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HEAD START

Challenges Faced in Demonstrating Program Results and Responding to Societal Changes

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Head Start: Challenges Faced in Demonstrating Program Results and Responding to Societal Changes

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Head Start program. The 30-year-old Head Start is widely viewed as one of the most successful social programs of our time. Head Start's ultimate goal, or program purpose, is to improve the social competence of children in low-income families. Critical to achieving this goal, according to Head Start, are enhancing children's growth and development and strengthening their families. Built on a philosophy that emphasizes the benefits of a comprehensive, interdisciplinary program, Head Start has provided funding for a broad set of educational, medical, mental health, and social services to low-income preschool children and their families. Especially during Head Start's early years, it provided services that participants probably would not otherwise have received. Administered by the Department of Health and Human Services (HHS), Head Start has served over 16 million children at a total cost of more than $38 billion. Annual funding for the program has grown substantially in recent years—from $1.5 billion to almost $4 billion between fiscal years 1990 and 1997—and the program is currently poised for a major expansion. The administration's goal now is to expand the program's annual enrollment to one million children by 2002.

This proposed program expansion, combined with the current reexamination of Head Start's underlying legislation as well as the demand for results-oriented programs called for by the Government Performance and Results Act of 1993 (Results Act), offer a timely occasion for considering the two major issues that my statement addresses today: (1) How well does HHS ensure that the Head Start program is achieving its purpose? (2) How well is Head Start structured to meet the needs of program participants in today's social context, which differs significantly from that of 30 years ago?

My statement is based primarily on information from two of our recent Head Start reports. One report provided descriptive information[1] on the program that we obtained in part from surveying local Head Start agencies; the other reviewed the research literature on the impact of Head

[1]For our descriptive study, we surveyed all regular Head Start programs, and we obtained responses from 86 percent of them. By "regular" Head Start, we mean programs that operate within the scope of established Head Start program options and under normal Head Start requirements. These are distinguished from demonstration and other special programs, which may serve populations or offer services not normally found in Head Start. Regular Head Start serves 85 percent of the children in Head Start.

Start.[2] My statement is also based on the preliminary results from an ongoing study that we are conducting at your request on how HHS ensures that Head Start programs are accountable for complying with laws and regulations and for achieving program purposes. "Achieving program purposes" refers to (1) whether the Head Start program has achieved outcomes such as differences in Head Start participants' growth and development and (2) whether the program has an impact. We define impact as differences in outcomes, such as improved school readiness or health status, caused by Head Start participation. Implicit in this definition is that differences in outcomes would not have occurred without program participation.[3]

In summary, Head Start has, through the years, provided a comprehensive array of services and, as envisioned by the Results Act, has in recent years substantially strengthened its emphasis on determining the results of those services. Its processes still provide too little information, however, about how well the program is achieving its intended purposes. HHS has developed a performance assessment framework that effectively links program activities with the program's overall strategic mission and goal. This framework also includes measurable objectives for how the program will be implemented and what outcomes will be achieved. HHS has new initiatives that will, in the next few years, provide information not previously available on outcomes such as gains made by children and their families while in the program. Currently, however, these initiatives are limited to assessing outcomes at the national level, not at the local agency level. In addition, we are not convinced that these initiatives will provide definitive information on impact, that is, on whether children and their families would have achieved these gains without participating in Head Start. Although obtaining this kind of impact information would be difficult, the significance of Head Start and the sizeable investment in it warrant conducting studies that will provide answers to questions about whether the program is making a difference.

In addition to questions about the program's impact, questions exist about whether Head Start is structured to meet the needs of today's participants who live in a society much changed since the mid-1960s when the program was created. Families' needs have changed as more parents are working full time either by choice or necessity. In addition, children and their families can now receive services similar to Head Start's from a growing

[2] Head Start Programs: Participant Characteristics, Services, and Funding (GAO/HEHS-98-65, Mar. 31, 1998) and Head Start: Research Provides Little Information on Impact of Current Program (GAO/HEHS-97-59, Apr. 15, 1997).

[3] See Head Start: Research Insufficient to Assess Program Impact (GAO/T-HEHS, 98-126, Mar. 26, 1998).

number of other programs. These social trends raise questions about how well Head Start is structured to meet participants' needs and, if changes are needed, what those changes should be. For example, the predominantly part-day, part-year structure of Head Start programs may not be as suited to meeting the participants' needs as it was in the past. Moreover, a lack of information about the array of community programs available and about actions local Head Start agencies have already taken hinders decisionmakers' ability to respond to these trends.

Background

Head Start was created in 1965 as part of President Johnson's War on Poverty. It was built on the premise that effective intervention in the lives of children can be best accomplished through family and community involvement. Fundamental to this notion was that communities should be given considerable latitude to develop their own Head Start programs. Head Start's primary goal is to improve the social competence of children in low-income families. Social competence is the child's everyday effectiveness in dealing with both the present environment and later responsibilities in school and life. Because social competence involves the interrelatedness of cognitive and intellectual developmental, physical and mental health, nutritional needs, and other factors, Head Start programs provide a broad range of services. Another essential part of every program is parental involvement in parent education, program planning, and operating activities.

Head Start is administered by HHS' Administration for Children and Families (ACF), which includes the Head Start Bureau—one of several under ACF. Agencies that deliver Head Start services at the local level may be either grantees or delegate agencies. Unlike some other federal social service programs that are funded through the states, HHS awards Head Start grants directly to local grantees. Grantees numbered about 1,460 in fiscal year 1997. They may contract with organizations—called delegate agencies—in the community to run all or part of their local Head Start programs. Grantees and delegate agencies include public and private school systems, community action agencies and other private nonprofit organizations, local government agencies (primarily cities and counties), and Indian tribes.

HHS distributes Head Start funds by using a complex formula that is based upon, among other things, previous allotments and the number of children, aged 5 and under, below the poverty line in each state compared with the number in other states. Head Start is a federal matching grant program,

and grantees typically must contribute 20 percent of program costs from nonfederal funds. These funds can be cash, such as state, county, and private money, or in-kind contributions such as building space and equipment. The average amount of funds available per child in Head Start programs in the 1996-97 program year was $5,186;[4] an average of $4,637[5] of this amount came from Head Start grant funds. Total funds per child varied widely by program, however, ranging from $1,081 to $17,029 per child. Before using Head Start funds for services, local agencies are required by Head Start regulations to identify, secure, and use community resources to provide services to children and their families. Consequently, Head Start programs have established many agreements for services.

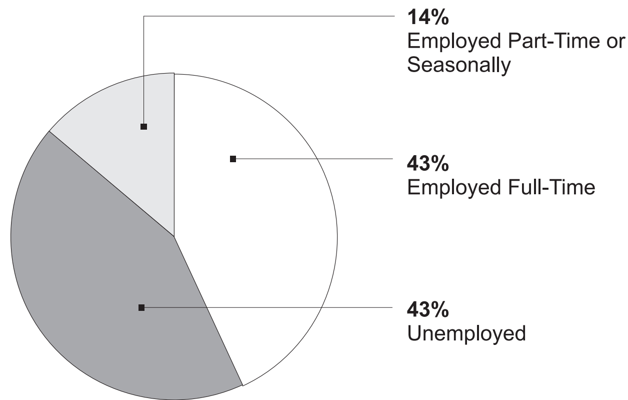
Head Start targets children from poor families, and regulations require that at least 90 percent of the children enrolled in each local agency program be low income. As shown in figure 1, Head Start families are poor as indicated by several measures. During the 1996-97 program year, more than one-half of the heads of Head Start households were either unemployed or worked part time or seasonally, and about 60 percent had family incomes under $9,000 per year. Furthermore, only 5 percent had incomes that exceeded official poverty guidelines, and 46 percent received Temporary Assistance for Needy Families (TANF)[6] benefits.

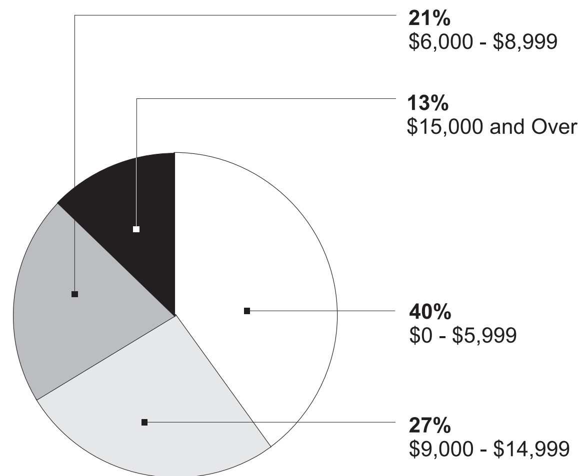
[4]Total funding per child was calculated by dividing the funding from all sources, including Head Start grant funds, by total funded enrollment.

[5]Average Head Start grant funding per child was calculated by dividing Head Start grant funds by Head Start-funded enrollment.

[6]TANF, enacted in 1996, replaced the Aid to Families With Dependent Children program.

Figure 1: Employment and Income Status of Head Start Families



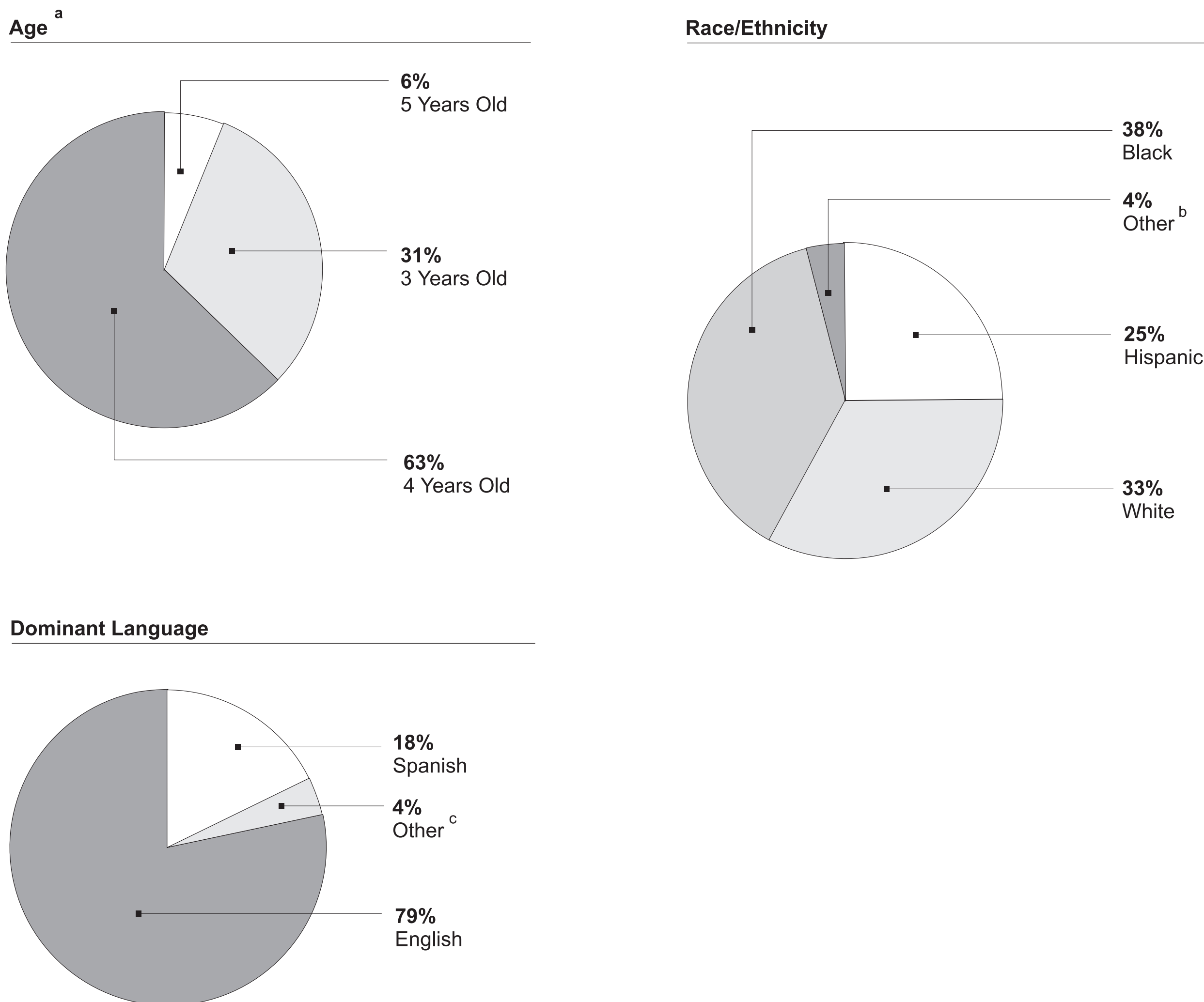


Source: Head Start's 1996-97 survey.

Head Start is authorized to serve children at any age before the age of compulsory school attendance; however, most children enter the program at age 4. In the 1996-97 program year, most children were either 3 (31 percent) or 4 (63 percent) years old (see fig. 2). They also shared other

similar demographic characteristics. Most of the children—79 percent—spoke English as their main language. Spanish-speaking children constituted the next largest language group—18 percent. About 38 percent of the children were black, 33 percent were white, and 25 percent were Hispanic. About 13 percent of Head Start children had some sort of disability.

Figure 2: Age, Ethnicity, and Dominant Language of Head Start Children



[a]Regular Head Start, which excludes Early Head Start and Migrant programs (which serve a number of children in this age group), also serves children who are under 3 years old—as well as children who are 6. However, both groups represent less than 1 percent of the total.

[b]Other includes children who are Asian or Pacific Islanders and American Indian or Alaska Native.

[c]Other includes children whose dominant language is an Asian, Native American, or other language.

Source: Head Start's 1996-97 survey.

Head Start Initiatives Reflect Increased Focus on Results, but Still Provide Too Little Information About Whether Program Makes a Difference

The Congress has recently acted to strengthen Head Start's emphasis on achieving program purposes by, for example, requiring the program to develop performance measures. In reauthorizing the Head Start Act in 1994,[7] the Congress required HHS to develop specific performance measures for Head Start so that program outcomes could be determined. This requirement is consistent with the Results Act, which seeks to shift the focus of federal management away from inputs and processes and toward outcomes. Under the Results Act, agencies are required to develop goals and performance measures that will be assessed annually to show progress toward reaching the goals. Agencies are also expected to conduct specific evaluation studies as needed to obtain additional information about what federal programs are achieving.

In response to this emphasis on performance assessment, Head Start has developed a framework that links program activities of local Head Start grantees to the program's overall strategic mission and goal. This framework emphasizes the importance not only of complying with statutes and regulations, but also of achieving demonstrable outcomes. Head Start has developed five measurable, performance-based objectives. Two of these focus on outcomes: (1) enhancing children's growth and development and (2) strengthening families as the primary nurturers of their children. The other three focus on program activities that the agency believes are critical to achieving the two outcome objectives: (1) providing children with educational, health, and nutritional services; (2) linking children and families to needed community services; and (3) ensuring well-managed programs that involve parents in decision-making.

Overall, HHS has a methodologically and conceptually sound approach to assessing outcomes. HHS developed multiple performance measures to use in assessing progress in meeting these objectives. For each measure, HHS

[7]P.L. 103-252.

has established one or more performance indicators by which to track the percentage of change. Because data on many of these indicators were not previously available, HHS has designed initiatives to collect the data. Head Start intends to assess progress toward these goals mainly through the Family and Child Experiences Survey (FACES). This survey will collect data from families with children enrolled in a random sample of Head Start centers (3,200 families were selected when the survey began in fall 1997), assessing them on a wide range of characteristics at the beginning of program participation, at the end of each year they participate, and at the end of kindergarten. Thus, Head Start will know, for example, if participants' physical health and emergent literacy and math and language skills have improved.

The FACES survey, however, will collect information only at the national level. At the local level, HHS does not require individual Head Start agencies to demonstrate that they have achieved program outcomes. They are only held accountable for achieving the objectives linked specifically to activities, such as providing a developmentally appropriate educational environment. HHS officials told us, however, that they intend in the future to require local agencies to assess what outcomes they have achieved, as some agencies already do. HHS has no specific plan or timetable yet for when this transition will take place.

In addition, these HHS initiatives will not address the need for information on Head Start's impact, limiting its ability to assess how well the program is achieving its purpose. That is, the initiatives will not explain what caused any improved outcomes—whether the same outcomes would have occurred if children and families were in other kinds of early childhood programs or none at all. Although we acknowledge the difficulty of conducting impact studies of programs such as Head Start, we believe that research could be done that would assure the Congress and HHS that the current $4 billion federal investment in Head Start is achieving its purpose.

Head Start has described its FACES initiative as useful for drawing conclusions about impact as well as outcomes, but we believe a more rigorous research design is needed. HHS officials have told us, for example, that the FACES results can be used to determine program impact because each time the performance of Head Start participants is assessed it will be compared with the "norm" or typical performance of some other group of children on the same test. Although this approach has some merit, it also has many limitations. For example, if the group of children used to establish the norms is unlike the children in Head Start, conclusions about

program impact will be unclear. The most reliable way to determine program impact is to compare a group of Head Start participants with an equivalent group of nonparticipants. Comparable groups of participants are important to determining impact because they prevent mistakenly attributing outcomes to program effects when these outcomes are really caused by other factors. For instance, a recent evaluation of the Comprehensive Child Development Program,[8] a demonstration project involving comprehensive early childhood services like those of Head Start, found positive changes in the families participating. Because the study could compare participants with a comparable group not in the program, however, researchers discovered that families that had not participated also had similar positive changes. They concluded, therefore, that the positive changes could not be attributed to the program. Because of the importance of being able to attribute outcomes to Head Start rather than to other experiences children and their families might have had, we recommended in our 1997 report[9] that HHS include in its research plan an assessment of the impact of regular Head Start programs.

Changed Social Environment Raises Questions About Head Start's Role

Head Start operates in a social environment that differs greatly from that of 30 years ago when the program was established: more parents are working full time, either by choice or necessity, and many more social service programs exist to address the needs of disadvantaged children and their families. These circumstances raise policy questions relevant to any consideration of the Head Start program's future.

Predominantly Part-Day, Part-Year Head Start Programs May Not Be Meeting the Needs of Today's Families

The need for early education and child care beyond the home has increased dramatically in the last 20 years due to changes in family structure, women's employment, and the demand for preschool education.[10] The proportion of children under age 6 who live with only one parent has increased. Due partly to the growing proportion of single mothers, the number of those with children under 6 who work outside the home has also increased dramatically. Welfare reform legislation, passed in 1996, may further intensify families' need for full-day, full-year education and child care services. Under TANF, which was created by the 1996 legislation, states must place 25 percent of adults receiving TANF benefits in work and work-related activities in fiscal year 1997 to avoid

[8] National Impact Evaluation of the Comprehensive Child Development Program, Abt Associates (Cambridge, Mass.: June 1997).

[9] GAO/HEHS-97-59, Apr. 15, 1997.

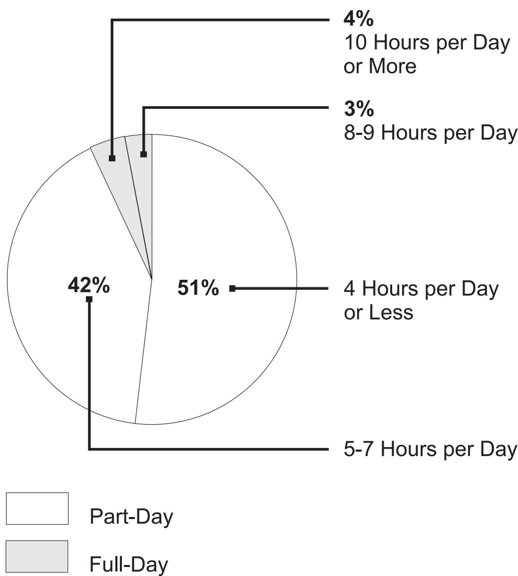
[10] A Profile of Child Care Settings: Early Education and Care in the 1990s, Volume 1, Contract No. LC88090001, Mathematica Policy Research, Inc. (Princeton, N.J.: 1991), p. 1.

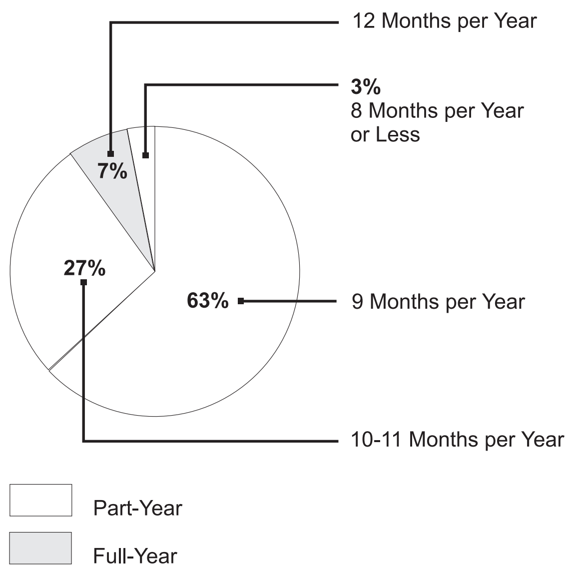
financial penalties. The required participation rate rises to 50 percent in fiscal year 2002. Head Start's own data show that about 38 percent of Head Start families needed full-day, full-year child care services in 1997. About 44 percent of the families that needed full-day, full-year child care services left their children at a relative's or unrelated adult's home when the children were not in Head Start.

Because Head Start is predominantly a part-day, part-year program, the full-day needs of families conflict with the way program services have traditionally been delivered. In program year 1996-97, most Head Start children (90 percent) attended programs at group centers, rather than in home settings;[11] about half of them (51 percent) attended centers that operated 3 to 4 hours per day. Only 7 percent of the children attended centers that operated 8 or more hours a day (see fig. 3). Almost two-thirds of the children attended centers that operated 9 months of the year; only one-fourth (27 percent) of the children attended centers that operated 10 to 11 months. And even fewer—7 percent—attended centers that operated year round.

[11]Head Start has three approved program options: (1) children receive most services in a center but some home visits are required, (2) children receive most services in their home with some opportunities to interact in a group setting, and (3) children receive services that combine center attendance with home visits. Local agencies may also get approval for a locally designed option such as family day care homes.

Figure 3: Most Children Attend Part-Day, Part-Year Programs





Note: For this figure, programs operating 8 hours per day or more are considered full day.

Source: GAO survey.

Program officials have been asking themselves fundamental questions about how they will operate in an environment in which more parents are working, according to our research. For example, a New York City Head Start official described a critical dilemma: Do we serve more children for fewer hours or fewer children for more hours? Given the large number of unserved children in New York City, serving fewer children was considered unwise and impractical. On the other hand, if the program continued to serve children in part-day programs, it would not be meeting needs of many children who need full-day services. This program has also received anecdotal reports of families who have left Head Start programs because their hours of service are insufficient to meet families' needs. According to the director of a program in Ohio, this part-day Head Start program was "out of sync" with the needs of families who need longer

hours of care for their children. The director stated that the need for part-day services is "evaporating."

Other aspects of the program may also conflict with the priorities of working parents. For example, Head Start's emphasis on strong parental involvement, its requirement that staff visit children's homes, and its home-based service delivery option may be more difficult to implement given the schedules of working parents. Head Start program officials told us that welfare reform was already seriously affecting their programs' makeup. For example, a Head Start director in Montana reported that the program eliminated some of the home-based slots so that more children could attend centers. According to a Head Start director in Pennsylvania, the changed environment presents considerable obstacles to the home-based program. This program will try to accommodate families' schedules and perhaps conduct home visits in the evening, but the director acknowledged that sometime in the future home visits may no longer be feasible.

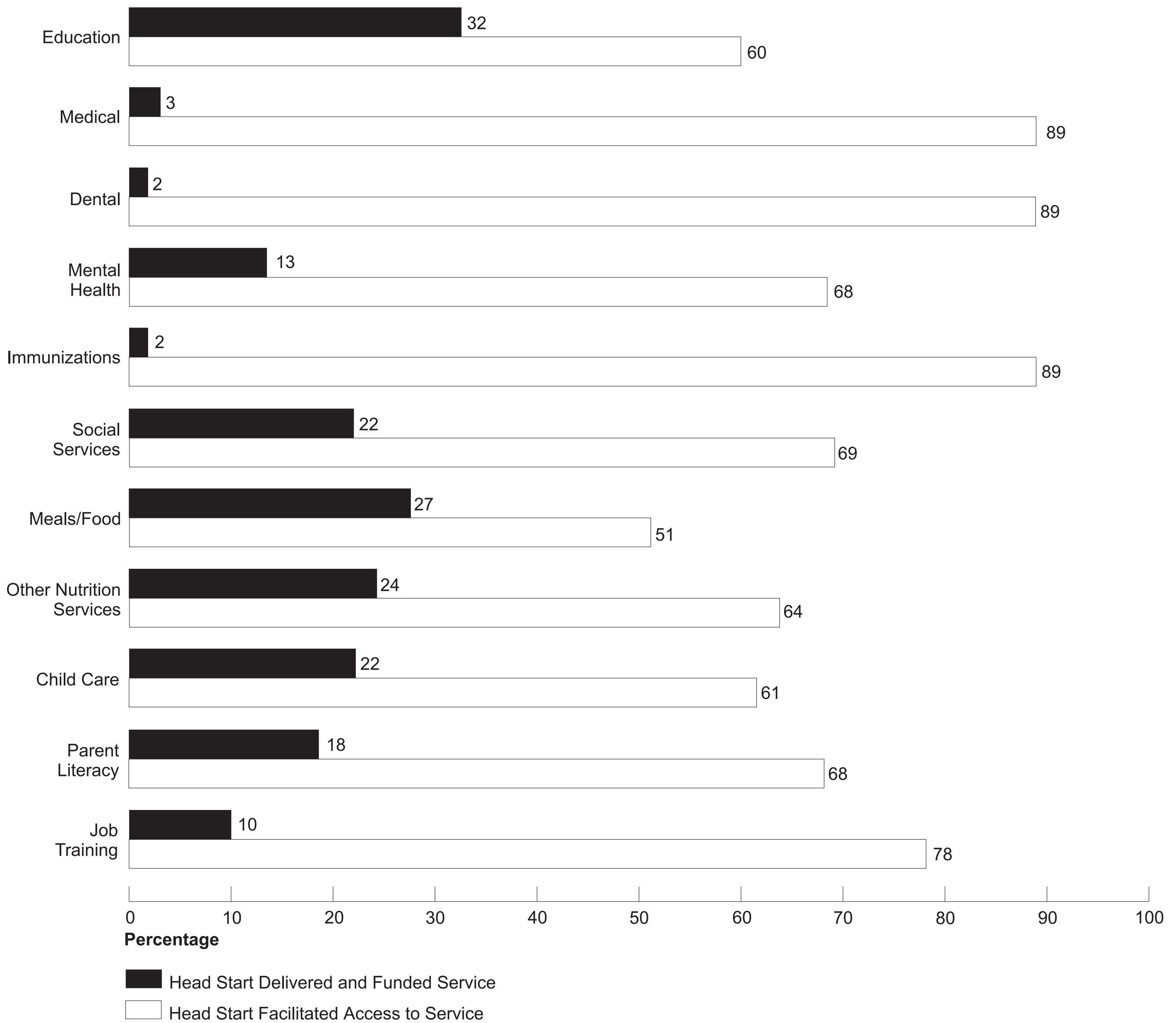
In 1997, the Congress appropriated additional funds to, among other things, increase local Head Start enrollment by about 50,000 children. The Head Start Bureau's priorities for allocating these funds differed from those of the past. In the past, priorities for allocating funds to expand Head Start emphasized part-day, part-year, or home-based services. In recognition of the increasing proportion of Head Start families needing full-day programs for their children, however, the Head Start Bureau announced that programs providing more full-day, full-year Head Start services will receive special priority for the new funds. Head Start has urged local agencies to consider combining these new Head Start expansion funds with other child care and early childhood funding sources and to deliver services through partnerships, such as community-based child care centers. According to HHS officials, this shift in emphasis was responsible for the fact that more than 30,000 of the 36,000 new enrollment opportunities for 3- to 5-year-olds will be for full-day, full-year Head Start.

Additional Community Programs Supplement Services Available Through Head Start

Other federal, state, and local programs as well as private organizations now provide more services for disadvantaged children and their families than in the past. As a result, the role of local Head Start agencies has evolved from providing services directly to helping participants obtain services. Local agencies, in fact, are required to identify, secure, and use community resources in providing services to Head Start children before using Head Start funds for these services. As figure 4 shows, Head Start

often facilitates its participants' access to services, such as immunizations, rather than provide them directly. For example, when we asked Head Start programs the main methods used to provide medical services for enrolled children, 73 percent of survey respondents said that they referred participants to services, and some other entity or program, such as Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program, primarily paid for the services. Dental services were also mainly provided by entities other than Head Start programs.

Figure 4: Head Start's Role in Providing Many Services Is Facilitating Access



Note: Head Start programs deliver services in a variety of ways. This figure highlights the most direct and indirect ways Head Start programs deliver services.

Source: GAO survey.

Although the number of other programs that provide educational services has also grown in the past 30 years, education is the one service that local Head Start agencies typically provide by delivering it directly rather than facilitating access to it from another source. Some Head Start program officials who contracted with private preschools or child care centers to provide education services described the arrangement as offering benefits to both Head Start and the other program. For example, the arrangement eliminated the need to find a facility for the Head Start program as well as to provide the facility startup costs. The private center benefited from the arrangement as well because the Head Start funds allowed the center to do some repair work and purchase computers and playground equipment. We do not know the numbers of community programs that may provide education services, their capacity, or the overall quality of these programs. Head Start programs reported, however, that an array of early childhood programs operate in their communities and serve Head Start-eligible children. For example, 70 percent of Head Start program respondents reported to us that their area had state-funded preschools; 90 percent had other preschools and child development and child care centers in their area; and 71 percent reported that family day care homes served Head Start-eligible children in their area.

Just as Head Start is not the only community program providing specific services to disadvantaged children and their families, it is also not the only program that uses a community's network of services to facilitate access to a comprehensive set of services. In a 1995 report (which used 1990 data from a nationally representative sample of early childhood centers),[12] we concluded that most disadvantaged children did not receive a full range of services from early childhood centers in part because of the limited number that could be served and limited subsidies and in part because of such centers' limited missions. More recent evidence, however, suggests growth in the availability of such services for children. HHS has no information about the number of community programs providing comprehensive services, nor did we obtain this information in our recent study; we plan to explore this further in another study.

We do know, however, that some programs other than Head Start that serve disadvantaged children also help children and families obtain additional services such as medical and social services. For example, the Head Start grantees responding to our survey in some cases also operated other early childhood programs for disadvantaged children. We found that

[12] Early Childhood Centers: Services to Prepare Children for School Often Limited (GAO/HEHS-95-21, Mar. 21, 1995).

about 11 percent of the local Head Start agencies served some children who were eligible for Head Start through other early childhood programs. (Respondents reported serving about 14,000 such children in program year 1996-97.) These children received some or most—but not all—of the services typically provided to children in Head Start programs. These programs were more likely to provide education services, meals, social services, and immunizations; dental and medical services were least often provided. In addition, some states offer preschool programs that emulate Head Start's comprehensive model. In fact, some states provide services that are seemingly identical to those provided through Head Start. For example, in 1993, Georgia initiated its first statewide prekindergarten program. The program coordinates services for families, and children receive basic health and dental screenings and meals. In addition, Ohio has a state-funded Head Start initiative that coordinates closely with the federal Head Start program. The state-funded initiative offers children services that are identical to Head Start's. In addition, Ohio has a state-funded preschool program for disadvantaged children that operates according to Head Start performance standards.

Lack of Information Hinders Decisionmakers' Response to Social Trends

While recognizing that these social changes may significantly affect Head Start now and in the future, the Congress and Head Start lack information needed to decide what specific actions to take in response to them. Information is lacking about families' needs for services, how well Head Start's current structure can respond to those needs, and the array of options available to disadvantaged children and their families. For example, although we expect the need for full-day services to grow, we do not know the extent to which families will choose Head Start—a predominantly part-day educational program—over full-day programs that offer child care, even if the Head Start program has an arrangement with another provider for child care for the rest of the day. Moreover, evidence suggests that more states, for example, are investing in child care and prekindergarten initiatives. The number of such initiatives is not known, however, nor do we have information on their quality. In addition, only limited anecdotal information exists about Head Start agencies' initiatives for responding to these trends and the success of those initiatives. Additional information on family service needs and the options available to them would be valuable to Head Start and the Congress in ensuring that the significant investment of federal dollars is used to the greatest advantage to improve the social competence of children in low-income families.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee may have.

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