# DYSFUNCTIONAL FAMILIES IN THE HEAD START PROGRAM: MEETING THE CHALLENGE

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# EXECUTIVE SUMMARY

## PURPOSE

This Head Start program inspection was conducted to (1) assess the needs of dysfunctional families, (2) estimate the number of enrolled children from dysfunctional families and (3) identify ways to overcome service delivery barriers faced by dysfunctional families.

## BACKGROUND

Head Start operates on the premise that children are best prepared for success in grade school and beyond when they and their parents are involved in a comprehensive program that addresses their educational, economic, social, physical and emotional needs. Head Start addresses the needs of the entire family by identifying the family's social service needs and promoting cooperative relationships among the family, Head Start staff and service providers.

In recent years, Head Start staff have expressed concern about adequately serving dysfunctional, or multiproblem, families. Although most Head Start families have some difficulty coping with certain aspects of daily living, the dysfunctional family's problems are considered so severe that the family is unable to fulfill the necessary physical, social and psychological needs of the children and other family members.

## MAJOR FINDINGS

**The comprehensive needs of dysfunctional families pose a special challenge for Head Start grantees.**
According to Head Start grantees, the problems most frequently faced by dysfunctional families involve substance abuse, lack of parenting skills, child abuse, domestic violence and inadequate housing. As a result, dysfunctional families need a wide range of services. While all agreed that Head Start should serve dysfunctional families, some grantees were concerned about the additional demands that these families place on their programs and staff.

**The number of dysfunctional families in Head Start varies widely from grantee to grantee.**
The estimated percentage of children from dysfunctional families currently enrolled in Head Start ranges from zero to 85 percent. No clear growth trend emerges, since almost half of the grantees reported a decrease or no change in the number during a 3-year period. Several grantees reported an increase in the severity of the problems faced by dysfunctional families.

**Although grantees have difficulty providing services to dysfunctional families, they have found some creative solutions.**
Service referrals for dysfunctional families are frequently inadequate or unavailable. Grantees have alleviated some of the service delivery barriers by developing innovative approaches including the establishment of parenting programs, support groups and special classes.

**Income guidelines, performance standards and lack of resources limit grantees' ability to serve some of the children from dysfunctional families who are not eligible for federal "safety net" programs.**
Grantees agree that social needs should be considered as part of enrollment criteria. Nevertheless, many children from dysfunctional families are not enrolled because the families are the working poor and therefore exceed the income guidelines or because other poor families have lower incomes and are accorded higher priority for enrollment. These children may need Head Start even more than some children from currently eligible families who have the "safety net" of public assistance, Medicaid, food stamps and subsidized housing.

## RECOMMENDATIONS

1. Head Start should revise its enrollment criteria to provide grantees greater flexibility to enroll children from dysfunctional families.

2. Head Start should use its discretionary grant authority to (a) develop ways of providing better access to community resources, (b) develop and test new and better approaches for Head Start grantees to assist dysfunctional families and (c) collect and disseminate successful strategies and best practices that grantees are using to meet the needs of dysfunctional families. (NOTE: This recommendation is consistent with the recommendations developed by the National Head Start Social Services Task Force.)

## COMMENTS

We have modified our recommendations based on comments received from the Assistant Secretary for Human Development Services (HDS). The complete HDS comments are included in the appendix to the report.

## TABLE OF CONTENTS

# INTRODUCTION

## The Head Start Program

Head Start is a comprehensive early childhood development program for preschool children from low-income families. Established in 1964, Head Start annually serves approximately 450,000 children between the age of 3 and school entry age. A low-income family, for Head Start enrollment purposes, is a family whose income is below the poverty level (as defined by the Office of Management and Budget) or a family who is receiving public assistance, even if the family's income exceeds the poverty level. At least 90 percent of the children who are enrolled in each Head Start program must be from low-income families. The Head Start regulations state: "If applications for admission . . . are received for more children from low-income families than the Head Start program can accommodate, the children from the lowest income families shall be given preference."

Head Start consists of four major components (education, health, parent involvement and social services) which are designed to serve children and their families. In Fiscal Year 1988, Head Start was administered through 1,291 local public and private non-profit grantee agencies at a cost of approximately $1.2 billion. The grantees are approved and funded by the Office of Human Development Services (HDS) of the Department of Health and Human Services (HHS).

Although grantees are encouraged to tailor their programs to local community needs and resources, HHS has developed national program goals, objectives and performance standards. According to HHS regulations, the overall goal of Head Start is to increase social competence for children of low-income families. To accomplish this goal, objectives and performance standards are concerned with such things as the child's health, self-confidence and mental skills, as well as the child's ability to relate to his family and the enhancement of the child and the family's sense of dignity and self-worth. Specific performance standards for each of the four major components of Head Start require, among other things, that grantees:

- involve parents in educational activities and provide parent training,
- provide a health education program for parents,
- identify the social service needs of Head Start families and
- provide methods and opportunities for involving parents in the identification and use of family and community resources to meet the basic life support needs of the family.

Head Start emphasizes the role of parents in their children's education and development and promotes cooperative relationships among the family, Head Start staff and service providers.

In order to assess the needs of the family, Head Start has developed the Family Needs Assessment (FNA). Head Start has issued a model FNA, but grantees can develop local variations. All grantees are required to administer an FNA for every family at the time of enrollment or shortly thereafter. The FNA is intended to help Head Start staff and the family identify family needs and obtain appropriate services.

Currently, Head Start has the capacity to enroll only about one in six preschool children eligible for the program. President Bush has requested an additional $250 million in the Fiscal Year 1990 budget to expand Head Start to serve more eligible children.

### Dysfunctional Families and Head Start

In recent years, Head Start staff have expressed concern over the growing number of dysfunctional, or multiproblem, families enrolling in the program. This concern was reiterated by the National Head Start Social Services Task Force which was created by the Commissioner of the HDS Administration for Children, Youth and Families. The Task Force issued a report in November 1988 that stated:

> *With the ever increasing number of multiproblem or 'dysfunctional' families being seen in the country, Head Start programs have had to carefully examine their current approaches to determine if they are suitable or effective in successfully assisting many of these families to overcome those plaguing problems confronting them.*

Since Head Start enrolls the "neediest of the needy," most Head Start families have special needs and experience difficulty coping with aspects of daily living. A dysfunctional family's problems are so severe, however, that the family is unable to meet the physical, social and psychological needs of the children and other family members. They are, therefore, unable to benefit fully from the Head Start program.

The terms "dysfunctional family" and "multiproblem family" are often used interchangeably. The following description of multiproblem families, taken from Lisa Kaplan, Working With Dysfunctional Families, closely mirrors the description of dysfunctional families that we heard from Head Start grantees:

> *The multiproblem family has a number of problems that cut across many dimensions of family life. Such a family can neither handle these problems itself nor find help in services available in the community. Its inability to cope with its problems distinguishes this family from others. Repeated negative interactions destroy the possibility of positive communication and understanding among family members.*
>
> *Multiproblem families are often isolated and alienated, possessing few, if any, positive support networks. External problems may include the family's inability to get help from community agencies because it does not*

*know how to access services or because it has been thoroughly overwhelmed by the service system and/or angered by past encounters because of the failure of human service agencies to meet the family's needs. The relationship between human service agencies and the dysfunctional family is characterized by mutual alienation.*

For this inspection, we told grantees that we were interested in discussing those families with serious problems that present barriers to their full participation in Head Start, particularly in such areas as attendance, parent participation, referrals and home visits.

## METHODOLOGY

We drew a random sample of 117 Head Start grantees from the universe of approximately 1,170 grantees. The sample consisted of Head Start programs throughout the country and included both urban and rural grantees with enrollments ranging from 20 children to over 3,500. We did not include Indian, migrant and territorial Head Start programs for two reasons: (1) they are administered separately from regular Head Start programs and (2) these grantees are so different from regular Head Start grantees that they should be studied separately. Grantees were contacted by telephone and requested to provide (1) estimates on the numbers and percent of dysfunctional families served, (2) the nature of the families' problems and (3) information about services needed by dysfunctional families, barriers to getting services, impact on staff and enrollment policies. We completed interviews with 116 of the 117 grantees.

## FINDINGS

### THE COMPREHENSIVE NEEDS OF DYSFUNCTIONAL FAMILIES POSE A SPECIAL CHALLENGE FOR HEAD START GRANTEES.

#### Dysfunctional families face serious physical, mental and social problems.

Although dysfunctional families face many different types of problems, some are clearly more pervasive than others. Grantees ranked substance abuse, lack of parenting skills, child abuse, domestic violence and inadequate housing as the most common problems shared by dysfunctional families. In discussing the most reported problem, substance abuse, grantees mentioned both alcohol and illicit drugs, including cocaine, crack cocaine and heroin. Altogether, grantees identified about 30 different problems that may characterize dysfunctional families. Included in the list were such things as mental illness, a jailed parent, severe health problems and illiteracy.

Grantees cited substance abuse and child abuse and neglect most often as the problems that have worsened since 1986-87. Some grantees felt that increased drug use has led to increases in other problems, such as child abuse and domestic violence. Some stated that the increase in drug-related crimes resulted in declining parent participation because people are afraid to leave their homes in the evening.

Many grantees mentioned an increase over the last 3 years in the third most reported problem, lack of parenting skills. These grantees described the typical parent as a teen-age, single mother who lacks basic parenting skills, education and job training. She is apathetic towards parental duties and defers to her mother for primary caretaking. These mothers require substantial Head Start staff commitment.

The following grantee comments illustrate how difficult it is for Head Start to identify and treat the problems associated with dysfunctional families:

> *Substance abuse is more a 'result' than the problem; it stems from other issues like economics and mental illness.*
>
> *Lack of education, job training programs, incentives to work and low self esteem are the PROBLEMS; the reasons that families become dysfunctional... problems like alcohol and substance abuse are symptoms of the dysfunction not the causes.*
>
> *The problems are so interrelated; for example, homelessness often results from substance abuse.*

*The combination of financial, social and emotional problems results in so much stress that the family cannot function.*

Grantees told us about several case studies that illustrate the problems faced by dysfunctional families:

*This single mother is depressed and suicidal. She had been told as a child by her mother that she was not wanted. She grew up in foster homes. Her husband was emotionally abusive and left her, and her eldest son recently died. She is on welfare and lacks all educational, homemaking, parenting and job skills. Her twins are nonverbal because she never talked to them. They also do not walk well because they were kept in their cribs or play pen and seldom had freedom of movement.*

*The four children in this family have three different fathers. Their mother was sent to prison for 4 months last year, and the family was broken up and scattered among family members. The children's behavior was so inappropriate that they were placed in foster care. While in counseling, the Head Start child disclosed information about abuse in the house. When the mother regained custody of the children, the Head Start child became more violent, used profanity and displayed extreme mood changes. The child has also developed an ulcer.*

*The parents of this Head Start child are illiterate and have no parenting skills. The Child Protective Service had already taken away three of the mother's other children due to neglect and abuse. Afterwards, she gave birth to three more children. The Head Start child was still in diapers because the mother did not know how to toilet train. The children were locked in their bedroom because the mother could not stand their activity. The children were abused, neglected and lacked basic medical care, including immunizations. The mother lacked transportation, and the father was not willing to transport the children if it required him missing work. The mother greatly distrusted social service agencies.*

*The family lives in a rural area, with no running water or sewage system. Both parents are lacking parenting and job skills. The father has a drug abuse problem and abuses his spouse. He openly states that he expects his son to fail as he did. The child has a fear of socializing when at the center.*

*This single mother is overwhelmed by responsibility. She often leaves her children alone and unsupervised while she sleeps. Substance abuse is suspected but not confirmed. Her lack of parenting skills and the other family problems are reflected in the behavior of the Head Start child. The child has little self-confidence, is withdrawn in class and rebels*

*against her mother. The family's lack of transportation has made it virtually impossible for the child to attend the center.*

**Almost all grantees believe that Head Start is the best program for children from dysfunctional families despite the additional demands placed on staff.**

Despite the difficulties they face in providing services to dysfunctional families, 90 percent of the grantees believe that Head Start is the program best able to serve these families. According to the grantees, Head Start is successful in serving dysfunctional families because:

- Head Start treats family problems holistically and comprehensively by providing support for physical, social and educational needs. Outside service providers are unsuccessful because they treat problems in isolation.
- Head Start builds trust with families when they do not trust other social service providers. Families feel comfortable coming into the Head Start center and are more willing to accept treatment.
- Knowledge about the family helps Head Start staff get better results. "We know every minute detail about the family because of the amount of contact we have," said one respondent.
- Many grantees emphasized local flexibility as a reason for Head Start's success in serving dysfunctional families. As one grantee stated, "The strong performance standards make possible a flexible structure; in fact, the beauty of Head Start is that it can adapt to every community and every family."

Grantees offered specific examples of their successes working with dysfunctional families. The first success story involves the mother of twins who was mentioned in the first case study on page 5:

*This mother was involved in the Head Start program for a total of 4 years--2 years with the twins and 2 years when the baby was Head Start age. The home visitor helped by first working on her self-esteem and then on life skills. A homemaker was secured by the Head Start program to teach her homemaking and cooking skills. This mother was brought to parent workshops where, at first, she only looked at the floor. Gradually, she became involved in the policy council and eventually was elected president of the State parents' association. The home visitor assisted her in receiving vocational money which she used to attend a State college where she graduated magna cum laude in journalism. She now works for a local newspaper.*

Another case study also illustrates the success of the Head Start home visit program:

> *At the time she enrolled her daughter in Head Start, this mother was in the middle of a difficult divorce. Her self-esteem was very low, and she was having behavior problems with her two children. Although she attended parent meetings, she was too shy to participate. Through the home visit program, Head Start was able to help her gain self-confidence. She was elected to the Head Start policy council, where she served as Secretary and was encouraged by the home visitor to take the entrance exam for the job training partnership program. She passed with flying colors and has since enrolled in a State university where she is a straight 'A' student and will be graduating with an associate degree in information processing and office technology next year.*

Several respondents felt that, while Head Start may be the best resource, it should not be viewed as the exclusive resource. As one grantee stated, "I would not want to see Head Start work only with dysfunctional families or go out of its way to enroll dysfunctional families."

While dysfunctional families caused some difficulties in meeting performance standards and some problems for staff, most grantees reported that these were not overwhelming or crippling. For example:

- About 62 percent said parent participation stayed the same or increased during the last 3 years. Some grantees reported that their parent participation rates could only be maintained through increased staff efforts.
- Overall, attendance is down about 0.5 percent during the last 3 years, but most grantees attributed this to sickness and transportation problems, not dysfunctional families. Only 9 out of the 51 who reported decreases in attendance mentioned causes that could be related to dysfunctional families.
- About 73 percent of the grantees indicated that they experience major classroom disruptions, but only 16 percent said the disruptions were very frequent or severe. A majority of grantees said that major disruptions were infrequent and limited to a small number of children. While some attributed the disruptions to normal 4-year-old behavior, many of the grantees that reported increased disruptions since 1986 associated the disruptions with dysfunctional families.
- Most grantees (86 of 116), said there was no change in the difficulty in making home visits, while 27 said it is getting more difficult and 3 said it is easier. Approximately one-fourth of the grantees did, however, express concern about potential violence or harm to staff during home visits.

Grantees report that working with dysfunctional families takes much more staff time and often leads to stress and burnout. About 84 percent noted increased demands on staff time. One-to-one counseling, assistance to parents and families, extra home visits, referrals for outside treatment and dealing with the children in the classrooms takes the most time. About two-thirds said staff are adversely affected by stress, burnout and frustration. Despite these problems, only 22 percent of the sample reported increasing staff turnover. Moreover, while stress related to dysfunctional families was mentioned as a cause of staff turnover, most grantees stated that low pay was a more important factor.

Approximately one-third of the grantees said that some children should not be enrolled in Head Start. Violence and major handicapping conditions were most frequently mentioned as categories of families that Head Start might not be able to serve. "We will not serve a family if there is reason to believe it is unsafe to do so. Violence in the household, chairs thrown at our workers or threatening with guns are reasons why we would not serve a family." Families or children with severe handicapping conditions such as the profoundly retarded were also mentioned, primarily because some Head Start grantees feel they do not have the resources to serve such families effectively.

**THE NUMBER OF DYSFUNCTIONAL FAMILIES IN HEAD START VARIES WIDELY FROM GRANTEE TO GRANTEE.**

Measurable, objective standards to identify dysfunctional families do not exist, and grantees do not usually identify dysfunctional families during the Family Needs Assessment. Also, grantees are not required to maintain statistics or separate records on dysfunctional families. Most grantees said that they usually do not know the full extent of a family's problems at the time of enrollment, because people are reluctant to discuss their problems during the FNA. Grantees feel that there is no way to get information until trust is established. As one grantee said:

> *After talking to them awhile, they open up. No real change has to take place. You just have to take the time to get to know the family, and that takes at least one home visit.*

The grantees arrived at their estimates of the number of children from dysfunctional families primarily through discussions with staff and personal knowledge. Almost 60 percent of the grantees also conducted a record review to identify those families whom they consider dysfunctional.

The estimated percentage of children from dysfunctional families currently enrolled in Head Start ranges from zero to 85 percent and has no relationship to the size or location of the program. Nine grantees with enrollments ranging in size from 34 to 524 reported that none of their current children are from dysfunctional families. Sixteen grantees with enrollments ranging in size from 30 to 2561 reported that 50

percent or more of their current children are from dysfunctional families. There was an equal distribution of high and low percentages among rural and urban grantees.

The 116 grantees estimated that 16 percent of the enrolled children came from dysfunctional families in 1986 and 21 percent were from dysfunctional families in 1988. No clear trend emerges, since almost half of the grantees reported a decrease or no change in the number during the 3-year period.

**CHANGE IN PERCENTAGE OF DYSFUNCTIONAL FAMILIES COMPARED TO TOTAL ENROLLMENT (1986 TO 1988)**

| | Number of Grantees Reporting |
|---|---|
| Decreases in percentage | 15 |
| No change | 41 |
| Increase of less than 5 percentage points | 23 |
| Increase of 5-9 percentage points | 16 |
| Increase of 10 percentage points or more | 21 |
| TOTAL | 116 |

The highest increase over the period was 26 percentage points reported by only one grantee. Grantees that reported increases in the number of dysfunctional families also reported that parent participation has decreased, home visits and referrals are more difficult and classroom disruptions have increased.

The data show that the problem of dysfunctional families is an ongoing one that most grantees have been coping with over time. Some grantees perceive the severity of the problem as correlated with local community phenomena such as factory closures or changes in the farm economy. Thus, they see changes as cyclical rather than representative of a trend.

Several grantees (even some that reported a decrease in the number of dysfunctional families) reported an increase in the severity of the problems faced by dysfunctional families.

## ALTHOUGH GRANTEES HAVE DIFFICULTY PROVIDING SERVICES TO DYSFUNCTIONAL FAMILIES, THEY HAVE FOUND SOME CREATIVE SOLUTIONS.

### Dysfunctional families have difficulty obtaining needed services.

Grantees encounter many service delivery barriers when they try to help dysfunctional families. Two-thirds of the grantees have difficulty making referrals because services are not readily available in their communities. Grantees also have concerns about the quality and accessibility of key services for dysfunctional families.

They face the problem of providing services when the family is unable or unwilling to accept referrals.

According to the grantees, dysfunctional families most frequently need:

- mental health services,
- housing,
- substance abuse treatment,
- education/job training,
- medical/dental services,
- parenting skills training and
- child abuse counseling.

Grantees reported dissatisfaction with services provided by community mental health centers because the centers are drastically understaffed and may not be sensitive to the needs and problems of dysfunctional families. The grantees find that families do not feel comfortable using the centers which do not generally address the mental health needs of young children.

Grantees reported difficulty obtaining medical and dental services for all their families. Dysfunctional families, because of their multiple needs, have an especially difficult time obtaining these services. For example, grantees said:

> *Prenatal care has been cut drastically. The well-baby clinic is nonexistent now. Immunizations are no longer free.*

> *Doctors won't take Medicaid because the State is so late with the payments. We have tried to pay the doctors ourselves and then take the reimbursement, but we can only do this on a limited basis.*

Grantees expressed strong dissatisfaction with the decrease in resources for child protective service agencies (CPS). They feel that CPS staffs are overburdened, inexperienced and can deal only with crisis situations. Several grantees said that a referral to CPS is "meaningless." This problem is complicated by the fact that Head Start grantees are legally required to report child abuse. Grantees are concerned that if they report child abuse to an agency which will not follow up, they may only alienate the family and perhaps lose any help for the child and parents.

About 72 percent of grantees indicated difficulties in making referrals because of the families' unwillingness or inability to accept the referral. Many qualified their responses, however, by indicating that difficulties happen only with certain types of referrals or that they happen infrequently.

Grantees note that denial and fear are major reasons families are unwilling to accept referrals. Denial is most common in families with substance abuse problems. It is also a problem when referrals involve domestic violence, mental health or children with special needs. Families are also unwilling to accept referrals due to fear of reprisal (e.g. removal of the children from the home), failure and stigmatization. This seems to be common in small communities. Other explanations for a family being "unwilling" to accept a referral include pride, hopelessness and lack of interest.

Grantees feel that Head Start should provide more transportation. Transportation is the most common reason that families are "unable" to complete a referral. Dysfunctional families, more than other families, lack transportation or the motivation to get transportation. Grantees who cannot provide adequate transportation rate this high on their "wish list."

**Grantees have creatively overcome some service delivery barriers.**

Grantees have implemented many good ideas for dealing with dysfunctional families. These ideas can be grouped under such topics as mental health training, parenting programs and support groups, special classes or groups for severely disturbed and dysfunctional families, stress reduction and tracking families after they leave Head Start. Specific projects include the following:

- Some grantees have a mental health expert on staff or a mental health consultant under contract. These professionals deliver mental health services in the Head Start center. These grantees believe direct provision of mental health services is the most effective way to meet the needs of dysfunctional families.
- Some grantees use other agencies to train Head Start staff; they concentrate on developing the staff's interviewing techniques so they can acquire better information from the families.
- Some grantees have a "personal safety curriculum" for all kids and parents. The program teaches the difference between "good touches" and "bad touches" and has resulted in several children reporting child abuse each year.
- In some Head Start programs, when a problem is first identified in the classroom, the teacher meets with other Head Start staff and the mental health consultant to formulate a "team approach."
- Some grantees have a key or lead contact within each referral agency which makes the referral process easier. The contact in the agency trusts Head Start and knows that if Head Start calls there is a pressing problem that must be taken care of immediately.
- One grantee acquired an "innovation grant" for children of alcoholic parents to form a support group which helps the child acquire better coping skills.

The following are a few examples of specific programs initiated by Head Start grantees to serve dysfunctional families better and help them overcome barriers to service:

### TEEN PREGNANCY PROGRAM
### CENTER, COLORADO

This Head Start grantee has become acutely aware of the increasing problem of teen pregnancy. In response to this concern, the grantee formed a coalition which has met regularly over the past 2 years. The coalition has coordinated with the Governor's Initiative on Teen Pregnancy, supported legislation for Comprehensive Health Education in public schools, sponsored activities for youth and supported Moms-to-Moms efforts. The group is dynamic and positive and will continue to work to solve the problem of teen pregnancy.

### CHILD ABUSE TREATMENT PROGRAM
### SPOKANE, WASHINGTON

Spokane Community Mental Health Center and Spokane County Head Start recognized there are increasing numbers of dysfunctional families where children are at risk. The two agencies established a joint effort to change the lives of abusive parents and abused children. The partnership provides intensive services for families without means to seek other resources.

The typical parent in the program is white, single and female. She is between 18 and 24 years old and is a recipient of Aid to Families with Dependent Children. She most often comes from a childhood where she was a victim of sexual abuse, physical abuse or neglect or a combination of these. The average child in the program has experienced moderate to severe abuse and/or neglect.

The parents meet three times weekly in a therapy group, which focuses on personal, partnership and family problems. This cooperative effort has enabled staff to integrate child and adult therapy programs. The program allows for a comprehensive coordinated effort by community agencies to work more effectively with families and the issues surrounding child abuse and neglect in a mainstream setting.

### THE MENTAL HEALTH PLAYERS
### ELMIRA, NEW YORK

The Head Start program has developed an agreement with the Elmira Mental Health Players to provide nontraditional training for parents leading to increased awareness of mental health issues. The Elmira Players work at the Elmira Psychiatric Center and use role playing for community education. Where lectures left audiences cool and unresponsive, role-playing involved and moved them. The

Elmira Players have made hundreds of presentations before diverse audiences on scores of mental health themes.

The Elmira Players, working without script, spontaneously role-play a scene or situation before an audience. The situation might be that of a parent grieving for a child, an alcoholic mother in the family, a hyperactive child in the classroom, a depressive patient in a mental hospital or a pregnant teenager confronting her parents. A moderator tells the audience about role-playing and about the problem to be portrayed. The players come to the platform, already in character and act out the scene. This may take from 8-15 minutes. The audience participates by questioning the Players. The Players respond in character, sustaining the feeling of authenticity. The moderator closes with an interpretive synopsis.

A real life situation, acted out on a stage, involves the audience on an emotional level. Better understanding, acceptance and constructive attitude changes are more likely to occur in this process than would occur in reaction to a lecture or even a film. The Players are helping Head Start establish its own players group to focus on mental health issues affecting Head Start families.

**INCOME GUIDELINES, PERFORMANCE STANDARDS AND LACK OF RESOURCES LIMIT GRANTEES' ABILITY TO SERVE SOME OF THE CHILDREN FROM DYSFUNCTIONAL FAMILIES WHO ARE NOT ELIGIBLE FOR FEDERAL "SAFETY NET" PROGRAMS.**

More than one-third of the grantees believe that current income guidelines do not allow them to enroll the most needy families. In particular, grantees believe the guidelines exclude many of the working poor. These are families who may have severe needs but with incomes above the guidelines and usually with no health insurance or other benefits. These families do not receive Aid to Families with Dependent Children, food stamps, subsidized housing or Medicaid because their incomes slightly exceed the poverty level. Some grantees stated they specifically excluded such enrollees because Head Start would have to pay medical bills:

> *I often accept AFDC kids before others who may need help more so we won't be stuck with medical bills on that child--so our medical dollars will go farther.*

Almost all grantees believe enrollment should take into account the socially needy. Some programs already are doing this in determining the "neediest of the needy" within the current income guidelines. Guidelines used by some grantees take into account such factors as income, age of the child (with 4-year olds having precedence over 3-year olds), isolation of the family, a single parent family and referrals from other agencies. Some grantees say these criteria should be given as much weight as handicapping conditions when deciding to enroll a family.

Several grantees stated that the performance standards for attendance and parent participation sometimes actually worked against serving dysfunctional families. Because these families have erratic attendance in the classroom and at Head Start functions, many are dropped from enrollment.

Many grantees observed that dysfunctional families frequently "fall through the cracks" and are not enrolled. The following are examples of families who are hard to reach:

> *At the farms and shanties on the outskirts of town, they are afraid of social workers, they are hard to reach, they are transient people living in cars and tents.*

> *We don't reach the mother lying drunk in the trailer park who is not able even to enroll a child--she will be caught later in public school, which is compulsory.*

## RECOMMENDATIONS AND COMMENTS

### RECOMMENDATION #1--ENROLLMENT CRITERIA

**RECOMMENDATION:** Head Start should revise its enrollment criteria to provide grantees greater flexibility to enroll children from dysfunctional families.

**DISCUSSION:** Current eligibility criteria require that at least 90 percent of families have incomes below the income eligibility guidelines and that families with the lowest income be accorded the highest priority. This latter requirement prevents grantees from enrolling poor dysfunctional families even if their needs are greater than other families with lower incomes.

### RECOMMENDATION #2--DISCRETIONARY GRANTS

**RECOMMENDATION:** Head Start should use its discretionary grant authority to (a) develop ways of providing better access to community resources, (b) develop and test new and better approaches for Head Start grantees to assist dysfunctional families and (c) collect and disseminate successful strategies and best practices that grantees are using to meet the needs of dysfunctional families.

**DISCUSSION:** Although grantees generally are coping with the special needs of dysfunctional families, they face service delivery barriers. These barriers include inaccessible services and inadequate community resources. (NOTE: This recommendation is consistent with the recommendations developed by the National Head Start Social Services Task Force.)

### COMMENTS

We received comments from the Assistant Secretary for HDS. Originally we recommended that Head Start set aside funds from the FY 1990 budget to serve dysfunctional families. The HDS disagreed with this recommendation, stating that a policy decision had been made to use additional Head Start funds to serve up to 95,000 additional children. We recognize that nationally the need for Head Start services is great and that the realities of making a choice between serving additional children and increasing services to dysfunctional families is difficult. Therefore, we defer to HDS on this matter and have dropped this recommendation. We are pleased to note that HDS will give grantees as much flexibility as possible to target and serve dysfunctional families.

We originally recommended that HDS consider revising its eligibility criteria to provide greater flexibility to enroll dysfunctional families with incomes above the income eligibility guidelines. The HDS disagreed, stating that most of its grantees had not yet exhausted their current authority to enroll up to 10 percent of their

clients from families with incomes above the poverty income guidelines. The HDS further stated that it has prepared a Notice of Proposed Rulemaking (NPRM) which would provide greater flexibility to grantees to enroll dysfunctional families. Although we continue to believe that grantees should have greater flexibility to serve over-income dysfunctional families, we agree that the NPRM is a step in the right direction, and we have changed our recommendation accordingly.

The HDS fully concurred with our recommendation to use its discretionary grant authority to help dysfunctional families. Complete HDS comments are in the appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

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IG ✓
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AIG-A [redacted] ✓
AIG-I ✓
ADM ✓
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EX SEC ✓
DATE RCVD 9/15

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary
for Human Development Services

SUBJECT: Draft Report on "Dysfunctional Families in the Head Start Program: Meeting the Challenge," OAI-09-89-01000

Attached are comments on the draft report by the Office of Inspector General (OIG) on "Dysfunctional Families in the Head Start Program: Meeting the Challenge," OAI-09-89-01000.

This report is valuable as it captures current impressions on the nature and prevalence of dysfunctional families in Head Start. It also describes how Head Start programs are responding to the special needs of these families.

I would like to thank your office for the timely completion of this report. It was especially useful that Paul Gottlober, Region IX, Office of Analysis and Inspections, could share the findings at the recent First National Institute for Head Start Social Services Coordinators. The report's content was most relevant to the Institute's attendees. Mr. Gottlober will be working with the Head Start Bureau on further analysis of the OIG report data using demographic data that the Head Start Bureau collected in the 1987-88 program year. The demographic data on each Head Start grantee include, for example, the distribution of income among families served by the program as well as the parents' educational attainment and employment status. These data bases are being shared to explore relationships between program demographic information and reported incidence of dysfunctional families.

We appreciate the opportunity to comment on this draft report. I am pleased with the amount of communication between the Office of Human Development Services and OIG. This communication can assist in effectively coordinating efforts which will result in useful information. If you have any questions on the comments on this draft report, please call Deborah Bass at 245-3176.

Mary Sheila Gall

Attachment

COMMENTS OF THE OFFICE OF HUMAN DEVELOPMENT SERVICES ON THE OFFICE OF INSPECTOR GENERAL'S REPORT, "DYSFUNCTIONAL FAMILIES IN THE HEAD START PROGRAM: MEETING THE CHALLENGE," OAI-09-89-01000

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General Comments

I would like to commend the staff of the Office of Inspector General (OIG) for the timeliness and quality of this report. The report captures current impressions on the nature and prevalence of dysfunctional families in Head Start. It also describes how Head Start programs are responding to the special needs of those families. Most of the respondents to the OIG felt that Head Start was an appropriate vehicle to serve dysfunctional families.

It is noted that the report excluded any information on the Indian or Migrant Head Start programs. There was no explanation of why these groups were not included. Alcoholism is a major, if not the leading, problem among the Indian population, yet this group was not included. In addition, the Indian community has had years of experience in dealing with the kinds of problems that are now characterized as "dysfunctional." Many migrant families are dysfunctional primarily because of the instability of their lifestyles. It would have been useful to see how migrant programs cope with the severe needs of families who face some of the same problems as families in traditional programs.

Many of the issues raised in the OIG report will be addressed in proposed Head Start evaluation projects for fiscal year 1990. The Office of Human Development Services (OHDS) will be gathering more specific information on the characteristics of families served by Head Start and the responses of grantees to those needs. Particular attention will be given to those problems rated in your study as most prevalent in dysfunctional families, i.e., substance abuse, child abuse and neglect, domestic violence, and inadequate housing.

OIG Recommendation #1

"If additional funds are available for the Head Start program, as proposed in the President's 1990 budget, a portion of the funds should be set aside to address the needs of dysfunctional families."

OHDS Comment

We do not concur with the recommendation.

In distributing new funds for expansion, our primary objective will be to ensure that all communities in the country have an opportunity to receive a fair share of Head Start funds that is proportionate to their population of eligible children. However, although we do not intend to reserve funds specifically for serving dysfunctional families, we will continue to actively encourage grantees to serve families with special needs.

Within the framework of the national goal of serving up to 95,000 additional children, grantees will be given as much flexibility as possible to target expansion resources on dysfunctional families and to design special services to meet their needs.

In addition, the Head Start Bureau, Administration for Children, Youth and Families (ACYF), has received the report of the Head Start Social Services Task Force. That report includes specific recommendations for allocating social service resources to address the needs of dysfunctional families. We will incorporate these recommendations in a plan for better serving the social service needs of all families, including those described as being dysfunctional.

OIG Recommendation #2

"Head Start should consider revising its enrollment criteria to assure that grantees have the flexibility to enroll children of dysfunctional families even if their income is above the poverty level."

OHDS Comment

We do not concur with the recommendation.

The Head Start Bureau, ACYF, encourages grantees to consider multiple criteria in filling the ten percent over-income slots available in current law and regulation. However, analyses of

the 1987-88 Program Information Report (PIR) indicate that 54 percent of the programs report that less than five percent of the families served are over-income; only 19 percent of the grantees report that more than nine percent of their families are over-income guidelines. For most grantees, there is room for flexibility, within existing guidelines, to increase the number of over-income families served.

The Administration for Children, Youth and Families is drafting a revision of 45 CFR Part 1305. The revision will specify the recruitment, selection, and enrollment procedures which will require that each grantee has a formal process for selecting children from among applicants that considers specific family needs in addition to income. The comment and review process for this Notice of Proposed Rulemaking will provide us with an opportunity to further consider the question of whether changes in Head Start enrollment policy should be made.

Additionally, ACYF will promote grantee responsiveness to opportunities at the State and local levels to extend the Head Start model of services to a wider range of families. For example, in Rhode Island, programs are now able to use State funds to extend services to more of the "working poor." The Head Start Bureau recognizes it must increasingly become involved in technical assistance to support the coordination of services and funding to meet the needs of families.

OIG Recommendation #3

"Head Start should use its discretionary grant authority to (a) develop ways of providing better access to community resources, (b) develop and test new and better approaches for Head Start grantees to assist dysfunctional families, and (c) collect and disseminate successful strategies and best practices that grantees are using to meet the needs of dysfunctional families."

OHDS Comment

We concur with the recommendation.

Head Start's coordinated discretionary grants authority has been, and will increasingly be, directed to enhancing the capacity of grantees to effectively serve dysfunctional families and to promote family self-sufficiency. The OIG's report, feedback from OHDS Regional Offices, and the Head Start Social Services Task Force report have all underscored the need for high-quality resources and technical assistance to enable grantees to address the needs of dysfunctional families.