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Center for Law and Social Policy

POLICY BRIEF

Head Start Series

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Brief No. 4

Head Start Comprehensive Services:
A Key Support for Early Learning for Poor Children

By Kate Irish, Rachel Schumacher, and Joan Lombardi

Head Start, a federal early education program for low-income children and families, was scheduled to be reauthorized by Congress in 2003 and may still be considered in 2004. First launched in 1965, Head Start was designed to be a comprehensive school readiness program addressing the emotional, social, health, nutritional, and educational needs of low-income preschoolers. The Early Head Start program, created in 1995, serves low-income infants and toddlers (birth to age three) and pregnant women. Today, these programs provide, directly or through referrals, a range of services to support families and early learning.

This policy brief uses available information to describe those services.[1] We present data from Head Start Program Information Reports (PIR) from the most recent program year, 2001–2002, and compare them, when possible, to national data on the services low-income children and families receive. Some of the main findings are:

- Head Start children appear more likely to receive screenings for medical conditions than low-income children enrolled in Medicaid managed care. In 2002, 86 percent of Head Start children were screened for health and development, whereas a 1997 study found only 28 percent of children enrolled in Medicaid managed care were up-to-date in required screenings, and an estimated 60 percent received *no* screenings.
- Head Start children tend to be more up-to-date in their immunizations than other children. Ninety-three percent of Head Start children received all immunizations possible, while 72 percent of children 19-35 months living below the poverty line and 79 percent of higher-income children received the recommended combined series of vaccines.
- Head Start children are more likely to receive a dental exam and preventive dental treatment than other low-income children. In 2002, 78 percent of children in Head Start received a dental exam, while a 2000 General Accounting Office (GAO) report indicates just over 20 percent of two- to five-year-olds below the poverty level visited the dentist in the preceding year.
- Almost one-quarter of the 7,669 pregnant women enrolled in Early Head Start had pregnancies that were identified as medically "high risk." Ninety-four percent of the enrolled pregnant women received prenatal and postpartum health care, and 92 percent received prenatal education and information on breastfeeding directly from the program or through referrals.
- Thirteen percent of Head Start children were diagnosed with a disability in 2002, and 93 percent

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ABOUT THIS SERIES

This policy brief is the fourth of a series of analyses of Head Start Program Information Report (PIR) data by CLASP, which have been made possible by a grant from the A.L. Mailman Family Foundation. The first three briefs are available at www.clasp.org.

of those children received special services.

- Head Start helps families access a variety of support services through direct provision or referrals. In 2002, the family services most often received by Head Start families were parent education (32 percent); health education (27 percent); and adult education, job training, and English as a Second Language (23 percent).

Head Start Program and Children and Families Served

The Head Start program serves preschool children between the ages of three and five, while Early Head Start serves pregnant women and children from birth through age three. Migrant Head Start works with children from birth through age five.

In 2002, 1,002,891 children and 922,499 families received Head Start early education and support services at some point in the program year.[2] The Head Start child population is diverse, with 32 percent black or African American, 30 percent Hispanic or Latino, 28 percent white, 3 percent American Indian or Alaskan Native, 3 percent bi-racial or multi-racial, 2 percent Asian, and 1 percent Hawaiian or other Pacific Islander.[3] In addition, the primary language for 26 percent of children was a language other than English. The great majority of the families participating in Head Start had family incomes below the federal poverty level, and the majority of families included one or both working parent(s).

The Early Head Start program served 60,663 children from birth through age three and 7,669 pregnant women over the course of the 2002 program year.

What Comprehensive Services Are Provided Through Head Start?

All Head Start programs must adhere to the federal Head Start Program Performance Standards, which were designed to promote healthy development for low-income children through a range of services involving child health, parental involvement, and linkages to support services. The performance standards are very specific about what services are required, including comprehensive health and developmental screenings, health care referrals, and follow-up; special services for children with disabilities; nutritious meals; vision and hearing tests; immunizations; on-site family caseworkers; and home visits.

These services are either provided directly through the Head Start program and personnel or through linkages and referrals with community organizations. Head Start programs are required to help children and families access existing services in the community and supplement them when there is no alternative.[4] To this end, Head Start programs employ staff who work with other agencies and programs to coordinate services for children and families. About 20 percent of the Head Start budget is spent on health (3.9 percent), nutrition (4.6 percent), and social services (11.7 percent).[5]

Why Comprehensive Services Matter for Poor Children

Research suggests that provision of health, parent involvement, nutrition, and social support services are necessary to promote school readiness in poor children. The National Research Council's report, *From Neurons to Neighborhoods*, concludes that environmental factors play a crucial role in children's development, especially during the early years.[6]

Research indicates that poor children are at a greater risk for impaired brain development due to exposure to risk factors associated with poverty.[7] For example, poor children are almost twice as likely as non-poor children to be reported in fair or poor health, and they experience increased rates of low birth weight and infant mortality, growth stunting, and lead poisoning, all of which are associated with physical disabilities, reduced IQ, and grade repetition.[8] As a result, it is important to provide low-income children and families with additional services to promote child development. A recent review of studies on health and nutrition services for low-income children indicates that children are less likely to receive physical and dental check-ups and follow-up care and tend to have a less nutritional diet compared to children enrolled in Head Start, where these comprehensive services are a requirement of the program.[9]

Health Services

Medical Screenings and Services

Head Start children appear more likely to receive health and development screening than other poor children. Head Start Program Performance Standards require that children enrolled in the program be screened for developmental, sensory, and behavioral concerns within 45 calendar days of entering

the program.[10] In 2002, 86 percent[11] of Head Start children were screened for medical conditions, and almost one-quarter (24 percent) of screened children were diagnosed as needing treatment.

Medicaid provides health coverage for low-income children, including screenings, through a program called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).[12] A 1997 study by the U.S. Department of Health and Human Services' Office of Inspector General estimated that just 28 percent of children enrolled in Medicaid managed care[13] received all required EPSDT screenings, while 60 percent received no screenings at all.[14]

Head Start programs are also required to follow up with families to assure they secure further diagnosis and treatment for Head Start children, track all the health services Head Start children receive, and individualize how programs and staff respond to children's health and developmental needs.[15] Of the children diagnosed as needing treatment in 2002, 89 percent received treatment for a variety of conditions, including asthma, anemia, and hearing difficulties (see Figure 1).

When looking at the Early Head Start data independently, 81 percent of Early Head Start children received a medical screening, and 23 percent of those children were diagnosed as needing treatment. Ninety-three percent of Early Head Start children diagnosed as needing treatment received it. Early Head Start children were more likely to receive treatment for asthma than Head Start preschool-age children —33 percent and 25 percent, respectively.

Head Start children appear to be more up-to-date in their immunizations than other children. According to the National Immunization Survey, in 2002, 72 percent of children 19-35 months living below the poverty line and 79 percent of higher income children had received the recommended combined series of vaccines.[16] In 2002, 93 percent of Head Start children received all immunizations possible.

Services for Pregnant Women

As part of the Early Head Start program, pregnant women may enroll and receive health and support services. Early prenatal care is particularly important for low-income women, who may be more likely to have a high-risk pregnancy due to worse health or lack of preventive health care before pregnancy.[17]

In 2002, 7,669 pregnant women enrolled in Early Head Start, and nearly one-quarter of those women had pregnancies that were identified as medically "high risk" (see Figure 2). These women receive services, including prenatal and postpartum health care and prenatal education, directly from the program or through referrals.

One way pregnant women enrolled in Early Head Start receive these services is through coordination with the federal Women, Infants and Children (WIC) Program. Nearly 70 percent of Early Head Start families were enrolled in the WIC Program, which provides nutritious food to supplement diets, information on healthy eating and breastfeeding, and referrals to health care to pregnant women and women with children under the age of five.

FIGURE 1

Medical Screenings, Treatment, and Services for Head Start Children, Program Year 2002

Percentage of Head Start children receiving medical screening	**86% (866,005)**
Percent diagnosed as needing treatment, of those screened	24%
Head Start children receiving follow-up services, of those needing treatment:*	89% (185,013)
Asthma	26%
Anemia	17%
Hearing difficulties	11%
Overweight	21%
Vision problems	14%

** Note: The PIR survey only gathers data on the specific services listed in this chart. There is an 'Other' category that accounts for 24% of the children receiving services, but there is no information on what services could be included in this category.*

Source: 2002 Head Start PIR data.

Dental Exams and Preventative Care

Low-income children suffer from poor dental health; tooth decay is most prevalent among poor children.[18] According to the 2000 GAO report, just over 20 percent of all children ages two to five and below the poverty line visited the dentist in the preceding year. In 2002, 78 percent of children in Head Start received a dental exam (see Figure 3). Seventy-six percent of the 223,455 children that were diagnosed as needing treatment received it. In 1999, 19 percent of all children eligible for dental services under EPSDT received a preventive dental service,[19] while 60 percent of Head Start children received preventative dental treatment in 2002.

Mental Health Services

The U.S. Surgeon General notes that 1 in 10 children under 18 suffers from mental health issues significant enough to cause some level of impairment; however, fewer than 20 percent of these children receive treatment in any given year.[20] Head Start and other early childhood services provide an important opportunity to provide access to mental health services. Preschoolers make up about 30 percent of the current population of young people receiving mental health care, at an estimated average per child cost that is much less than the cost for mental health treatment when these children become adolescents.[21]

In 2002, for 13 percent of all Head Start children, a mental health professional consulted with the program staff about the child's behavior, and, for 35 percent of those children, the mental health

FIGURE 2

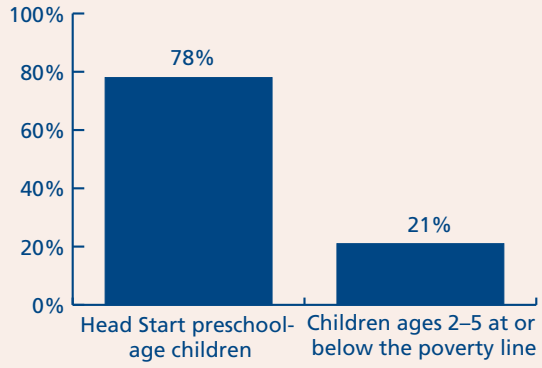
Pregnant Women Enrolled in Early Head Start, Program Year 2002

Enrollment of Pregnant Women in Early Head Start	**7,669**
Pregnant women enrolled by 1st or 2nd trimester	**72%**
Percent of pregnant women enrolled under the age of 18	**23%**
Pregnant women whose pregnancies were identified as medically "high risk"	**24%**
Health Services for Pregnant Women	
Prenatal and postpartum health care	94%
Prenatal education and fetal development	92%
Information on benefits of breastfeeding	92%
Mental health interventions	28%

Source: 2002 Head Start PIR data.

FIGURE 3

Percentage of Children Who Had a Dental Exam Within the Preceding Year (Head Start Children vs. Low-Income Children Overall)



Source: 2002 Head Start PIR data. Comparison data from 1996 Medical Expenditures Panel Survey (MEPS), Agency for Healthcare Research and Quality (AHRQ), reported in General Accounting Office. (2000). Dental Disease is a Chronic Health Problem Among Low-Income Populations. *Washington, DC: Author.*

professional provided three or more consultations with program staff during the operating period (see Figure 4). In 2002, 2 percent of Head Start children were referred for mental health services outside of the program, and 74 percent of those children received services during the program year.

Services for Children with Disabilities

The Head Start Act requires that at least 10 percent of the total number of enrollment opportunities be available to children with disabilities. In 2002, 13 percent of Head Start children were diagnosed as having a disability—118,737 preschool children in the Head Start program and 7,818 infants and toddlers in the Early Head Start program. Ninety-three percent of the children who were diagnosed received special services.

Head Start works in partnership with the Individuals with Disabilities Education Act (IDEA) programs in each state to serve children with disabilities. IDEA has two programs serving young children with disabilities, the IDEA Part C Early Intervention Program for Infants and Toddlers and the IDEA Section 619 Program for Preschoolers. Most of the children who received Part C supports were served in their homes or in a child care setting, and half of the children participating in IDEA Section 619 received services in inclusive settings appropriate for any child of the same age, including public school, child care, and Head Start.[22]

Head Start children with disabilities may either receive all of their specialized services at the Head Start program from Head Start personnel or in collaboration with other providers in the community. Of the Head Start and Early Head Start children with disabilities, 92 percent had an individualized education plan (IEP) or an individualized family services plan (IFSP), which are the service agreements worked out between schools and families specifying goals and necessary services for children with disabilities. The most common service provided to preschool children was for speech or language impairment, and the second most common was for non-categorical/developmental delays (see Figure 5).

FIGURE 4

Mental Health Services Provided to Head Start Children, Program Year 2002

	Percentage of Head Start Children
Consulted with program staff about child's behavior and or mental health	13%
Provided an individual mental health assessment	7%
Consulted the parent(s)/guardian(s) about their child's behavior and/or mental health	5%
Facilitated a referral for mental health services	3%

Source: 2002 Head Start PIR data.

FIGURE 5

Head Start Disability Determination and Special Services, Program Year 2002

Children determined to have a disability	126,555
Percentage with a disability out of all Head Start children	13%
Children who received special services, of those determined to have a disability	93%
Services provided, by most significant disability, for which **preschool** children received services:	
Speech or language impairments	64%
Non-categorical/developmental delay	20%
Multiple disabilities, including deaf-blind	4%
Health impairment	3%
Emotional/behavioral disorder	3%
Learning disabilities	2%
Other	4%

Source: 2002 Head Start PIR data.

In Early Head Start, 7,818 infants and toddlers were diagnosed as needing treatment for a disability, and 82 percent of those children received it. Those 6,391 Early Head Start children received special services through coordination with Part C of IDEA.

Family Services and Parental Involvement

In addition to working to improve child development, the Head Start program focuses on the well-being of families. The vast majority of Head Start children are in families at or below the federal poverty level or receiving welfare assistance; most families have one or both parents working. Most families do not include a parent with more than a high school education. Also, low-income women are about twice as likely to suffer from depression as higher income women.[23] Research indicates that the brain development of poor children is at a greater risk due in part to these types of environmental factors.[24] Given these increased risk factors, it is important to provide low-income families with additional support services to support their parental role.

Head Start programs coordinate with other agencies to support parents in identifying and accomplishing their goals. Staff work with parents to develop family partnership agreements that identify goals, responsibilities, and timetables and strategies for achieving these goals.[25] Head Start programs help families access necessary support services, either directly or through referrals to community resources. In 2002, the services most often received by Head Start families included parent education; health education; and adult education, job training, and English as a Second Language training (see Figure 6).

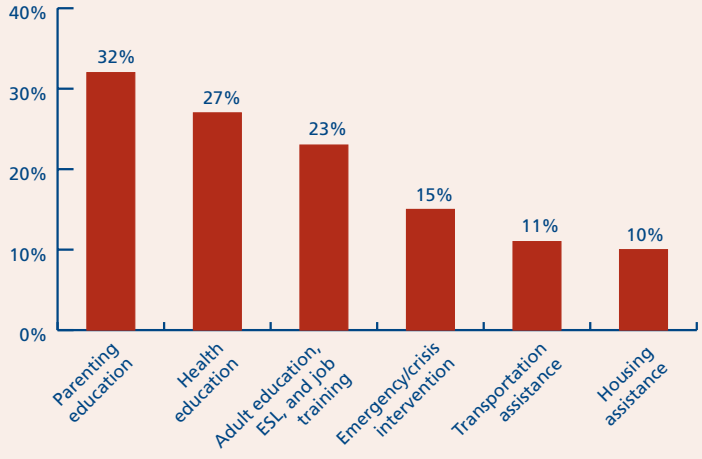
In addition, Head Start also seeks to involve parents in the operation of the program through either volunteer or employment opportunities. In 2002, 65 percent of the volunteers and 27 percent of staff were current or former Head Start parents. Head Start Performance Standards require programs to involve parents in program decision-making and governance, to stay open to parents at any time during operation, and to involve parents in the development of program curricula.

Conclusion

The Head Start program was designed to provide or link children and families to necessary support services as an essential component of promoting early learning. The Head Start Performance Standards require programs to pay attention to a specific set of comprehensive services based on family needs and to assign staff to coordinate and/or provide these supports. Research indicates the importance of early childhood brain development and the necessity of eliminating the risk factors associated with poverty that may impair brain development. Consequently, it is important that programs promoting early learning for low-income children are grounded in a comprehensive approach that addresses health, family, and education issues. In addition, comprehensive services should remain an essential part of Head Start—and any reauthorization proposal should be judged, in part, on its effects on the provision of comprehensive services.

FIGURE 6

Family Services Most Often Received by Head Start Families, Program Year 2002



Note: ESL = English as a Second Language.
Source: 2002 Head Start PIR data.

Endnotes

1 Throughout the text, we use the term "Head Start" to describe data on all children and families served in Head Start and Early Head Start. We use the term "Early Head Start" when we are describing data just for the program serving infants and toddlers and their families, and pregnant women.

2 The PIR collects data on all program participants at any point in the year, including those who may not have completed the year. Therefore, data reported here are different than annualized figures.

3 Note that the language used to describe these racial and ethnic categories are as the PIR collects them.

4 1304.40 (b)(1) and 1304.20 (c)(5).

5 Data provided by the Head Start Bureau, December 2003.

6 Shonkoff, J., & Phillips, D. (Eds.). (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academy of Science.

7 National Center for Children in Poverty. (1999). *Poverty and Brain Development in Early Childhood.* Washington, DC: Author. Available at www. nccp.org/media/pbd99-text.pdf.

8 Brooks-Gunn, J., & Duncan, G. (1997). The effects of poverty on children. *The Future of Children*, *2*(2), 55-71.

9 Koppelman, J. (2003) *Reauthorizing Head Start: The Future Federal Role in Preschool Programs for the Poor.* Washington, DC: National Health Policy Forum; Herman, A. (2003). *Head Start Program Information Report, Health Services Report, Descriptive Analysis.* Presented at the Anderson School at University of California, Los Angeles.

10 Head Start Performance Standards. 45 CFR 1304.20 (b)(1). CLASP's calculations of the percentages of children who received medical screenings, dental exams, and immunizations or were referred to mental health specialists may slightly under-represent the percentage of children who received these services, because there is no way to adjust the figures to exclude those children who dropped out of Head Start within the first 45 calendar days.

11 Note that this number includes children who left the program in the first 45 days of enrollment, which may have been prior to the day the program screened children.

12 The Omnibus Budget Reconciliation Act of 1989 required states to cover low-income children under age six in families with incomes at or below 133 percent of the federal poverty level.

13 States have increasingly turned to managed care as a way to deliver Medicaid services. Fifty-eight percent of the Medicaid population was enrolled in Medicaid Managed Care in 2002. See http://cms.hhs.gov/medicaid/managedcare/mmcss02.asp.

14 U.S. General Accounting Office. (2001). *Medicaid: Stronger Effects Needed to Ensure Children's Access to Health Screening Services.* Washington, DC: Author. The GAO report found that "reliable national data are not available on the extent to which children in Medicaid are receiving EPSDT services. However, a number of studies of limited scope indicate that many children in Medicaid are not receiving EPSDT services." GAO cited the 1997 report, which examined a sample of 338 children's medical records from 12 health plans in 10 states.

15 Schumacher, R. (2003). *Promoting the Health of Poor Preschool Children: What Do Federal Head Start Performance Standards Require?* Washington, DC: CLASP.

16 Federal Interagency Forum on Child and Family Statistics. (2003). *America's Children: Key National Indicators of Well-Being, 2003.* Washington, DC: U.S. Government Printing Office. Available at www.childstats.gov/ac2003/pdfindex.asp.

17 Braveman, P., et al. (2003). *Promoting Access to Prenatal Care: Lessons from the California Experience.* Menlo Park, CA: The Kaiser Family Foundation. Available at www.kff.org/womenshealth/3332-index.cfm.

18 U.S. General Accounting Office. (2000). *Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations.* Washington, DC: Author.

19 U.S. Department of Health and Human Services. (2002). *Child Health USA 2002.* Washington, DC: Author. Available at www.mchirc.net/pdf%20docs/chusa02.pdf.

20 RAND. (2001). *Mental Health Care for Youth: Who Gets It? How Much Does It Cost? Who Pays? Where Does the Money Go?* Research Highlights Series. Available at www.rand.org/publications/RB/RB4541.

21 RAND, 2001.

22 Mezey, J., Beh Neas, K., & Irish, K. (2003). *Coming Together for Children with Disabilities: State Collaboration to Support Quality, Inclusive Child Care.* Washington, DC: Center for Law and Social Policy and Easter Seals.

23 Lennon, M.C., Blome, J., & English, K. (2001). *Depression and Low-Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs.* New York: National Center for Children in Poverty. Available at www.nccp.org/media/dlw01-sum.pdf.

24 National Center for Children in Poverty, 1999.

25 42 USC 9836A Sec. 641A.

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ABOUT CLASP

The Center for Law and Social Policy (CLASP), a national nonprofit organization founded in 1968, conducts research, legal and policy analysis, technical assistance, and advocacy related to economic security for low-income families with children.

CLASP's child care and early education work focuses on promoting policies that support both child development and the needs of low-income working parents and on expanding the availability of resources for child care and early education initiatives. CLASP examines the impact of welfare reform on child care needs; studies the relationships between child care subsidy systems, the Head Start Program, pre-kindergarten efforts, and other early education initiatives; and explores how these systems can be responsive to the developmental needs of all children, including children with disabilities.

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