positive overall, particularly in regard to items such as, "My FSS is friendly and supportive," and "My FSS really cares about me and my child."

Strategies For Adolescent Parents

One of the unique challenges facing family support specialists in the Phoenix Early Head Start program is that parents in the target population are adolescents. Family support specialists, therefore, must understand adolescent development and possess effective strategies for working with adolescents in order to help them create better outcomes for their children.

One training session during the first half of 1999–2000 addressed strategies for working with adolescent parents, and it was targeted for supervisors. Over three prior years, the number of trainings offered in this category has also been relatively low (annual average from 3-4). Nevertheless, site supervisors' ratings of individual family support specialists have consistently shown that they believe their staff are using appropriate strategies for working with teen parents. Parents have agreed: on surveys each year, they have consistently agreed with statements that their family support specialist "knows how I feel," "listens when I have something to say," and explains things in ways "I usually understand." But staff self-ratings of their knowledge in this area have not been as positive. Over the course of the program evaluation, they have generally rated themselves as "moderate" or lower on items related to

working with teens (e.g., recognizing risk and protective factors; the importance of mentoring). Most years, family support specialists have also said they needed more trainings on the subject of working with adolescents. And with the recent increased focus on child development and parent-child relationship issues during home visits, they have wondered how much time they could devote to dealing with parents' personal problems.

Core Knowledge

Family support specialists need basic knowledge covering a broad array of topics, including adolescent health and development, family planning, perinatal care and well-child care, and community-based services and resources. With the exception of adolescent health and development, which has already been discussed in the category "Strategies for Adolescent Parents," these subjects are grouped under the heading of "Core Knowledge."

During the first half of 1999–2000, nine training sessions were offered on subjects considered core knowledge. This is a somewhat higher rate than the annual average over the past three years (12-13 trainings per year). Among the trainings held in 1999–2000 were sessions related to First Aid/CPR, child abuse, transition to Head Start, and early intervention for children. Two of these training sessions were rated by more than one family support specialist (Table 13), and their ratings were uniformly high. Ratings for core knowledge training sessions have been high overall throughout the program.

Table 13

Staff Training: Core Knowledge

Training Session	N	Training Was Useful*
Transition to Head Start	7	4.5
Early Intervention/Preschool Special Education	9	4.5

*Training was worthwhile; staff learned from training; will use what was learned.
Ratings: Scale ranges from 5=Strongly Agree to 1=Strongly Disagree

On staff self-ratings of knowledge through the years, family support specialists have consistently characterized their core knowledge as "moderate," and have generally indicated each year that they have "sufficient knowledge to carry out the goals of the EHS program." Family support specialists with at least one year of experience with EHS, however, have consistently rated themselves higher than staff with less experience, and while veterans have said they feel comfortable in their core knowledge, some of the newer employees in years past have said they felt unprepared and unsure.

One issue that has cut across all training categories throughout EHS's history is staff turnover and its related effects. As mentioned earlier, staff members have left the program in relatively high frequencies, eroding the knowledge and experience base that help a program deliver its services efficiently and smoothly. The appointment of a training specialist was one response to persistent staff comments regarding the negative effects of employee turnover. In interview and focus groups, however, staff have continued to comment that a major cause of staff turnover has not been addressed: the feeling that they have little opportunity for advancement in terms of salary, benefits, or responsibilities.

Summary

The primary focus of EHS staff training over the years has been child development and parent-child relationships. Staff assessments in 1997–1998 identified gaps in staff knowledge in this area, and these results were also supported by staff comments. In response, EHS developed a new training strategy beginning in January 1999 that featured an expanded and systematic schedule of more practical, "hands-on" child development offerings targeted at specific EHS needs, as well as closer working relationships between family support specialists and child development/disabilities specialists. A child study group was also established for supervisors and managers, to help them provide better training and supervision regarding child development and parent-child relationships.

After a year and a half of this intensified effort, results have been mixed. An assessment of staff knowledge in child development showed gains over prior years, particularly for longer-term family support specialists. In addition, family support specialists considered most of the trainings to be very useful, and supervisors considered their staff to be stronger in child development. When observing actual parent-child interactions on videotape, however, family support specialists could not consistently identify key child development issues or the concepts underlying the issues. And on self- surveys of their knowledge, they rated themselves slightly lower over time regarding knowledge of child development.

Bearing on these results is the issue of staff turnover and its influences on overall staff knowledge and skills. This has been a continuing challenge for EHS. While comparison data must be interpreted with caution due to small sample sizes, most measures through the years have shown that staff with longer EHS employment — and consequently more training — scored higher than their less experienced, less trained counterparts on objective and subjective measures. Interrelated with the staff turnover problem is the issue of new employee orientation, which had received little direct attention through the years. In October 1999, however, a new half-time training specialist position was established to provide guidance and assistance to new employees during their first weeks as family support specialists. This step has been well received and has reportedly given several new family support specialists greater confidence and support. Nevertheless, staff have commented that little has been accomplished regarding one of the major causes of staff turnover — lack of advancement opportunities in terms of salary, benefits, or responsibilities. Administrators, however, have been actively working during the past year to address some of these salary and personnel issues.

The emphasis on child development and parent-child issues in recent years has meant that other training topics have received less attention, particularly in the goal areas related to supportive alliances with families and strategies for adolescent parents. Nevertheless, most subjective indicators, including surveys of the parents themselves, show that most family support specialists have worked well with their families, and an earlier concern about setting appropriate boundaries with families has dissipated. In addition, most of the more experienced staff through the years have indicated that they have sufficient core knowledge to do their jobs. Most years, however, staff have commented that they would like to see additional training on topics related to understanding adolescents and the role of male involvement. And in recent years, staff have wondered how to balance the needs of child development with needs of parents during their home visits.

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Community Outcomes

No single program can meet all the needs of a child and a family. It is important, therefore, that programs like Early Head Start not only attend to their primary goal of providing child and family development services, but also help create a community environment that supports very young children and their families.

The national Early Head Start initiative identified community-building as one of four cornerstones essential for a high-quality comprehensive program. Revised Head Start Program Performance Standards (*Federal Register*, November 5, 1996) indicate that grantees "must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs…" The revised standards also direct grantees to "take an active role in community planning to encourage strong communication, cooperation, and sharing of information among agencies and their community partners to improve the delivery of community services to children and families." (Subpart C, 1304.41, (a)1, (a)2).

Phoenix Early Head Start program goals reflect national performance standards through the following desired outcomes: 1) to facilitate the development of parent/child support services (*e.g.*, child care, health, and education), and 2) to establish relationships with community service providers and provide coordinated services to program families. A third, broader policy outcome proposes to translate knowledge gained from the program into state and local actions to address the needs of very young children and their families.

Information about community outcomes has been gathered in several ways: review of program documents, observations of selected program meetings, and annual interviews and focus groups. Periodic meetings between the evaluator and program administrators have also provided ongoing reflection about larger scale collaborative actions. In addition this year, a survey was sent to selected community leaders to obtain broader feedback. While specific documentation of EHS community activities is contained in the program's administrative reports, the discussion that follows takes a wider view of community outcomes, looking at progress in establishing accessible service networks and collaborative leadership efforts to improve the community environment for vulnerable young families.

Community outcomes in Phoenix Early Head Start have primarily been pursued through three paths: linkages, collaboration, and leadership. Program participants are linked with existing community services to help meet specific needs; collaborative relationships are developed with other programs and/or agencies to maximize resources; and broader initiatives are led by program administrators to help develop more integrated, comprehensive service networks and to marshal public support for very young children and their families.

Over the course of the program, some relationships between EHS and community groups and organizations have remained steady, while others experienced shifts in their level of involvement. Some associations continued to link EHS participants with ongoing community services; others shifted over time, beginning as a linkage, moving towards a higher degree of

involvement/collaboration, and subsequently scaling back. Still other alliances have continued to grow, starting as linkages and expanding into more collaborative ventures.

One relationship, considered to be a "natural" collaboration, was the original program partnership between EHS and the City of Phoenix Head Start. Since EHS families were recruited from an area served by both groups, this approach made sense for a program designed to create a coherent system of services for participants. Collaboration was operationalized through a joint technical team to help with "big-picture" problem-solving and advisement. However, declining attendance and increasing uncertainty about the team's purpose during the first two program years eventually resulted in its dissolution. At the same time, however, collaboration with other City initiatives grew.

Establishing Linkages

Ongoing linkages with several agencies have continued to benefit EHS participants over the course of the program. With a grant received early in the program from the Red Cross, EHS nurses have been able to offer periodic training and certification in CPR/First Aid and child care to interested program parents. Some of the teens who completed a child care course went on to earn money by providing child care services during EHS activities. Planned Parenthood also provided a continuing linkage, offering parents access to affordable family planning services and offering periodic program activities about sexuality, sexually transmitted diseases, and family planning. EHS has also worked with the Arizona Family Planning Council and other agencies to increase the availability of family planning services to parents. EHS recently piloted a staff training curriculum on family planning that was developed by the Arizona Family Planning Council and Planned Parenthood.

For a variety of reasons, some program linkages have diminished over time. In one instance an organization lost the funding it needed to continue its activities for EHS parents; another linkage faltered due to the organization's inconvenient service hours and location. Other linkages have ebbed and flowed. For example, an early link with the Department of Economic Security's Division of Child Support Enforcement became more of a collaborative working relationship during the second year of EHS program. Later it moved back to the "resource and information" role that it initially played, but recently the two groups began writing a grant together that, if successful, would reestablish closer ties.

Community alliances with educational institutions have also fluctuated over time. An initial linkage with the Village charter school for pregnant and parenting teens expanded to a bona fide collaboration when SWHD took over temporary management of the school's child care facility and provided professional and financial support. Subsequently, the Village resumed management responsibility and also experienced some internal changes, after which the relationship reverted to a resource and referral linkage for EHS parents. On the other hand, an early collaboration with the Phoenix Union High School District and South Mountain High School shifted toward a simple referral linkage as a result of changes in district policy and direction. Currently, EHS and school officials have begun to explore a broader relationship once again, but staff have indicated only limited progress thus far.

Expanding Resources

By joining forces and coordinating resources, organizations and programs expand the breadth of existing services and maximize the benefits for families. One area in which EHS has followed

this path has been in its work with young fathers. EHS partnerships with the City of Phoenix Step-Up Program for young fathers and the Young Fathers Network, a community alliance of programs serving young fathers, have helped coordinate and enhance services for this group of parents. One consequence of the EHS program emphasis on male involvement is that SWHD has assumed a prominent community role in young father issues, partnering with public agencies such as the City of Phoenix Human Resources Department and the Arizona Department of Economic Security. Through grants to help support coordinated services and provide technical assistance, and through coordination and sponsorship of male involvement conferences, SWHD and the EHS male involvement specialist have played an important part in the evolution of services for young fathers. In addition, the EHS relationship with Step-Up has continued to grow over the years. Managers from both programs have attended each other's meetings, and program staff continued to collaborate on joint activities throughout the years.

Southwest Human Development and EHS have also continued exploring options for expanding resources in the area of child care. The options include pursuing possible alliances with other organizations as well as developing plans to operate an in-house facility. A current linkage with Crisis Nursery is providing some infant and toddler slots for EHS children in that agency's child enrichment center. In a growing collaborative arrangement, EHS plans to use federal expansion money to fund additional placements in the Crisis Nursery center, which has committed to increase its capacity to serve these children. At the same time, SWHD is continuing to search for its own child care center, with the intention of developing and operating a facility that will accommodate children birth to five years old.

Over the past four years, EHS has developed an ongoing relationship with the state Developmental Disabilities Division (DDD) and Early Intervention Program (AZEIP) to help coordinate services for special needs families. A team composed of staff from EHS and DDD, along with an EHS parent, has continued to participate in a national Early Head Start training initiative to support families with children with disabilities, attending periodic national workshops to broaden their knowledge and skills. Locally, periodic meetings between the agencies have continued to promote a more integrated approach for addressing families' needs. During the past year, EHS has focused on refining their internal referral system for DDD and AZEIP; managers also report strong emphasis on facilitating the transition of special needs families leaving EHS to appropriate community services.

Developing Integrated and Comprehensive Services

Collaboration to expand the breadth of available resources for young families, and also create new possibilities, is one step towards developing more integrated, comprehensive services. The efforts on behalf of young fathers and for families with special needs children have begun this process. In addition, many benefits are derived from EHS's relationship with other SWHD initiatives and programs, such as the Good Fit Center's statewide leadership in infant mental health, and collaboration with the agency's Early Intervention Department. The October 1999 merger of EHS into the SWHD Head Start program further paved the way for development of a system of integrated services for children 0-5 and their families.

At the state level, EHS managers and staff have consistently articulated their commitment to integrating birth-to-three issues into the early childhood policy arena through their participation in the Arizona State Head Start Association. Southwest Human Development's work with the Head Start/Child Care Collaboration in the governor's office, and active

involvement around the issue of child care financing, is also contributing to the early childhood agenda in Arizona.

Through broader activities and actions, SWHD/EHS administrators have also used their experience and knowledge to further the development of comprehensive, integrated services. Southwest Human Development, spurred by knowledge from EHS and other agency programs, played a key role in the statewide "Smart Beginnings" initiative. This was a multi-year research, planning, and system development effort to design a public/private model for supporting families and for promoting the healthy development of children 0-3. In partnership with the Children's Action Alliance, a child advocacy organization, and funded through St. Luke's Charitable Trust, Smart Beginnings focused on three goals: to design a zero-to-three family support system for providing a continuum of services, to advocate for improvements in infant and toddler child care, and to create a public awareness and parent education strategy that will inform families about child development and encourage them to promote their children's healthy development. The work of Smart Beginnings culminated in the development of the "Healthy Children, Healthy Families" Initiative, which has been placed on the November 2000 general election ballot. Efforts are currently underway to implement a public awareness campaign.

Effecting Change

In March 2000, a *Community Leader Survey* was sent to select leaders to appraise EHS progress in helping develop a community environment that supports young families. The recipients were identified by EHS/SWHD administrators and managers as knowledgeable about the program and likely to provide valuable feedback. Two versions of the survey were circulated; one was targeted to organization directors, the other to higher-level policy leaders (*e.g.*, the early childhood program administrator in the Governor's Division for Children).

One of the benefits that accrues when programs and organizations work together is that they often help generate new approaches to issues. While some respondents described their connection to EHS in terms of resource and referral, 9 of 14 agency directors said that their association with EHS/SWHD "changed the way their organization 'does business.'" For some, that meant better implementation of existing processes; for others it meant improvements in policy and practice. One organization leader reported that their child care program lowered child-to-staff ratios as a result of collaboration with EHS, while another leader indicated that an EHS representative to the organization's steering committee had greatly contributed to the direction of that program. The superintendent of an inner city school district said "we have learned from [EHS's] family focused/family centered model." And more broadly, one agency director said that EHS staff involvement in the agency's policy-making committee "influenced public policy directions of the organization." Respondents' suggestions for EHS program enhancement included a more intensive focus on job skill training for parents, greater visibility in the community, and a broader reach for program services.

Nearly all the policy-level leaders who responded to the survey exhibited a good understanding of the EHS program; only one of ten said he was not familiar with the program. Most described EHS as a program that targets at-risk teen parents and their young children by improving parenting skills and knowledge of child development. Two additionally described program benefits in terms of decreasing risk and increasing resilience. Four people felt that their knowledge about EHS had influenced decisions they made related to teen parents and/or their children. One person said their organization "had supported increased investment in

prevention programs and referral services for teen parents" because of EHS, while another indicated EHS had influenced some allocation decisions related to state resources for prenatal case management services. Of those respondents who said EHS has not influenced or would not influence their decisions, one was a person who — before working with EHS — had already believed that teen parent programs were important, while the other said that no data or reports had been shared to demonstrate the impact of the program on children.

When asked what factors most affected their decision-making about social policy issues such as teen parenting, these community leaders indicated they were *most* influenced by research results and their personal experience. Other influential factors included testimony to legislative committees and media attention to issues.

Summary

Over the course of the EHS program, community connections and relationships have ebbed and flowed. Some linkages grew into collaborations, while some anticipated collaborative relationships fell short of program expectations. A multi-faceted, multi-year program like EHS can expect these shifts. But while EHS has developed many community relationships over the years, program stakeholders have continued to identify "community-building" as an area in need of improvement. Much of the discussion has centered around the *evolvement* of linkages and collaborations.

Some progress, however, occurred during the 1999–2000 program year. EHS relationships with City of Phoenix Head Start delegate agencies became more firmly established as more EHS children began to transition into Head Start. Southwest Human Development and EHS also moved forward in exploring child care options, including specific plans to expand a current linkage with Crisis Nursery and fund additional placements for EHS infants. Meanwhile, SWHD is continuing with plans to operate its own child care center.

EHS's community-building efforts were validated in a survey of community leaders, who said that knowledge gained through EHS had influenced their decision-making. Also, and on a broader scale, SWHD administrators have pursued development of integrated, comprehensive services over the past years. Most notably, they took a leadership role in Smart Beginnings, a system development effort that culminated in the November 2000 "Healthy Children, Healthy Families" ballot initiative.

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Summary and Analysis

During the past several years Phoenix Early Head Start has developed a considerable reservoir of experience and knowledge regarding how to serve infants and toddlers and their teen parents. At the beginning of the five-year EHS demonstration grant, project stakeholders defined the program's direction, identified a broad course of action, and developed pathways to follow. At the end of the five years, Phoenix Early Head Start remains "on track." While the program has had to negotiate some curves in the road, the journey has been valuable. Program parents and children have received support through a wide array of services; a range of community linkages and partnerships have helped expand resources and options for families; and much has been learned about how to train the staff who work with children 0-3 and their families. In the years ahead, EHS services can build on this foundation of experience and knowledge and continue moving forward. The subsections that follow discuss progress and outcomes over the past five years — for EHS children, families, staff, and the community.

Children and Families

EHS was designed to assist low-income children and their teen parents by providing a combination of services that not only address the health and developmental needs of the child, but also address the needs of the parents, particularly helping them to become better caregivers and to become more economically self-sufficient. The key service delivery strategy through the years has been a schedule of regular and frequent home visits by family support specialists and resource staff. During these visits, issues of child development and parent-child relationships have predominated. Additional support for parents and children has come from parent-child play groups, site-based socialization activities, parent support group meetings, and outside referrals.

Program services appear to have had a positive effect in many areas. Parents have generally increased their knowledge of raising infants and toddlers, engaged in more positive interactions with their children, and provided more nurturing home environments. They have also maintained relatively positive mental health in the face of continuing life stressors, and many have worked toward self-sufficiency by holding jobs or attending school or training programs. They have shown overall improvement in the area of health care: more parents are using birth control consistently, and more are practicing appropriate health prevention and treatment for themselves and their children. Also, more parents are using appropriate safety practices at home and in cars. One issue of previous concern showed considerable improvement — transition of families leaving the program. Initial confusion about transition policies and practices was resolved, and parents reported feeling well-prepared and comfortable about moving on.

Some areas, however, were not as encouraging. More than half of EHS children had developmental concerns, primarily in speech and language development. Many parents held developmentally inappropriate expectations for their toddlers and resorted to spanking or other inappropriate forms of discipline. Medical care for families was still not universal, and in some cases mothers were not getting prenatal or postnatal care. English literacy levels for many parents remained low, making it difficult for them to pursue their education or qualify for good-

paying jobs, yet few were attending programs to improve their literacy. Many parents enrolled in educational or training programs failed to complete them, and reported salaries for most working parents remained low. And while many aspects of home safety showed improvement, some did not, particularly the number of parents who protected their children from electrical outlets.

While areas of concern might appear troubling, they should not be unexpected. The breadth of the EHS intervention virtually ensures that staff engage in an ongoing balancing act between the needs of the children and the needs of their teen parents. Furthermore, since EHS participants are teens, it is likely they are influenced by many of the cultural beliefs of *their* parents and extended family, which can affect their receptiveness to program information. For example, the philosophy of "positive discipline" is a fundamental program value, but not a widely-shared outlook in many of the teens' extended families — with whom they often still live. Educational goals also seem susceptible to family beliefs and values. Little reinforcement or modeling to continue education comes from many of the teens' families, which may account for some of their lack of motivation to do so. And, for several EHS families, their undocumented status presents another obstacle towards gaining self- sufficiency — restricting the family's access to state-supported child care and affecting the parents' ability to obtain employment and attend school.

One difficulty in determining the effects of program services is a lack of direct objective data on child outcomes. While the available descriptive data indicate that the program's focus on child development has been increasing and the quality of caregiving has improved, there are currently no direct measures of child development outcomes that can generate inferences about whether or not EHS services are influencing children's development.

Staff Development

Since its inception, EHS has placed strong emphasis on staff development in its four key goal areas: child development and parent-child relationships, supportive alliances with families, strategies for working with adolescent parents, and core knowledge. In recent years, the thrust of training has focused primarily on child development and parent-child relationships. With this focus has come a commitment to evaluate the effectiveness of training — not only what staff know, but also whether they can apply what they know in their work with children and families.

Early assessments of staff knowledge identified gaps in their knowledge of child development and parent-child relationships. In response, program managers developed a focused, expanded agenda of training in these areas. Subsequent assessments yielded mixed results. Staff increasingly seemed able to recognize and identify examples of strengths and concerns in both the development of young children and in parent-child interactions, but they struggled with the conceptual issues and constructs that inform developmentally appropriate intervention services.

Based on these results, it appears that conceptual issues and constructs need to become a conscious part of the regular discourse of day-to-day staff supervision. For this to occur, program managers and supervisors must agree on and understand what those concepts are. Toward this end, SWHD initiated an agency-wide quarterly child study group for all program managers and supervisors of child development staff as a means of helping them identify core theoretical and conceptual issues. Ultimately, the child study group is intended to help

managers and supervisors provide better training and supervision to their staff regarding child development and parent-child relationships.

It is likely that high staff turnover in EHS has also impacted training results because newer staff generally do not have the same level of training and experience as do longer-term staff. One challenge associated with staff turnover — new employee orientation — was highlighted in previous evaluations and addressed by program managers during the 1999-2000 program year, when a longtime family support specialist was appointed as training specialist to work with and guide new staff members. Nevertheless, a systematic and comprehensive staff training agenda is most effective when staff members are employed long enough to apply their newfound knowledge to practice. But the problem of staff departures — and the loss of experience and invested training time that goes with it — has yet to be resolved, and program managers will need to focus attention and resources in the coming years on addressing its causes.

One consequence of the increased training emphasis on child development and parent-child relationships in recent years has been reduced emphasis on other staff training goal areas. While family support specialists have embraced the new training focus, they have expressed some concerns about the fact that it has led to less time spent on issues related to working with adolescent parents — both in training and in home visits. While most indicators suggest that staff continue to work well with their families, some family support specialists have asked for more training sessions on understanding and working with adolescents. They have also wondered how best to balance their home visits between the needs of children and the needs of teen parents. Considering the complexities of this age and the importance of EHS's teen parents in the lives of their children, it would be wise to offer more training in this area.

Community

Over the course of the program, Phoenix Early Head Start has established a network of linkages and collaborations to provide specific services and expand community options for program families. Several of these efforts have tended to ebb and flow over time — some due to circumstances within the partnering agencies, others due to broader shifts in institutional or community policies and philosophy. Throughout the years, EHS program managers and administrators have continued to identify "community linkages and collaboration" as an area in need of improvement.

Some progress, however, has occurred in program activities that help create a community environment supportive of young children and families. As expected, relationships between EHS and some of the City of Phoenix Head Start delegate agencies have become more firmly established as more EHS children have turned three years old and begun to transition into Head Start. Some progress has also occurred in two other areas — child care and education — but it has been slow going. This is particularly true with regard to education. While a great deal of talk has taken place during the past few years about "renewed and revitalized" relationships with the Phoenix Union High School District and with the Village charter school, progress has been sporadic. At the close of the five-year EHS demonstration grant cycle, these collaborations still have a long way to go.

Internally, also, EHS has experienced major changes in its relationships within its parent agency, SWHD. As part of an alignment with federal guidelines for Early Head Start programs across the country, the EHS program was integrated into the Southwest Human Development

Head Start Department in October 1999. This merger has precipitated a variety of internal activities designed to form a continuum of support for children 0-5 within SWHD Head Start. With the new alignment has also come additional funding through Head Start that continues EHS program services after the five-year demonstration cycle ends. To underscore this newly-defined continuum of services, SWHD Head Start has renamed its two programs: Infant/Toddler Head Start (for children 0-3), and Preschool Head Start (for children 4-5).

In the process of continuing to integrate the two programs under the Head Start umbrella, administrators should be sensitive to "past history." Due in part to the fact that EHS evolved outside of the SWHD Head Start Department, some difficulties have arisen in generating collaborative relationships between the two programs – at both a conceptual and programmatic level. One area in which there *has* been positive collaboration is the Head Start Policy Council, which successfully embraced EHS parents and helped them assume leadership positions. Future relations should build on that positive experience, and learn from past problems. The synthesis of the two programs into one department will certainly alleviate many of the early issues, and administrators have already articulated the belief that EHS has generated some "best practices" that could benefit the Head Start Department. At the same time, they believe that as EHS moves from being an individual "internally-focused" program to being part of a larger and more established program, some of EHS's program and administrative practices will need to be adjusted. Key to the success of the transition will be the degree to which staff at *all* levels have an opportunity to help shape the process.

In Summary

Family-centered programs are called upon to provide a wide range of services. For programs like Phoenix Early Head Start – where primary emphasis is on children 0-3, and child development is paramount — the challenge is complex. It requires constant and intensive attention to the development of healthy parent-child relationships and positive child outcomes, and a well-trained staff to do it. It requires balancing the program's primary child-focus with the needs of the teen parents, and it requires attention to the services that will help parents move towards long-term economic stability. It requires engaging young fathers in the lives of their children. And ultimately, it compels programs like EHS to use their accumulated knowledge and their lessons learned in ways that benefit the larger community. Much has been accomplished in EHS over the past several years, and much has been learned that can help improve services for families in future years. To build on this foundation, the following recommendations are offered.

Program Recommendations

- **Adopt a child development instrument to determine the effects of program services on EHS children.**

  Early Head Start is, foremost, an intervention designed to support the healthy development of infants and young children. Evaluation results, however, have relied primarily on descriptive assessments of developmental progress. A new measure of child development is needed that more specifically determines the effectiveness of program services on its primary constituents.

- **Allocate resources to address employment/training issues for program parents.**

  Program stakeholders believe that EHS must do better at addressing the employment and training issues of EHS parents. If employment ranks as a high priority for moving parents towards economic self-sufficiency, EHS needs a staff member assigned to focus on this area. To support this staff position, program managers should seek partnerships with state or local agencies that receive welfare reform funds targeted for employment-related services.

- **Take action to retain staff.**

  Agency managers must consider the impact of EHS's high staff turnover. It compromises the effectiveness of the program's ongoing staff training strategy. It also stands contrary to EHS strategies of relationship-building and developing supportive alliances with families. For these strategies to work — and ultimately have a positive effect on families — agency managers must find effective ways to retain staff.

- **Maintain an intensive, ongoing staff training agenda in child development *at all program levels* — and regularly review its effectiveness.**

  In order for staff training to "take," key conceptual issues presented in training activities should be reinforced and applied as part of regular staff supervision. For this to occur, staff at all program levels must have a clear understanding of child development concepts and be able to apply that knowledge to their specific work responsibilities.

- **Get the word out.**

  Decision-makers surveyed for this report indicated that research plays an influential role in the decisions they make about social policy issues. A group of agency leaders familiar with EHS said they have already benefitted from "program knowledge." Now other community leaders and decision-makers need to hear the lessons learned from EHS's experience. Utilizing legislative briefings, media coverage, presentations, and conferences — it's time to get the story out and tell it to a larger audience.

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Policy Perspective: Building Community Capacity to Support Children Birth to Three and Their Teen Parents

"Building community capacity" to support at-risk young families is a concept that eludes precise definition. Community capacity isn't a matter of "yes, we have it," or "no, we don't." Rather, it is a process that evolves through deliberate actions taken by thoughtful communities to improve the odds for vulnerable young children and their families. Still, there are some concrete indicators of progress that can serve as markers of capacity building for young families — such as an increase in child care options, or a reduction in barriers to employment. By identifying community capacity as a cornerstone of its national initiative, Early Head Start has recognized the importance of fortifying and expanding community service networks. Locally, Phoenix Early Head Start has participated in activities designed to contribute to this process.

Building a Foundation

As a result of experiences and knowledge gained over the past five years, EHS/SWHD administrators have accumulated a reservoir of information with which to help individual families and, equally important, to help identify and facilitate strategies for assisting a larger population of families in the community. The program has also begun to lay groundwork for longer-term community change, particularly in three arenas: 1) issues and needs related to teen parents, 2) services and programs for young fathers, and 3) staff training focused on child development and home visiting.

According to SWHD administrators, much of what has been learned through EHS is being extended to other agency initiatives as well, particularly regarding how to train staff who work with children 0-3 and their families. And because of Southwest Human Development's leadership role in early intervention and infant mental health, this knowledge is also being disseminated into the broader professional community — enlarging the circle of young children and families who can benefit from it.

Challenges Along the Way

Building community capacity is not a linear process. Some efforts ultimately prove more successful than others. And as community programs and institutions connect and collaborate with one another, inevitable challenges arise in the attempt to achieve balance among different policies and philosophies. For example, changes in policies in the Phoenix Union High School District resulted in the loss of EHS's original program site at South Mountain High School, an impediment that derailed the program's envisioned school-based focus of services and activities for teen parents. EHS and school officials have only recently begun to reconnect. Also, a broadly conceived collaboration with the City of Phoenix Head Start became considerably narrowed in actual practice; however, other collaborations between EHS and City initiatives grew substantially. Meanwhile, a dearth of available high-quality community child care options has caused ongoing concerns.

Taking Stock

The experience of Phoenix Early Head Start offers a number of insights into the concept of community capacity. Building community capacity, first, means expanding efforts to promote positive outcomes for teen parents. Such efforts are currently handicapped by a limited universe of coordinated services. While good services and programs for teen parents certainly exist, more are needed — ones that are targeted, responsive, and coordinated.

Education, in particular, has presented challenges for many EHS parents. Many school-based services for pregnant and parenting teens have disappeared in recent years, yet it is difficult for teen parents to complete regular high school programs while still maintaining their role as caregiver to their child or bread winner for their family. Health care, also, has been a difficult hurdle for EHS families. While most EHS teen parents have had access to a regular source of health care, the system is clearly not user-friendly. Teens have frequently been dropped from the AHCCCS system and some have been denied reentry for months. Moreover, EHS staff and parents have chronicled many experiences with medical personnel that showed lack of responsiveness to, and respect for, the teens.

Other types of services also leave wide gaps in the support net. Many EHS parents, like other at-risk teens in the community, present histories punctuated by community violence, domestic violence and abuse, and mental health problems or substance abuse. But services and programs addressing these concerns are limited — particularly for a target population of teens.

Building community capacity also means focusing on the role of young fathers. Concentrated work with these young men helps bring them into their children's lives. Services must view young fathers as integral to their children's lives; then they must focus these fathers on accepting emotional and financial responsibility for their children, and help them develop good parenting skills.

Another fundamental underpinning for building capacity — albeit one not typically perceived as a public policy concern — is investment in staff skills and knowledge. People who work in family-centered programs are called upon to address a multiplicity of issues in their work, and consequently they must be knowledgeable in a range of disciplines. There has been growing recognition, however, of the importance of a child's early development. Programs must offer services that focus directly on this area, and their staff must be equipped to provide them. Therefore, people who work in early intervention programs must receive comprehensive, intensive, and ongoing training in early childhood development.

Finally, building community capacity to support very young children and their families means promoting and supporting the development of affordable, accessible, high-quality child care. This is an issue for teen parents and all low-income parents, particularly in light of welfare reform regulations and the need to place more and more people in full-time jobs.

The Next Step

Federal support has ensured Early Head Start's place as an established part of the landscape for infant/toddler services. Along with other programs across the country, Phoenix Early Head Start has received funding to continue its operations. This is certainly good news for EHS program families, but service delivery is only one of the roles that EHS can play.

Programs such as Phoenix Early Head Start should also be viewed as an opportunity for continued learning. It can help us better understand what it takes to help children 0-3 and their teen parents. At the national level, Early Head Start constructed a bridge from "research" to "practice." Now, in Arizona, a second bridge is needed — from practice to the broader policy arena. Supportive local and state actions must be taken to achieve meaningful progress.

Moving Forward: Policy Actions

Community capacity to address the needs of children birth to three and their families will increase only when appropriate public policies are put in place. Creating these policies requires a political climate that champions a broad spectrum of family support initiatives. The experiences of Phoenix Early Head Start during the past five years suggest that state and local decision- makers must take action:

- ***Develop and fund a statewide system of services for teen parents.*** Teen parents in Arizona require a more comprehensive system of support, through a network of services that are targeted, responsive, and coordinated.
- ***Expand programs that help young fathers***. These often disenfranchised teen parents need a web of services and support to integrate them into their children's lives and help them assume financial responsibility.
- ***Invest in comprehensive, ongoing child development training for people who work with very young children***. To ensure that services effectively address publicly-held goals for young, low-income children, the right training must be provided to the professionals who work with them.
- ***Provide financial incentives that encourage development of high-quality child care facilities and reward providers who deliver these services***. Young families need affordable, high-quality child care in order to continue their education and move towards economic self-sufficiency.

Opportunities are surfacing at the state and local levels to expand services and community support networks for vulnerable young children and their families. Upcoming ballot initiatives and collaborations among local governments, community organizations, educators, and business leaders, are intended to provide early intervention and prevention services for young children and parents. These efforts signal movement in the right direction.

Investments in new programs, however, should be accompanied by ongoing review, so that "lessons learned" in helping young families can be incorporated into future planning in a continuous cycle of improvement. This will help ensure a positive evolution of community support services, and increase the likelihood of a solid return on investment.

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Appendix A

Phoenix Early Head Start Continuous Improvement Evaluation Plan

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A. Family		
A1. Adult - Child Relationships Parents and other primary caregivers will develop positive adult-child relationships with the child, including: a. positive mother-child interaction b. positive father-child interaction c. effective parenting skills d. reduction of negative parenting behaviors	To what extent do EHS parents show evidence of positive adult-child relationships (including parenting skills)?	Raising a Baby/Raising a Child Parent-Child Activities Home Assessments Discipline Parent-Child Observations checklist
A2. Parent Mental Health Parents will exhibit indicators of positive mental health, including: a. using appropriate decision-making skills b. using effective coping skills in stressful situations c. not engaging in addictive behaviors (e.g., drug abuse, alcohol abuse, chronic gambling, eating disorders) d. demonstrating evidence of positive social interaction appropriate for their age	To what extent do EHS parents exhibit indicators of positive mental health?	Parenting Stress Index General Life Events Scale Coping Strategies Checklist Self-Efficacy Scale Self-Esteem Scale Program data
A3. Personal Health Care Practices Parents will exhibit recommended personal health care practices, including: a. obtaining appropriate prenatal, delivery, and postnatal care b. preventing unplanned pregnancies c. seeking appropriate medical care for routine and chronic health problems d. using preventive health care services	To what extent do EHS parents follow recommended personal health care practices?	Program data Case studies
A4. Educational Self-Sufficiency Parents will demonstrate progress in high school *or* higher education *or* job training programs appropriate to their individual goals.	Do EHS parents participate in high school, higher education, or job training programs appropriate to their goals?	Program data Case studies

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A5. Economic Self-Sufficiency Parents will make progress along a continuum toward economic self-sufficiency as evidenced by: a. progress toward outcome A4. b. employment status and earned income c. reduction in dependence upon subsidies and/or community emergency resources d. access to dependable and reliable transportation e. access to and use of quality infant-toddler child care for their child f. adequate housing g. using effective household management and budgeting skills h. literacy	Do EHS parents show evidence of progress along a continuum toward economic self-sufficiency ?	Program data Case studies
B. Infant-Toddler		
B1. Infant-Toddler Development Infants and toddlers (who do not have developmental delays or disabilities) will demonstrate age-appropriate development in all developmental areas including: a. cognitive development b. language and speech development c. social-emotional development d. physical (fine and gross motor) development	To what extent do infants and toddlers in the EHS program demonstrate positive developmental indicators (cognitive, language, social-emotional, physical)?	IDA Denver
B2. Developmental Delays or Disabilities Infants and toddlers who are identified with potential developmental delays or disabilities will be referred to and receive appropriate intervention services and will show progress in all developmental areas within the capacity of their ability.	Do infants and toddlers in the EHS program who are identified to have developmental delays or disabilities receive appropriate intervention services and show developmental progress?	Program data IDA Denver
B3. Healthy Parent-Child Relationship Infants and toddlers will show evidence of a healthy (i.e., developmentally appropriate) parent-child relationship including: a. responsiveness to parent(s) b. positive interactions with parents	To what extent do infants and toddlers in EHS show evidence of a healthy parent-child relationship?	IDA Parent-Child Activities Home Assessments Parent-Child Observations checklist

Desired Outcomes	Evaluation Questions	Data Sources/Measures
B4. Infant-Toddler Health Infants and toddlers will be healthy, as evidenced by: a. evidence of thriving (i.e., no non-organic failure to thrive) b. receive immunizations according to CDC periodicity schedule c. receive well-baby and well-child check-ups according to CDC periodicity schedule d. receive appropriate medical treatment for routine and chronic health problems e. receive additional developmental evaluations and related services if recommended f. live in a safe home environment that is free from hazards	Are infants and toddlers in the EHS program physically healthy?	Program data National Health Study: Safety
C. Staff		
C1. Supportive Alliances with Families Staff will acquire knowledge and demonstrate skills in establishing supportive and effective alliances with EHS families as evidenced by: a. non-threatening, sensitive, and ethical interactions b. empathic, genuine, and collaborative relationships c. sensitivity to families' culturally related values/issues	Did staff learn about and develop supportive alliances with EHS families?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups
C2. Strategies for Adolescent Parents Staff will utilize appropriate strategies for working with adolescent parents and at-risk families that reflect an understanding of the importance of: a. developmentally appropriate goals and program activities b. a family systems perspective c. self-determination d. self-sufficiency e. risk and protective factors	Do staff understand and use intervention strategies appropriate for EHS parents?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups

Desired Outcomes	Evaluation Questions	Data Sources/Measures
C3. Child Development and Parent-Child Relationships Staff will acquire knowledge and demonstrate skills in working with families on early child development and parent-child relationships including: a. infant-toddler development b. attachment c. positive parent-child interaction d. the role of young fathers	Do staff understand and help EHS parents develop positive adult-child relationships (including parenting skills and parent-child interactions)?	Staff surveys Supervisor survey Videotape analysis Parent survey
C4. "Core" Knowledge Staff will acquire "core" knowledge essential for implementing the Phoenix Early Head Start program including: a. adolescent development b. adolescent health/mental health c. perinatal care d. family planning e. well-child care f. community-based resources g. child care	Did staff acquire the core knowledge necessary to implement EHS program services?	Staff surveys
D. Community		
D1. Phoenix Early Head Start will facilitate the development of parent/child support services including: a. child care b. health services c. education	To what extent were support services established?	Program documentation
D2. Phoenix Early Head Start will establish cooperative relationships with community service providers and provide coordinated services to program participants.	To what extent were cooperative efforts with community service providers implemented?	Documentation of the collaborative process Survey, interview, and observation data
E. Policy		
E1. State and local policy makers will become aware of the benefits of Early Head Start and support policies that address the needs of pregnant and parenting teens and their young children.	Are state and local policy makers knowledgeable about the benefits of the Early Head Start program? To what extent does knowledge gained from the Early Head Start program influence policy makers in their decision-making related to teen parents and their young children?	Documentation of efforts to communicate Early Head Start program results to state and local policy makers (e.g., meetings, briefings) Survey of selected state and local policy makers

Appendix B

Evaluation Methodology

Evaluation Design

Phoenix Early Head Start has been engaged in a continuous improvement program evaluation structured around the four original cornerstones of the national Early Head Start initiative and aligned with the 1998 revised Head Start Program Performance Standards. The evaluation was designed to answer questions about program services, child development, family development, staff development, and community building. Policy outcomes of local interest were also considered.

A process evaluation during Year One examined program development and start-up. Formative evaluation, begun in Year Two and extending through Year Five, examined the effectiveness of program components, identifying successes and challenges in achieving program objectives for children, families, staff, and the community, and providing program managers with continuing feedback. Program outcomes in the domains described below formed the focus for the evaluation.

Infant-Toddler outcomes addressed four areas: infant-toddler development, developmental delays or disabilities, healthy parent-child relationships, and infant-toddler health.

Family outcomes addressed five areas: adult-child relationships, parent mental health, personal health care practices, educational self-sufficiency, and economic self-sufficiency.

Staff outcomes addressed four areas: supportive alliances with families, strategies for adolescent parents, child development and parent-child relationships, and "core" knowledge.

Community and policy outcomes addressed collaborative efforts and the program's influence on public policy.

Instruments and Data Collection

Both qualitative and quantitative data were gathered, with a large part of the data collection conducted by EHS program staff. Some child and family assessment data were used both programmatically and evaluatively. For example, two infant-toddler instruments selected by EHS administrators to assess developmental status for program purposes were also used to follow child progress over time. An instrument for program nurses to monitor the home environment was incorporated into the evaluation data. And parent assessment batteries developed for the evaluation became part of the program files, thereby enabling family support specialists to use the information in their work with individual families.

Parent assessment batteries incorporated established instruments, items adapted from the national Early Head Start evaluation, and locally developed tools. The local Parent-Child Observation Checklist provided family support specialists with uniform criterion for continually assessing the quality of parent-child interactions as they observe them. This instrument was first administered during the six-month assessment, and then again as part of each subsequent parent assessment battery.

Parent and staff surveys, and interview and focus group protocols addressed questions about program implementation. Interview protocols to elicit more specific and in-depth information were utilized with 12 families and their family support specialists as part of a case study analysis that followed families throughout their involvement in the EHS program.

Two instruments designed to help assess the effectiveness of staff training were implemented in 1997-98. The first asked family support specialists to analyze videotapes and respond to several questions. The second was a staff knowledge assessment.

Data collection occasions for EHS were based on three timetables: 1) Parent assessments were linked to a family's time in the program; 2) child assessments were administered based on the child's age; and 3) interviews, surveys, focus groups, and staff assessments were completed annually. This document, therefore, reports on data sets that vary in both "size" and "cycle." Following are descriptions of the types of instruments and the data collection procedures for each.

Child Assessments

Child development was appraised using the Infant-Toddler Developmental Assessment (IDA) and the Denver II. These instruments were also used programmatically to identify initial developmental delays or concerns, and to monitor an individual child's developmental progress.

Since the 1997-98 program year, the IDA has been administered by the child development/disabilities specialists when children are 18 months old and again at 30 months old. The Denver II has been administered by EHS nurses when children are 45 days old, six months, 12 months, 24 months, and 36 months. Prior to 1997-98, the administration schedules for these two instruments were reversed. The change was instituted because program managers felt it would provide a better schedule both developmentally and programmatically.

The quality of the home environment was assessed for program purposes by the EHS nurses using the Infant/Toddler Home Inventory (HOME). Initially, administration of the HOME occurred when the child was 45 days old or less or upon program entry, and again at 12-18-month intervals. Since 1998-99, the HOME has been administered at three assessment occasions: 0-45 days or upon program entry, 18 months old, and 30 months old.

Qualitative information from these assessments was entered into the database maintained by the EHS program and used by staff in working with their families. IDA information was also converted to quantitative summary data enabling evaluators to track overall child outcomes. Evaluators also reviewed Denver II screening data and the HOME scores to help describe children's developmental status and the quality of the home environment over time.

The home environment was also assessed at six-month program intervals using a subset of questions from the Infant/Toddler Home Inventory. Family support specialists completed this Home Assessment as part of the parent assessment battery described in the section that follows.

Parent Assessments

Parent assessment batteries were administered according to a family's length of time in the program. Family support specialists administered the enrollment assessment to collect baseline data within three weeks of the start of program services. This was followed by subsequent participant assessments at six-month intervals throughout the program. Evaluators and program administrators agreed that this was the most effective way to address the burden of work for family support specialists who were responsible for assessing each of their families.

Since parent assessment occasions were linked to time in the program rather than to a child's age, each assessment battery had to incorporate instruments that were developmentally appropriate for the full spectrum of possible ages of children at that time. Therefore, the array of individual instruments included in each assessment battery--and the specific instruments that each parent completed--was determined, respectively, by the age range anticipated for the total group of children, and the actual age of each child when the assessment was administered. Instruments addressed desired program outcomes in such areas as: knowledge of infant/toddler development; knowledge and practice of home safety; parent-child relationships and interaction; and parent mental health.

Family support specialists administered the parent assessment batteries during regularly-scheduled home visits. They had a one-month "window" following the six-month target date within which to complete the assessment. Spanish translations of assessment batteries were used with approximately 20 percent of program families.

Surveys

Phoenix Early Head Start parents and staff completed annual surveys that provided information about program implementation. Initial distribution of parent surveys took place during one of the monthly activities at the program site. Attending parents completed the survey at that time, mothers and fathers each answering their own survey. For Spanish-speaking parents, a Spanish-language version of the survey was available and a translator helped the evaluator explain the process. Parents who were not present at the initial session received their surveys from family support specialists during their next home visit. In families where both parents were involved in the program, individual surveys were left for each parent, and parents were instructed to complete the survey after the family support specialist left. They were provided with a stamped, self-addressed envelope to mail the completed survey directly to the evaluator.

Staff surveys were conducted annually with family support specialists, at a meeting with the evaluator. Site supervisors were also asked to complete a brief questionnaire about each of the family support specialists they supervised, as well as a questionnaire about their staff as a whole. Supervisors mailed their completed questionnaires to the evaluator.

Since 1997-98, family support specialists have also been asked to complete a "staff knowledge assessment," with questions based on information taught as part of a SWHD child development course. These assessments were scored by the SWHD staff person responsible for the training.

In 1999-2000, a Community Leader Survey was used to gather information about EHS's influence on community processes. The survey was faxed to select community leaders identified by EHS/SWHD administrators as knowledgeable about the program. Two versions of the survey were distributed, one targeted to agency directors, the other to higher-level policy leaders.

Videotape Analysis

A staff video-clip analysis instrument was administered beginning in 1997-98, to help gauge whether staff training made a difference in the way family support specialists worked with families. Family support specialists watched video-clips of mothers and their children at two different stages of child development and, based on what they saw, they were asked to make several observations and assessments related to child development and parent-child interactions.

Interviews and Observations

Qualitative data about program implementation were gathered through focus groups, interviews, and observations of program meetings and activities. Three focus groups were conducted annually, with family support specialists, English-speaking parents, and Spanish-speaking parents. Groups were guided by interview protocols developed by the evaluators. Sessions lasted between one and two hours, and were audiotaped and transcribed. The evaluator facilitated the family support specialist focus group and the group for English-speaking parents. The parent focus group for bilingual and monolingual Spanish-speakers was facilitated by a consultant working with the EHS evaluation team who has some familiarity with the program. The evaluator reviewed the interview protocol with the consultant prior to the focus group, and also attended the session. For their participation, parents received a $20 gift certificate for use at a local store.

Personal interviews have also been conducted annually with EHS/SWHD management and administrative staff, site supervisors, and the male involvement specialist. Interview protocols focused on strengths and challenges in implementing program components, community linkages and collaboration, and staff development.

The evaluator attended key EHS meetings and activities throughout the course of the program, primarily in the role of participant/observer. This included selected all-staff meetings, site-based team meetings, site-based socialization activities, and parent policy committee meetings. Meeting observations were documented and analyzed, and when available, meeting minutes were reviewed. In addition, periodic evaluation management meetings and EHS evaluation subgroup meetings have focused on emerging issues related to continuous program improvement.

Case Studies/"Family Stories"

Case studies were conducted with a subset of EHS families to provide background and contextual information about their experiences with the program. Parents involved in the case study each agreed to be followed throughout their participation in the program so that their "stories" could be updated as they unfolded from one year to the next. A representative random sample of 12 families—reflective of program participants' age and ethnicity—were selected. Four of the families were Spanish-speaking.

Case study methodology outlined by Yin (1994) and standards for case study research from the U.S. General Accounting Office (1990) guided evaluators in developing the case study outline and interview protocols for parents and family support specialists. Components of the case study/family story included an annual interview with participating families, annual interviews with their family support specialists, and a review of their participation and assessment data. Upon completion of each of their yearly interviews, families received a $20 gift certificate for use at local stores. All the families were interviewed by the same evaluator, and the four interviews with Spanish-speaking families also included a translator. Interviews generally lasted less than one hour, and were audiotaped for later review.

Appendix C

Summary of Data Collection Instruments And Methodological Notes

Findings were reported only for those correlations that were statistically significant at probability $\leqq .05$.

Data analyses do not include special needs families-with three exceptions. Special needs families *are* included in the Public Assistance Snapshot, the Profile of Families with Inadequate Resources, and the General Life Events data.

Data analyses are based on all participants for whom data were available regardless of whether or not these participants subsequently disenrolled from the program.

The participant assessment instruments described below are included in the Phoenix Early Head Start Enrollment Assessment and the six month, 12-month, 18-month, 24-month, 30-month, and 36-month assessments.

Raising a Baby/Raising a Child, Safety, Parent-Child Activities, Parenting Stress Index and the Home Assessment were adapted from the national *EHS 14-Month Parent Interview* and *Interview for Parents of Two Year Old Children*.

Raising a Baby/Raising a Child are, respectively, nine-item and 13-item scales adapted from the Knowledge of Infant Development Inventory (McPhee, 1981). Items assess participants' knowledge of infant/toddler norms and milestones, developmental processes, and caregiving strategies. The total score on these scales is comprised of the total number of correct responses.

Infant/Toddler Home Inventory assesses the quality of stimulation found in the early home environment. The instrument contains 45 items composing six aspects of home environment: emotional and verbal responsivity of mother; avoidance of restriction and punishment; organization of physical and temporal environment; provision of appropriate play materials; maternal involvement with child; and opportunities for variety in daily stimulation. An item receives a plus (+) if the behavior is observed during the home visit or if the parent reports that the condition or event described is characteristic of the home environment, with a total possible score of 45.

Home Assessment includes questions adapted from the Infant/Toddler form of the Home Inventory. For the purposes of this evaluation, a summary score is calculated to assess parents' contacts and interactions with their child. The instrument was expanded beginning with the 18-month assessment to include developmentally appropriate items for parents with toddlers. Some items are based on parent responses, and the majority of items are based on interviewer observations. Interviewers code their observations after completing the visit.

Parent-Child Activities is a tool designed to provide information about the types and frequencies of parent-child activities. Items draw upon parents' encouragement of language development, routine activities, and experiences outside the house. Parents are presented with age-appropriate parent-child activities and asked how often they engaged in each activity with their children (ranging from "more than once a day" to "a few times a month" to "not at all"). Five items focus on activities between the primary caregiver and the child. If the child's other biological parent is also involved in the child's life, the primary caregiver responds to five additional items about the child's activities with that parent.

Parent-Child Observations Checklist is a locally developed instrument designed to elicit the family support specialist's perceptions of the quality of parent-child interactions, based on their observations over a six-month period. Family support specialists are asked their level of agreement (from "strongly agree" to "strongly disagree") with ten items describing specific aspects of parent-child relationships. The average of all responses is calculated to produce a score. Possible scores range from 1 (lower quality interactions) to 5 (higher quality interactions). In addition, family support specialists are asked to rate the overall parent-child relationship and to characterize its overall emotional tone.

General Life Events is a shortened version of the *General Life Events Schedule for Children* (Sandler, Reynolds, & Ramirez, 1986). On this measure participants are asked to indicate which of the 20 stressful life events presented have occurred in their lives in the past month. The score is equal to the total number of "yes" responses given.

Coping Strategies is a measure composed of 24 items taken from the *Children's Coping Strategies Checklist* (Preventive Intervention Research Center, Arizona State University, 1992). These items represent different types of positive strategies that young people can use to deal with stressful life situations. For each statement, participants are asked to choose among four responses to best describe how often they have used each strategy to deal with their problems in the past month (never, sometimes, a lot of the time, and almost always). The average of all responses is calculated to find the score. Scores range from 1 (infrequent use of positive coping strategies) to 4 (very frequent use of positive coping strategies).

Parenting Stress Index (PSI) is an abbreviated version of an instrument developed by Abidin (1995) which presents 13 statements that reflect parental distress and dysfunctional parent-child interaction. Parents are asked how much they agree with each statement (strongly agree, mildly agree, mildly disagree, strongly disagree). Scores on the PSI are calculated by reversing the weights for all items and calculating their average. Possible scores range from 1 (low parenting stress) to 5 (high parenting stress).

Self-esteem was measured with an adapted form of Rosenberg's 10-item *Self-Esteem Scale* (1965). Participants are asked whether they strongly agree, agree, disagree or strongly disagree with a variety of both positive and negative statements. Item responses combine to yield a seven-point scale. Scores range from 0 to 6, with low scores indicating high self-esteem and high scores indicating poor self-esteem.

Self-Efficacy Scale is based on Pearlin's *Mastery Model* (1981) and measures the extent to which an individual views their life circumstances as within their own control. The scale is comprised of seven statements, with which participants indicate whether they strongly agree, agree, disagree, or strongly disagree. The self-efficacy score is calculated by taking the average of the item responses, with reversed weights for positive statements. Scores range from 1 (low self-efficacy) to 4 (high self-efficacy).

Infant-Toddler Developmental Assessment (IDA), Provence Birth-to-Three Developmental Profile, uses observation by professional practitioners and parental report to assess the child's development in eight domains. For the purposes of this evaluation, a "developmental risk score" was created by summing across the domains of: gross motor, fine motor, relationships to inanimate objects, language/communication, self-help, and social/emotional (a composite of relationships to persons, emotions and feeling states, and coping behavior). Only scores for competent functioning were included; therefore, a higher score indicates higher functioning.

Denver II is a 1990 revision of the *Denver Developmental Screening Test*. The Denver is widely used to detect potential developmental problems in infants and young children by comparing the child's performance on a variety of tasks to performance norms. The tasks are arranged in four sections: Personal-Social, Fine Motor Adaptive, Language, and Gross Motor.

Safety is evaluated by assessing parents' knowledge of safety precautions. Participants are asked a number of questions from the *Early Head Start 14-Month Parent Interview*. Questions address the use of smoke alarms, car seats, and covers for electrical outlets, as well as participants' knowledge of what to do if their child swallows something poisonous.

Parent Survey is administered annually and is designed to elicit information directly related to EHS program services. Respondents are asked their level of agreement (from "strongly agree" to "strongly disagree") with 18 statements about different aspects of their relationship with their family support specialist. The survey also includes two open-ended questions about the program in general.

Staff Video-clip Analysis is a locally developed instrument designed to assess whether staff training makes a difference in how family support specialists work with families. They view two video-clips: a mother with her infant and a mother with her toddler. For two domains-child development and parent-child relationships-the family support specialist identifies critical strengths and critical concerns. Responses are compared to an answer key developed by an ad hoc EHS evaluation group. Two scores are calculated for each video-clip: 1) exemplar score — the number of correctly identified examples of a concept, 2) conceptual score — the number of correctly identified concepts underlying an exemplar.

Staff Knowledge Assessment is a local instrument that asks questions about concepts presented during a SWHD Child Development Course. Family support specialists are asked to respond to a variety of short-answer questions.

Staff Surveys provide information about staff's self-assessment of their knowledge and training. Family support specialists are asked to rate (extensive, moderate, barely adequate, inadequate) their knowledge of and/or training on 40 topics. They are also asked their level of agreement (from "strongly agree" to "strongly disagree") with 13 statements related to EHS program "values" and practices.

Community Leader Survey is a locally-developed instrument designed to elicit feedback about EHS's contribution towards a community environment supportive of children 0-3 and their teen parents. There are two versions of the survey, one targeted to organization directors, the other to higher-level policy leaders. A combination of short answer and open-ended questions focus on how EHS has influenced the way organizations "do business," and the extent of its influence on policy decisions.

Focus Groups are small discussion groups designed to obtain information about the perspectives of project participants and stakeholders regarding the EHS program. An interview protocol consisting of 6 to 10 open-ended questions is developed for each group. Participants are encouraged to engage in an exchange of ideas and explore various aspects of the project in depth.

Appendix D

Stressful Life Events—At 24 Months in Program

Event	Percent of Occurrence*
One of your brothers/sisters was very angry or upset	56.8%
Your parent(s) acted very worried, upset or sad (not because of anything you did)	50.0%
Your mom/dad talked about having serious money troubles	45.7%
You saw your mom/dad drunk	34.8%
A close family member or someone you live with committed a crime, got in trouble with the law, or was sent to jail	28.3%
Your brother/sister had serious trouble (with the law, school, drugs, etc.)	27.3%
Your relatives said bad things about your parent(s)	26.7%
Your mom/dad suffered from serious illness or injury (requiring hospitalization or at least one week in bed)	26.1%
Your close friend had serious troubles, problems, illness or injury	24.4%
Your mom/dad forgot to do important things for you that they promised they would do (such as take you on a trip, take you to nice places or come to your school or athletic event)	23.9%
A close family member died	19.6%
Your mom/dad fought or argued with your relatives (aunts, uncles, grandparents)	17.8%
People in your family physically hit each other or hurt each other (parents, brothers/sisters)	15.2%
You suffered from a serious physical illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	13.0%
Your parent(s) acted badly in front of your friends (yelled at them, criticized them, or was drunk in front of them	13.0%
A close friend died	10.9%
Your brother or sister suffered from a serious illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	9.1%
A close friend of yours moved away	8.9%
One of your parents lost their job	8.7%
People in your neighborhood said bad things about your parent(s)	2.3%

*Event occurred during the prior month.