Executive Summary

A Two-Generational Child-Focused Program Enhanced with Employment Services

Eighteen-Month Impacts from the Kansas and Missouri Sites of the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project

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The findings and conclusions in this report do not necessarily represent the official positions or policies of HHS.

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Overview

Children living in poverty face considerable developmental risks. This report presents interim results from an evaluation of parental employment and educational services delivered within a two-generational, early childhood program targeting low-income families who are expecting a child or who have a child under age 3. This study is part of the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation project, sponsored by the U.S. Department of Health and Human Services, with additional funding from the U.S. Department of Labor.

The program model tested here aims to dually address both the employment and educational needs of parents who are at risk of unemployment and the developmental needs of their young children. The program's effects are being studied by examining 610 families who were randomly assigned to a program group, which received the enhanced two-generational program, or to a control group, which could only access alternative services in the community.

Key Findings

- **The programs increased their focus on parental employment and educational needs, but the implementation of the enhancements was weak.** Programs hired on-site "self-sufficiency" specialists, developed tools to assess parents' employment and educational needs as well as resource guides of employment and educational services in the community, and conducted trainings for program staff and participating families that focused on these topics. However, programs struggled to provide as one of their core services a proactive focus on parental employment and educational needs.

- **Take-up of the enhanced parental employment and educational services was lower than expected.** Only 63 percent of families in the program group ever discussed employment, educational, and self-sufficiency needs with program staff.

- **The program increased families' receipt of child-focused developmental services, but the control group also reporting receiving high levels of such assistance.** Among program group families, 91 percent reported receiving assistance in this area, compared with 80 percent of control group families.

- **The short-term impacts of the program 18 months after families entered the study are mixed.** For the full research sample, the program affected the use of center-based child care but had limited impacts on other outcomes. Beneficial program impacts were evident among families who were expecting a child or who had an infant less than 12 months old at study entry; for this subgroup, the program had positive impacts across several outcomes related to employment, child care, parenting, and children's social and emotional adjustment. Program impacts were more variable among families with a toddler who was 12 months old or older at study entry.

This evaluation is in an early stage and will eventually include three and a half years of follow-up. Future investigation will be valuable in determining the extent to which the patterns of impacts presented here are enduring and robust over time. A final report is planned to be released in 2011.

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checking; Robert Weber edited the report; and David Sobel and Stephanie Cowell prepared it for publication.

Finally, we are deeply grateful to the families and children in the study sample. Whether participating in Enhanced EHS or as members of the control group, these families went through random assignment, granted us access to confidential information about themselves, and participated in surveys and assessments as part of the research effort. Without these families, our research would not have been possible.

The Authors

Executive Summary

Living in poverty can have profound effects on young children's development and their prospects for the future. One promising strategy for addressing the challenges that low-income parents and their young children face is through two-generational services that aim to address both children's developmental risks and the often-precarious and unstable economic circumstances of low-income families.

As part of the multisite Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project (the Hard-to-Employ project), MDRC, together with its research partners, is conducting a rigorous evaluation of an enhanced version of the Early Head Start (EHS) program. In the program model being tested here, formalized parental employment and educational services were implemented within EHS, resulting in "Enhanced EHS," a two-generational, early childhood developmental program that serves low-income families who are expecting a child or who have a child under age 3. The Hard-to-Employ project is sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS), with additional funding from the U.S. Department of Labor.

This report discusses the challenges faced in implementing this Enhanced EHS program and presents short-term effects of the program on parents and their children approximately 18 months after families first enrolled in the study. MDRC randomly assigned families either to a program group that was eligible to receive Enhanced EHS or to a control group that was not enrolled in EHS services but could receive alternate services available in the local community. Any subsequent differences between families in the program and control groups can be attributed to Enhanced EHS.

Key Findings

- Though the programs in Kansas and Missouri were able to increase their focus on parental employment, educational, and self-sufficiency needs, enhanced EHS employment and educational services were modest in intensity, and participation rates were lower than expected.
- Consistent with a traditional EHS model, Enhanced EHS provided comprehensive child-focused, parent education, and family support services through home visits and center-based child care; however, receipt of similar services was also high among control group families.

- Aside from affecting the type of child care used by families, Enhanced EHS had few impacts on parental employment, parenting behavior, and child well-being and development among the full research sample. These findings are not entirely surprising, given that programs had difficulties implementing enhanced EHS employment and educational services and that there was a relatively small differential in receipt of child development, parent education, and family support services between research groups.

- Beneficial impacts of Enhanced EHS are more evident among families who were expecting a child or who had an infant (a child younger than 12 months old) when they entered the study and are more variable among families who had a toddler (a child 12 months old or older), but this finding should be interpreted with caution because the research subgroups are small.

What Is the Program Model?

The program model that is being tested in two sites in Kansas and Missouri is an expanded version of EHS. It includes an array of intensive early childhood developmental services, parent education, family support, and social service assistance that are commonly found in traditional EHS programs *plus* formalized services aimed at proactively addressing parents' employment, educational, and self-sufficiency needs. The programs utilized mixed-approach service delivery models whereby families had the flexibility of receiving EHS services through either home-based or center-based delivery options. (See Table ES.1.) Families could cycle from one service option to the other, depending on their needs, but they could not receive both home- and center-based service options at the same time.

The programmatic enhancements that were aimed at parents' employment, educational, and self-sufficiency needs include:

1. Hiring on-site "self-sufficiency" specialist(s) to oversee and develop the programs' employment and educational services; to work directly with families on employment, educational, and self-sufficiency needs and goals; and to act as "resource experts" by developing resource guides to help staff identify available employment and training-related opportunities in the community

2. Building partnerships with welfare agencies and local programs that provide employment and training services

3. Conducting staff trainings on the use of employment and educational resource guides to further develop the skills and competencies of frontline EHS

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Table ES.1

Core Components and Service Delivery Options of Traditional EHS and Service Delivery Options of Enhanced EHS

Early Head Start with Enhanced Self-Sufficiency Services

Component	
Home-based service option	Families receive weekly home visits with bimonthly group socialization experiences that facilitate interaction among families receiving EHS. Home visits are conducted by EHS program staff and primarily focus on conducting individualized developmental activities with children, demonstrating activities that parents and children can engage in together to foster parent-child interaction, modeling appropriate parenting behaviors, assessing children's developmental progress, and addressing families' social service needs.
Center-based service option	Families receive high-quality, center-based child care for at least 6 hours a day, 5 days a week, either directly through EHS/HS centers or through child care centers in the community that provide care in line with EHS quality and safety requirements. While in center-based care, children receive daily lesson plans and activities tailored to their individual developmental needs and those of other children in the classroom. Families also engage in parent-teacher conferences or home visits conducted on at least a quarterly basis (depending on the program site and where children receive center-based care) in which parent education and family support and social service needs are addressed.
Other specialized EHS services	All families, regardless of whether they receive home- or center-based service options, also are offered an array of health, mental health, nutrition, and child disability services directly through EHS or through referrals to other providers in the community.

staff, so that they were able to work with parents on employment, training, and self-sufficiency goals as needed

4. Conducting parent trainings focused on employment, educational, and self-sufficiency issues

Whom Did the Program Serve?

Enhanced EHS targeted low-income families with infants and toddlers or families who were expecting a child. Beginning in 2004 and ending in 2006, in two program sites in Kansas and Missouri, a total of 610 families who were new applicants to Enhanced EHS were random-

ly assigned in this study.[1] About 90 percent of the primary parents who are identified on the EHS application forms are women. More than half were single and never married when they entered the study. Of the parents in the sample, 86 percent identified themselves as white, 8 percent as black, and 5 percent as Hispanic/Latino(a) regardless of race. Slightly more than half worked more than 12 months in the three years prior to random assignment; about one-third worked 12 months or less; and 15 percent had not worked at all during that period. Slightly less than one-third of families were receiving Temporary Assistance for Needy Families (TANF), and slightly less than half reported ever having received TANF before random assignment. At study entry, relative minorities of the sample were pregnant (11 percent) or teenage parents (12 percent). As expected, children in the sample were about evenly distributed between boys and girls. On average, they were about 17 months old on entering the study.

Although the study's sample mirrors in many ways the range of characteristics of families being served by EHS programs across the United States, it does include more white and fewer black and Hispanic/Latino(a) parents and children.[2] This difference could have implications for the impacts detected here. Among sample members in the Early Head Start Research and Evaluation Project examining the effects of traditional EHS services, for example, impacts are larger in magnitude for ethnic minority families.[3]

How Was Enhanced EHS Implemented?

Following are the key findings about how Enhanced EHS was implemented in the two program sites in Kansas and Missouri.

- **Programs were able to increase their focus on parental employment and educational needs; however, they struggled to make employment, educational, and self-sufficiency services core components of Enhanced EHS.**

Programs successfully developed tools to assess parents' employment and educational needs and resource guides of available employment and educational services in the community,

[1]As is true with all applications to EHS, families identify a particular child who is up to age 3 or during the prenatal period and who will be enrolled in the program. In this study's 18-month parent survey and direct child assessments, this child is identified as the focal child who is the target of program services and is the focus of all questions related to child care and early educational experiences, parenting practices, and child development and well-being.

[2]Center for Law and Social Policy, "Early Head Start Participants, Programs, Families, and Staff in 2006" (Washington, DC: Center for Law and Social Policy, 2008).

[3]U.S. Department of Health and Human Services, Administration for Children and Families, *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start,* Vol. I: *Final Technical Report* (Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, 2002).

and they hired on-site specialists who worked with program staff and families on issues related to parental employment, education, and self-sufficiency needs. Programs struggled, however, to integrate into their core EHS services and interactions with families a proactive focus on parental employment, educational, and self-sufficiency issues. Shifting the culture of a child-focused program to address parental employment and educational needs was difficult. Many frontline staff had little experience discussing such issues with parents. Some staff also did not feel comfortable encouraging parents to spend time away from their children in pursuit of employment or educational activities. Furthermore, Enhanced EHS staff noted in these interviews that some parents were not interested in receiving employment or educational services because they preferred to stay at home, especially when their children were young.

- **The strength of Enhanced EHS was the provision of comprehensive home visiting and center-based child care aimed at enhancing infants' and toddlers' development and well-being, even though participating programs did not enhance these aspects of program services as part of this evaluation.**

The Enhanced EHS programs in Kansas and Missouri did not seek to further enhance basic home visiting and center-based child care services as part of this evaluation. Like most traditional EHS programs, Enhanced EHS provided a comprehensive array of intensive child-focused developmental services, parent education, and family support and social service assistance, even as they sought to implement enhanced services aimed at addressing parents' employment, educational, and self-sufficiency needs.

- **Among program group families, receipt of Enhanced EHS was relatively high, but receipt of enhanced parental employment and educational services was relatively low.**

About 81 percent of families in the program group ever met with program staff or enrolled in Early Head Start or Head Start (EHS/HS) child care. Although 63 percent of program group families ever discussed employment, educational, or self-sufficiency issues with program staff, only 32 percent of parents in the program group ever met with the programs' self-sufficiency specialists. These participation rates likely reflect the voluntary nature of EHS programs, the lack of interest on the part of some families in receiving EHS employment and educational services, and difficulties in implementing the programmatic enhancements that focused on parental employment, educational, and self-sufficiency needs.

- **Programs engaged a higher percentage of families with infants and pregnant women in Enhanced EHS services, and for longer periods of time, than families with toddlers (children 12 months or older) at study entry.**

In the program group, about 90 percent of families with infants and pregnant women ever met with Enhanced EHS program staff or enrolled in EHS center-based child care, compared with 73 percent of families with toddlers. Families with infants and pregnant women were also engaged in Enhanced EHS services for longer periods of time than their counterparts with older children, since they were less likely to age out of Enhanced EHS over the course of the 18-month follow-up period.

Furthermore, families with infants and pregnant women receiving Enhanced EHS were more likely than families with toddlers at study entry to receive home-based services, which provided more opportunities to interact directly with parents on a regular basis. Families receiving home-based services were also more likely to receive employment and educational services from the participating Enhanced EHS programs than families receiving center-based services.

- **Enhanced EHS increased families' receipt of early childhood development, parent education, and family support services, but control group families also reported high levels of assistance in these areas.**

Not surprisingly, a high proportion of families (91 percent) in the program group reported receiving assistance across these domains. Yet it appears that other early childhood development, parent education, and family support services were also readily available in these communities. Eighty percent of families in the control group reported receiving assistance in these areas, though the services provided by other community programs were generally less intense in terms of dosage and scope of services offered.

Did Enhanced EHS Make a Difference for Parents and Children?

Enhanced EHS had few overall impacts for the full research sample, but it shows some evidence of differential impacts on key employment, parenting, and child well-being outcomes, depending on the child's age.

- **For the full research sample, Enhanced EHS affected the type of child care that families used but had no statistically significant impacts on employment, economic, and parenting outcomes. The program slightly increased children's abilities to regulate their behaviors, but it had no significant impacts on other aspects of child well-being and development.**

As shown in Table ES.2, Enhanced EHS significantly increased families' use of formal child care, by 20 percentage points, and their use of EHS/HS center-based care, in particular, by 33 percentage points. However, Enhanced EHS did not significantly affect parental employment, economic, and parenting outcomes for the full research sample. The program did slightly

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Table ES.2

Impacts on Selected Outcomes for the Full Research Sample
18 Months After Random Assignment

Early Head Start with Enhanced Self-Sufficiency Services

Outcome	Program Group	Control Group	Difference (Impact)	Effect Size[a]	P-Value
Child care use outcomes (%)					
Any formal care	57.2	37.1	20.1 ***	0.40	0.000
Early Head Start/Head Start care	42.1	8.7	33.4 ***	0.77	0.000
Other formal care	21.3	30.5	-9.2 **	-0.21	0.018
Any home-based care	54.7	63.6	-8.9 **	-0.18	0.044
Care provided by relative	42.9	47.3	-4.4	-0.09	0.333
Care provided by nonrelative	24.1	38.4	-14.3 ***	-0.31	0.001
Employment and income outcomes					
Ever employed, Quarters 1-6 (%)	86.2	84.0	2.3	0.06	0.422
Total household income in prior month ($)	1,904	2,001	-96	-0.07	0.439
Hours worked per week	20.9	21.8	-0.9	-0.05	0.572
Hourly wage ($)	5.4	6.0	-0.6	-0.11	0.209
Any job benefits (%)	38.3	43.7	-5.4	-0.11	0.220
Parenting outcomes (%)					
Frequency of parenting warmth:					
At least once a day	98.2	98.5	-0.2	-0.02	0.839
Frequency of social play and cognitive stimulation:					
At least once a day	59.4	54.2	5.2	0.11	0.245
Percentage of parents who suggest using only mild disciplinary strategies in hypothetical situations	86.4	82.4	4.0	0.11	0.240
Parental psychological well-being outcomes					
Parenting stress and aggravation[b]	1.5	1.5	0.0	-0.02	0.851
Parental psychological distress[c]	5.1	4.6	0.5	0.13	0.146
Child social and emotional outcomes					
Self-regulation					
Behavioral regulation[d]	0.9	0.7	0.2 **	0.22	0.026
Delay of gratification/impulse control[e]	15.7	17.5	-1.8	-0.09	0.374
Total social and emotional problems	11.6	11.8	-0.2	-0.03	0.754
Total social and emotional competencies	17.6	17.4	0.2	0.09	0.321
Sample size (total = 481)	237	244			

(continued)

Table ES.2 (continued)

SOURCES: MDRC calculations based on responses to the 18-month survey, direct child assessments of children's self-regulation outcomes, and the National Directory of New Hires database.

NOTES: Statistical significance levels are indicated as follows: *** = 1 percent; ** = 5 percent; * = 10 percent. The significance level indicates the probability that one would incorrectly conclude that a difference exists between research groups for the corresponding variable.

Results in this table are regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics.

[a]The effect size is calculated by dividing the impact of the program (difference between program and control groups) by the observed variation for that outcome within the control group (the control group standard deviation).

[b]Parenting stress and aggravation are measured by a composite scale (from 1 to 5) that averages seven items assessing the degree of difficulty that parents experienced in caring for the focal child (Abidin, "Parenting Stress Index — Short Form," 3rd ed. Odessa, FL: Psychological Assessment Resources, Inc., 1995).

[c]Parental psychological distress is measured on a scale of 1 to 25 using the K-6 Mental Health Screening Tool (Kessler, Barker, Colpe, Epstein, Gfroerer, Hiripi, Howes, Normand, Manderscheid, Walters, and Zaslavsky, "Screening for Serious Mental Illness in the General Population," *Archives of General Psychiatry* 60: 184-189 [2003]).

[d]Children's behavioral regulation is measured by a composite measure based on whether the child slowed down during none, one, or two direct child assessment tasks in which the child was asked to draw circles and to walk a line at varying speeds.

[e]Children's delay of gratification is measured by a single direct assessment in which children are asked to wait and not to peek while the interviewer noisily pretends to wrap a "gift." The outcome is the latency to first peek, in seconds, during the waiting period.

increase children's abilities to regulate their behaviors, but it had no impacts on other aspects of children's language, cognitive, and social and emotional outcomes, for the full research sample. It is likely that the lack of overall significant impacts for the full research sample reflects difficulties in implementing enhanced EHS employment and educational services, lower-than-expected participation rates and service receipt among program group families, and high levels of engagement in child-focused, parent education, and family support services among control group families.

- **Consistent with prior studies of EHS, positive impacts of Enhanced EHS seem to be more evident among families who had infants and pregnant women when they first entered the study, but this finding should be interpreted with caution because the research subgroup is small.**

As shown in Table ES.3, a clustering of more pronounced positive impacts on key parent and child outcomes was found among families who were expecting a child or had infants at study entry. It could be that families with infants and pregnant women were more likely to benefit from Enhanced EHS because they were engaged in program services, particularly Enhanced EHS home-based services, at higher rates and for longer periods of time than their counterparts with older children at study entry.

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Table ES.3

Impacts on Selected Outcomes 18 Months After Random Assignment, by Age of Child at Random Assignment

Early Head Start with Enhanced Self-Sufficiency Services

	Age of Child at Random Assignment											
	Infant Group						Toddler Group					
Outcome	Program Group	Control Group	Difference (Impact)		Effect Size[a]	P-Value	Program Group	Control Group	Difference (Impact)		Effect Size[a]	P-Value	†[b]
Child care use outcomes (%)													
Any formal care	52.2	17.7	34.5	***	0.73	0.000	61.2	53.9	7.3		0.15	0.223	†††
Early Head Start/Head Start care	32.1	3.4	28.7	***	0.76	0.000	49.0	14.1	35.0	***	0.75	0.000	
Other formal care	22.7	14.6	8.2		0.21	0.135	21.3	43.4	-22.1	***	-0.47	0.000	†††
Any home-based care	56.4	66.6	-10.2		-0.21	0.116	53.6	60.9	-7.4		-0.15	0.226	
Care provided by relative	42.4	46.8	-4.4		-0.09	0.523	43.4	47.6	-4.1		-0.08	0.503	
Care provided by nonrelative	29.6	47.0	-17.4	***	-0.36	0.009	19.8	31.1	-11.3	**	-0.26	0.036	
Employment and income outcomes													
Ever employed, Quarters 1-6 (%)	85.4	83.5	1.9		0.05	0.667	87.3	83.9	3.4		0.10	0.357	
Total household income in prior month ($)	1,820	1,908	-88		-0.07	0.614	1,976	2,081	-105		-0.08	0.559	
Hours worked per week at current job	23.8	19.4	4.4	*	0.24	0.064	18.8	23.7	-4.9	**	-0.26	0.030	†††
Hourly wage ($)	5.7	5.2	0.6		0.11	0.392	5.3	6.6	-1.3	**	-0.23	0.048	††
Any job benefits (%)	48.1	36.4	11.7	*	0.24	0.071	31.7	49.0	-17.4	***	-0.35	0.003	†††
Parenting outcomes (%)													
Frequency of parenting warmth:													
At least once a day	100.2	97.2	3.1	*	0.26	0.061	97.0	99.2	-2.2		-0.16	0.204	††
Frequency of social play and cognitive stimulation:													
At least once a day	66.3	63.8	2.5		0.05	0.708	54.3	45.6	8.7		0.17	0.167	
Percentage of parents who suggest using only mild disciplinary strategies in hypothetical situations	85.9	76.8	9.1		0.23	0.107	86.6	87.6	-1.0		-0.03	0.809	

(continued)

Table ES.3 (continued)

Outcome	Age of Child at Random Assignment: Infant Group Program Group	Infant Group Control Group	Infant Group Difference (Impact)	Infant Group Effect Size[a]	Infant Group P-Value	Toddler Group Program Group	Toddler Group Control Group	Toddler Group Difference (Impact)	Toddler Group Effect Size[a]	Toddler Group P-Value	†[b]
Parental psychological well-being outcomes											
Parenting stress and aggravation[c]	1.2	1.6	-0.4 **	-0.30	0.031	1.7	1.4	0.3	0.17	0.189	††
Parent psychological distress[d]	4.3	4.7	-0.4	-0.10	0.483	5.7	4.6	1.1 **	0.27	0.033	††
Child social and emotional outcomes											
Self-regulation											
Behavioral regulation[e]	NA	NA	NA	NA	NA	1.0	0.8	0.2 *	0.23	0.055	
Delay of gratification/impulse control[f]	NA	NA	NA	NA	NA	19.6	21.7	-2.1	-0.09	0.435	
Total social and emotional problems	10.3	12.3	-2.0 **	-0.30	0.035	NA	NA	NA	NA	NA	
Total social and emotional competencies	17.7	17.2	0.5	0.19	0.166	NA	NA	NA	NA	NA	
Sample size (total = 481)	103	114				134	130				

SOURCES: MDRC calculations based on responses to the 18-month survey, direct child assessments of children's self-regulation outcomes, and the National Directory of New Hires database.

NOTES: Statistical significance levels are indicated as follows: *** = 1 percent; ** = 5 percent; * = 10 percent. The significance level indicates the probability that one would incorrectly conclude that a difference exists between research groups for the corresponding variable.

Results in this table are regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics.

The Infant Group is defined as families with children less than 12 months old at random assignment. The Toddler Group is defined as families with children 12 months or older at random assignment.

[a]The effect size is calculated by dividing the impact of the program (difference between program and control groups) by the observed variation for that outcome within the control group (the control group standard deviation).

[b]When comparing impacts between two subgroups, an H-statistic is generated. The H-statistic is used to assess whether the difference in impacts between the subgroups is statistically significant. It is interpretable in much the same way as the T-statistic and the F-statistic from analysis of variance (ANOVA) tests are interpreted. Significance levels are indicated as follows: ††† = 1 percent; †† = 5 percent; and † = 10 percent. The significance level indicates the probability that one would be making an error in concluding that there is a difference between research groups for the variable in question.

[c-f]See Table ES.2 for notes explaining these outcome measures.

Consistent with impacts for the full research sample, Enhanced EHS appears to have increased the use of formal child care, and of EHS/HS care in particular, while decreasing the extent to which families with infants and pregnant women on study entry relied on home-based care arrangements provided by nonrelatives.

Enhanced EHS did not affect most employment and economic outcomes examined; however, it appears to have improved parents' earnings late in the follow-up period among families who were pregnant or had infants (not shown). In addition, Enhanced EHS might have improved employment and job-quality outcomes for parents in this subgroup of families (Table ES.3): parents with infants and pregnant women at study entry in the program group worked more hours, were more likely to receive such benefits as sick or vacation days with full pay and health insurance coverage, and perceived greater workplace flexibility to tend to the needs of their families and children than parents with infants and pregnant women in the control group.

Lastly, Enhanced EHS increased parental warmth and decreased parenting-specific stress and aggravation among families who were pregnant or had infants when they entered the study (Table ES.3). Again, these effects are generally modest in magnitude. Parents in the program group also reported that infants showed fewer social and emotional behavior problems than parents in the control group did.

- **Enhanced EHS appears to have had varying impacts among families with toddlers at study entry, but this finding should be interpreted with caution because this research subgroup is small.**

Enhanced EHS increased the extent to which families with toddlers relied on EHS/HS care and decreased their reliance on home-based care provided by nonrelatives. However, in contrast to impacts among families with infants at study entry, Enhanced EHS decreased the use of other forms of formal care but did not affect the overall use of formal child care among families with toddlers at study entry (Table ES.3).

Although Enhanced EHS did not affect most employment and economic outcomes examined, toward the end of the follow-up period, program group parents with toddlers appear to have earned slightly less than their counterparts in the control group (not shown). Enhanced EHS also appears to have reduced the hours that parents worked, their wages, and whether they received benefits at their jobs (Table ES.3). Yet, among families with toddlers (not shown), Enhanced EHS appears to have facilitated the balance between family and work demands by reducing the extent to which family life interfered with parents' abilities to go to work.

Lastly, Enhanced EHS did not significantly affect parenting behaviors or parenting-specific stress, but it appears to have increased parents' reports of psychological distress among families with toddlers at study entry (Table ES.3). However, in line with earlier findings for

families with infants, Enhanced EHS also appears to have enhanced toddlers' self-regulation, as evidenced by their abilities to regulate their behaviors on tasks when they were asked to walk a line and draw circles at varying speeds.

What Are the Implications of the Results?

The foregoing findings illuminate the real-world challenges of implementing enhanced parental employment and educational services within the scope of an early childhood intervention. First, it can be difficult to ensure that program staff view addressing parents' employment, educational, and self-sufficiency needs as core components of program services and are comfortable encouraging parents to pursue employment and educational activities, particularly when children are very young. Second, some parents who seek out early childhood development services prefer to be at home while their children are young.

The story is still unfolding as to whether a parental employment, educational, and self-sufficiency enhancement to an early childhood, two-generational program — such as Enhanced EHS — can be effective at promoting better employment, economic, and child well-being outcomes for low-income families. The short-term results of this study are mixed. The study finds little evidence that the program improved outcomes for low-income parents and children in the full research sample approximately 18 months after families first enrolled in the study. However, preliminary evidence suggests that beneficial impacts of the program may be evident among families who were expecting a child or had a very young infant when they first entered the study.

To better understand the long-term effects of Enhanced EHS, this study will continue to track sample members and will collect information on key employment, economic, parenting, and child well-being outcomes about 42 months after families first entered the study. Future analyses will also aim to disentangle the mechanisms by which Enhanced EHS might influence outcomes for parents and children.