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ABSTRACT

Site visits (1973-74) to 52 regular Head Start programs, 14 experimental programs, and 10 selected non-Head Start preschool enrichment programs were conducted to evaluate the response of Head Start programs to a 1972 Federal mandate requiring at least a 10 percent enrollment of handicapped children. Sources of information included interviews with Head Start directors, classroom observations, and case studies of individual handicapped children served. Among findings in regular Head Start programs were that reports by many programs of at least 10 percent handicapped children reflected a population of primarily mildly disabled children with very few severely impaired children being served; that essentially no programs had made significant modifications in their physical facilities or programs for severely handicapped children; and that the mandate appeared to have positive effects in increasing a coordinated involvement and effort with families and other community agencies. (LS)

quality of services?

(b) What has been the effect of the mandate on the Head Start programs?

(c) What relationship exists between the inclusion of handicapped children and differential costs in total programming?

(d) What handicapped children can or should be included in Head Start?

(e) What role should Head Start play with respect to the handicapped?

(f) What cost differential could be anticipated with optimal implementation of the handicapped effort in Head Start?

(g) What can be done to improve the Head Start performance with respect to the handicapped?

The second round involved visits to 36 regular Head Start programs (six of which were designated as exemplary projects), 10 non-Head Start preschool enrichment programs (selected as exemplary projects), and visits to three experimental programs which were not seen in the fall. These visits averaged from one to three days per site; they began April 1 and were completed by May 31, 1974.

In contrast with visits during the first round, a questionnaire-type instrument was developed and used for the reporting of data in the spring. This instrument provided

FINAL REPORT

ON

ASSESSMENT OF THE HANDICAPPED EFFORT IN EXPERIMENTAL REGULAR HEAD START AND SELECTED OTHER EXEMPLARY PRE-SCHOOL PROGRAMS SERVING THE HANDICAPPED

VOLUME I

CHAPTERS 1-7

Prepared and Submitted by:

Division of Special Education and Rehabilitation

Syracuse University

Submitted to:

The Office of Child Development

U.S. Department of H.E.W.

October 1974

ACKNOWLEDGMENTS

This final report represents the efforts of many in thought, word, and deed. Our task, involving visits to 76 regular Head Start, experimental, and other selected preschool exemplary programs serving the handicapped, was a formidable one. In its doing, we have learned a great deal about ourselves and other people. To those who have participated and made all of this possible, we wish to acknowledge our indebtedness and deepest appreciation.

During long weeks of observation in the field, numerous staff meetings, and diligent report writing, many sacrificed classes, other work, and time with their families. Those students, faculty, and project staff included the following: Bill and Marcia Beneville, Burt Blatt, Alan Bogatay, Bob Bogdan, Aura and Frank Garfunkel, Bob Griffith, Carolyn Harmon, Sandy Haynes, Mike Hogan, Phil Jones, Lenny Lempel, Betsy Mathis, Tom Miller, Dave Nason, Russ Rice, Dan Sage, Walt Sowles, Howard Spicker, Dan Vasgird, and John Watkins.

Much of the responsibility for the research design, sampling and program selection rested with Selcuk Ozgediz. He enlisted the additional help of several others at Policy Research including Bill Baucom, Gerry Fiala, Sandy Filion,

and Debbie Grether. For these and many other individual contributions along the way, we ar deeply indebted to Mr. Ozgediz.

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It is difficult to imagine the formidable administrative responsibilities assumed by a Project Officer in a study as complex and comprehensive as the current project. Over the past 15 months, Mrs. Helen Howerton of the national Office of Child Development has served in such a capacity. Her active participation and enthusiasm has been an enduring source of strength.

The present report has been prepared, in total, by four principals on the Syracuse project staff (i.e., Burt Blatt, Bob Bogdan, Gail Ensher, and Dan Sage) and by three doctoral students, Bill and Marcia Beneville and Dan Vasgird.

At the beginning of this project, a panel of distinguished educators and psychologists knowledgeable in the areas of special education and early childhood was selected to reflect on the Task III site visit data and related issues and to aid the project staff in the formulation of policy recommendations for the Head Start handicapped effort. Those who participated in the preparation of the final document which is reflected in the recommendations of Chapter VII of this report were: Burt Blatt, Frank Garfunkel, John Johnson, Merle Karnes, Ed Newman, Seymour Sarason, Howard Spicker, and Wolf Wolfensberger.

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Finally and perhaps most importantly, we wish to acknowledge the cooperation and sincere efforts of all of the Head Start, experimental, and preschool exemplary project staffs and parents, who took the time to talk with us during our visits with the hope that some benefits might come from this study on behalf of handicapped children.

Gail L. Ensher
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CHAPTER I

BACKGROUND AND PURPOSES OF SITE VISITS TO REGULAR HEAD START, EXPERIMENTAL, AND EXEMPLARY PROGRAMS

In June, 1973, the Office of Child Development (OCD) launched a 15-month study to evaluate Head Start efforts on behalf of handicapped children. Impetus for the project first came from legislation passed by Congress in 1972 that Head Start programs better serve handicapped children in integrated settings. One phase of this study (i.e. Task III) has involved site visits to 52 regular Head Start programs, 14 experimental programs, and 10 selected non-Head Start pre-school enrichment programs. The present document is a report of the results of those site visits, our interpretations and conclusions, and final recommendations for future development of the handicapped effort in Head Start.

This first chapter is intended to provide background information and an overview of the scope and purposes of the Task III site visits. Specifically, it will: review the 1972 legislation and current OCD policies for providing services to

handicapped children in Head Start; summarize some opportunities and problems posed by the handicapped effort; describe particular purposes and the scope of the site visits; and, finally, present the general plan of this final report.

Current Legislation and OCD Policies for Providing Services to Handicapped Children in Head Start

During the past decade, the public has witnessed two important trends in providing educational opportunities for children--one toward offering services in the preschool years; and the second, a guarantee of rights to a meaningful education for all handicapped children--regardless of the nature or degree of their impairments. Both of these developments converge in the Economic Opportunity Act Amendments of 1972, which now require that policies and procedures be designed "to assure that not less than 10 per centum of the total number of enrollment opportunities in the Nation in the Head Start program shall be available for handicapped children and that services shall be provided to meet their special needs."

As defined in the legislative amendments, the term "handicapped" includes those children who are considered to be

"mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, and other health impaired children who by reason thereof require special education and related services." Further, as a matter of OCD policy, Head Start agencies must now take "necessary steps to insure that all handicapped children in the program receive the full range of comprehensive services normally available to Head Start children, including provisions for participation in regular classroom activities." Simply stated, programs have now been charged with the responsibility not only of providing comprehensive developmental programs for children with special needs, but also, with serving them in integrated settings. In prior years, several states have independently passed legislation mandating pre-school education for children with handicapping conditions. However, present OCD efforts constitute the first national attempt to offer extensive public service opportunities to preschool handicapped children who meet eligibility requirements.

OCD guidelines for Head Start services to handicapped children include several specific requirements. Covering issues of recruitment, enrollment, diagnosis, community and parent involvement, the following are of key importance to the new endeavor:

1. In cooperation with other community groups and agencies serving handicapped children, Head Start programs are obligated to make special efforts to develop outreach and recruitment procedures to identify and enroll handicapped children.

2. Just as programs must now make special recruitment efforts, they also are supposed to arrange for or provide screening and diagnosis in order to insure an adequate basis for special education, treatment, and related services. Where children are identified or suspected to be handicapped, staffs are required to confirm such observations by seeking the judgments of qualified professional personnel. Evaluations must be pursued as on-going processes. Finally, the guidelines caution against mislabeling children as handicapped "because of economic circumstances, ethnic or cultural factors, or normal developmental lags."

3. Head Start has always had an official open policy for including handicapped children. However, both the 1972 legislation and OCD policies are now more explicit on the issue of severity. Specifically, while obviously they do not exclude children with mild to moderate handicapping conditions, there is now an emphasis on the need to include and integrate children who have more severely disabling impairments.

Further, OCD has specified that the termination of a child's activities in Head Start may be made only with the mutual agreement of staff and qualified professionals on the basis that such participation does not remain in the best interests of that child.

4. Finally, particular attention [illegible] to involving parents of handicapped children as much as possible in Head Start activities and special services provided for their children. This last priority is especially important in view of considerable evidence that families of disabled children often are faced with frustrations, problems of physical care, deep concern about the future, poor information, lack of support, and other difficulties which confront families of typical children less frequently.

Overall, such objectives hold much potential for the development of wide-scale resources within Head Start which until recently have remained unavailable to many children with special needs. In this respect, the 1972 legislation opens many far-reaching possibilities. At the same time, however, there are several potentially troubling areas that require attention. In the next section, we turn to a discussion of some of these, as well as the opportunities posed by the handicapped effort.

Opportunities and Difficulties Posed by the Handicapped Effort

One immediate problem posed by the handicapped effor[illegible]erns the identification and diagnosis of disabled children. Educators dealing with the preschool population of children with special needs have frequently made two observations. First, mildly disabling hidden impairments (e.g., mental retardation) are difficult to identify prior to the elementary school years. Second, severe handicapping conditions, more frequently than not, represent multiple impairments and require sophisticated clinical accumen to differentially evaluate and treat. The handicapped effort offers possibilities for providing services to moderately and more severely handicapped children who might not otherwise receive ongoing treatment between three and six years of age. For these children, the benefits of Head Start are manifold. On the other hand, there is a large segment of the preschool poverty population who, while they certainly profit from their participation in a stimulating preschool environment, may not be recognized as suffering from any specific handicapping conditions--and, in fact, ought not to be so labeled. The new handicapped effort raises different opportunities and problems for these two groups of children.

Enrollment of children in Head Start brings to the forefront another set of issues--the integration of handicapped children in typical preschool programs. There is a fair amount of evidence that supports the hypothesis that physical placements of handicapped children in heterogeneous educational settings do not guarantee conditions of psychological and social integration. Further, as their impairments become more severe and readily apparent to teachers and their classroom peers, tendencies to isolate children with special needs may increase. With the present OCD emphasis for Head Start to enroll more severely handicapped children, there is a mixed range of possibilities. On the one hand, if teachers and typical children interact in ways to help handicapped children become a viable part of classroom activities, integration may yield positive experiences for all children. If, however, the severely handicapped are isolated, the potentials for problems are heightened and they may result in untoward consequences for children. This issue is a central concern to the Head Start handicapped effort.

In the long run, the extent to which disabled children are served in gainful ways by Head Start will depend on many factors, perhaps the most important of which is the classroom staff. This consideration raises another issue,

i.e., staffing, staff training, and technical assistance. Contrary to common belief that special skills and abilities are essential to teach children with special needs, there is another view that, with the exception of a small number of severely impaired, education beyond good preparation in child development is not essential. It may be that Head Start programs already have many adequate resources to provide comprehensive, developmental services for the majority of handicapped children. Staffs, however, may not perceive the situation in this light and, if this is the case, may need some assistance in developing positive attitudes toward the effort. In addition, it is likely that they will require help in planning and providing special services for more severely disabled children.

Parent participation and changes in community agencies present a fourth major area of challenge to Head Start programs. There is considerable evidence in the early childhood education literature to indicate that both parent and community involvements are critical factors to sustaining long-range changes in children. Both efforts, however, will require special attention of Head Start staffs. As we have pointed out earlier, for example, some parents of handicapped children have their own special needs. These may call for special counseling and guidance beyond that normally provided

for other poverty families. Second, given the emphasis on providing normalizing educational settings for handicapped children and the need to care for their problems, it is particularly important that schools and other community agencies continue to offer such opportunities to children after Head Start. Again, the initiative in establishing this kind of continuity probably will remain largely with Head Start staffs.

A fifth and formidable challenge of the handicapped effort lies with the ultimate benefits for children with special needs. Up to this time, alternatives for education and special services for handicapped children, especially the moderately and severely impaired, have been extremely limited. While the long-range effects of these endeavors will not be realized this first year, their importance for children who might not receive services otherwise cannot be underestimated. We especially hope that the new effort might ultimately help us in the prevention of some secondary learning and emotional problems that are so commonly observed among more severely disabled preschool children and their families. Such is the potential of the handicapped effort in Head Start, providing that a few of the problems discussed above are resolved.

The Purposes and Scope of the Task III Site Visits

The Task III site visits had the major purpose of providing an opportunity for conducting indepth assessments of Head Start and other selected preschool programs and, on the basis of those evaluations, determining how the handicapped effort might be strengthened and improved. During the first round, visits were made to 16 regular Head Start programs who were reportedly serving handicapped children before the legislative mandate and 11 additional special experimental projects funded by the Office of Child Development or the Bureau of Education for the Handicapped. The first round of visits was exploratory in nature and helped to illuminate particular questions to be addressed in the larger round of visits in the spring. Averaging about three to four days per site, the visits began November 5 and were completed by December 21, 1973.

In contrast with that of the fall, the second round of visits was designed to concentrate on selected issues and aspects of Head Start services for handicapped children--in particular, for the severely disabled. Specifically, we sought to answer these questions:

(a) How well are severely handicapped children being served in selected programs with respect to their integration with all children and

quality of services?

(b) What has been the effect of the mandate on the Head Start programs?

(c) What relationship exists between the inclusion of handicapped children and differential costs in total programming?

(d) What handicapped children can or should be included in Head Start?

(e) What role should Head Start play with respect to the handicapped?

(f) What cost differential could be anticipated with optimal implementation of the handicapped effort in Head Start?

(g) What can be done to improve the Head Start performance with respect to the handicapped?

The second round involved visits to 36 regular Head Start programs (six of which were designated as exemplary projects), 10 non-Head Start preschool enrichment programs (selected as exemplary projects), and visits to three experimental programs which were not seen in the fall. These visits averaged from one to three days per site; they began April 1 and were completed by May 31, 1974.

In contrast with visits during the first round, a questionnaire-type instrument was developed and used for the reporting of data in the spring. This instrument provided

for the collection of basically four types of information:

(a) Identifying material

(b) Program-level data which were obtained primarily from Head Start directors

(c) Child-specific data obtained from teaching staffs, and

(d) Observations designed to evaluate quality of classroom services delivered to children.

On the basis of this instrument, data were collected in the 36 regular Head Start programs, 74 child case studies were completed, and 44 classroom observations were made.

As a whole, the Task III visits had at least three other important purposes, in addition to that of assessing the handicapped effort on-site. First, they provided a basis, in part, for interpreting data collected in the full-year questionnaire of this study (i.e., Task II) and secondly, they facilitated the accumulation of data for the cost analysis portion of the project (i.e., Task IV). Finally, the field observations were helpful in shedding light on some of the key policy issues that were considered in still another phase of the study (i.e., Task V).

Plan of the Report

The remaining sections of this report will have six major parts. These will include:

(a) A discussion of methodology, procedures, and problems of generalizability (Chapter II)

(b) Findings from the first round of visits to regular and experimental programs (Chapter III)

(c) Findings of the second round of visits to regular Head Start programs (Chapter IV)

(d) Findings of visits to exemplary programs and implications for the Head Start handicapped effort (Chapter V)

(e) Summary and discussion of major findings of Task III site visits (Chapter VI)

(f) Conclusions, policy issues, and recommendations (Chapter VII)

(g) Appendices including selected case summaries of children (A),[1] descriptions of regular Head Start, experimental, and exemplary programs visited for Task III (B), reflections on Task III data and related issues: Minutes from Senior Consultant Group meetings (C), interview guides used in first round visits (D), and the questionnaire used in the second round (E).

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[1]Basically, Appendix A includes data that were reported in our Interim Report on the Task III visits, submitted to the Office of Child Development on February 4, 1974. Additional case studies on children from the second round of visits have been added to this section.

CHAPTER II

METHODOLOGY, PROCEDURES, AND PROBLEMS OF GENERALIZABILITY

This chapter discusses methodology, procedures, and problems of generalizability of our data. We describe, first, the methodological approaches to both rounds of site visits. Second, we cover procedures used for selecting the 16 regular Head Start programs visited in the fall and the 36 programs visited in the spring. In addition, criteria and procedures for the identification and final selection of the six exemplary Head Start programs and the 10 preschool enrichment programs will be presented. In parts three and four, we describe observer training, field visits, and our analysis of the data. Finally, in part five, we will present our views on the representativeness of the sample of 52 regular Head Start programs and the generalizability of the findings discussed in other sections of this report.

Methodological Approaches to the First and Second Rounds of Site Visits

The methodological approaches to the first and second rounds of site visits differed substantially. In

the fall of 1973 the visits were much more exploratory and open-ended than they were in the spring. Participant observation was the principal technique used for obtaining data in this first round and, in accordance with this approach, interview guides were developed for the field observations. These provided a basis for collecting information around 11 areas of inquiry at the grantee, delegate agency, and center levels including:

(a) Experiences of handicapped children prior to their entry into Head Start

(b) Identification, recruitment, and enrollment processes

(c) Assessment and diagnosis

(d) Delivery of services to handicapped children and their families

(e) Plans for handicapped children after Head Start, in public schools or with other community agencies

(f) Start-up and planning activities of programs after the mandate

(g) Integration of typical and handicapped children in classroom settings

(h) Involvement of community agencies and public schools

(i) Involvement of parents in the handicapped effort

(j) Staffing, staff training, and technical assistance

(k) Costs in serving handicapped children in Head Start

In addition, data about approximately 50 case study children were complied.

Basically, the same approach was used in our visits to the nine regular Head Start experimental projects.[2]

There were several reasons that we selected a more open-ended approach for the fall visits. Two considerations that were uppermost in our minds at the time of the research design development were the following:

1. At the time of the first round of visits, Head Start staffs had just started their program year and were only in the beginning stages of identifying, recruiting, and enrolling children who were thought to have special needs. It was unreasonable to have expected that staffs

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[2]Among the experimental projects we differentiated between those who attempted to develop special methods for the regular Head Start programs (nine visited in the first round) and those who had a more primary role of providing technical assistance (two visited in the first round and three in the second). In the latter case, our inquiry was mainly focused on the special nature of the experimental effort.

would have completed evaluations of children, have had time to develop adequate services, or have collected much information about costs, unless they had a good deal of prior experience. Thus, we decided that it was inappropriate to use a highly specific, structured interview and observation approach.

2. Our second concern was related to our own limited knowledge about Head Start programs and the importance of certain areas of inquiry that we planned to explore during the site visits. More specifically, even though at the outset of the study we had identified some key areas for in depth assessment during the field work, the full dimensions and components of each of these areas were still open questions. We needed an approach that would enable us to make judgments about some of these issues.

Based on our findings from the first-round visits, we defined several issues and areas of inquiry that we wanted to study in greater depth in the second round of visits. As we have already mentioned in Chapter I, these were mainly related to questions about serving more severely disabled children. For example, in those programs who had enrolled severely handicapped children, we wanted to evaluate how well these children were being served and

what factors seemed to enhance the development of high-quality programs. By comparison, in those programs where very few severely handicapped were included, why were these children not enrolled? The questionnaire subsequently developed for the second round was designed to collect data at the program level, child case study information, and classroom observations that addressed each of these issues.

Program-level information, the first of the three major sections of the questionnaire, was collected from Head Start directors or personnel responsible for the handicapped effort at the grantee or delegate agency. We inquired about 14 areas of interest including:

(a) Background information about program notification of the mandate

(b) Attitudes toward serving mildly, moderately, and severely handicapped children in Head Start

(c) Program definitions of handicap, diagnosis, and prescription

(d) Past experiences in serving handicapped children

(e) Staff resources, i.e., current personnel and new staff added for the handicapped effort

(f) Community resources, i.e., agencies currently serving handicapped children and the nature of those provisions

(g) Provisions for financing the handicapped effort

(h) Physical facilities

(i) Training and technical assistance

(j) Program planning for the effort

(k) Recruitment and enrollment procedures

(l) Relationships with other Head Start programs and Regional OCD Offices

(m) Self-evaluation of capabilities to serve mildly or moderately and severely handicapped children

(n) Leadership-management effectiveness of the Head Start director, as perceived by the field observers.[3]

In the second part of the questionnaire, information about three, and sometimes four, handicapped children was obtained from teachers and other center-level personnel.[4]

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[3]This section was eventually dropped from the final analysis because several of the observers felt that they did not have an adequate basis for such judgments from brief discussions of two to three hours.

[4]These data were collected in only 26 of the 36 programs reportedly serving handicapped children at the time of the initial sample selection. Observational data and child-specific information were not obtained in programs that were initially selected as having no handicapped children.

In general, we covered seven areas of inquiry about each of the 74 case study children finally selected. These were:

(a) The nature and severity of handicapping conditions

(b) Identification, enrollment, and assessment

(c) Classroom plans and programming

(d) Special services received outside the classroom

(e) Parental involvement

(f) Observed changes in children since enrollment in Head Start

(g) Plans for next year, i.e., Head Start, public school, or other special arrangements

The third part of the questionnaire dealt with classroom observations and teacher behaviors. On the basis of two three-hour observations per class, we assessed nine dimensions of classroom instruction, teacher-child, and child-child interactions. Part of this analysis also involved determining those differences in the delivery of services for typical and handicapped children, reasons for special arrangements, and making some judgments about the responsiveness of children in integrated Head Start settings.

Given these variations in approach to the first and second rounds of visits, the nature of the data collected in the fall and spring differed considerably. In the first round, there was a primary emphasis on qualitative information, and lengthy reports were written about each program visited. Data from the second round was much more quantitative in emphasis, with closed-ended responses that were supplemented with descriptive, anecdotal comments.

Selection of Programs

Our selection of the 52 regular Head Start programs in the fall and spring were largely determined by the respective purposes of the first and second rounds of visits. In particular, the following design features of Task III were given utmost consideration in developing the sampling scheme:

1. In view of the more open-ended, process approach of the first round and the structured interview approach of the second, we agreed that fewer programs should be visited and studied more intensively in the first round than in the second. Taking into account the total of 50 visits to regular Head Start programs budgeted for in Task III, staff available to conduct the field work, and the early stage of

the handicapped effort in the fall when we visited programs, we decided that approximately 15 sites should be visited in the fall and about 35 in the spring.

2. In contrast with the first round, major interests in the second round dictated that we select at least two groups of programs in the spring (i.e., those who had enrolled fairly large numbers of severely handicapped children and another group who were serving fewer or no handicapped children). At the beginning of the study in the fall, we wanted to know, in general terms, how the handicapped effort was proceeding in each of the 16 programs we visited. Thus, we selected only those who indicated that they had enrolled a significantly large number of handicapped children. On the other hand, our visits in the spring focused on questions of how well and why certain programs were able to serve more seriously disabled children.

Selection of Regular Head Start Programs Visited in the First Round

In accordance with the two design features described above, 16 regular Head Start programs were selected for the first round of visits. Fifteen of these were selected in a stratified random manner from the 10 regions of the Office

of Child Development. The last program was selected from the group of available Indian and Migrant programs. Procedures for the selection of this program will be discussed later. The following procedures were used in drawing the sample of 15 regular Head Start programs.

The sampling frame used for the selection of the 15 programs was the "Master Grantee Listing" of full-year Head Start programs, compiled and updated during our visits to Regional Offices during August and September, 1973. Of the information included in this listing, two were identified as stratification variables:

(a) Region, in which the program was located

(b) Size of the program, measured in terms of total full-year enrollment.

The distribution of Head Start programs according to their size was studied further in order to arrive at a few size clusters. Two criteria were used during the clustering process. These were:

(a) To use, as much as possible, the natural breakpoints in the frequency distribution for arriving at the clusters

(b) To approximate equal numbers (i.e., equal percentages of total national enrollment) of children in each cluster.

This process yielded four-size clusters which were used during sampling. These are presented in Table 1 below.

TABLE 1

FOUR CLUSTERS USED IN SAMPLING OF REGULAR HEAD START PROGRAMS SELECTED FOR THE FIRST ROUND

Size Cluster	Number of Programs	Enrollment Range	Percent of Total National Enrollment
I. Small programs	602	1- 200	22.1
II. Medium programs	321	201- 400	26.3
III. Large programs	94	451-1000	24.0
IV. Extra large programs	32	1000+	27.6
Total	959		100.0

In view of the purposes of the first round visits and the fact that little information about numbers of handicapped children enrolled in each of the 959 programs was available, the following procedures were utilized to implement a two-stage sampling plan and arrive at the final 15 programs.

1. A stratified random sampling of 50 programs was selected. This was done in the following way. First, programs were assigned probabilities of selection based on

their size. Second, the sample size of 50 was divided into sample quotas for each size cluster, based on the percentage of total enrollment in each cluster. Third, cluster quotas were further distributed into regional quotas, on the basis of the regional distribution of the numbers of programs in each cluster. This procedure yielded the regional and cluster quotas of Small, Medium, and Large programs presented in Table 2. In the case of the 14 Extra Large programs selected, no assignments were made to the regions. Instead, the 14 programs were selected individually from the 32 because of the size of the variance of the enrollment figures of programs in this cluster. Finally, for Small, Medium, and Large programs, the required numbers of sites in each region-size cluster group were selected randomly from the available programs.

2. Telephone interviews were then conducted with each of the 50 programs to determine the number of handicapped children enrolled and the extent of the program involvement with the handicapped effort. Programs with no or very few handicapped children were eliminated and given no further consideration; there were 17 such sites. The final selection was made from the remaining 33 programs. Eight who seemed to be more advanced than the others in

TABLE 2

DISTRIBUTION OF HEAD START GRANTEES (TOTAL POPULATION AND SAMPLE OF 50 P
SELECTED FOR THE FIRST ROUND OF VISITS

Region	Cluster I: Small				Cluster II: Medium				Cluster III: Large				Cluster IV: Extra Large		
	Population		Sample		Population		Sample		Population		Sample		Population		S
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
1	54	8.9	1	9.1	11	4.8	1	7.7	1	1.1	0	0	1	3.1	0
2	58	9.6	1	9.1	8	3.5	1	7.7	3	3.2	1	8.3	4	12.5	3
3	60	9.9	1	9.1	17	7.4	1	7.7	5	5.3	1	8.3	0	0	0
4	94	15.6	1	9.1	69	29.9	3	23.1	35	37.2	4	33.3	10	31.3	5
5	114	18.9	2	18.2	39	16.9	2	15.4	9	9.6	1	8.3	6	18.8	3
6	68	11.3	2	18.2	43	18.6	3	23.1	28	29.8	4	33.3	4	12.5	1
7	39	6.5	0	0	14	6.1	1	7.7	3	3.2	0	0	3	3.4	1
8	40	6.6	1	9.1	5	2.2	0	0	0	0	0	0	1	3.1	0
9	33	5.5	1	9.1	20	8.7	1	7.7	8	8.5	1	8.3	3	9.4	1
10	42	7.0	1	9.1	5	2.2	0	0	2	2.1	0	0	0	0	0
Total	602	100.0	11	100.0	231	100.0	13	100.0	94	100.0	12	100.0	32	100.0	14

TABLE 2

IBUTION OF HEAD START GRANTEES (TOTAL POPULATION AND SAMPLE OF 50 PROGRAMS) SELECTED FOR THE FIRST ROUND OF VISITS

1	Cluster II: Medium				Cluster III: Large				Cluster IV: Extra Large				Total			
nple	Population		Sample		Population		Sample		Population		Sample		Population		Sample	
%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
9.1	11	4.8	1	7.7	1	1.1	0	0	1	3.1	0	0	67	7.0	2	4.0
9.1	8	3.5	1	7.7	3	3.2	1	8.3	4	12.5	3	21.4	73	7.6	6	12.0
9.1	17	7.4	1	7.7	5	5.3	1	8.3	0	0	0	0	82	8.6	3	6.0
9.1	69	29.9	3	23.1	35	37.2	4	33.3	10	31.3	5	35.7	208	21.7	13	26.0
18.2	39	16.9	2	15.4	9	9.6	1	8.3	6	18.8	3	21.4	168	17.5	8	16.0
18.2	43	18.6	3	23.1	28	29.8	4	33.3	4	12.5	1	7.1	143	14.3	10	20.0
0	14	6.1	1	7.7	3	3.2	0	0	3	3.4	1	7.1	59	6.2	2	4.0
9.1	5	2.2	0	0	0	0	0	0	1	3.1	0	0	46	4.8	1	2.0
9.1	20	8.7	1	7.7	8	8.5	1	8.3	3	9.4	1	7.1	64	6.7	4	8.0
9.1	5	2.2	0	0	2	2.1	0	0	0	0	0	0	43	5.1	1	2.0
100.0	231	100.0	13	100.0	94	100.0	12	100.0	32	100.0	14	100.0	959	100.0	50	100.0

terms of their development of services for disabled children were chosen first as part of the sample of 15. To complete the process, we examined the remaining 25 programs and selected seven to yield a relatively even regional distribution and fill quotas previously established for each of the four clusters.

Among the 15 programs selected, the Head Start director of only one refused to allow site visitors. This program, randomly selected from the sample of 33 sites, was replaced with another in the same size cluster and same region.

Information about programs in the 10 regions of OCD was not consistently available for all Indian and Migrant programs. For this reason, we decided to select only one Indian or Migrant program after consultation with the staff of the Indian-Migrant Program Division of OCD. This resulted in the identification of four Indian and two Migrant programs. These were subsequently interviewed by telephone to collect data on the extent of their handicapped involvement. One of the Indian programs who appeared to be more heavily involved with handicapped children was then selected for a first-round visit.

Selection of Regular Head Start Programs Visited in the Second Round

Thirty-seven regular Head Start programs were originally selected for the second round of visits. Thirty-four of these were distributed among the 10 OCD regions; three were Indian programs. The three-stage sampling process of the second round involved these procedures:

1. In contrast with that of the first round, the sampling frame used for the selection of programs in the second round was the total universe of 1,353 grantee and delegate agencies who had responded to the Task II full-year survey of this study, conducted from September to November, 1973. This population represented ar approximate 80 percent return of the questionnaires sent to all Head Start programs in the fall. We might add, that even though 20 percent of the programs were not represented in this group, telephone interviews with the non-respondents following return of the questionnaires seemed to indicate that they did not differ significantly from the 80 percent who had returned the questionnaires.

The first step of the sampling process involved obtaining a distribution of the 1,353 programs by percentage

of severely handicapped enrolled and size of programs. The decision to use severely handicapped as a major stratification variable rather than total enrollment of handicapped children was largely based on the fact that the key issue of this study, from its inception, has concerned the inclusion of more seriously impaired children.

Let us consider, first, the stratification of programs into clusters by enrollment of severely handicapped children. It was obvious early in the sampling process that, in order to address the inclusion-exclusion question, we needed one group of programs that reportedly served no handicapped children. Second, to make meaningful comparisons among groups of programs, at least two additional clusters were required. This second decision was followed-up with a search for natural breakpoints in the enrollment figures among the 1,191 programs reportedly serving handicapped children. After examination of the questionnaire data, we finally split the programs into clusters I and II on the basis of a determining point of 3.5 percent enrollment of severely handicapped children. Thus, cluster I included those programs serving 3.5 percent or more severely handicapped children; cluster II included those programs with an enrollment of less than 3.5 percent

severely handicapped (i.e., programs serving mildly and moderately handicapped children); and cluster III consisted of those programs serving no handicapped children. Table 3 presents the distribution of programs by size and handicapped enrollment.

Stratification of programs by size involved a more complicated process. Basically, we explored two alternatives before arriving at the most satisfactory solution. First, we considered the possibility of dividing the programs by thirds so that each cluster would include 33 percent of the programs; this option was discarded because of the large proportion of small programs included in the sample with this procedure. A second possibility involved splitting the programs so each of the clusters included approximately equal percentages of handicapped children enrolled. This second option was also eliminated since so few large programs were included with such a procedure. A more workable solution to these problems was finally reached in a compromise between options one and two.

TABLE 3

DISTRIBUTION OF TOTAL UNIVERSE OF HEAD START PROGRAMS BY SIZE AND H
ENROLLMENT USED IN THE SELECTION OF PROGRAMS FOR THE SECOND ROUN

Handicapped Enrollment / Size	Programs Reporting No Handicapped Children Enrolled	Programs Reporting Handicappe Children Enrolled	
		Severely Handi-capped Less Than 3.5 % of Total Enrollment	Severely H capped 3.5 More of To Enrollment
Small (1-120)	128	566	138
Medium (121-300)	22	281	48
Large (Over 301)	11	144	15
Total	161	991	201

TABLE 3

OF TOTAL UNIVERSE OF HEAD START PROGRAMS BY SIZE AND HANDICAPPED
T USED IN THE SELECTION OF PROGRAMS FOR THE SECOND ROUND VISITS

Programs Reporting No Handicapped Children Enrolled	Programs Reporting Handicapped Children Enrolled		Total
	Severely Handicapped Less Than 3.5 % of Total Enrollment	Severely Handicapped 3.5% or More of Total Enrollment	
128	566	138	832
22	281	48	851
11	144	15	170
161	991	201	1,353

The third and final alternative yielded the following groups:

TABLE 4

CLUSTERS USED IN THE SELECTION OF REGULAR HEAD START PROGRAMS FOR SECOND ROUND VISITS

Size Cluster	Number of Programs	Enrollment Range
Small	832	1-120
Medium	351	121-300
Large	170	300+

2. For the purposes of selecting the 74 case study children of the second round, additional screening criteria were applied to all programs reporting handicapped children enrolled. They were:

(a) For programs in which the number of severely handicapped was less than 3.5 percent of total enrollment, we required representation of at least three handicapping conditions--each disability category having at least two mildly or moderately impaired children.

(b) For programs in which the number of severely handicapped was 3.5 percent or more of total enrollment, we required representation of at least three handicapping conditions, again each with disability category having at

TABLE 5

DISTRIBUTION OF NUMBER OF HEAD START PROGRAMS WHICH MET THE SC
CRITERIA BY SIZE AND HANDICAPPED ENROLLMENT

Handicapped Enrollment / Size	Programs Reporting No Handicapped Children Enrolled	Programs Reporting Handicapp Children Enrolled	
		Severely Handi-capped Less Than 3.5% of Total Enrollment	Severely capped 3. More of T Enrollmen
Small (1-120)	128	76	6
Medium (121-300)	22	149	14
Large (Over 301)	11	100	6
Total	161	325	26

TABLE 5

UTION OF NUMBER OF HEAD START PROGRAMS WHICH MET THE SCREENING CRITERIA BY SIZE AND HANDICAPPED ENROLLMENT

	Programs Reporting Handicapped Children Enrolled		
Programs Reporting No Handicapped Children Enrolled	Severely Handicapped Less Than 3.5% of Total Enrollment	Severely Handicapped 3.5% or More of Total Enrollment	Total
128	76	6	210
22	149	14	185
11	100	6	117
161	325	26	512

least two severely impaired children. Table 5 presents the distribution of Head Start programs who met the sereening criteria by size and handicapped enrollment.

Finally, two additional factors were taken into account at this second stage of the sampling process. First, we wanted to achieve, as much as possible, an adequate representation of handicapping conditions. Second, we tried to obtain adequate representation across regions.

Thus, with these factors in mind and the constraint that we could visit no more than a total of 37 programs in the second round, we selected the final sample. From a total of 161 programs reporting no handicapped children enrolled, we randomly selected 10 sites for cluster III. From the 325 programs serving mildly and moderately handicapped children, we first randomly selected 25 percent of the programs in each of the size clusters, then selected 15 programs that appeared to include all regions and handicapping conditions. In cluster I which included programs enrolling severely handicapped children, only 26 remained after the screening criteria were applied. Thus, we were unable to use any random sampling procedures;

instead, we again selected programs on the basis of distribution across region and representation of handicapping conditions.

3. The third stage of the sampling process involved telephone interviews to each of the 37 programs selected. These served the purposes of verifying representation of the particular handicapping conditions of children for whom programs were selected and confirming final arrangements for visits with Head Start directors. As a result of these interviews, four programs were dropped from the sample because of field arrangement problems. These programs were replaced by new sites in the same regions.

In addition, one program withdrew two days before our visit as a result of scheduling difficulties and unanticipated commitments. Since many programs were drawing close to the end of the school year, we decided not to select another site at that time.

Modification of Program Clusters of the Second Round

The selection scheme described above seemed initially to be workable and, further, offered the prospect for making some important comparisons between programs who were and were not serving handicapped children. This plan, however, was eventually modified

for purposes of analysis in view of the large discrepancies between first reported numbers and actual enrollments of handicapped children determined during the site visits. Put somewhat differently, there was such variance between handicapped enrollments which were reported in the full-year survey of these programs[5] and actual enrollments of handicapped children observed on-site, the project team had concern that our analysis would have been highly questionable if based on these cluster groups. For these reasons, we reorganized the 36 programs into the following clusters:

(a) Cluster I including programs with enrollments of 4.5 percent or more severely handicapped children

(b) Cluster II serving mildly and moderately handicapped children in programs which met one or both of the following criteria: enrollments of some severely handicapped children (up to 4.4 percent); enrollments of many mildly and moderately handicapped children (10 percent or more)

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[5]These figures were also verified by Head Start directors during the sampling process.

(c) Cluster III consisting of programs with no or very few severely handicapped children (enrollments of less than 1.5 percent) and some mildly and moderately disabled children (less than 10 percent).

The new breakpoints used as criteria for the revised clusters were determined by inspection of the data collected on-site. Basically, the three groups remained the same with two exceptions:

(a) One program originally selected as having no handicapped children was moved to the second cluster.

(b) One of the programs in the original cluster II representing programs with mildly handicapped children was moved to cluster III.

(c) Two programs initially selected as having mildly and moderately handicapped children were moved to cluster I.

All considered, we felt that these changes were a much more accurate representation of actually enrolled handicapped children (i.e., percentages) in the 36 programs we visited. The revisions, however, did create one problem which caused some difficulty in the final analysis of data. Based on the original cluster groupings, we collected data only in Parts I and II (see Appendix E of Task III Report) of the questionnaire,

i.e., identifying information and program-level data, in those programs which were reported to have no handicapped children. In programs with handicapped children, we obtained child-specific information and did classroom observations. Thus, there was a mixing of data from the two programs that were changed to different clusters. Specifically, for the one program moved from cluster III to cluster II, we lacked child-specific information and observations; for the second program moved from cluster II to cluster III, we had additional data not obtained for other programs in cluster III.

Selection of Exemplary Programs for the Second Round

Two groups of exemplary programs were selected for the second round of field visits. Ten preschool enrichment programs were identified by telephone interviews before the site visits; six regular Head Start programs were chosen after the collection of data. In both instances, however, we used the same screening criteria for the initial selections. These were:

(a) Programs had an enrollment of 4.5 percent or more children who had clearly identified impairments of a moderate to severe degree.

(b) Second, programs had integrated classroom settings or were characterized by integration components that involved placement of handicapped children in "normal" community settings.

The non-Head Start "model" preschool programs were selected on the basis of several sources of information. In order to compile a master list of potential candidates, we first called a few key persons with the Bureau of Education for the Handicapped and the Office of Child Development and asked for recommendations. We also talked with several people who were knowledgeable about programs for preschool handicapped children; these persons included professionals with the Council for Exceptional Children, university personnel, and the directors of two experimental projects visited in the fall and spring. From these recommendations, we then developed a list of approximately 200 federal, state, and privately sponsored projects. About 50 programs were subsequently called and, on the basis of the information we obtained about the nature of the population served, the degree of integration, and the total scope of services provided, we selected 10 sites.

The six regular Head Start exemplary projects were identified in a different manner. Of the 36 programs of

the second round sample, only 14 in cluster I serving severely handicapped children qualified for initial consideration. These programs were then rank-ordered in terms of their degree of integration of severely handicapped children and overall program quality, and the top six were selected as exemplary programs.

Observer Training and Field Visits

The Task III site visits were conducted in the fall and spring by professionally trained graduate students from Syracuse University and Boston University, university professors of special education,[6] and other members of the project team. In total, 20 persons participated in the field visits over the course of the year, with 16 observers involved in the fall and 10 in the spring.

In accordance with the purposes of the field visits, observer training and our approach to visits in the fall differed substantially from those in the spring. For

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[6]Three professors were part of the project team of this study and held positions at Syracuse University. The other two, who served as Senior Consultants to the project, were on the faculties of Boston University and Indiana University.

example, observer training for the first round was spread over a longer period of time (approximately two months), was much more "process" centered in terms of training the observers in techniques of open-ended interviewing, and devoted considerable time to providing the field staff with information about Head Start. The two-month training period of periodic meetings in Syracuse and Boston was concluded with three days of intensive discussion and review of the observation guide with six members of the project team and all field staff present. After the more formal training phrase, all observers made pilot visits to experimental programs or additional sites not included in the sample. Upon their return, the field staff met again for a full-day session to discuss their observations and work out any problems that they had encountered in the field. Visits that followed ranged from two to four days per site, and in most instances, were made by two observers. A "typical" visit involved conversations with Head Start directors on the first day, followed by discussions with teaching staffs, parents, coordinators of the handicapped effort, and other relevant Head Start personnel. We also completed at least two classroom observations per site.

Training of the observers for the second round of visits, conducted over a one-week period, was much more structured in approach. The first phase of training involved two-day sessions where two members of the project team and a consultant from the Department of Special Education of Rhode Island College met with field staff and reviewed the field instrument. These meetings were followed-up with three days of formal classroom observation with Part III of the questionnaire. Six observations were made in three carefully selected preschool and special education settings that represented a range of early childhood education philosophies from open education to highly structured, teacher-directed classes. During this segment of the training, one member of the project team served as the "criterion observer." The consultant provided interpretation of observer differences and assisted in analyzing results. Given the high degree of agreement that was achieved on most items of the observation schedule (i.e., between 75 and 85 percent), the project staff was able to proceed with confidence that observations in the Head Start classes would have a common basis for interpretation.

Visits to programs in the second round were completed over a six-week period. In contrast with those of

the fall, they were made on a "round-robin" basis so that observers remained in the field for two to three weeks at a time and traveled to several sites in one geographic area. Programs reporting no handicapped children were visited for one day; two to three days were spent in those with handicapped children. With the exception of five Head Start programs and one exemplary project, each site was visited by only one observer. Finally, and again in contrast with our approach to the first round, data were collected and reported on questionnaire response forms at the time of the site visits.

Analysis of Data from Visits to Regular Head Start and Experimental Programs

The considerable differences in the kinds of data collected in the first and second rounds dictated different procedures for analysis. In the fall, the task at hand required careful scrutiny and interpretation of the data of lengthy reports. Major themes and hypotheses about key areas such as parent involvement, integration, and involvement with community agencies were determined with the combined efforts of four members of the project team. These were later discussed among the entire staff who had been involved in the field operations. These and other

hypotheses formed the basis for tentative impressions and preliminary findings which were presented in the Interim Report submitted to the Office of Child Development in February, 1974. We might add, at this point, that for a great majority of the findings reported mid-year, there was almost unanimous agreement among the observers on the validity of the observations with respect to the programs they had visited.

Data from the second round, by comparison, required both quantitative and qualitative analyses. With regard to the quantitative analysis, we obtained the following:

1. Frequency distributions of all discrete variables of the program level, child-specific, and observational data

2. Crosstabulations between cluster groupings (i.e., I, II, III) and selected program-level variables

3. Transformations of selected variables, i.e., composite scores for: attitudes toward serving the mildly handicapped and severely disabled, perceived capabilities of programs to serve handicapped children, severity levels of handicapping conditions of case study children, and quality scores

4. Correlations

a) Attitudes of directors and total enrollment of handicapped children, enrollment of mildly and moderately

disabled children, and enrollment of severely disabled children

(b) Perceived capabilities and total enrollment of handicapped children, enrollment of the mildly and moderately handicapped, and enrollment of the severely disabled

(c) Composite quality scores obtained from classroom observations and cluster groupings, attitudes of program directors, perceived capabilities to serve handicapped children, and percentages of handicapped children enrolled.

The anecdotal information was analyzed separately. By program, these data were taken off the questionnaires and typed, question by question, on separate index cards. Responses were later sorted and analyzed by two members of the project team, knowledgeable about procedures of qualitative analysis. They subsequently compiled reports about each of the key areas of inquiry of the questionnaire which included comparisons of responses of programs in each of the cluster groupings. As we will describe in Chapter IV, such analyses were extremely important in illuminating some critical differences among those programs who were and were not serving severely handicapped children.

Generalizability of the Data

Generalizability of the data from visits to regular Head Start programs was an important question for the first round. Likewise, it is important for the second. Simply put, the major issue is this: Given the known wide variance in Head Start programs across the country, what degree of confidence can we place in the findings, and can generalizations be made about the handicapped effort on the basis of the 52 site visits? The issue obviously requires consideration of several factors. However, all taken into account, we think that there is reasonable justification for concluding that key conclusions can be drawn confidently.

First of all, while the programs selected for both rounds of visits are not necessarily representative of the total population of Head Start programs, we have no reason to believe that these sites differed in any substantial way from those not included in the sample.

Secondly, while we regarded our findings from the first round to be tentative--because of the small sample and the early stage at which sites were visited in the fall--our observations from the second round, almost without exception, supported the major impressions from the fall

and have led us to basically the same conclusions about the status of the handicapped effort.

Finally, we need to address the issue of key differences that we found between programs in the second round that were and were not serving severely handicapped children. Our observations in those programs serving more disabled children are perhaps more representative of other such sites who also provide services for more seriously impaired children. For example, the programs in cluster I, in general, seemed to be differentiated from programs in cluster II in terms of greater individualization of instruction, more parent involvement, and more meaningful relationships with community agencies. On the other hand, we do not believe that these differences weaken the strength of our observations which so consistently revealed similar patterns of events across all programs we visited over the course of this first year of the handicapped effort in Head Start, and therefore, our confidence in the generalizability of the findings to other Head Start programs.

CHAPTER III

SUMMARY OF MAJOR FINDINGS FROM THE FIRST ROUND OBSERVATIONS OF REGULAR HEAD START PROGRAMS AND DESCRIPTIONS OF EXPERIMENTAL PROJECTS

This chapter has two parts. The first presents a summary of major findings from the first round of visits to regular Head Start programs. The second includes brief descriptions of the experimental projects visited in the fall, the three programs visited in the spring, as well as follow-up data on the experimental programs collected by telephone in the spring.

Summary Observations of Regular Head Start Programs Visited in First Round

As we mentioned in Chapter II of this report on the methodology and procedures, a number of basic hypotheses were generated on the basis of the first round visits. These were later elaborated and discussed in the Interim Report. In order to summarize the major points of those data from the first round of site visits, we have listed the main hypotheses for the reader's review.

Definitions and Problems of Terminology

1. Head Start staffs were initially confused by the concept "handicapped" and thought that the terms of the mandate were ambiguous.

2. Staffs developed their own definitions of "handicap" and applied them in order to come to grips with the mandate.

3 While some staffs used the term "handicapped" to refer to all Head Start children, many others--particularly at the center level--were reluctant to do so and felt uncomfortable with the notion of labeling children with mildly handicapping conditions.

4. Head Start staffs, especially at the administrative level, felt the pressure to label both severely and mildly impaired children in order to meet the guidelines.

Pre-Mandate Efforts on Behalf of Handicapped Children

1. All of the Head Start programs we visited reported that they had always served handicapped children and, with the exception of a few severely handicapped youngsters, had not consciously excluded children.

2. While few staffs, if any, had systematic, comprehensive programs for providing services to children with special needs, they had established some working relationships with community agencies prior to the mandate.

Program Planning after the Legislative Mandate

1. Program planning for handicapped children varied considerably across the programs we visited.

2. For the most part, Head Start activities directed at increasing services to the handicapped proceeded more as an evolving than a pre-planned process.

3. Planning efforts were primarily concentrated on the identification and diagnosis of handicapped children and on staff training.

4. Staff commitment to the value and effectiveness of planning was reduced as a result of funding uncertainties and the frequency with which policy guidelines were passed down to local programs.

Handicapped Children in Head Start: Numbers, Conditions, and Severity Levels

1. Overall, the population of handicapped children in local programs has changed only modestly between this

year and last. This change has been reflected in a slight increase in the numbers of children with severe impairments served.

2. Staffs of the programs we visited reported that the nature of impairments of children enrolled in programs has not changed significantly since last year and, in retrospect, they have always had handicapped children.

3. One major deleterious effect of the mandate has been the increased labeling of children in Head Start.

4. The majority of children identified as "handicapped" in the programs we visited were the mildly disabled.

5. Compared to the number of mildly disabled children, the percentage of severely impaired children designated as "handicapped" was very small.

Identification, Recruitment, and Enrollment

1. The majority of Head Start programs we visited were making more special efforts to identify, recruit, and enroll more handicapped children this year than heretofore.

2. Most handicapped children in programs we visited were identified through regular Head Start rather than through special recruitment efforts.

3. With the exception of severely impaired children, identification of most handicapped children took place after enrollment in programs.

4. The implementation of the fee schedule guidelines generated special difficulties in enrolling handicapped children.

Diagnosis and Assessment

1. Head Start programs were making a significantly greater effort to professionally diagnose handicapping conditions this year than heretofore.

2. Diagnoses by outside agencies did not influence child experiences in Head Start, as did the informal diagnoses conducted by inhouse Head Start staffs.

3. As a result of the handicapped effort, Head Start staffs were making more detailed individualized assessments of the developmental needs of all children this year than heretofore.

Service Delivery

1. Most of the programs we visited offered the resources to adequately serve most minimally, moderately, and some severely impaired children.

2. Current physical facilities of most Head Start programs we visited did not meet the minimum standards for preschool children in developmental programs.

3. Local programs were making greater and more systematic efforts to provide or arrange special services for handicapped children.

4. Staffs of most programs we visited were attempting to meet the special needs of handicapped children by more intensive and systematic use of already existing components of the Head Start model, rather than through the development of specialized services.

Integration

1. Mildly, moderately, and most severely handicapped children have been physically and psychologically integrated into Head Start settings.

2. Some programs were considering the possibility of forming special classes for handicapped children as a result of the mandate.

3. Most of the programs we visited had positive attitudes toward the increased inclusion of handicapped children in a totally integrated setting.

Parent Involvement

1. Involvement of parents of handicapped children in Head Start was the same as or greater than that of parents of typical children.

2. Parents of handicapped and typical children in the programs we visited expressed very positive attitudes toward the Head Start programs, in general, and in particular, toward efforts on behalf of handicapped children.

3. The majority of parents of severely impaired children we talked with reported that Head Start has had a significant impact on their lives in terms of providing relief, care, special services, educational services, and alternative ways of thinking about their children.

Involvement with Community Agencies

1. The handicapped effort has increased involvement with community agencies and, to some extent, has led to the development of new relationships.

2. Community agencies were providing a variety of supportive services for the handicapped effort, including ongoing therapeutic services and staff training to improve programming. The major thrust of changes at the time of

our visits appeared to be related to the identification, diagnosis, and enrollment of handicapped children.

3. Some Head Start programs were not defining their relationships with community agencies in ways that maximized benefits to the handicapped effort.

4. Community agencies initially had mixed reactions to the Head Start handicapped effort. Many reportedly questioned the qualifications of staffs of local programs.

5. Some staffs were having difficulty recruiting handicapped children because of community agency competition.

6. Observers reported that some handicapped children who were eligible, by age, for public school were being maintained in Head Start.

Staffing, Staff Training, and Technical Assistance

1. All of the Head Start staffs we spoke with expressed a strong need and desire for "good" training that would aid them in serving hand apped children.

2. Staff receptivity to enrolling severely handicapped children increased as contacts with those children increased.

3. Some staffs hired or assigned personnel to coordinate and assume major responsibility for the handicapped effort.

Post-Head Start Plans for Children

1. Staffs were making special efforts to build continuities between Head Start and public school programs.

Attitudes toward the Mandate

1. Most staffs of programs we visited had mixed reactions to the mandate. They disagreed not so much with the intent of the new legislation but the ways that it was implemented with little support or direction from National and Regional OCD Offices.

2. Staffs also felt overwhelmed that they had to cope with two other national requirements in addition to the mandate to serve more handicapped children, i.e., the fee schedule and the performance standards.

The Experimental Projects

Since their inception, Head Start programs have been involved in the development of several innovative approaches to the delivery of child development services,

including Parent and Child Centers, Health Start, Home Start, and Child and Family Resource programs. The recent Head Start experimental effort for handicapped children represented yet another phase of this ongoing demonstration thrust.

In late spring of 1973, the Office of Child Development announced its intent to fund approximately 12 experimental projects to develop new approaches to offering Head Start services to handicapped children. Specifically, prospective grantees were charged with the responsibility of:

(a) Demonstrating alternative approaches to serving handicapped and typical children in integrated Head Start settings

(b) Identifying benefits which handicapped children might derive from Head Start participation

(c) Developing program models and delivery systems through relationships between local Head Start programs and other community organizations

(d) Designing replicable diagnostic procedures to identify special needs of handicapped children

(e) Demonstrating replicable approaches to enhance parent and family participation

(f) Demonstrating approaches for providing continuity of services to handicapped children from Head Start through the early school years

(g) Developing replicable approaches for training Head Start staffs

(h) Designing evaluation procedures to measure the effectiveness of proposed services for handicapped children.

Fourteen programs, representing diverse geographic locations, social and ethnic backgrounds, and program sizes, were subsequently awarded grants to carry out these objectives. Six were jointly supported by OCD and BEH, and designated as Phase I projects. They were:

(a) A Model Providing Individualizing Instruction to Preschool Children with Special Needs in Portage, Wisconsin

(b) A Model Preschool Central Experimental Education Unit in Child Development and Mental Retardation in Seattle, Washington

(c) The Liberty County Head Start Development Program in Bristol, Florida

(d) The UNISTAPS Project for Hearing Impaired, 0-6, and Their Parents in St. Paul, Minnesota

(e) The Chapel Hill Training Outreach Project in Chapel Hill, North Carolina

(f) The Head Start Project to Serve Handicapped and Other High Risk Children in Anchorage, Alaska.

With the exception of Liberty County which had an ongoing Head Start program, we distinguished these programs as special experimental projects.

Eight remaining Phase II projects were sponsored by OCD, in cooperation with established Head Start programs that reportedly were serving handicapped children prior to the Congressional mandate. These were:

(a) The Southeastern Tidewater Opportunity Project--Head Start in Norfolk, Virginia

(b) The Otsego County Head Start Program in Cooperstown, New York

(c) ECKAN Head Start in Ottawa, Kansas

(d) People's Regional Opportunity Program--Head Start in Portland, Maine

(e) Demonstration Project for the Integration of Handicapped Children into Head Start in Tucson, Arizona

(f) KiBois Head Start in Stigler, Oklahoma

(g) Project Head Start, Big Horn Community Center in Crow Agency, Montana

(h) Adams County Head Start in Brighton, Colorado

These 14 experimental projects were the second focus of field study in the first round of Task III site visits. The remainder of this chapter will be devoted to summary descriptions of the experimental projects, additional data on the three programs in Alaska, North Carolina, and Minnesota that were collected in the spring, and follow-up data collected by telephone on the 11 projects visited in the fall. A summary of major findings and conclusions with respect to all of the projects has been included in Chapter VI of this report.

Summary of Experimental Approaches

While all of the experimental projects shared some degree of commonality in emphasis, as they did indeed with all regular Head Start programs, each possessed its own distinctive features. Below we have summarized a few of these characteristics of each of the projects visited in an attempt to reflect the broad array of models developed and programs included in this current demonstration effort.

The Preschool Project in Portage, Wisconsin. Purposes of the Portage Project were threefold: the development, demonstration, and dissemination of information about a training model for individualized instruction to preschool

children with special needs. The project emphasized precision teaching techniques, including assessment of present behavioral competencies, the pinpointing of emerging behaviors, and procedures for recording data. A major component of the effort specifically involved the development of a model curriculum which focused on five areas of child growth, i.e., cognition, self-help, motor, language, and socialization. Each of these behavioral areas was broken down into sequential developmental components, extending in age from birth to five years. The performance of each child was assessed with the help of the Alpern-Ball Developmental Profile Manual. The curriculum also included a set of approximately 500 cards which provided detailed information for parents and teachers on ways to attain particular behavioral objectives.

At the time of our visit, these special techniques were being demonstrated in both Head Start centers and in a home visitation program. Two Head Start programs were providing services to handicapped children in an integrated setting. In a third program, parents had the option of either enrolling their handicapped child in a Head Start class or of receiving home instruction by means of the Portage home visitation model. The project staff indicated

that most parents elected to send their children to a classroom, if that option was available. In most instances, parents selecting the home visitation approach did so because they lived beyond the school district or their children were not recommended for classroom placement.

Another distinctive feature of the Portage Project was the large amount of specialized in-service training required of staff, at the time of our visit.

The Experimental Education Unit in Seattle, Washington. This project differed significantly from regular Head Start projects in many respects and from other experimental projects in a number of notable ways. The grantee for this project was the Experimental Education Unit at the University of Washington. This unit was a part of a larger complex at the University, i.e., the Child Development and Mental Retardation Center, which has held many research and training projects and dealt extensively with multidisciplinary, clinical services, and experimental education areas.

The basic thrust of this experimental project was the development and testing of replicable models for use in other Head Start agencies. The point of application of the models at least during the initial stages of the

project, was the Central Area Motivation Program (CAMP), selected because that particular delegate agency operated a year-round program, including a day care program serving children from 9 to 10 hours per day. Also, the four centers were sufficiently close to the University of Washington facilities to minimize loss of time in travel. The population served by these centers was quite representative, consisting mostly of inner-city Black families, but with a significant number of other racial and ethnic groups represented in one of the centers where university student housing was present.

The three models, developed and tested in the project, generated from the recognized needs of the total Head Start community to better understand the identification of handicapped children, to respond to their needs effectively for correcting or alleviating problems, and to do so in a maximally integrative setting. The three models, closely related, were identified as follows:

(a) The assessment-referral-follow-up model
(b) The staff training model
(c) The integration model.

The relationship of this project to other Head Start activities, particularly in Region X but to some

extent nationally, was best evidenced by staff invitations to provide consultation and training to a number of other agencies. For example, members of the staff had provided training to other delegate agencies in the Seattle area, conducting workshops and individual technical assistance in day care programs such as Model Cities. Also, training assistance had been provided to community colleges which had established demonstration day care programs as a part of their curriculum for students in child development and family living.

Finally, in addition to continuing the development and testing of the first three major models described above, activities for the project during its second year included exploration of a number of new models.

Liberty County Head Start Development Program in Bristol, Florida. Liberty County, an extremely rural area located approximately 50 miles from Tallahassee, Florida, was designated a demonstration center and the site of an experimental project which was responsible for outreach services to 50 Head Start centers with a combined staff of 366 people. In-service education and laboratory experiences were provided for teachers, directors, and teacher aides from those centers by regular Head Start staff and

two resource persons, an Outreach Project Coordinator and Media Assistant, recently hired in early fall. The integrated classroom setting in Bristol, organized into eight learning centers, served as a laboratory where other personnel could learn to understand and cope with the needs of handicapped children in a non-categorical program. The Head Start center provided direct services to approximately 55 children including all eligible four-year olds in the county and some three- and five-year old handicapped children. The population of the service area was predominantly White, approximately 85 percent, and 15 percent Black.

Especially distinctive features of outreach and on-site, in-service training activities of this experimental project were:

(a) An increased emphasis on systematic, on-going classroom assessment of individual and parental needs of all children on the basis of the Learning Accomplishment Profile, developed by Ann Sanford at the University of North Carolina

(b) The collection of resource materials, particularly relevant to the handicapped

(c) Development of an instructional materials network check-out system for outreach centers

(d) A "needs assessment" of each of the 50 outreach centers

(e) The development of teacher training packets to be used with the Bristol Head Start staff and outreach centers

(f) An increasing emphasis on various dimensions of classroom service, e.g., the individualization of child programs, language and speech development.

The Southeastern Tidewater Opportunity Project in Norfolk, Virginia. The Southeastern Tidewater Opportunity Project, located in Norfolk, Virginia, provided direct services to approximately 450 children of a predominantly Black community. The experimental effort of this program focused on four principal objectives including:

(a) Demonstration of effective ways that handicapped children could be mainstreamed into the regular Head Start class

(b) Demonstration of ways that community resources could be mobilized to provide comprehensive child care services to handicapped children

(c) Demonstration of innovative ways of working with families of handicapped children

(d) Demonstration of new methods directed at improving community, parent, staff, and other child attitudes toward handicapped children.

Toward an accomplishment of these goals, the newly hired experimental team of three persons had engaged in several activities. For example, beginning early July, the team made numerous visits to community agencies and public schools in order to obtain referrals, learn about the availability of services for preschool handicapped children, and acquaint agency staff with the experimental programs and legislative mandate. Second, they developed a model for integrating handicapped children into regular Head Start programs. These new developments required intensive family and child care on the part of the project team, arrangement of special services with outside community agencies, and frequent meetings with teachers of classes when children were to be enrolled.

As described by the project team at the time of our visit, future plans included close collaboration with regular Head Start teachers who had handicapped children already enrolled in classes, as well as in-service training sessions later in the year. As part of this overall training effort, the team members themselves had already participated in several workshops and special education courses and had obtained considerable practical experience with children who suffered from a variety of disabling conditions.

Otsego County Head Start Program in Cooperstown, New York. The Otsego County Head Start Project operated five centers in scattered locations around the county and a mobile unit which provided a modified "home-based" program. Each center consisted of one class of 10 to 15 children for a total average enrollment of 115 Head Start children. The Community Action Program agency, located in the northernmost region of "Appalachia" served a predominantly White community.

With the awarding of the experimental project grant, the Otsego program changed in several notable ways. First, additional personnel, including a half-time project coordinator and two child service specialists, were employed to work in the daily classroom programs and with families of handicapped children.. They were essentially responsible for serving as itinerant, resource persons to assist teachers on a planned basis. Also, they acted as "crisis" persons whenever children had particularly difficult behavioral problems that interfered with optimal integration.

The project had effected some other changes in the local program. For example, it was chiefly responsible for a considerable increase in available community services for handicapped children and their families. Second, the

staff had developed some rather unique strategies for screening and assessing individual needs of children with special problems. Specifically, these had involved the use of video tapes to accumulate observational data, identify problems, and evaluate child progress. At the time of our visit in the fall, this last development was still at an early stage. Staff indicated at that time, however, that data collected would eventually be used to aid teachers in planning educational prescriptions for children. Finally, as with the programs described above, staff training to better meet the needs of the handicapped constituted another major change of a specialized nature that took place as a result of the experimental effort.

ECKAN Head Start in Ottawa, Kansas. This project sought to design and demonstrate a program model for serving handicapped children in Head Start programs in an integrated setting with typical children. Direct services to children were provided at two levels. For the most part, children with mildly handicapping conditions received special help in regular classes which covered a rural five-county area. Moderately to severely handicapped children were served in a University Affiliated Clinical Training Center, a class setting jointly sponsored by the Special

Education Department at Kansas University and the Lawrence Public Schools. Approximately one-fourth of the staff time was devoted to the development of this demonstration facility.

Remaining efforts in this experimental project were devoted to developing a training model for Head Start personnel serving preschool handicapped children. Under the guidance of a special education teacher, hired for the handicapped effort, this component of the program had two parts: (a) short-term, in-service training of Head Start staff at a full-day program in Lawrence, and (b) training in the form of workshops for all Head Start staff.

In addition to the teacher trainer, Ottawa had also hired several other persons who were responsible for the handicapped effort. New staff included a classroom teacher and substitutes who participated in the UAF program. Also, at no direct cost to Head Start, the project had acquired the services of several resource persons from the University, e.g., speech therapists, occupational therapists, psychologists, and specialists in child growth and development.

People's Regional Opportunity Program in Portland, Maine. By the time of our visit in the fall the experimental

effort had already had wide-spread influence across several dimensions of the Portland Head Start program. Overall, these developments had been directed toward enhancing comprehensive, developmental services for all preschool handicapped children and toward the program's serving as a demonstration project. More specifically, the following changes had taken place. The program was attempting more and more to place primary emphasis on the prevention of learning and emotional problems of young, handicapped children before they entered Head Start. At the time of our visit, these plans were in the process of being implemented in a newly developed Verbal Interaction Project. The Special Services Coordinator had attended a week-long training session in order to learn how to develop this early intervention program in Portland. Other staff had also received special training. As reported by various persons, such developments, in retrospect, represented a "stepping-up" of activities over those of the past year. Parent involvement, always an integral part of program efforts, had seen some modification, with the creation of a parent group for families of handicapped children. Assessment procedures had taken a new turn as a result of the experimental effort; specifically staff were attempting

to combine a multidisciplinary diagnostic team consisting of a learning specialist, teachers, a psychologist, parents, and other relevant persons. To obtain a full picture of "the whole child," this group emphasized a "holistic" approach to evaluation and focused, in particular, on the needs of parents and teachers in carrying out an individualized program.

Finally, in addition to the Special Services Coordinator, the program had also enlisted the help of a special education consultant who worked with parents and at the center level with teachers.

A Demonstration Project for the Integration of Handicapped Children into Head Start in Tucson, Arizona. Project PLUS, located in Tucson, Arizona, sought visibility in the experimental effort purposes of demonstration and replication. It was a part of a regular Head Start program which provided services for a racially mixed (i.e., Black, Chicano, and Caucasian) population of children. As described in the project plan, the first demonstration year was intended to accomplish five major objectives:

(a) The development of curriculum models for mainstreaming handicapped children into integrated classroom settings

(b) The development of a staff training program

(c) The development of a meaningful and effective parent education program which involved parents in the classroom and home

(d) The development of a coordinated system to maximize effective delivery of community services to handicapped children

(e) Development of lines of communication and capabilities within the public school structure to insure the acceptance of handicapped children.

A project team of six members, including a director and five assistants, had been given primary responsibility for follow-up activities pursuant to these goals. At the time of our field visits, these activities had involved these program developments.

Five demonstration centers, serving about 220 children, were initially selected from 13 Parent-Child centers as representative of the variety of settings available in the five-county service area. Members of the staff divided their time between a coordinated team approach two days a week and individual work in assigned centers three days a week. Work at the center level consisted of developing curricula, assisting staff as resource persons, and providing limited direct services to individual handicapped children. Like some of the other experimental efforts,

this project had placed special emphasis on the diagnosis of disabling conditions prior to a child's enrollment in the program. The project staff had developed a rather unique strategy in this endeavor, i.e., they had designated one setting as a diagnostic classroom to be attended by all children prior to their regular Head Start class placement. Finally, this project also placed priority on pre-service and in-service training for teachers. This involved a variety of activities such as on-site visits to selected agencies and preschool programs providing services to handicapped children, technical assistance from a model Indian preschool program, and several workshops.

KiBois Head Start in Stigler, Oklahoma. The KiBois Head Start, like the experimental effort in Tuscon, Arizona, served as a demonstration project focusing on the delivery of services to handicapped children in regular Head Start settings. This project, however made a unique contribution to the development of service delivery models within an extremely rural area, covering four counties over approximately 4,279 square miles. The location of this project placed unusual constraints on local programs in terms of identification and assessment of children, transportation, and the delivery of special services. An especially

important part of the experimental effort was thus devoted to the training of paraprofessionals to work closely with handicapped children and their families since highly specialized personnel were at least 100 miles distant. Also in this regard, training of teachers was largely centered on developing abilities to observe children on an ongoing daily basis and securing special consultants to work directly in the classroom setting with staff. The project also sought to provide information to parents about the meaningful use of available community resources.

The KiBois Head Start program enrolled approximately 755 children in a total of 44 classes.

Project Head Start in Crow Agency, Montana. Problems faced and major objectives of the Crow Agency, Montana, experimental effort were not unlike those of the Stigler, Oklahoma project. Because of the sparsity of population in the state, transportation and the arrangement of special services presented unusual and special difficulties. Identification posed no particular problems, for all of the pre-school children from the Crow Indian reservation, totaling approximately 225 children, were enrolled in Head Start.

Underlying the entire effort of this program was the concept of total involvement of the family and community

in the education of the handicapped. In view of limited community agency resources, this program, like Stigler, had placed a high premium on providing maximally beneficial services for handicapped children directly in the classroom setting. In order to accomplish this goal, the program had hired two new staff members for the handicapped effort, including a Special Services Coordinator and Handicapped Curriculum Coordinator. Also as needed, they brought in consultants on individual children. Within the constraints of limited resources, the program also has provided some special training for staff.

Adams County Head Start in Brighton, Colorado. Experimental activities in the Adams County Head Start represented a program-wide effort to extend delivery of services which had not previously been available to handicapped children and to improve existing provisions. Specific changes in the program as a result of the experimental project included:

(a) An intensive recruitment effort in search of handicapped children

(b) Greater individualization of classroom services for handicapped children

(c) The development of special assessment techniques to be used by regular Head Start teachers

(d) Special training for staff

(e) The addition of staff who were chiefly responsible for the handicapped effort, i.e., a Special Services Coordinator, three teachers, a speech therapist, and an occupational therapist who served in a consultant capacity

(f) A significant increase in community agency contact.

Overall, the Brighton program served a mixed population (Chicano and Caucasian) of approximately 320 children who were enrolled in 16 Head Start classes.

Head Start Project to Serve Handicapped and Other High Risk Children in Anchorage, Alaska. This project sought to develop a system of comprehensive services for all possible categories of handicapped children and their families in Alaska Head Start programs. A core group of professionals and paraprofessionals worked directly with Head Start programs to ensure delivery of services, coordinate efforts of already existing agencies, and supplement available services, particularly in the areas of language development and psychological services. In addition, direct training and technical assistance were provided to Head Start personnel in areas such as identification and screening techniques to adequately meet the needs of handicapped children.

One major problem that confronted the program, as we have already mentioned with respect to the Stigler, Oklahoma experimental project, was the extreme isolation of the small communities. The Alaska project was responsible for providing services to 38 Head Start centers serving a total of 1,100 children. Thus, it was not surprising that attempts to provide training and technical assistance to local programs posed some unique and formidable problems for the experimental project.

One major accomplishment of the experimental effort was the development of an increased awareness of individual needs of all young children and growing abilities of staffs to evaluate special problems.

The UNISTAPS Project for Hearing Impaired, 0-6, and Their Parents. Involving a team of two speech pathologists and two psychologists, this OCD-BEH collaborative experimental project sought to develop a statewide system for helping Head Start programs successfully integrate handicapped children into their classrooms.

In general, the project activities focused on four areas. These were: (a) workshops, (b) on-site, in-service training application of workshop materials, (c) development of local and statewide referral systems with a trained core

of case managers or mediators to work at the Head Start local agency level. More specifically, the case managers had the purpose of guiding agency activities necessary to provide special services, e.g., observation skills, referrals, and screening and diagnosis. The project staff did not provide direct services to handicapped children per se; the major thrust of the project was to develop resource personnel at the local level to assume responsibility for the handicapped effort. On-site visits were conducted to familiarize agencies with the experimental project, the services it offered, and to assess needs of local programs. The experimental team used a combination of planning and demonstration techniques in working at the local program level.

The UNISTAPS project was involved in providing services to programs that worked with handicapped infants and young children between birth and six years of age.

The Chapel Hill Training/Outreach Project in Chapel Hill, North Carolina. The primary goal of the Chapel Hill Outreach Project was to provide early educational intervention for young developmentally handicapped children throughout the state of North Carolina. Seven children between the ages of three and eight received direct services in the project's demonstration classroom housed with the Division

of Disorders in Development and Learning on the University of North Carolina campus. The major thrust of the project, aside from these activities, was to promote change in community services for the handicapped through intensive training programs for kindergarten, first, second, and third grade teachers and for personnel involved in Head Start and day care programs. In its fourth year of operation, the project has provided technical assistance and conducted workshops for more than 400 professionals and paraprofessionals over the past year--offering methods, materials, and curricula developed during the three-year project demonstration period.

The educational approach of this experimental effort has emphasized individual prescriptive programs for both children and their families. Techniques, demonstrated in the classroom and presented in training sessions, have included behavioral assessment, establishment of developmentally appropriate objectives, task analysis, and the systematic use of reinforcement. Practical materials developed by the project staff have included a 45-week curriculum guide and the Learning Accomplishment Profile (LAP), a developmental assessment inventory prepared by Ann Sanford of the University of North Carolina.

Over the past year, the project has been able to

extend its outreach services to programs in eight areas across the state and, at the same time, has continued its direct service component by bringing together the coordinated resources of many agencies and educational institutions including the North Carolina Council on Developmental Disabilities, the University of North Carolina, the Chapel Hill-Carrbora public school system, and North Carolina's Technical Institutes and Community Colleges.

Follow-Up Data on Experimental Programs

Our telephone interviews in the spring to the 11 experimental programs visited in the fall were generally concerned with four areas of inquiry. These were:

(a) Changes in the handicapped population and/or program approach since the on-site visit

(b) Significant problems that programs were encountering in serving handicapped children

(c) Perceived needs

(d) Costs in serving handicapped children.

While there had been some changes between the fall visits and spring follow-up, the handicapped effort in most of the experimental programs had remained basically the same. Only one project indicated that it had made substantial changes in its approach, i.e., moving from a

university based center to a regular Head Start program. Five of the programs noted that they had enrolled a few more severely handicapped children. Also like the regular Head Start programs, they had made more determined attempts to solidify relationships with public schools and other community agencies, and for the most part, had been fairly successful in these endeavors. As a result, they had been able to acquire more diagnostic and therapeutic services for handicapped children and their families.

Continuing problems noted by staffs of the experimental projects again were similar to those experienced by the regular Head Start programs. In only one or two instances had programs dropped children because of the nature of their handicapping conditions; more frequently, children left because of family moves. This finding, however, does not minimize the substantial problems that programs were having with some disabled children, in particular, the more severely retarded and emotionally disturbed. In addition, staffs mentioned a wide range of other difficulties including persistent funding problems, minimal parent involvement, perceived needs for more support and direction in carrying out the mandate, and inadequate coordination with regular Head Start programs, an observation that was especially troubling in the first round of visits.

Finally, as with all of our attempts to obtain cost information throughout this evaluation study, our efforts to determine project estimates of the costs in serving handicapped children were less than satisfactory. Our information was not complete. We were promised budgets and supportive data that were never sent, and in those instances where we did obtain material, projections were so variable that we deemed them highly questionable.

CHAPTER IV

SECOND ROUND VISITS TO REGULAR HEAD START PROGRAMS

In earlier chapters the purposes, research approach, and procedures of the second round of visits were discussed in detail. In this chapter we present relevant findings from our visits to the 36 regular Head Start programs. As reminders, two factors need to be kept in mind with respect to the second round visits.

First, data reported here were collected by means of questionnaire, which provided opportunities for the field staff to include anecdotal comments in order to supplement the information they received from direct closed-response questions. The findings presented in this chapter represent our analysis of both the quantitative and qualitative data collected in the second round.

Second, the 36 programs we visited were divided into three cluster groupings for the purpose of data analysis. Cluster I consisted of programs with the highest proportion of severely handicapped children (i.e., at least 4.5 percent of the total selected program enrollment). Cluster II included programs serving primarily mildly and moderately handicapped children (10 percent or more) and some severely impaired

children (up to 4.4 percent). Programs in cluster III, on the other hand, had no or very few severely handicapped children (enrollments of less than 1.5 percent) and some mildly and moderately disabled children (less than 10 percent). This chapter discusses data with respect to the total sample, as well as differences among the cluster groupings.

The chapter has three major sections. In the first, we present program-level information which was obtained in interviews with Head Start directors and personnel chiefly responsible for the handicapped effort. In the second, data on the 74 case studies of handicapped children are discussed. This information was obtained through discussions with center-level staffs, i.e., teachers, teacher aides, social service workers, and others directly involved in providing services for children. Part three presents data concerning the general nature and quality of classroom services. These data were collected by means of an observation schedule and interviews with members of the teaching staffs in 44 classrooms, all of which contained at least one case study child. Part four presents correlational data.

Program-Level Information

The Mandate

Notification of the mandate. The majority of Head Start directors we interviewed (i.e., 26 of the 36 programs visited) indicated that they first heard about the mandate through official notification from their Regional OCD offices. Six directors had official notification from the National Office, and three indicated that they had received unofficial communication about the new legislation. Further discussions with program directors suggested, however, that most staffs expected to receive additional information about the implementation and intent of the mandate. In most instances, such information was not forthcoming and, thus, a disappointment and source of frustration.

Table 6 provides information about the length of time, prior to fall enrollment of children, that programs were notified about the new legislation.

Attitudes toward the mandate. We asked this question of Head Start directors, "How did you feel about the requirement to serve handicapped children? Very few indicated that they disagreed with the notion of serving handicapped children, but they were strongly opposed to ways that they were notified

TABLE 6

TIME OF MANDATE NOTIFICATION

Number of Programs	Number of Months prior to Fall Enrollment that Programs were Notified
2	No notification
10	1
2	2
5	3
3	4
3	5
5	6
4	9
2	No response[a]
36	

[a]These data indicate that more than half of the programs we visited were notified only three months in advance, or less, prior to the time that handicapped children were supposed to be enrolled. Such timing may have weakened the efforts of some programs to enroll more disabled children since many programs begin to recruit children for the fall during the spring semester.

In repeated instances, responses to certain questions on the questionnaires were absent. These missing data, most frequently, were a result of the failure of directors or other Head Start personnel to respond to particular questions. Thus, frequencies do not always reach their maximum totals, i.e., 36 programs, 74 child case studies, and 44 classroom observations.

about the new requirement. These attitudes need to be taken into account in examining the data presented in Table 7.

TABLE 7

REACTIONS OF HEAD START DIRECTORS TO THE MANDATE

Reactions	Numbers of Head Start Directors
Strongly Agree	8
Agree	9
Neutral	13
Disagree	1
Strongly Disagree	2
No Response	3
Total	36

In part, these data also reflect problems some staffs had in understanding the intent of the mandate and the concerns of others about serving the more severely impaired. For example, 13 directors indicated that they had reservations about whether they had the personnel and physical resources to serve the severely handicapped. The following are some of the comments noted by field observers during their interviews with Head Start directors.[5]

[5]The reader should note that these anecdotal comments and others included throughout the report, have the primary purpose of further illuminating interpretations of the quantitative data collected in the questionnaires. They are often "sketchy" or incomplete but reflect the nature of comments made to the field observers while on-site.

. . . Initial reaction was one of apprehension and worry over children (e.g. blind) walking around with no assistance.

. . . Initial reaction was neutral, but more concern arose when it was realized that severely handicapped children were to be served.

. . . . We were not capable of serving severely handicapped. (The program) feared working with these children because of a lack of training.

(The program is) not sure Head Start is set up to serve all handicapped; especially the really severely handicapped.

(The program had) real concern at the time--how was it to be funded. (They) thought it would be severely handicapped coming in.

If the children are mildly handicapped, I (program director) have no problem; but with the severely handicapped, we would need more money, staff, and transportation.

The program director did not feel the staff currently employed could effectively deal with the handicapped. If limited to mildly handicapped, (there was) no problem.

(The staff was) very concerned about how they were going to handle seriously handicapped children. (They) disagreed because there were not enough facilities or staff, but agreed with the philosophy of it all.

Other directors, who responded either neutrally or positively, indicated they also had mixed reactions to the new legislation. At times, they were confused about what the mandate meant or thought that the mandate referred only to mildly handicapped children. Many said that they had always served the handicapped and, thus, the new requirement had little meaning. Still others, in general, were very positive about the effort.

The following are a few of the comments made by the directors of programs we visited.

> We had no real feelings (about the mandate). We had already been doing it.

> . . . We always had a large number of handicapped. We had over 10 percent last year without the mandate.

> . . . (We) felt that Head Start always served the handicapped anyway.

> . . . At first I said, here we go again. But after the survey, I found out we already were serving the handicapped.

There were many other comments. In essence, however, these led to the same conclusion, i.e., interpretation of the mandate and its specific charge varied from director to director. Further, those who agreed with the mandate favored different

things and those who disagreed were negative about different issues. Such variance in attitudes was evident across each of the three cluster groups.

Parent notification of the mandate. Thirty-one of the 36 directors we talked with indicated that they had informed Head Start parents about the mandate. At least 22 of the programs informed parents at one of the Policy Council or other formal meetings. Others were told through informal communication or through written notices.

TABLE 8

PARENT REACTION TO THE MANDATE

Reactions of Parents	Numbers of Program Directors Reporting Such Reactions of Parents
Strongly Agree	5
Agree	8
Neutral	16
Disagree	2
Strongly Disagree	1
No Response	4
Total	36

Information presented in Table 8 and anecdotal comments of program directors about parents correspond closely to the reported reactions and attitudes of directors toward the mandate. Directors suggested that while parents had concern about the severely handicapped and confusion over what the term "handicapped" meant, by and large they were not very concerned about the mandate--in fact, most agreed with it. We found no significant differences between the program clusters with respect to parent attitudes.

Parent influence on programs to serve handicapped children. In light of the passive parent acceptance of the mandate reported by Head Start directors, it was not surprising to find that 28 of the 36 programs also indicated that parents had little or no influence on their decisions about serving handicapped children. Anecdotal data on this question were limited, but five directors indicated that because the mandate came from Washington, the parents really had no decision to make in regard to compliance.

Knowledge of community agencies about the mandate. We asked program directors whether other agencies in their communities who served handicapped children were aware of the new Head Start requirement. Sixty-eight percent of the directors of programs we visited indicated that special service

agencies had been notified. Some programs (i.e., five) indicated that they had made special efforts to inform community agencies through written or other purposeful communication; others (i.e., six programs) allowed the information to pass to agencies by word of mouth. Still others (i.e., eight programs) knew or assumed that their CAP agencies or Regional or National OCD Offices had informed community agencies. Finally, we found that some programs simply did not concern themselves with communicating such information. We found no significant difference with respect to the degree to which programs in clusters I, II, or III notified community agencies ($S > .80$).

Reactions of community agencies to the mandate. Table 9 presents data on the reactions of community agencies to the mandate, as reported by Head Start directors. Not unlike the reported reactions of parents, more than half of the programs said that community agencies had agreed with the idea that Head Start programs ought to serve more handicapped children. In contrast with the data on parent reactions, however, we did find significant differences ($S < .05$) among the clusters, with programs in cluster I reporting fewer negative reactions than those in clusters II and III and those in cluster II less negative than those in cluster III.

TABLE 9

REACTIONS OF COMMUNITY AGENCIES TO THE MANDATE

Reactions of Community Agencies	Numbers of Program Directors Reporting Such Reactions
Strongly Agree	8
Agree	9
Neutral	13
Disagree	1
Strongly Disagree	2
No Response	3
Total	36

Influence of community agencies on program service to handicapped children. Eleven program directors indicated that they thought that community agencies had influenced their decision to serve the handicapped. The remaining 25 said that agencies had no effect. Ten said that the influence had taken the form of help and support in recruiting or providing services for children.

Influence of other groups and organizations on program decisions to serve handicapped children. Twenty-seven directors indicated that no other local groups or organizations (e.g., organizations for parents of handicapped children, PTA's, or local political groups) had influenced

their decisions to serve the handicapped. The anecdotal information suggests, however, that there was some confusion over this question and that program directors found it difficult to distinguish between "community agencies that served the handicapped" and "other groups and organizations."

Attitudes of Head Start Directors toward Serving Handicapped Children

One of the major findings from the first round of field visits concerned the attitudes of program staffs toward serving handicapped children in Head Start. Basically, we found that personnel had considerable anxiety and concern about serving more severely involved youngsters. On the other hand, they had few problems with the notion of including children with less disabling conditions; in fact, in the past, they really have not considered these children to be "handicapped."

Data from the present round of visits seem to lend continued support to this division of attitudes toward serving severely handicapped and less involved children. For example, the majority of programs indicated that Head Start was an appropriate setting for the mildly handicapped, staffs felt that these children and typical youngsters could benefit from being in the same setting, and they thought that they

could serve the mildly and moderately handicapped as well as community agencies. There were some differences of opinion, however, on the question of whether it was just as easy to serve these children in Head Start as it was to serve typical children.

Perceptions about serving the severely handicapped differed a good deal from these views. While the majority of programs thought that severely handicapped children would benefit from being in the same setting with typical children, it was also clear that they had considerable concern about whether Head Start was an appropriate setting or whether they could provide the kinds of services needed by these children. Finally, 32 of the 36 programs felt that it was more difficult to serve severely handicapped children. It should be noted, however, that in spite of such concerns about serving more disabled children, the majority of directors still expressed more positive than negative attitudes about the notion of providing services for these children.

In conclusion, we obtained composite attitude scores of program directors toward serving first, the mildly and

moderately handicapped and secondly, the severely handicapped.[6] These are presented in Table 10.

TABLE 10

COMPOSITE ATTITUDE SCORES OF PROGRAM DIRECTORS TOWARD SERVING MILDLY, MODERATELY, AND SEVERELY HANDICAPPED

Composite Score Ranges	Numbers of Programs Reporting Attitudes toward Serving the Mildly and Moderately Handicapped	Numbers of Programs Reporting Attitudes toward Serving the Severely Handicapped
6 - 7	0	3
8 - 9	0	1
10 - 11	1	1
11 - 12	0	1
13 - 14	0	5
15 - 16	2	4
17 - 18	2	3
19 - 20	4	4
21 - 22	4	6
23 - 24	3	4
25 - 26	11	2
27 - 28	4	0
29 - 30	14	0
No Response	1	2
Total	36	36

[6]Composite scores were obtained by assigning the following weights to the following attitude responses: strongly negative (1); moderately negative (2); moderately positive (4); extremely positive (5); and neutral responses received scores of (0). After assigning these respective weights, all scores referring to the mildly and moderately handicapped were totaled, and similarly all scores for the severely handicapped were added. The highest possible positive scores for both composites were 30.

Examination of Table10 reveals that the composite attitude scores toward the mildly and moderately handicapped of only five programs fell below 18, while 18 programs had composite scores for the severely handicapped that were less than 18. The differences are clearly evident.

Enrollment of Handicapped Children

Problems of definition. Earlier in this chapter, we noted that Head Start staffs were confused about the meaning of the term "handicap." When we raised questions about the numbers of handicapped children enrolled, responses often were unclear. Frequently we were asked, "What kind of child are you referring to?" While we were told by one director that all handicapped children in his program were severely disabled, the majority of programs reported children with very mild handicapping conditions--the same kinds of children who have always attended Head Start, who never have been considered handicapped.

Data presented in the next section on percentages of handicapped children enrolled need to be interpreted in the light of these problems of definition, terminology, and strong program concerns about meeting required quotas of handicapped children. At best, the figures presented are "crude" estimates

of the handicapped population. Our researchers did not see every child listed as "handicapped." Further, the professional judgments our field staff did not always agree with those made by program directors and other Head Start staff. For example, our observers described a situation in one program where a child reported to be "blind," was severely visually impaired in one eye but had good vision in the other and functioned very well in the classroom with little assistance.

Total enrollments of handicapped children. Considerable controversy has surrounded this study concerning the numbers of handicapped children currently enrolled. We, therefore, felt that it was imperative to make an attempt--however gross--at determining the percentages of handicapped children served in the programs we visited.

The following is a distribution of percentages of total enrollments of handicapped children.

From Table 11, it is apparent that 33 percent of the program directors reported enrollments of less than 10 percent. Sixty-seven percent of the programs reported enrollments exceeding the required quota of 10 percent handicapped children.

TABLE 11

REPORTED TOTAL ENROLLMENTS OF HANDICAPPED CHILDREN

Total Enrollments of Handicapped Children (Reported by Program Directors)	Numbers of Programs
0 - 2%	4
2.1 - 4%	2
4.1 - 6%	2
6.1 - 8%	2
8.1 - 10%	2
10.1 - 12%	5
12.1 - 14%	6
14.1 - 16%	3
16.1 - 18%	0
18.1 - 20%	0
20.1 - 22%	2
22.1 - 24%	1
24.1 - 26%	2
26.1 - 28%	2
28.1 - 30%	0
30.1 - 32%	0
32.1 - 34%	0
34.1 - 36%	1
36.1 - 38%	1
38.1 - 40%	0
40.1 - 42%	0
42.1 - 44%	0
44.1 - 46%	0
46.1 - 48%	1
Total	36

Enrollments of severely handicapped children. Table 12 which includes percentages of severely handicapped children enrolled presents quite a different picture. Seventeen percent, or 5 of the 36 programs, exceeded 10 percent. Eight programs reported between three and 8 percent severely handicapped. Twenty-two of the 36 programs reported percentages of less than three percent severely handicapped.

TABLE 12

ENROLLMENTS OF SEVERELY HANDICAPPED CHILDREN

Percentages of Severely Handicapped Children Enrolled	Numbers of Programs
0%	15
0.3%	1
0.6%	1
0.8%	1
0.9%	1
1.7%	1
2.3%	1
2.6%	1
4.7%	1
5.3%	1
5.5%	1
6.1%	2
6.6%	1
7.0%	1
7.5%	1
11.1%	1
11.6%	1
12.5%	1
12.9%	1
13.6%	1
37.5%	1
	36

TABLE 13

ENROLLMENTS OF MILDLY AND MODERATELY HANDICAPPED CHILDREN

Percentages of Mildly and Moderately Handicapped Children Enrolled	Numbers of Programs
0%	4
0.5%	1
1.1%	1
2.4%	1
4.0%	2
4.2%	3
5.0%	1
5.4%	1
7.7%	1
7.9%	1
8.1%	1
8.7%	1
8.9%	1
9.6%	1
10.0%	1
10.1%	1
10.9%	2
11.9%	1
12.0%	1
12.5%	2
13.5%	1
14.8%	2
16.7%	1
18.1%	1
21.0%	1
26.3%	1
36.4%	1
	36

Enrollments of mildly and moderately handicapped children. In contrast with the small numbers of severely handicapped children, many more mildly and moderately handicapped children were reported by programs. A little less than half (i.e., 41 percent) of the programs indicated that they were serving numbers of mildly and moderately handicapped children that exceeded 10 percent. An additional 22 percent of the programs we visited (i.e., eight sites) reported enrollments between five and ten percent. These data are presented in Table 13.

Disabling conditions among the severely handicapped. Table 14 presents data on the distributions of handicapping conditions among the severely handicapped enrolled in programs we visited. These figures show that a very limited number of blind, hard of hearing, and deaf children have been included (we might point out that this has also been a typical pattern of enrollment of handicapped children in non-Head Start preschool programs). A few more health and developmentally impaired and severe speech and language disabled were enrolled across all programs. Further, there was a tendency toward higher percentages of health and developmentally impaired, physically impaired, speech and language disabled, and emotionally disturbed. A few more programs took children who were moderately and severely retarded, but in no program did these percentages exceed three to four percent.

TABLE 14

DISTRIBUTIONS OF HANDICAPPING CONDITIONS AMONG THE SEVERELY HAN

Percentages of Severely Handicapped Children	The Numbers of Programs Reporting						
	Blind	Visually Impaired	Deaf	Hard of Hearing	Health/ Developmentally Impaired	Physically Impaired	Speech & Language Impaired
0 - 1%	36	31	33	32	29	31	24
1.1 - 2%	0	3	1	3	1	1	2
2.1 - 3%	0	2	2	1	3	1	4
3.1 - 4%	0	0	0	0	1	2	3
4.1 - 5%	0	0	0	0	0	0	2
5.1 - 6%	0	0	0	0	1	0	1
6.1 - 7%	0	0	0	0	0	0	0
7.1 - 8%	0	0	0	0	0	1	0
8.1 - 9%	0	0	0	0	0	0	0
9.1 - 10%	0	0	0	0	1	0	0

116

TABLE 14

BUTIONS OF HANDICAPPING CONDITIONS AMONG THE SEVERELY HANDICAPPED

The Numbers of Programs Reporting							
sually mpaired	Deaf	Hard of Hearing	Health/ Develop- mentally Impaired	Physically Impaired	Speech & Language Impaired	Emotion- ally Dis- turbed	Mentally Retarded
31	33	32	29	31	24	30	28
3	1	3	1	1	2	2	5
2	2	1	3	1	4	2	1
0	0	0	1	2	3	0	2
0	0	0	0	0	2	1	0
0	0	0	1	0	1	0	0
0	0	0	0	0	0	0	0
0	0	0	0	1	0	0	0
0	0	0	0	0	0	0	0
0	0	0	1	0	0	1	0

Diagnosis and Program Prescription

Identification of children not yet diagnosed as handicapped. Program directors were asked whether there were any children who were believed to be handicapped, but whose handicapping conditions had not yet been clearly diagnosed. Fifty-four percent of the directors who responded to this question indicated that, despite the lateness of the school year, their program did have children whose suspected handicapping conditions had not been confirmed.

Primary reasons that children were considered to be severely handicapped. Program directors were asked to indicate the primary reasons that they had identified children as severely handicapped (who had reported enrollments of such children). Forty-eight percent of the directors said that they had based their judgments on professional diagnosis; 30 percent indicated that children so labeled had been compared with less disabled or typical children. Nine percent had based their judgments on child needs such as the necessity for one to one relationships and the degree of assistance required in the classroom, and 13 percent gave miscellaneous reasons for such designations.

Plans and prescriptive programs developed to meet the special needs of handicapped children. In spite of the fact that 69 percent of the programs reported having prepared plans for recruitment and prescriptive programs for handicapped children, data with respect to planning from our child case studies and observations did not support these claims. The majority of case study children were enrolled in programs through regular recruitment procedures; not infrequently involvement of parents of handicapped children was reported to be about the same as or less than that of parents of typical children; and classroom activities for typical and handicapped children were not significantly different in most programs. Perhaps this finding is reflected in the fact that only six programs reported that their plans had been extremely successful. Fourteen programs thought that they had a moderate degree of success and three programs perceived that they had been unsuccessful in implementing a plan.

Program directors were questioned about the preparation of their plans. Most frequently, they mentioned that educational coordinators and teachers had been chiefly responsible for these tasks--although most programs indicated that several staff persons had been involved in such processes.

We asked directors to describe the basis for their special planning for handicapped children. Eleven said that these preparations had been made in light of child needs; 16 referred to formal diagnosis or testing. Finally, four mentioned that the capacities of teachers and the program were important in determining the plan.

Past Experience

Handicapped children served last year. We asked the directors of the 36 programs we visited whether they had any handicapped children in their programs last year. Thirty-five of the 36 programs indicated that they had served handicapped children in the past; however, only eight were able to give firm figures on their enrollments. The following comments exemplify some of the most frequently mentioned reasons for this lack of information, as reported by directors of the program.

> (They) did not keep separate records. (They did not label.

> (They) were not labeling them handicapped (children).

> (The children) were not labeled as handicapped--only identified as children with special needs.

(Staff) were not documenting at the time.

We did not keep our handicapped separate before. We always accepted them but didn't classify them.

We had them and knew of hearing and speech problems . . . but we didn't pull the information out as separate information.

No records were kept on this. . . .

When the directors were asked if they had served any severely handicapped children last year, 17 of the 36 programs indicated that they had provided services for such children.

Changes in staff perceptions of serving handicapped children. Program directors were asked whether their perceptions about serving handicapped children had changed between this year and last (we might note, in retrospect, that the validity of data based on such a question may be open to speculation). Fifty-three percent, or 10 of the programs, indicated that staff attitudes had not changed to any noteworthy extent. Among those who reported that their perceptions had not changed, many directors mentioned that they had always served handicapped children.

Reactions among directors who felt that staff attitudes had changed were more varied. In most cases, the directors had become more accepting of handicapped children,

in general, and in particular, reported that they were more at ease with the idea of the integration of handicapped youngsters. Others noted that, while they had handicapped children last year, heretofore they had not consciously searched for children with handicapping conditions as they did this year. Still other directors indicated that they had become more aware of the needs of the handicapped children and they felt more knowledgeable. The following remarks by program directors illustrate some of these points.

> (They were) much more aware of handicapped children and their needs.

> (We) feel that we have become more knowledgeable. Handicapped children should not be segregated.

> Now that the staff has an idea of how 'handicapped' is defined, they feel comfortable. They've had them all along--the definition changed them.

> I didn't really understand what was meant by 'handicapped child.' I thought it meant severely handicapped, but now I know it means mild or moderately handicapped.

> We know more (and are) more sensitive to handicapped children.

> At first, (we) thought "handicapped" referred to severe physical or developmental handicaps. Now (we) include retarded, emotionally disturbed, and other disabilities.

Staff Resources

Staff added for the handicapped effort. Sixty-three percent of the programs we visited said that they had not added extra staff this year for the handicapped effort. Some programs, however, did mention taking the handicapped effort into account in hiring their regular staff personnel.

Perceived needs for additional staff. While the data indicated that, in general, new staff members had not been added to serve the handicapped, 23 of the 36 programs said that they could have used additional personnel. Such persons needed by programs included speech therapists, health staff, psychologists, experienced outreach people, special education teachers, psychiatric workers, physical therapists, handicapped administrators, and medical consultants. Lack of funds was the primary reason that most programs had not hired such persons.

We found no significant differences among programs in the three clusters in terms of their perceived needs for additional staff.

Staff persons formally trained in the area of special education. Eleven directors indicated that at least one

person on their staffs had taken at least one college-level course related to special education.

Staff experience in working with handicapped children. We questioned directors about persons on their staffs who had prior experience in working with handicapped children. While most indicated that a large number of their staffs had such experience, it was also clear that there was some confusion in their interpretation of this question. Anecdotal information suggests that many programs viewed themselves as having served handicapped children in the past and, thus, as having had prior experience with handicapped. However, very few had really worked with severely disabled children before this year, and this was one of the main reasons that staffs were anxious about the prospect of including the more seriously handicapped.

Perceived capabilities to serve handicapped children. We questioned program directors about the kinds of handicapped children their staffs were best and, in contrast, least able to serve. These data paralleled other findings. Usually they expressed one of the two following points of view: their staffs could work well with all children, or they were best able to serve mildly and moderately handicapped children. Approximately 50 percent of the programs remarked that they

would have difficulty with serving the more severely handicapped.

Personnel chiefly responsible for the handicapped effort. Programs have handled primary responsibilities for the handicapped effort in various ways. Twenty-seven percent indicated that more than one person was in charge, e.g., the social service coordinator, educational coordinator, or health and medical services personnel. Twenty percent said that the Head Start director had the main responsibility. Seventeen percent indicated that they had either hired a new person or assigned a regular staff member to assume responsibilities as the handicapped coordinator.

The tasks of such personnel varied from program to program. In some instances, these staff members were in charge of carrying out already existing general duties with other children, as well as with handicapped children. Under other circumstances, personnel were assigned only those responsibilities that dealt with developing services for handicapped children.

Community Resources

Resources provided by community agencies. We asked directors about agencies that were providing special services for handicapped children in their programs. Eighty-three

percent[7] indicated that they were receiving special services for handicapped children from at least one agency. Seventy-seven percent listed more than one. A variety of community agencies were mentioned; these included private clinics, county departments of mental health and family services, state divisions, and universities. Types of services provided by these agencies and the frequencies with which they were mentioned by program directors are presented in Table 15.

In general, community agencies working with Head Start usually provided several services. Seventy-nine percent of the programs said that handicapped children then receiving such services in collaboration with Head Start, had not had the benefit of these services prior to their enrollment.

A more detailed picture of the nature of these agencies and the services that they are providing will be presented when we discuss the case study material in the next section of this report.

Community services needed. When asked whether additional services from community agencies were desired, directors of only eight programs said that they had such a

[7]This figure includes community agencies that were serving typical, as well as handicapped children, before, as well as after, the new legislation.

TABLE 15

TYPES OF SERVICES PROVIDED BY COMMUNITY AGENCIES

Types of Services	[d]Frequency of Services Mentioned by Program Directors
Diagnosis and Assessment	45
Speech Therapy	15
Physical Therapy	14
[a]Psychological Services	14
[b]Family Services	7
[c]Other	2

[a]This category includes all services other than diagnosis.

[b]This category includes counseling to both children and parents.

[c]This category includes such services as providing hearing aids and glasses.

[d]With programs receiving one or two services, the highest frequency possibly noted by directors was a total of 58.

need. Of those programs requesting additional community agency resources, two reasons for not receiving them were cited more frequently than others, i.e., agency refusals and funding difficulties.

Physical Facilities

Thirty-one or 86 percent of the programs we visited had made no modifications in their physical facilities this year. Twenty-five programs felt that their facilities were a hindrance to serving handicapped children, although only five reported not having taken children because of such problems. Fourteen specifically mentioned their concern about children in wheel chairs. More than 20 program directors commented about the problem of stairs or the fact that they didn't have ramps. In addition, a few programs were concerned about inadequate bathroom facilities, transportation problems, and inadequate passage ways. These comments seemed to be born out in those few instances when children were not enrolled because of inadequate physical facilities, i.e., those excluded were children with severe physical handicaps. Not surprisingly, five programs that had made changes in their physical facilities this year were cluster I sites, serving greater numbers of severely handicapped children. All such changes were reported

to have occurred last fall; they involved installing more carpeting and ramps, developing special resource rooms, leveling a floor, and building a special toilet facility.

Training and Technical Assistance

Training and technical assistance provided. Thirty-three of the 36 directors who talked with us reported having received training and technical assistance this year for the primary purpose of serving handicapped children. For the most part, those activities involved in-service workshops--although a few programs had training for credit on college campuses.

Training and technical assistance needed. Despite the experience noted above, however, program directors indicated that they continued to have substantial needs for additional training and technical assistance and that they had wanted such activities this year, both before and after enrollment. Relevant in-service training was most frequently mentioned as the most pressing need. Fifteen of the 24 programs claimed that lack of funds was the major reason that training activities had not been provided.

Recruitment and Enrollment

During the first round of field visits, we found that the majority of programs were having difficulty recruiting handicapped children. In the second round of visits, we wanted to know whether this situation had changed.

In this regard, about half of the programs reported that they were experiencing problems in this area. These difficulties appeared to be a result of several factors including competition with community agencies, parental resistance, and lack of knowledge about the preschool handicapped population (28 of the 36 programs indicated that they had no knowledge about the preschool handicapped population).

Twenty-six programs had some assistance from community agencies in recruiting handicapped children.

We asked about youngsters identified, enrolled, but later excluded from programs. Twelve programs said that they had to drop children as a result of family moves, parental resistance, illnesses of children, and the nature of child impairments.

We had no way of determining how many children were never even considered for enrollment. Our informal conversations with program personnel seemed to suggest, however,

that the numbers of children excluded were considerably higher than reported numbers of children referred to other agencies (i.e., 12 programs).

Relationships with Other Head Start Programs and Regional OCD Offices

In addition to the training and technical assistance received by programs, we were also interested in the kinds of relationships that programs had established with other Head Start programs and Regional OCD Offices. We found that 26 of the 36 programs were working with or coordinating their efforts with other Head Start projects. About 27 noted that they had received some help from their Regional Offices in the form of workshops, consultants, general information and communication, and some financial support.

We have some questions, however, about this second finding. The extent to which such support from the Regional Offices was actually satisfying critical needs of programs may be open to speculation; our observations from both the first and second round of visits seemed to support the notion that most of the programs we visited functioned fairly independently of their Regional Offices.

Perceived Capabilities to Serve Handicapped Children

Related to the important area of attitudes are issues concerning the perceived abilities of programs to serve handicapped children. Thus, we asked Head Start directors this question: Taking into account the present capabilities of your staff, the physical resources and budget of your program, and the resources available to you from other agencies in the community, what kinds of handicapped children do you think you could serve?

Table 16 presents the frequency distribution of responses to this question by handicapping condition and level of severity.

The differences in perceived capabilities to serve mildly and moderately handicapped children, rather than the severely disabled, are clearly apparent. Similarly, staff concerns about serving severely handicapped children who were blind, deaf, physically handicapped, retarded, and disturbed are clearly evident.

Finally, program directors thought that the opportunity to participate in an integrated, normal setting with typical children was the most important service they offered to handicapped children. They also emphasized that the diagnosis and treatment they provided for children with special needs was beneficial.

TABLE 16

PERCEIVED CAPABILITIES OF PROGRAMS TO SERVE HANDICAPPED CHILDREN

Handicapping Conditions	Numbers of Programs Who Could Serve	
	Severely Handicapped	Mildly and Moderately Handicapped
Blindness	11	24
Visual Impairment	20	34
Deafness	13	25
Hearing Impairment	21	33
Health/Developmental Impairment	23	34
Physical Handicap	14	35
Speech Impairment	25	34
Mental Retardation	13	33
Emotional Disturbance	16	32
Children with Undifferentiated Diagnoses	14	27

Child-Specific Information

As we mentioned in Chapter I, we concentrated on seven areas of inquiry in talking with teaching staffs about the 74 case study children selected in the second round. They were:

(a) Handicapping conditions of case study children

(b) Identification, enrollment, and assessment

(c) Classroom plans and programming

(d) Special services received outside the classroom

(e) Parental involvement

(f) Observed changes in children since enrollment

(g) Plans for next year

Handicapping Conditions of Case Study Children

Primary handicapping conditions of the case study children. The primary handicapping conditions of the 74 case study children selected for the second round are presented in Table 17.

It should be noted that this sample was chosen not on the basis of representativeness of handicapping conditions in Head Start but for purposes of ensuring that all nine categories of impairment were present in sufficient numbers for study. Table 17, therefore, does not show the distribution of handicapping conditions throughout Head Start.

TABLE 17

PRIMARY HANDICAPPING CONDITIONS OF CASE STUDY CHILDREN

Primary Handicapping Conditions	Numbers of Children
Blindness	3
Visual Impairment	8
Deafness	3
Hearing Impairment	7
Health/Developmental Impairment	7
Physical Impairment	12
Speech Impairment	13
Emotional Disturbance	14
Mental Retardation	6
No Response	1
Total	74

The nature of severity of impairments. From conversations with classroom teachers and on the basis of field observations, we attempted to make an assessment of both the nature and severity of handicapping conditions of each of the case study children visited in the second round. Table 18 presents data on these characteristics.

TABLE 18

NATURE AND SEVERITY OF HANDICAPPING CONDITIONS OF THE CASE STUDY CHILDREN

Handicapping Conditions	Numbers of Children and Levels of Severity of Handicapping Conditions					
	No Impairment	Mild	Moderate	Severe	No Response	Total
Sensory or Physical	18	14	16	26	0	74
Intellectual	35	16	13	11	0	74
Behavioral	16	24	14	19	1	74
Lang./Speech	23	16	13	22	0	74
Health/ Development	37	20	7	9	1	74

Again, these data are not representative of the population of handicapped children in Head Start programs in general.

In addition, we calculated a composite severity score for each case study child. These data are presented below in Table 19.

TABLE 19

COMPOSITE SEVERITY SCORES[a] OF CASE STUDY CHILDREN

Severity Scores	Numbers of Children by Respective Levels of Severity
0	1
1 - 2	5
3 - 4	15
5 - 6	15
7 - 8	18
9 - 10	10
11 - 12	9
In excess of 12	0
Data not complete	1
Total	74

[a]Composite severity scores were calculated by assigning these weights to the following severity scores: mild (1); moderate (2); severe (3); no impairment (0). These individual scores for each of the five categories were then totaled in order to obtain the composite for each child. The highest score possibly obtained by any one child was a total of 15, which represented conditions of the most severe degree.

More detailed information on the nature of the handicapping conditions of 10 case study children is available in Appendix A.

Identification, Enrollment, and Assessment

Recruitment and enrollment of case study children:

Eighty percent of the case study children entered Head Start in the fall or winter of 1973. Seventy-five percent of these children were enrolled through the regular recruitment efforts rather than through special entry procedures. Of those who were enrolled through special efforts, five were referred by the County Department of Social Services, four by the Crippled Children's Foundation, and three by Developmental Day Care Centers. The remaining referrals were made through special clinics, public schools, Operation Shoestring, and private social service agencies.

The fact that the majority of the case study children were recruited through the regular Head Start recruitment procedures seemed to further support the conclusion that most children, identified as "handicapped" by Head Start programs this year, were the same kinds of children who had always been enrolled (the more severely handicapped, in Head Start and other preschool programs are usually known and referred by community agencies). On the other hand, we should add that we have no data to indicate how regular recruitment procedures might have been affected by the publicity in the community about the new effort. Moreover, we don't know how many children in the past have been referred by special agencies to the Head Start program.

The majority of case study children who were recruited through special procedures were enrolled in programs in the cluster I group with more severely handicapped children.

Identification of handicapping conditions among case study children. Teaching staffs were asked about the time that handicapping conditions of specific case study children were first recognized, i.e., before or after enrollment in Head Start. Programs reported that handicapping conditions of 61 percent of the children were identified before they entered Head Start. Staffs indicated that in nine cases parents of the children were aware of problems soon after birth; in six cases, parents had suspected difficulties prior to Head Start. Other children, who were recognized through special recruitment efforts, were identified through contact with hospitals and special agencies. Again, more of the case study children enrolled in programs in cluster I were known prior to enrollment.

Assessment of handicapping conditions. Staffs indicated that 54 percent of the case study children had been evaluated prior to their enrollment in Head Start. Again, compared with children in the cluster II programs with mildly

and moderately impaired children, a disproportionately larger number in cluster I had diagnoses before entry.

We inquired about the basis for the initial assessment of the handicapping condition of children. Forty-six percent mentioned formal evaluation; 28 percent, formal evaluation and observations; and 26 percent, informal observations. Some of these assessments were made (by community agencies) before enrollment in Head Start; others were made as a result of referrals to Head Start; still others were part of regular Head Start screening processes.

Ongoing evaluations of children. Staffs indicated that most of the case study children had follow-up diagnostic assessments. Some of these were made by outside specialists. Others took place as part of the periodic assessment by Head Start. Several programs also mentioned having received professional consultation with respect to their evaluations of children.

We obtained data on the nature of the information provided by these evaluations. Programs reported that, in those instances where subsequent assessments had been made, follow-up evaluations overwhelmingly confirmed initial diagnoses (i.e., 37 of 40 cases). In at least three instances, these assessments provided more specific insights about the

problems of children; in 10 cases subsequent diagnoses indicated some improvement in the conditions of children; and with eight children, evaluations led to additional services. In three cases, staffs had not seen the results of subsequent assessments.[8]

Staffs were asked if any special costs had been involved in the diagnosis of the case study children that would not normally have been incurred for typical children. For slightly over 50 percent of the case study children, costs of evaluation had been greater. In 18 such cases, Head Start funds had paid directly for these assessments. Finally, we inquired about diagnostic services needed by the case study children, which had not been provided. For 31 percent of the case study children, programs had hoped for additional diagnostic services.

Classroom Plans and Programming

Classroom plans. In the areas of classroom planning and programming, we asked questions about such concerns as

[8]The reader is reminded that the frequencies of responses reported here represent unsolicited comments and not responses to direct questions.

the presence of a classroom plan, persons hired specifically to work with the child, modifications of physical facilities, and monitoring processes. For 57 percent of the children, staffs had developed no special programs or plans. In about one-half of those cases where special efforts had been made, these had been developed by Head Start staffs. In other instances, they had been made as a result of the coordinated efforts of Head Start and community agency personnel. In the remaining 19 cases, professionals from outside agencies had provided technical assistance in developing programs for children.

Persons hired specifically to work with case study children. As with all children in Head Start, teachers and teacher aides were primarily responsible for the educational experiences of the case study children. Education and backgrounds of these people varied considerably. Some had little or no formal training. Others, on the other hand, had advanced degrees. In either case, however, we found that persons working most closely with 72 percent of the case study children had some form of special pre-service, in-service, or college training.

We asked the teaching personnel if any persons had been hired or provided on a voluntary basis for the specific purpose

of working with case study children. For 20 percent of the children, such persons had been added to staffs.

Special assistance required by case study children. We asked teaching personnel about the degree of special assistance, if any, case study children required in the classroom. Staffs perceived that 23 percent of the children needed almost constant assistance; 33 percent required a fair amount; and 44 percent needed little or no special assistance.

Among those who required constant attention, teachers mentioned that children needed adult assistance for eating, using the bathroom, and engaging in play activities. More frequently, however, staffs noted the need for a one-to-one relationship for independent work or close supervision during their participation in group activities.

In addition to our inquiries about needs for special assistance, we also asked this question of teaching staffs: As compared to typical children, how much special attention of classroom personnel does this childrrequire? Staffs reported the following: Twenty-six percent needed almost constant attention; 26 percent needed a fair amount; 33 percent needed little; and 15 percent, none.

Modifications in physical facilities and the purchase of special materials and equipment. We asked about special modifications in physical facilities. As might be expected from the program-level data, we found that such changes had been made for only four percent of the children.

More programs indicated that special equipment or materials had been purchased. Such purchases were made for about 14 percent of the children, and included such items as portable toilets and toilet training seats, Peabody Language Development Kits, high chairs with special supports, balance beams, special clothes, and rockers.

Monitoring progress of children. Teachers were asked if records on the developmental progress in class were being kept for the case study children. Staffs indicated that in 95 percent of the cases, records were being maintained. For the most part (i.e., 86 percent of the case study children), records took the form of informal observations. In addition, teachers indicated that they also used more formal measures such as the Peabody Picture Vocabulary Test and the Denver Developmental Scale; some developed their own informal developmental scales. Some teachers kept daily logs; others made reports weekly; still others recorded changes over longer periods of time of one, two, or three

months. Teachers indicated that monitoring processes for 75 percent of the case study children were different from those for typical children.

Transportation. Teachers were asked about the transportation arrangements and any related problems. For 25 percent of the case study children, special arrangements were being made. These services often involved additional travel to clinics and other agencies which were providing special services to a child. In some cases, special arrangements were provided for handicapped children who, otherwise, might have walked to programs.

Teaching staffs were asked if they needed special transportation arrangements that were not being provided. Eight percent indicated that they had such a need.

Special services received outside the classroom. Teachers were asked about special services that case study children were receiving outside the classroom, which non-handicapped children did not receive. They reported that 58 percent of the children were receiving at least one service from community agencies; 16 percent were receiving two services; and four percent had three or more.

With respect to their satisfaction with the quality of services, staffs indicated that, for 84 percent of the case

study children, such provisions were adequate. These involved a wide variety of services including on-going evaluation, speech therapy, physical therapy, special supplemental classes, medical services, mental health services, skill tra ning, and home visits. Speech therapy and physical therapy were the most frequently provided special experiences outside the classroom. Most of these services were arranged by Head Start personnel with the community agencies.

Even with these services, however, teachers said that they had needs for additional special services such as speech therapy and physical therapy. The most frequently mentioned reasons for not providing these services were lack of funds and insufficient personnel among community agencies.

Parental Involvement

In 66 percent or 49 of the 74 case studies, programs reported that parents were receiving special help. Such assistance included a variety of activities, e.g., educational services and training, home visits, special counseling, parent transportation to special services, and special arrangements for observation of therapy sessions with their children. In addition, several teachers mentioned frequent conferences

with the parents in order to inform them about the progress of their children.

Degree of involvement in center activities was a second point of major interest with respect to parents of the case study children. For 36 percent of the children, staffs indicated that their involvement was more than that of parents with typical children; for 36 percent, it was about the same; and, in 38 percent of the cases, they were less involved (again, the reader is reminded that these figures are not representative of parental involvement in all Head Start programs but only with respect to the case study children). In all but two cases, parents had been informed about the services that their children were receiving. Further, according to the Head Start staffs we interviewed, parents were overwhelmingly satisfied with services; in only two cases, comments were made about parental discontent. As with other services provided for or by Head Start, we asked staffs if parents had needs that were not being met by their programs. Counseling, additional training, additional money for clothing and medical expenses, and travel were noted in this regard.

Finally, although we mentioned this point earlier in our report, we believe that it is important enough that it deserves to be re-emphasized here. It is simply this: In those programs serving more severely handicapped children,

parent involvement was an extremely strong component and seemed to be one of the key factors in the provision of quality services. In particular, we found that in cluster I with more severely handicapped children, about 80 percent of the parents were receiving special help that had been arranged by Head Start. In about two-thirds of the cases, this special help involved home visits and counseling; the rest entailed primarily medical services and formal education. Moreover, approximately 40 percent of the parents of handicapped children of cluster I were participating more than the typical parent in Head Start.

Observed changes in case study children since enrollment in Head Start. Teachers perceived that many of the case study children had changed since their enrollments in Head Start. Data on the nature and degree of such changes are presented in Table 20.

Table 20 reveals that there was a good deal of improvement among the case study children over the course of the year, as perceived by teaching staffs. Most noteworthy was the finding that teachers thought that the behavioral and emotional problems of 34 percent of the case study children had improved "substantially" and speech and language difficulties of 26 percent had shown marked differences. Of

TABLE 20[a]

REPORTED CHANGES IN CASE STUDY CHILDREN SINCE THEIR ENROLLMENT IN HEAD START

Handicapping Conditions Reported to have Changed	Numbers of Case Study Children and Degrees of Change				
	Substantial	Moderate	Slight	No Change	No Response
Sensory of Physical Abilities	11	10	11	41	1
Intellectual Abilities	7	11	13	40	3
Behavioral Abilities	24	23	11	15	1
Health/Developmental Abilities	2	3	4	16	5
Speech/Language Abilities	19	14	14	24	3

[a]It should be noted that the large number of responses under the heading of "no change" at least in part was a function of the way that questions were asked on the questionnaire. Teachers were asked to indicate changes only in those areas of impairment where children originally had problems.

course, we have no way of knowing from our data the degree to which reported changes were a direct result of Head Start experiences or attributable to other factors, such as maturation. None the less, the data are impressive--especially in light of the substantial numbers of case study children who posed problems for teachers and other children when they first entered the programs.

In 54 cases, teachers indicated that children were becoming increasingly better able to cope. These were a few of the comments of the field observers in this regard:

> He improved in ability to interact without withdrawing from activities.
>
> (His) tantrum behavior was essentially eliminated; (he) now seeks affection.
>
> (His) attention span increased from five minutes to over 20 minutes.
>
> Wetting pants decreased significantly.
>
> He'll climb now and get off the floor.
>
> (He is) following three times as many commands as when he came in.
>
> (He) makes eye contact now. (He notices) other children. (He has) started laughing.

(He imitates) more sounds now and is saying some words.

(He has) learned to interact comfortably with adults and peers; (he) seeks affection and attention from adults and peers. (He's not) withdrawn any more.

(He) uses sentences; (he) didn't speak when he entered the program.

He was completely nonverbal when first entered. Now he can talk with adequate facility.

(His) walking has improved. Before he was clumsy and awkward--like he was always going to fall.

(He is) showing more use of his eye. His operation is too recent for re-evaluation of sight, but his teacher has noticed substantial changes since surgery.

(His) manipulative skills increased greatly. (He) can do things he could never have done before.

Finally, teachers suggested that reactions to the case study children by other children had been overwhelmingly positive and that, for the most part, the handicapped were not singled out as being "special" or "different." In 16 cases, teachers reported that the handicapped children were treated no differently from their typical peers. Others commented that there was no awareness of handicapping conditions of children in their classes or that children had

been accepted. A few noted that children had been overprotected by other children and treated "like a baby." In only two cases did teachers indicate that children had been ridiculed or made fun of by other children. In no instance did teachers suggest that the interactions of children had deteriorated; either they remained about the same or they improved. Likewise, about 54 percent of the teachers noted their own initial frustrations with children when they first entered their classes, i.e., acting out and other disruptive behavior, difficulties with understanding children, and withdrawal. Their relationships, too, had changed for the better.

Plans for Next Year

Staffs were asked about educational plans for children. No plans had been made at the time of our visits for 16 percent of the children. It was reported that 43 percent would remain in Head Start, and 41 percent would go on to public school. Of those to attend public school, 71 percent were supposed to enter regular classes; 10 percent, special classes; and for others, arrangements were yet to be made.

In conclusion, one finding with respect to future plans for the case study children was especially important,

i.e., of the 32 children who were to remain in Head Start next year, at least 18 were eligible by age for public school. These problems were evident in programs of clusters I and II. Reportedly, these children were remaining in Head Start because public schools were not offering the services they needed.

Classroom Observations

The major purpose of the classroom observations during the second round was concerned with trying to determine how well handicapped children were being served in the Head Start classes we visited. Our observation schedule focused on 11 dimensions of classroom instruction, and teacher and pupil behavior. They were:

(a) Relative emphasis of the classroom instruction

(b) The adequacy and availability of materials

(c) Teacher planning, preparation, and presentation

(d) Speech and language development

(e) Individualization of instruction

(f) Teacher encouragement of child-independent activities

(g) Teacher response to child-initiated activities

(h) Teacher coping with deviant behavior

(i) Behavior of handicapped children

(j) Integration, and

(k) The case study children in the classroom.

Data relating to each of these areas were collected in site visits to 44 Head Start classes.

Relative Emphasis of Classroom Instruction

Field staff asked teachers to make three judgments about their classes. The first had to do with their relative emphasis on cognitive, social, and emotional development.[9] A little more than half of the teachers thought that they had a relatively equal balance of cognitive and social activities. Twenty-nine percent said that they stressed social and emotional development, and 10 percent emphasized cognitive development.

The second judgment asked of teachers dealt with their relative emphasis on child- and teacher-directed activities.[10]

[9] We arbitrarily defined cognitively oriented classes as having a greater emphasis on readiness skills such as learning colors, numbers, and the alphabet. Emphasis on social and emotional development had to do more with interpersonal skills and interactions.

[10] Child-directedness we described in the following terms: Staff taught structured activities primarily around child interests and experiences and responded to the immediate situation. Teacher-directedness placed a greater emphasis on pre-planned activities, where the teacher structured the greater portion of classroom sessions, with less attention given to child-initiated situations.

Fifty percent of the teachers characterized themselves as placing equal emphasis on teacher-directed and child-initiated activities. Twenty-nine percent saw themselves as being teacher-directed and 21 percent judged that they were more child-directed.

Teachers were asked about their emphasis on group versus individual activities. Eighty percent were somewhere between the two; 18 percent emphasized group activities; and only one class was reported to have had primary emphasis on individual activities.

Finally, we asked the observers to judge whether there seemed to be differences in class emphasis for handicapped children and instruction for typical children. Eighty-six percent of the programs were judged to have the same relative emphasis. The few differences that were noted mainly concerned a greater individualization of instruction for the handicapped children.

Adequacy and Availability of Materials

Observers were asked about the materials used by teachers during observed activities. All teachers used some form of materials during activities. In 30 percent of the cases, they made use of only commercially-made toys.

In 70 percent of the cases, however, teachers used a combination of commercially-made and teacher-prepared resources.

These materials were judged to be readily available in 89 percent of the classrooms and seemed to be adequate in 70 percent of the cases. The observers indicated that in 80 percent of the classes there were no differences in the type and availability, adequacy, and use of materials with respect to handicapped children. The differences that did exist c consisted mainly of extra or different materials bought for particular handicapped children. Teachers noted that in some cases the presence of handicapped children had served as an incentive to purchase materials for typical children, that otherwise might not have been bought.

We found little differentiation between classes in cluster I and those in cluster II with respect to the availability and adequacy of materials.

Teacher Planning, Preparation, and Presentation

Observers judged that in 41 of 44 observations, teachers were prepared for teaching activities. On the basis of more specific indicators of teacher preparation (e.g., continuity and logic across activities, clarity of purpose of activities),

however, it was apparent that those judgments were made along a continuum of evidence and may not be as uniformly positive as it appeared superficially. In 9 of 44 observations, our field staff indicated that there were differences in planning for the handicapped.

Observers were asked to note whether there was physical evidence of teacher planning for the observed activities. In 29 percent of the classes, they indicated that there was little or no evidence of physical classroom planning. In 34 percent of the cases, there was some evidence (e.g., teacher-prepared charts, children's work, readiness of materials for class activities). In 37 percent there was clear evidence of prior preparation.

In most of the classes, there was no evidence of differential planning for the handicapped. Again wherever such were noted, they consisted mainly of providing materials more appropriately suited to child needs or the planning of more intensive work with children.

In addition to assessing teacher preparation, observers also evaluated the effectiveness of teacher presentations during the activities observed. In 53 percent of the classes, the field staff indicated that presentations were adequate;

35 percent, minimally adequate; and 12 percent, effectiveness was inadequate. In cluster I, this dimension of teacher behavior was more uniformly positive, as compared with classes in cluster II. In particular, our anecdotal comments seemed to indicate that the teachers in group I tended to be quite imaginative and provided a good deal of individual help for children. Classes of programs in group II had a relatively higher number of minimal or inadequate presentations. Also, teachers in cluster II more frequently tended to have less "formal" presentations and simply followed a daily schedule of events.

In 46 percent of the classes, the field staff judged that there were differences in the presentations for handicapped and typical children. These referred mainly to extra or special attention given to the handicapped children during the course of class activities. Some teachers, for example, tended to "call on" handicapped children more frequently (although in some instances, we felt that this behavior was a function of our presence) and, in general, "watched" handicapped children more closely to ensure that they were following presentations.

Speech and Language Development

The observers made judgments about the degree to which teachers and other classroom personnel focused on speech and language development during the observed activities. In 14 percent of the classes, they indicated that this emphasis was extensive; in 44 percent, moderate; in 37 percent, minimal; and in five percent of the classes, there seemed to be practically no evidence.

The six classes where teacher emphasis seemed to be extensive were included in cluster I, with teachers encouraging children to talk in complete sentences, encouraging them to initiate conversation, and "correcting them gently." Nine observations in cluster I showed a moderate emphasis, with teachers labeling objects but not working as much individually with children and encouraging them to talk.

Our information about classes in cluster II was less uniformly reported. Thus, the basis for making clear distinctions between clusters I and clusters II is tenuous. Of those observations where the information was available to us, however, there was greater evidence of minimal and inadequate presentations.

Overall, in 14 of the 44 classes, there was evidence of differences in teacher emphasis on language development for handicapped and typical children.

Individualization of Instruction

The observers were asked to make judgments in each of the classes about the degree to which teachers and other educational staff provided for the individual needs of handicapped children. We found that in 25 classes, teachers were individualizing instruction to a moderate or extensive degree. In about one-half of the classes observed, there were differences in the degree of individualization for handicapped and typical children.

With respect to cluster I, analysis revealed a greater emphasis on individualization for all children, in comparison to the majority of classes in cluster II (although even in cluster I there were really two distinguishable groups, with one paying less attention to particular needs of children). Again in group I, there seemed to be a more consistent attempt of teachers to encourage children to engage in independent activities--although there were teachers in cluster II, who were making similar attempts.

Teacher Encouragement of Independent Activities

Closely related to teacher individualization of instruction were teacher attempts to encourage children to enter into independent activities. Again, in a little more than half of the classes, teachers were observed to be making such efforts, but only in about 15 cases did these techniques seem to be noticably different from those for typical children.

Teacher Response to Child-Initiated Activities

In about 50 percent of the classes, it appeared that teachers were responding to child-initiated activities to a moderate or extensive degree. In only 16 percent of the observations was teacher behavior judged to be different with respect to handicapped children.

Teacher Coping with Deviant Behavior

The observers were asked to assess ways that teachers attempted to cope with distracting or "deviant" behavior of children during the observed activities. In none of the observations did they see the use of bodily or other physical means for the purposes of punishment. In 21 percent of the cases, other threatening devices were used to cope with

distracting behavior. In 37 percent of the observations, verbal encouragement, help in understanding tasks at hand, use of alternative tasks, and other positive means of involving children in more acceptable or purposeful behavior was noted. In the remaining classes, teachers used a combination of verbal admonitions and verbal encouragements.

When asked if there were any differences in the ways that teachers dealt with deviant behavior of handicapped children as opposed to problems with typical children, the field staff indicated that there were such distinctions in 27 percent of the classes.

Behavior of Handicapped Children

Our observations generally showed that handicapped children seemed to be happy and relaxed in most classes (32), were involved in the greater portion of observed activities (35), and in most cases spontaneously interacted with teachers (32) and other children (25).

Integration of Handicapped Children

We asked two questions about integration. Our observations were as follows. In only 2 of the 44 classes we visited were children totally physically separated. In 12 cases, youngsters were partially separated, and in 30 cases, there was total physical integration.

Secondly, with respect to psychological integration, we found that again two cases (noted above) were totally separated. In 19 cases, observers judged that children were partially psychologically separated, and in 23 cases, they were fully integrated.

Observations of the Case Study Children

The observers were asked to take particular notice of the handicapped children who had been the subject of their case studies. All the case study children observed were reported to be totally integrated in their classes. In 86 percent of the programs, observers thought that individual special needs were properly cared for. In these observations, they were judged to have positive relationships with both their peers and classroom personnel.

Summary of Key Findings from the Second Round Visits

On the basis of the data presented above, let us summarize a few key points that emerged from the second round site visits.

1. With respect to most dimensions that we considered to be indicators of "quality" classroom services, the majority

of classes in cluster I serving severely handicapped children seemed to be distinguishable from those in cluster II, i.e., they were more positive.

2. In the majority of classes we visited, the number of severely handicapped children comprised less than five percent of total enrollments. Further, in view of comments of program personnel that their populations of children basically had remained the same, the large number of reported mildly and moderately handicapped children in some of the programs simply to meet required quotas may be questionable.

3. Programs, overall, continued to have quite different feelings and attitudes about the appropriateness and their capabilities to serve severely handicapped children. In particular, they had many reservations about taking blind, deaf, and severely physically involved and mentally retarded children.

4. One overall positive effect of the mandate was an increased involvement with community agencies and public schools.

5. Finally, in contrast to the first round of field visits, we found that not all handicapped children observed were totally physically and psychologically integrated, and parents of handicapped children were not as involved in program activities as we had first perceived.

Further Analyses

In addition to the frequency distributions, chi-square analysis, and qualitative analysis of anecdotal information, we obtained a few selected correlations. These included relationships between the following variables:

(a) Attitudes of program directors and total enrollment of handicapped children, enrollment of mildly and moderately disabled children, and enrollment of severely disabled children

(b) Perceived capabilities to serve handicapped children and total enrollment of handicapped children, enrollment of mildly and moderately disabled, and enrollment of the severely handicapped

(c) Composite quality scores obtained from classroom observations and cluster groupings, attitudes of program directors, perceived capabilities of programs to serve handicapped children, and percentages of handicapped children enrolled.

Overall, these analyses did not reveal many relationships of significance. However, in the concluding discussion of this chapter we will present the results of these analyses and brief interpretations of the data.

Attitudes of Program Directors and Enrollment of Handicapped Children

We found no relationships of significance between attitudes of program directors toward the mildly handicapped and: total handicapped enrollments, enrollments of mildly handicapped children, or enrollments of severely disabled children. Likewise, correlations between the attitudes of program directors toward the severely handicapped and total enrollments and inclusion of the mildly and moderately handicapped showed no significance. Finally, although the correlation failed to reach significance at the .01 or .05 level, the relationship between attitudes toward the severely handicapped and percentages of severely disabled included approached significance (0.091).

Perceived Capabilities to Serve Handicapped Children and Program Enrollments

Correlations between perceived capabilities to serve handicapped children and enrollments of disabled children were similar to the patterns described above. We found no relationships of significance between perceived capabilities of programs to serve the mildly handicapped and total handicapped enrollments or percentages of severely impaired.

Again, the relationship between perceived capabilities to serve the mildly handicapped and actual enrollments of these children was not significant, but there was a tendency in this direction (0.076). There were no apparent relationships between perceived capabilities to serve the severely handicapped and enrollments of severely or mildly handicapped. The one possibly important exception to these findings was a significant correlation between perceived capabilities of programs to serve the severely handicapped and reported total enrollments of handicapped children.

Our decision to examine relationships between attitudes, perceived capabilities to serve handicapped children, and enrollments of disabled children was predicated on an assumption that the inclusion of the handicapped was highly correlated with positive staff attitudes and ideologies. Indeed, conversations with program directors and teaching staffs seemed to strongly support this hypothesis. The fact then that we found only modest tendencies in this direction may have been, in part, a reflection of at least two other considerations. First, reported enrollments of children were only gross estimates of percentages of children and, as discussed earlier in this chapter, were complicated by many problems of interpretation. Second, enrollments of

handicapped children probably were affected by several variables in addition to staff attitudes, e.g., the influence of community agencies, and thus, these specified relationships were not as clearly defined as we had first anticipated.

Quality of Classroom Services and Cluster Groups of Programs Enrolling Mildly and Severely Handicapped Children

We obtained seven composite scores of the quality of programming on the basis of classroom observation. These were then correlated with the two cluster groupings of programs with mildly and severely handicapped children. Cluster III, with no reported handicapped children, was not included because we made no classroom observations in these programs. None of the correlations between the quality scores and cluster groups revealed relationships of significance or tendencies in this direction.

Attitudes toward Serving Handicapped Children and Program Quality

We obtained two sets of correlations that related to attitude and program quality. The first examined relationships between attitudes toward the mildly handicapped and

quality indicators; the second group was concerned with the severely impaired. Both analyses revealed several significant correlations.

Relative to attitudes toward the mildly handicapped, we found very significant relationships with the following quality scores:

(a) Teacher preparation (0.053)

(b) Teacher presentations (0.001)

(c) Emphasis on language and speech (0.001).

In addition, correlations between attitudes toward the mildly handicapped and composite socres for the availability and adequacy of materials (0.070) and teacher preparation of the psychological environment (0.095) showed similar tendencies.

Correlations between attitudes toward the severely handicapped and the following quality scores were significant:

(a) The adequacy and availability of materials (0.009)

(b) Teacher preparation (0.019)

(c) Teacher presentations (0.023).

These relationships do not exclude the possibility that those programs providing better services, overall, had more positive attitudes toward all children, not the handicapped alone. These correlations, nevertheless, partially

confirmed some speculations that we have had from the beginning of this study, i.e., attitudes of staff toward handicapped were of key importance to program quality.

It was somewhat surprising, in light of these data, that we found no relationships of significance between attitudes and composite scores of integration. In part, this finding may have been a result of questions asked in the interview guide and our "integration index," which really were not sensitive to quality differences of interaction and psychological integration.

Perceived Capabilities to Serve Handicapped Children and Program Quality

Like the correlations between attitude and program quality, we also examined two sets of relationships between perceived capabilities to serve the handicapped and composite scores, i.e., one that pertained to the mildly disabled and a second that concerned the severely impaired.

Summarizing these data, we found significant correlations between perceived capabilities to serve the mildly handicapped and:

(a) Teacher attention to the physical and psychological environment (0.048)

(b) Composite integration scores (0.017).

While none of the correlations between perceived capabilities to serve the severely handicapped and quality indicators were significant, there was a trend in this direction (0.082).

Enrollment of Handicapped Children and Program Quality

There were no significant correlations between total enrollment of handicapped children and any of the seven program quality indicators. Likewise, there was no evidence of significant relationships between enrollment of mildly handicapped and the composite scores.

Correlations between percentages of severely handicapped and program quality, however, revealed a slightly different pattern. We found significant relationships between inclusion and teacher preparation of the physical and psychological environment (0.038) and between enrollment of the severely handicapped and integration (0.031). In addition, the correlations between percentages of severely handicapped and the more general index of teacher preparation revealed tendencies toward significance (0.038).

In conclusion, this phase of the analysis did not disclose a consistent pattern that permits strong support of any hypotheses concerning relationships between attitudes,

perceived capabilities to serve handicapped children, enrollments, or program quality. At best, there are fragmented suggestions which seem to illuminate some possibilities, but these require much further exploration.

Perhaps in the final analysis, this conclusion was the most that we could have expected given the fact that we were sampling attitudes of administrative staffs and attempting to relate these to quality indicators, determined primarily from classroom observations. On the basis of our all too familiar experiences in the field, we were well aware that Head Start directors frequently were far removed from the course of daily events at the local program level.

CHAPTER V

SECOND ROUND VISITS TO EXEMPLARY PROGRAMS

In Chapter VI of this report, we will summarize some of the main general characteristics of the 16 exemplary programs visited in the second round of field visits and the educational implications of these projects for the Head Start handicapped effort. In the present chapter, we will describe these programs in greater detail and their individual potential contributions to the handicapped effort. As we have already pointed out elsewhere in this report, the six regular Head Start programs have not been identified because of our commitment to the confidentiality of information about specific sites.

In Chapter II on methodology and procedures, we discussed the two criteria which served as a basis for selection of the exemplary programs. The first was an enrollment of 4.5 percent or more children who had clearly identified impairments of a moderate to severe degree. The second was the requirement that programs had integrated classroom settings or were characterized by integration components

that involved placement of handicapped children in regular community settings. It is important to note that in order to identify the 10 non-Head Start programs that met these criteria, more than 100 telephone calls were made to potential candidates across the country. We found that most programs recommended were serving only mildly disabled children or were providing services for more involved children in separate settings. This observation seems to suggest that the difficulties of mainstreaming moderately and severely handicapped children are not exclusive to Head Start; early childhood education, in general, has been plagued by problems of segregation, categorization, and low expectations for change in the more severely impaired.

An Infant, Toddler, and Preschool Research and Intervention Project, Institute on Mental Retardation and Intellectual Develcpment, George Peabody College for Teachers in Nashville, Tennessee

In 1970, Drs. Diane and William Bricker launched an early intervention and research project at the John F. Kennedy Center for Research and Education and Human Development at the George Peabody College in Nashville, Tennessee. The program was designed for toddlers who had clearly identified developmental problems and high-risk children who seemed likely to develop such difficulties.

Four basic tenets have characterized this project since its inception including the following:

(a) A primary commitment to meaningful parent involvement

(b) An intervention program organized around a concept of "developmental programming"

(c) Enrollment of infants and toddlers under two years of age

(d) The placement of handicapped and typical children in integrated classroom settings (Bricker & Bricker, in press).

Initially the program was organized with a heavy behavioral emphasis; however, over the past year the staff has adopted a model largely based on a Piagetian view of growth and development. Classes usually have enrolled from 10 to 15 children; approximately half of these youngsters have been considered "developmentally delayed." Blind, deaf, and severely disabled children with cerebral palsy have not been accepted into the program, one reason being that the staff preferred to place their primary emphasis on the development of cognitive skills. Typically, the program has had a staffing ratio of one adult to three children; two full-time teachers were assigned to each class and students obtained practicum experiences with the project. Since the

inception of this program, the staff has had the benefit of resources of outside community agencies such as the Vanderbilt Genetic Counseling Service and Birth Defects Clinic, as well as specially hired team members, e.g., a social worker and a speech therapist.

Enrollment of children in this project, now terminated as of June 1974, almost tripled during the third and fourth years of its existence. This expansion occurred as a result of Title IV-A funds, acquired through the combined support and cooperation of the Tennessee Department of Public Welfare, the Tennessee Department of Mental Health, and the Joseph P. Kennedy Jr. Foundation. Transportation provisions offered by these funds have made it possible to include children from low income areas, and thus the population of children has covered a broad developmental and economic range.

While the Brickers have maintained that this project probably could not be implemented in a non-university setting, it does have special relevance to Head Start in at least three significant respects, i.e., a non-categorical approach, a model for integration, and active parent involvement. Speaking to the importance of each of these components, Bricker and Bricker (in press) have recently noted,

> The integration of delayed and nondelayed children into the same program produced an unexpected outcome. Not only have the children had the

> opportunity to explore and learn about each other but also the parents of nondelayed youngsters have had the chance to interact closely with parents of children who have moderate to severe problems. This interaction has the potential of being an enlightening experience for parents. An often heard comment by mothers in our project is that they had a real fear of and great uncertainty about handicapped children as they entered their child in the program. Their experience in the project quickly changed fear to calm once they realized that handicapped children are basically much like other children. In a sense the close interaction between parents has allowed for communication which we believe has been important in terms of educating a wide variety of people about developmental difficulties (p. 5).

In addition to regular interaction among parents of handicapped and typical children, the project has developed some unique approaches to the education of families of children enrolled. Turning again to descriptions provided by the Directors,

> The majority of parent education has focused on language, motor, sensorimotor, and social areas which also form the core classroom curriculum. Initially parents are trained in the use of behavior management skills as prerequisite to working in the curriculum areas. Training is generally conducted in small group sessions; however, when a parent has a special or particularly difficult problem, the parent advisor may shift to individual sessions. Video tapes are made of the parent training his child which then serve as the focal point for helping the parent improve his training skills. . . . Consumer education is carried out by exposing parents to appropriate films, books, and other printed matter informing them about organizations that are concerned with providing education and

> services for young children and by arranging meetings with local, state, and national personnel who are in decision-making positions. . . . All of these interactions are designed to provide the parent with knowledge about issues which directly concern their child's education (pp. 14-15).

In conclusion, this research and intervention project has added two components which have generally characterized many other recent early childhood programs. The project staff has extended the age for admission downward to include infants of eight months. Secondly, they have expanded the duration of the intervention program over a longer period of time.

The Model Preschool Center for Handicapped Children of the Experimental Education Unit, Child Development and Mental Retardation Center at the University of Washington in Seattle, Washington

The Model Preschool Center for Handicapped Children is part of the Experimental Education Unit of the University of Washington's Child Development and Mental Retardation Center. Overall, efforts of the EEU are threefold including research, training, and service components. At present, two major priorities dominate research endeavors. The first concerns the development of materials and procedures for teaching children who are severely handicapped; the second remains the development of ways to accommodate moderately handicapped children in the regular classroom. The general

focus on research, as with other program components, is one of early identification and intervention.

Currently the Model Preschool Center serves approximately 130 to 150 children in three types of programs. These include:

(a) Communication Programs

(b) Preschool Programs

(c) Field Programs.

The first of these projects, consisting of two classrooms includes four groups of preschool children who have communication disorders and other secondary disabling conditions. One classroom serves acoustically handicapped children--one group of deaf children of two to four years in age, and a second, youngsters of four to six years. Another classroom provides programming for children with language disorders unrelated to hearing losses (Annual Report of Experimental Education Unit, 1971).

Three additional classrooms in The Experimental Center serve four other groups of preschool age children. In one, enrolling multiply impaired children, primary emphasis is placed on extinguishing problem behaviors that interfere with classroom performance and on developing basic skills such as toilet training, attention to learning

activities, learning to manipulate materials and equipment, and engaging in basic social interaction with peers and adults of the immediate environment. Such skills are programmed to individual developmental levels of each child. The second classroom of this unit provides for children with moderate handicapping conditions and a third offers an integrated setting for both handicapped and typical children.

The third part of the Experimental Education Unit, the field-based program, is operated in cooperation with the Seattle Public Schools and Head Start programs. This phase of program has two main purposes: to provide for young moderately and severely retarded children and to give temporary placement and remediation to Head Start children who are unable to remain in their regular classes because of behavioral or learning difficulties. A third dimension of the field programs serves deaf and blind preschool children.

The Seattle programs, overall, seem to offer models for program development in several areas that are potentially relevant to Head Start. Perhaps most germaine to the handicapped effort, however, are some of the research and training activities conducted by the Model Preschool Center staff. One phase, for example, has involved a coordinated team effort to investigate instructional variables which seem to increase

appropriate communication, social, and academic performance, and to develop measurement procedures for determining the effects of such instructional variables on child performance. The staff have noted,

> While the research methodology emphasized has involved experimental analysis and the investigation of independent variables relevant to learning and behavior modification, it is essentially applied research in that the results are utilized directly and immediately toward improvement of instructional procedures and materials (Annual Report of Experimental Education Unit, 1971, p. 23).

A second series of research activities have been concerned with the application of precise instructional procedures in regular and special education classes. This project has combined work in the development of instructional programs, accurate classroom measurement, contingency management and the use of different forms of educational technology in classes throughout the state of Washington (Annual Report of Experimental Education Unit, 1971). These research activities have included five main phases:

(a) The development, testing, and refinement of instructional procedures and materials designed to increase efficiency in teaching

(b) Preparation of special and regular classroom teachers in the effective use of these instructional procedures and materials in a demonstration setting

(c) Re-development and refinement of instructional procedures and materials based on the experiences of teachers

(d) Dissemination of procedures and materials known to be effective in the natural school setting.

(e) Finally, re-evaluation of instructional procedures and materials in regular and special education classes.

One deficit consistently mentioned by Head Start programs during the on-site visits of this study was the lack of a relevant training system. While the model and particular activities pursued by the University of Washington may not have general applicability to all Head Start programs, certainly the development of organized approaches that are immediately available at the local level to teaching staffs seem to warrant careful consideration by the Office of Child Development, at both the national and regional level.

The Rutland Center Model for Treating Emotionally Disturbed Children at the University of Georgia in Athens, Georgia

Initially established as a two-year demonstration project, the Rutland Center at the University of Georgia has now become a prototype for a statewide network for serving young children with severe emotional and behavioral problems. Basic to this model project are several primary goals:

(a) To provide comprehensive services for children in the community

(b) To maintain active parent involvement

(c) To maintain children in regular school settings with the assistance of special education

professionals and the active involvement of regular class teachers

(d) To utilize child specialists from numerous disciplines "in a collective effort on behalf of these children."

By the end of July 1974, the Rutland Center and its coordinated network of 15 centers covering 113 counties served more than 3,000 severely disturbed children and their families (Wood, 1972).

Like the Washington model described above, the Rutland Center staff has developed several program components which--with some modification--might be relevant to Head Start programs in serving handicapped children. Three such dimensions include the following:

(a) The provision of psychoeducational services to children and their families "to increase the coping behavior of referred children in their home and school environment."

The Center provides psychoeducational services to approximately 200 to 300 severely handicapped children from infancy to 14 years of age. Clients are referred to the Rutland Center or to other field centers in rural areas primarily by school systems of counties served, parents, physicians, social workers, psychologists, or speech therapists. All children attend classes in their local schools for part of the day or day care centers, when appropriate, and attend class at the Rutland Center or field centers from one to two hours, four days a week (Wood, 1972, p. 4).

Upon admission to the Center, a child and his family are assigned to a psychoeducational team which consists of a special education teacher, a social worker, and a trained paraprofessional or volunteer aide. The teacher and aide are responsible for the child's classroom program; the social worker is involved primarily with the family and takes responsibility for interpreting the classroom program to the parents, providing home assistance to families for follow-up of school or day care activities, and providing special counseling or other social services, as required. Each psychoeducational team is responsible for approximately 15 children and their families. The social worker meets with the parents once a week and daily with the teachers and aide. One day a week each Center teacher works in the schools where Rutland Center children are enrolled; this arrangement provides a vehicle for consultation, crisis intervention, and continuity of program development.

(b) Technical assistance to enlist local support for psychoeducational centers, stimulate development of new centers serving disturbed children throughout the state, and to disseminate information about all phases of the project at local, state, and national levels.

Through the University of Georgia, the Rutland Center operates a technical assistance office, staffed by personnel who are intimately familiar with the purposes and functions of the psychoeducational centers. Each staff member is responsible for program development, in-service consultation on evaluation, training, and the coordination of mental health and special education resources for disturbed children in designated areas of the state (Wood, 1972, p. 6).

(c) Professional, paraprofessional, and volunteer training. The Rutland Center provides in-service education for mental health and school personnel throughout the state and a practicum site for University of Georgia graduate students. The Center has developed a program to train volunteer and paraprofessionals in Developmental Therapy management techniques. As part of this program, social workers involved with neighborhood follow-through are responsible for identifying paraprofessional resources to aid program development throughout the county.

A final and equally important part of the Rutland Center program is concerned with the development of a county-wide system for early identification of infants with developmental and emotional problems. This system

is implemented through the Infant Programs at the Public Health Department Well-Baby Clinic and through the Model Cities Infant Day Care Program. Infants and toddlers from three months to two years are evaluated by means of the Gesell Developmental Schedules. Accordingly, mothers are given suggestions for providing home care stimulation. The Rutland Center also is responsible for four therapeutic preschool classes--each with five to six handicapped children.

A Model Preschool Program for Mentally Retarded, Seriously Emotionally Disturbed, and Speech Impaired in Southwest Arkansas in Magnolia, Arkansas

Originally, the Magnolia Project was designed as a model for rural areas that could not afford to set up special classes. The major objective of this program is to provide comprehensive services to handicapped children in integrated settings. The program draws on the expertise of consultants to give specialized advice on particular problems; community agencies have also been a part of this support system. In general, however, programming for handicapped children has been developed and carried out by classroom teachers. Of the 176 children enrolled in the Magnolia Program at the time of our field visit,

125 had been identified as handicapped and 52 were non-handicapped. The program includes children with a wide range of learning, emotional, and physical handicaps.

Staffing patterns of this program closely approximate those of typical Head Start classes. One teacher is responsible for a class of 25 children; no aides are officially paid by the project. Volunteers from local colleges and the community are widely used. In addition, this setting serves as a practicum site for training teachers and pediatric nurses.

The program, now five years in operation, is considered to be one of the model kindergarten projects in Arkansas which has recently phased in mandatory preschool education. Like the Head Start programs which we identified as exemplary sites in the present study, two outstanding qualities seem to contribute to the strength of the Magnolia Program, i.e., leadership from the Director of the program, who is intimately familiar with community resources, and staff commitment to the development of services for handicapped and non-handicapped children in integrated settings.

Julia Ann Singer Preschool Psychiatric Center in Los Angeles, California

The Julia Ann Singer Preschool Psychiatric Center has been providing out-patient treatment for handicapped children and their families since 1961. Among those served by this program are children of a preschool age who suffer from hyperkinesis, aggressive behavior disorders, childhood psychosis, neurological problems, phobias, and so-called "infantile autism." Overall, the out-patient program has a major goal of maintaining disturbed children in regular community settings. The Directors of the Center have described the principal purpose in this way,

> The basic concept and purpose of (most recent) approaches (of the Preschool Center) revolve around providing the community and the child's family, in as brief a time as possible, with those therapeutic and educational tools which would enable teachers and family members to carry out the long-term care in regular community settings (Williams & Jones, 1974, p. 2).

Therapeutic interventions provided by the Center include several services. Among these are:

(a) Crisis intervention services

(b) Extended diagnostic assessment in the classroom situation

(c) Parent-education groups

(d) Family demonstration therapies

(e) Therapeutic nursery school

(f) Individual tutoring

(g) Behavior modification sessions for families

(h) Perceptual-motor training activities.

Other unique facets of the program emphasizing community involvement are:

(a) Training of paraprofessionals and volunteers

(b) Dissemination of techniques into the larger professional community

(c) Consultation with those who work directly with handicapped children

(d) A home visiting program

(e) Finally, a Liaison Community Counselor program to plan for the handicapped child's integration into the community.

This last component has been especially helpful in staff development of a total approach to the delivery of services to children and their families. Upon admission to the Center, a child is assigned a Liaison Counselor who serves as a community advocate. This staff member is immediately responsible for exploring, involving, and coordinating those community resources

which help to maintain children in regular community settings after they leave the Center (Williams & Jones, 1974, p. 11). The Liaison Counselor not only visits with the teacher in regular community nursery schools and public school kindergarten classes; he also serves as a long-term consultant to the setting in which the child is placed. In a sense, this person serves as a "catalyst" for parents and teachers once the child has left the JAS Program.

A second dimension of the community education program has also involved education of regular class teachers, as early as possible, at the Preschool Center. During the child's three- to six-month participation in the Preschool therapeutic programs, teachers are brought in for repeated observations to hopefully learn techniques for integrating children into the regular classroom settings.

In an effort to prepare seriously disturbed children for regular class, the staff has also established a nursery class where participation in larger group activities is encouraged. The class is staffed by volunteer-trainees--high school and college students--who are supervised by core staff members. Parents of the children observe daily and enter the class

setting on a rotating basis as teacher aides (Williams & Jones, 1974, p. 13).

To conclude, both the Liaison Counselor Program and parent-family activities developed by the Preschool Center staff are conducive to an intensive therapeutic approach and offer some innovative possibilities for involving parents and the community in the Head Start handicapped effort.

Precise Early Education of Children with Handicaps at the University of Illinois in Champaign, Illinois

A sixth non-Head Start early childhood project identified by this staff as an exemplary program is located at the University of Illinois in Champaign, Illinois. Under the direction of Dr. Merle B. Karnes, this program--now in its fifth year of operation--has several basic elements which, overall, provide a unique service delivery program for preschool handicapped children. They are the following:

(a) ive highly structured classrooms which are largely focused on the development of cognitive skills through an "ameliorative curriculum" (This program is basically organized around instructional models derived from the Illinois Test of

Psycholinguistic Abilities and the Guilford Structure of Intellect)

(b) County-wide screening of preschool children

(c) State-wide dissemination of information about the PEECH Project and early childhood education for children with special needs

(d) High classroom staffing ratios--one staff member/five children

(e) The use of interns in social work, psychology, and administration throughout various phases of the program

(f) Active parent involvement

(g) Integration of limited numbers of non-handicapped children in the five demonstration classes

(h) Close collaboration with county public schools

(i) A strong research and training component.

For the most part, the PEECH Project currently serves handicapped children who have mildly and moderately disabling conditions. Services for severely involved children are provided in other settings. In August and September 1973, the PEECH Project screened approximately 800 children in a 17-county area. These evaluations were

conducted at several local public schools--with the support of respective principals and superintendents. The premise basic to this undertaking--identification early in the preschool years may be helpful in preventing further development of learning and emotional problems in children.

While many of the components of the PEECH Project, to some degree, are relevant to the Head Start handicapped effort, one of the most unique and worthwhile features of the program has centered on activities surrounding development of the "ameliorative curriculum." As Karnes, Zehrbach, and Teska (1973) have importantly noted,

> The primary task in developing a viable and effective preschool program was considered to be the formulation of principles for making decisions rather than the production of static curricular materials. The curriculum developed at the University of Illinois, however, represents only one specific application of these principles. Another research staff working with different children and teachers in another area of the country and within the framework of public schools, for example, would develop a somewhat different curricular product (p. 5).

Such principles--although varying in specific content--might well serve as guidelines in the development of curricula and programs for children in Head Start. In fact, our field observations of regular Head Start programs revealed a

marked absence in most programs of any systematic approach to such problems.

Those principles which served as guides in formulating the content of the University of Illinois preschool amelioration program were the following:

(a) Frequency of occurrence of content in early childhood and primary grade sources examined (e.g., instructional materials such as basal readers and social studies, science, and mathematics books designed for young children)

(b) Information that could be organized to form a logical category (e.g., information concerning foods)

(c) Information that could be organized into a logical sequence

(d) Information that encouraged generalization and transfer

(e) Feasibility of providing concrete experiences

(f) Relevancy of material to the immediate community

(g) Interest and background of the teaching staff

(h) Staffing knowledge of the strengths and weaknesses of children in content areas (Karnes, Zehrbach, & Teska, 1973, pp. 17-18).

Intensive teacher training organized around this kind of approach might eventually be quite helpful to teaching staffs in developing programs for all children in Head Start because it provides a framework for thinking about children and programming for their individual developmental needs.

Sophia T. Salvin School in Los Angeles, California

Among the 10 non-Head Start exemplary programs visited in this study, the Sophia T. Salvin School, a public school located in mid-city Los Angeles, California, is unique in its large enrollment of severely retarded, physically impaired, and multiply handicapped children. The project currently includes two Early Childhood Units--one serving children from three to five years and a second serving children from five to eight years. Each unit includes approximately 50 children, four teachers, three aides, and resource personnel (Engel & Gold, 1974). About 40 children enrolled in each unit are handicapped; 10 are non-handicapped. In addition, the school serves a "broad racial intermixture," with 75 percent of the program population from minority groups.

Five major goals have served as an underlying basis for development of the Model Early Education Program since its inception. These are:

(a) To develop positive self-concepts, independence, communication, and academic skills in young handicapped children

(b) To provide an instructional model for teachers and student teachers demonstrating a classroom program which offers dual educational experiences for children, i.e., an "open-structured classroom environment" and a "teacher-selected plan of instruction" (This program, developed by the school, is referred to as the "Dual Educational Approach to Learning" or "DEAL.")

(c) To train secondary handicapped students to serve as teacher helpers in the Early Childhood Program

(d) To involve parents in a comprehensive program of parent education, school participation, counseling and group discussions. More specifically, these activities include regular contacts with parents in home settings and by telephone; parent participation in the preschool classes; workshops and lectures; availability of a community liaison staff member; and a "heart line" for parents

(e) To involve educational administrators from districts in surrounding communities by observation of the model program and discussion for purposes of replication in other schools (Continuation Proposal for a Model Early Education Program, 1973, p. 2).

In several respects, the Salvin School is not unlike the other non-Head Start exemplary programs visited by the field staff of this project. These projects share several common goals and some of the activities for providing services to children and families are quite similar. With the exception of the Julia Ann Singer Preschool Center, however, perhaps none of the other model programs was quite as diverse in terms of the population served. The Salvin School, in a very real sense, was providing learning opportunities for multi-racial, multi-competency groups of children and young adults, and their families. Second, while they were not working directly toward a goal of integrating children into regular school settings--as was the JAS Center--the Salvin School staff were very concerned about the education and training of school personnel from other districts with respect to handicapped children. Both characteristics speak to needs expressed by Head Start

staffs during our field visits. Head Start teachers felt especially unprepared (as do many teachers) to individualize instruction for severely handicapped children within the context of the regular preschool setting. Finally, with few exceptions, programs expressed desires for closer collaboration with the public schools.

Vista Larga Therapeutic School Project in Albuquerque, New Mexico

The Vista Larga Therapeutic School Project is one component of several programs for children, sponsored by the Bernalillo County Mental Health and Mental Retardation Center in Albuquerque, New Mexico. It is affiliated with the University of New Mexico School of Medicine Departments of Pediatrics and Psychiatry. Like most of the non-Head Start exemplary programs visited by our field staff, this project is funded by the Bureau of Education for the Handicapped.

Basically, the Vista Larga Program has three major service components: (a, psychoeducational and therapeutic services for children, (b) a parent program, and (c) training activities. In general, project activities are centered around the classrooms, with

parent involvement and training activities emanating from and inseparably connected to this group setting (Overall Planned Objectives for the Vista Larga Program: Fiscal Year, 1974-1975; 1974, p. 5). Children from birth to seven years and their families receive clinical and educational services in the program. As described by the project staff, children enrolled are characterized by a wide variety of emotional, learning, and physical problems including language disorders, social maladjustment, mental retardation, and neurological and other behavior disorders.

Currently the Vista Larga Program has five classes in operation, serving a total of 32 children and their families. Like the Salvin Program this project places heavy emphasis on "ability grouping" of children. Thus, the five classes are organized, as much as possible, in accordance with "clinical characteristics" of children. As described by the program staff, these groups are as follows:

(a) Severe behaviorally disordered children between five and seven years of age. Most of these youngsters attend public school on a part-time basis.

(b) Severe behaviorally disordered children between three and five years of age. Some children in this group also attend public nursery schools.

(c) Multiply handicapped children between four and six years. None of these children are enrolled in public school settings.

(d) Children with language and communication problems.

(e) Children with mild learning and emotional problems from four to seven years. Children enrolled in this class suffer from varying difficulties but in all instances, according to the staff, the primary disturbance is considered to be "emotional." Some of these children also attend public schools.

Each project classroom is staffed by a team of lead and support teachers who are primarily responsible for developing individualized programs for children enrolled in the project. One important component of this process, however, also involves parent participation in staff meetings and consultation from a supplementary staff including a psychologist, social worker, and educational coordinator. These treatment plans generally focused on five areas of child development:

(a) Cognitive skills

(b) Interpersonal relationships

(c) Language and communication skills

(d) Self-help skills

(e) Fine and gross motor abilities.

The second major concern of the Vista Larga Project, the parent program, consists of several services which have been designed to approximate a total family therapeutic approach for handicapped children. One, already mentioned above, consists of active parent participation in the program development process for individual children. Others include:

(a) Continuous sharing with parents of the classroom treatment plan and feedback from parents regarding this plan

(b) Regular parent-teacher conferences to inform parents of classroom progress, specific areas of concern, and particular needs of parents in terms of home management of the child

(c) Classroom observation with parents and demonstration teaching.

(d) Parent participation in the classroom setting on a regular basis for the purposes of learning to carry out

treatment plans and learning to cope with children in relation to parent concerns.

(e) Group work with parents

(f) Individual or joint therapy for parents

(g) Special provisions for siblings in the family who may also be having difficulty

(h) Home visitation for the purpose of home management and carry over of classroom treatment plans

(i) Regular meetings of project Parent Association (Overall Planned Objectives for the Vista Larga Program: Fiscal Year, 1974-1975, 1974, pp. 9-10).

The social worker is chiefly responsible for the coordination of the parent program for each family. In addition, each family is assigned a classroom teacher as "parent liaison" to maintain contact between each family and the classroom staff.

In the broadest sense, the Vista Larga Project has served as a training facility over its two years of operation. Approximately 50 individuals including project workers and students at the undergraduate and graduate levels in nursing, psychology, special education, sociology, guidance and counseling, and elementary

education have participated in the training program. Among several, training activities have been variously concerned with the development and application of classroom observation skills, diagnosis and evaluation, clinical and educational interventions, the development of decision-making skills, and parent education. Finally, the project staff have recently become engaged in three additional training efforts which are currently being implemented on a pilot basis.

> One is directed toward familiarizing medical students with the nature of problems attendant upon handicapping conditions in early childhood. A second provides workshops and laboratory training for classroom teachers and special educators in the Albuquerque public schools and a third, with the assistance of the State Department of Special Education, is directed toward providing a workshop practicum experience and outreach consultation for rural educators (Overall Planned Objectives for the Vista Larga Program: Fiscal Year, 1974-1975, 1974, pp. 13-14).

In terms of its specific relevance to the Head Start handicapped effort, probably the active involvement of parents in program development for children and the training and dissemination activities with regular and special education and medical are two areas most deserving of consideration and further development at the local program level.

Hocking-Athens-Perry Counties Comprehensive Child Development Center in Athens, Ohio

A great deal has been written about the benefits of preschool education for handicapped children. Yet programs for the severely handicapped, as opposed to high risk children are surprisingly rare. Likewise, increased importance is being placed on the proposed benefits thought to be derived from integrating the educational experiences of handicapped children with non-handicapped. Again, however, few such programs exist--especially for the severely impaired. The Day Care Component of the Hocking-Athens-Perry Counties Comprehensive Child Development Center is doing both of these things in such a bold and innovative way that it is an exemplary program in the finest sense of the word.

In an area lacking in many community services and having many needs, the staff of this program has voluntarily taken responsibility for providing services for profoundly handicapped children, and done so in a setting which allows and encourages interaction with non-handicapped children. Few more sophisticated or progressive areas are providing such services, and doing it so well.

In the judgment of the field observers of this study, several factors seem to contribute to the quality of this program. One major consideration has to do with classroom programming. Two of the five preschool centers are specifically organized to include handicapped children--although the other centers also have some children with mildly and moderately disabling conditions. Both of these centers use what might be best described as a "resource room" approach. At both settings, there are appropriately trained teachers and separate rooms with specialized equipment. A physical therapist consultant also works part-time at both centers. At the Athens Center, the teacher is trained as a speech therapist and works with the physical therapist to provide a language, speech, and physical therapy program to children on a one-to-one basis several times a week. As children begin to change and parents become more comfortable in the program, the children are then exposed to the regular classroom for increasing amounts of time. Often prior to this step, however, the teacher brings non-handicapped children to the resource room for purposes of socialization and increased interaction with handicapped children.

The child development program also benefits from being part of a comprehensive support and service delivery system. As part of such a system, they have access to counseling, medical, speech and hearing, and diagnostic services that are available to few programs. The staff is able to make referrals and can [illegible] anteed that services will be provided. Moreover, teachers are able to check, at any time, to determine the kinds of special services children have received in the past or are currently being provided.

A well-trained staff is a third strength of this Comprehensive Child Development Program. As already mentioned, both resource room teachers have training in related areas as does the physical therapist. The presence of this staff in such a rural area seems to reflect the valuable, though largely informal, influence of Ohio University. The Academic Community has attracted people to the area who probably would not otherwise reside in this location; such people make up a large proportion of the staff. This situation is quite unlike that of many Head Start programs where the staff is largely indigenous to the areas and populations served. In addition to these benefits, the University also provides

some training for the Child Development Program, quite surprisingly in a language aide program.

A fourth strength of this program lies in its research efforts--albeit they are limited. The program currently serves as an experimental project for the field testing of preschool language materials. This endeavor seems to be valuable to the staff in promoting an attitude toward accountability for change in children.

Lastly, two final points relevant to the Head Start handicapped effort deserve to be mentioned here. The first of these was the unusual sensitivity to parent concerns notable at the Athens Center. Indeed, the supportive/non-threatening manner in which parent anxieties were dealt with might serve as a model for all professionals. Second and equally important to the strength of the program was the apparent efficiency of the administrative staff and their sensitivity to problems of line-staff at the local level.

Resurrection Preschool in Alexandria, Virginia

The last program selected by this project staff for study as an exemplary project was located in Alexandria, Virginia. A small program serving

approximately 40 children (i.e., seven handicapped and 33 typical children), the Resurrection Preschool shared several common goals with other model preschool programs. Among its main objectives were the following:

(a) Early identification of preschool handicapped children

(b) Integration of handicapped children with regular preschool programs--wherever appropriate

(c) Parent education

(d) Training of professionals and para-professionals to work effectively with young children with special needs

(e) Dissemination of information to the community with respect to handicapped children

(f) Promotion of the growth and improvement of public and private facilities for young children.

In each of the programs described above, selected--sometimes unique--factors have contributed to the success of the program. For the Resurrection Preschool, these have been largely a result of active involvement of parents, assistance from community resources, program support by clergy, training and qualifications of staff

involved in the program, and finally, support from the community, at large. Over its two years of operational existence, the Resurrection Preschool has been able to establish fairly close working relationships with the Alexandria Public Schools, Community Mental Health Departments, and Georgetown University. Finally, additional funding for the 1974-75 academic year has opened possibilities for several program developments. For the most part, additional monies have been used to hire special education personnel for a "sheltered class" and home visits, increase salaries of regular class teachers who work with the handicapped, the addition of a consultant and speech therapist, and physical improvements in the classroom setting.

In closing, we might add that the descriptions above have largely focused on positive elements of the exemplary projects. Our purpose in so doing was to highlight a few model characteristics which deserve consideration for possible replication in regular Head Start settings. Such an interpretation, however, is not intended to minimize the importance of difficulties which these programs, like Head Start, experienced in establishing integrated settings for handicapped children.

They too had their problems with community and parental resistance, staff feelings of inadequacy, and partial segregation of the most severely disabled. In most instances, such difficulties were no less paramount than they were in Head Start.

There were, however, two key differences. The model programs, as a result of special funding, had the staff resources of trained personnel. In our judgment, this was one of the major critical differences between the non-Head Start and Head Start exemplary programs. Second and finally, the staffs of most of the non-Head Start programs were sufficiently knowledgeable about community resources and familiar with alternative approaches to resolving problems in integrated settings that they were able to achieve at least partial success in efforts to overcome their respective difficulties.

Six Regular Head Start Exemplary Programs and Concluding Statement

In other parts of this report we have alluded to some key differences that seemed to distinguish the six exemplary Head Start programs from other sites visited in the second round. To briefly review, these factors

were largely concerned with leadership qualities of the Directors of the exemplary programs, active parent and community involvement, some background of previous experience in working with more severely handicapped children, and finally a commitment to the importance of such efforts. Together, these variables--beyond the dictates of the congressional mandate--served as a critical source of staff motivation in providing comprehensive quality services for handicapped children and their families.

CHAPTER VI

SUMMARY AND DISCUSSION OF MAJOR FINDINGS

In four parts, this portion of the report summarizes major findings of the Task III site visits. The first presents data on visits to the 52 regular Head Start programs and covers the following areas:

(a) The current population of handicapped children

(b) Identification, diagnosis, and enrollment of children

(c) Quality of classroom services provided for handicapped children

(d) Integration and exclusion of handicapped children

(e) Involvement of community agencies and schools in the handicapped effort

(f) Involvement of parents in the Head Start handicapped effort, and

(g) Staffing, training, and technical assistance for the handicapped effort.

The second and third parts will discuss the 14 experimental projects, the 16 exemplary programs, and their

respective implications for the Head Start handicapped effort. In part four, we will present our concluding summary statement about the efforts of Head Start programs to serve handicapped children this year.

Regular Head Start Programs

The Current Population of Handicapped Children

One of the most important objectives of the field observations was to obtain information about the nature of the handicapped population in Head Start in terms of numbers of children identified and enrolled, types of disabling conditions, and the degrees of impairment of children. In this regard, we found that there has been a small increase in the numbers of the more severely disabled but that basically the population of children enrolled in local programs we visited has changed only modestly.

To realize its full implication, we need to examine this finding in the larger context of other observations. Forty-two of the 52 programs selected reported percentages of handicapped children this year exceeding 10 percent. This figure, however, tends to be misleading when we try to determine the nature of changes in the handicapped population this year. Reflecting on prior years, these programs

indicated that they had always included handicapped children.[11] Thus, in this sense, the notion of providing special services within the classroom setting was not an entirely new concept. Second, with a few exceptions, these children may be largely characterized as having mildly disabling conditions. This tendency still predominates this year, with conditions of health and developmental disabilities, physical impairments, speech problems, and behavioral problems accounting for higher enrollments of handicapped children across all degrees of severity in more programs. Put somewhat differently, Head Start programs are serving children with clearly disabling conditions; but, according to reports of Head Start staffs, these programs are few, their enrollments of handicapped children are considerably less than 10 percent, and most of these programs have provided services for more impaired children in the past. Moreover, in all programs we visited, children who are blind, severely visually impaired, deaf, severely hearing impaired, and retarded made up the smallest percentages of severely handicapped enrolled.

[11] The reader should note that we, in fact, have no baseline data for comparison of enrollments between this year and last since only a few programs were able to provide information about the numbers and characteristics of children included in the past.

Finally, all of the findings summarized above are related to one overriding problem which consistently pervaded our attempts to describe the handicapped population. This was the frequent mislabeling of children with minor problems. To be more specific, we found that almost without exception the programs we visited were applying the term "handicapped" to some children with very minor difficulties, who required no special classroom assistance or services, who have always been enrolled in Head Start without such classifications. The problem was a paramount concern to the programs who felt pressure to meet the 10 percent quota required by mandate, but who well recognized the potentially aversive effects of mislabeling that might follow children through their school years. In our view, this has been the most serious and deleterious effect of the new legislation, and it is the problem which requires our most immediate attention.

Identification, Enrollment and Diagnosis of Handicapped Children

Inclusion of more severely disabled children may lead to changes in identification and enrollment processes. We found, however, that while most programs we visited have made special efforts to use more services of community agencies to recruit handicapped children, basically they have

modified their procedures very little over the past year. Programs reported that, in general, they have identified more handicapped children through regular Head Start processes, e.g., interpersonal contacts, door-to-door canvassing, and mass media than through special recruitment efforts. This finding was quite understandable in light of the fact that most of the handicapped population in the Head Start programs were characterized by mild and moderate difficulties, which did not require special services of community agencies. The heavy reliance on already established procedures may also be partially explained by our observations that about half of the programs we visited were having problems in recruiting handicapped children. These difficulties appeared to be a result of several factors including competition with community agencies, parental resistance, and lack of knowledge about the preschool handicapped population.

There were some exceptions to these patterns. These usually involved programs which had greater numbers of more severely handicapped children with clearly identified problems, who were already being served by community agencies. We observed that two characteristics were especially paramount in such programs, i.e., active involvement of parents and strong leadership from the Head Start directors. In

part at least, these qualities seemed to contribute to differences in the recruitment procedures.

In contrast with identification and enrollment, changes in diagnostic and assessment processes were more widely apparent across the programs we visited. Some of these were positive and others, not so encouraging. For example, with the few exceptions of those who were not serving handicapped children, most programs were making a significantly greater effort to obtain professional diagnoses from community agencies. For the most part however, such evaluations were being used to certify or confirm suspected disabilities and to secure outside special services, and there was little evidence that they were really serving to provide insights for teachers that were carrying over into classroom activities. This latter course of events seemed to stem from several factors including staff inexperience with interpreting diagnostic data, the inappropriateness or absence of relevant report recommendations, and the frequent lack of ongoing diagnostic services by community agencies.

Aside from these observations, one of the most noteworthy positive effects of the handicapped effort that we found was the increasing emphasis on more detailed assessments of individual developmental needs of all children, not only

those with special needs. This change was obvious in almost all of the programs we visited, where teachers reported that they were monitoring the progress of children much more closely than they had in prior years. Moreover, in those programs serving greater numbers of more severely disabled children, we found that teachers were becoming increasingly skilled in developing their own means for informal evaluations and using more formal measures such as the Denver Developmental Scale or the Peabody Picture Vocabulary Test. In contrast with the formal evaluations by outside agencies, this information seemed to be extremely useful to teachers.

Quality of Classroom Services Provided for Handicapped Children

The major purpose of the classroom observations of both rounds was concerned with determining how well handicapped children are being served in Head Start. The approach of the first round, though open-ended, focused mainly on child-child and teacher-child interactions. In the second round, we concentrated on several dimensions of classroom instruction and teacher and child behavior (as described in Chapter IV) including:

(a) The use of materials

(b) Teacher planning, preparation, and presentations

(c) The use of language during instruction

(d) Individualization

(e) Teacher encouragement of independent child activities

(f) Teacher response to child-initiated activities, and

(g) Teacher coping with deviant behavior.

We also asked several questions, in general, about the responsiveness of children to their learning environments and, in particular, about provisions for the case study children.

Summarizing our observations from both rounds, we found the following. The majority of programs we visited offered more than adequate resources to most mildly, moderately, and some severely handicapped children; for the most part, these were provided in the course of regular Head Start activities. Furthermore, programs developed for all handicapped children did not differ very much from those for typical children. The same materials were used in most classes. Physical facilities had been modified in very few programs. In addition, staffs of most programs had not made special plans for handicapped children. Patterns of instruction and teacher interaction with mildly and moderately disabled children were practically the same, i.e., compared to the services for typical children, classroom activities for the mildly handicapped differed very little.

There were some exceptions, however, to the trends described above. These related mainly to the severely handicapped for whom methods of instruction and communication were more individualized. For example, we observed that those teachers who served more severely involved children tended to place greater emphasis on the use of speech and language developmental activities and more frequently encouraged children to initiate conversation and use language to communicate their needs. They offered more individual help. In general, the methods they used to present activities were quite imaginative. Finally, as compared to the others we observed, teachers serving the more severely handicapped provided more encouragement for children to engage in independent activities. In essence, we found that teachers in programs serving greater numbers of the more severely disabled were more sensitive to individual developmental needs of all children in their classes and, all considered, provided better instruction.

Finally, our observations from both rounds of visits showed that handicapped children seemed to be relaxed and happy in most classes, were involved in the greater portion of observed activities, and in most classes, spontaneously interacted with teachers and other children.

Integration and Exclusion of Handicapped Children

As we indicated earlier, OCD policy now requires that handicapped and typical children be served together in Head Start settings. This new obligation raises several questions about the short- and long-range effects on all children and the Head Start teaching staffs. These questions were the central focus of our inquiry about integration.

In general, we found that mildly, moderately, and most severely handicapped children have been physically and psychologically integrated into the mainstream of Head Start classroom activities. This accomplishment was evident in at least three respects: positive attitudes of teaching staffs about the integration of handicapped and typical children, interactions between teachers and handicapped children, and interactions among all children. Further, from our classroom observations, it was apparent that the integration of most handicapped children required only a minimum of additional resources, those instances being the support of additional staff.

In both rounds of visits, we observed some situations where children were partially psychologically separated from ongoing classroom activities. Also, teachers in one-third of the programs indicated that their staffs and other

children had difficulty coping with certain handicapped children when they first entered their classes. In all of these situations where apparent needs of teachers and children were not being met, the problems involved more severely disabled children, and often they seemed to be child rather than teacher initiated. In these cases, teachers usually made attempts to help children re-enter activities.

The few instances of partial or total physical separation that we observed occurred in those situations where teachers perceived that handicapped children were not capable of participating with other children because of physical or emotional difficulties. In spite of such problems, however, only two or three programs reported having dropped handicapped children after their enrollment.

Since we had no way of really determining how many children never were considered for placement, issues of exclusion were much more difficult for us to study than questions of integration. Our informal conversations with program personnel seemed to suggest, however, that the excluded population was considerably larger than the number of children reported to have been referred to other community agencies. In this regard, Head Start directors and teaching staffs most frequently commented that they were unable to

serve blind, deaf, severely retarded or physically involved children.

Involvement of Community Agencies and Schools in the Handicapped Effort

Head Start staffs reported that they have always had working relationships with some community agencies and, to a lesser degree, with public schools. Now as a result of the handicapped effort, however, the range of services provided by community agencies has increased and Head Start programs are making greater efforts to coordinate their activities with public schools and other Head Start programs.

Seventy-five percent of the 52 programs we visited reported at least one--and almost as many noted a second--community agency that was offering services to handicapped children. Among others, these agencies have included Mental Health and Mental Retardation Departments, Cerebral Palsy Clinics, Crippled Children Clinics, and various rehabilitation centers. Services offered have largely involved identification of handicapped children, diagnosis, and assessment; but agencies have also provided ongoing treatment such as physical therapy, speech therapy, counseling, and medical follow-up.

Contrary to our expectations that almost all programs would desire additional supportive services, about 50 percent of the Head Start directors we talked with mentioned such a need. Of those programs requesting additional community agency resources, staffs cited two reasons for the lack of services more frequently than others, i.e., agency refusals and funding difficulties.

There were other problems with community agencies. One we discussed earlier, i.e., most agencies were providing diagnoses that bore little relationship to ongoing classroom activities. Another involved competition with community agencies and their reluctance to refer handicapped children to Head Start. This second problem had a significant impact on the enrollment of more severely disabled children in some programs, especially in the early stages of the handicapped effort. According to Head Start personnel, agencies initially felt that they lacked appropriate qualifications. As compared with our observations in the fall, however, our spring visits seemed to indicate that the programs had resolved some of these difficulties with community agencies.

In addition to their relationships with community agencies, we were also interested in the efforts of programs to build continuity between Head Start and the public schools.

In the fall, staffs were having problems in this area; and despite their attempt to establish closer collaboration, not much change was evident in the spring. Programs continued to experience problems in arranging for public school placements of handicapped children--especially the severely disabled. As a result, they were retaining children who were eligible by age for public school. The magnitude of the problem was reflected in the fact that about one-third of the 74 case study children in the second round were remaining in Head Start for a second year.

There was a third part to our assessment of supportive services for the handicapped effort. This was the coordination of activities with other Head Start programs and the Regional and National OCD Offices. About 50 percent of the local programs we visited reported varying degrees of coordination with other Head Start projects; these activities took several forms including joint training and technical assistance meetings, exchange of materials and ideas, and sources of referral. Approximately 50 percent of the programs indicated that they had received help from their Regional Offices in terms of additional funding, training and technical assistance, and consultants; however, all of the programs thought that they could have used more support. Staffs felt,

too, that when the new legislation was first passed, they had received only minimal help from the National and Regional Offices--if any at all. This absence of support, they believed, had contributed to some of the problems of implementation of the handicapped effort.

All considered, our observations of the second round revealed that programs serving the more severely disabled received far more financial assistance to develop services for handicapped children than other programs. They had more self-perceived needs that weren't being met than other programs; and finally, they seemed to have a greater awareness of the needs of handicapped children.

Involvement of Parents in the Handicapped Effort

Our inquiry about parent involvement focused on two concerns. The first dealt with attitudes of parents of typical and handicapped children about the new effort. The second related to the degree of involvement of parents of handicapped children in Head Start and the benefits they derived from their participation. Our findings from the

two rounds of visits differed with respect to these two issues.[12]

Based on data from the fall visits, we found that all parents, those of typical and handicapped children, expressed favorable attitudes about Head Start, in general, and the handicapped effort, in particular. Only one or two programs reported that they had experienced parental concern or resistance when they were notified about the mandate. Equally important, our observations indicated that parents of handicapped children were as involved as those of typical children--if not more so. They had gained a variety of experiences in terms of formal instruction, learning about community resources, and learning how to care for their children. Moreover, for the majority of parents of the severely disabled, Head Start had provided relief, care, and services for their children which they might not have had.

In the second round of visits, there were two main points where the data differed from those of the first round.

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[12] Some of these differences may be partially explained by the fact that different sources were used in the two rounds to obtain data about parent involvement. In the first round of visits, our information was based primarily on discussions with parents of handicapped children. In the second round, the data were obtained from Head Start directors and teaching staffs.

First, we were informed that parents of handicapped children were not as intensely involved in the handicapped effort as we had perceived in the first round. For example, parents of the case study children were equally represented across all levels of involvement. In those instances where they were not participating as much as or less than other parents, the primary reason given often had to do with family needs such as work commitments. Second, programs reported that when they were first notified about the mandate, there was some resistance to the effort from parents. For example, in five programs, parents strongly agreed with the new legislation; in eight programs, they agreed; in 16 programs, they were neutral; and in three programs, they disagreed. Moreover, in 17 of the 36 programs we visited, staffs were having some difficulty in recruiting handicapped children because of parental resistance.

Concluding, we would like to emphasize a point that we made earlier in this chapter, i.e., the programs that had higher enrollments of more severely handicapped children also were characterized by strong commitments and active involvements of all parents in Head Start and their local communities.

Training and Technical Assistance for the Handicapped Effort

The majority of programs that we visited reported having received training and technical assistance for the purpose of serving handicapped children. For the most part, these included pre-service and in-service workshops, although a few programs had training in college courses and conferences.

In spite of this experience, however, most programs said that they continued to have substantial needs for additional training and technical assistance and that they had required such activities this year before and after enrollment. In 75 percent of the programs, staffs indicated that the training and technical assistance had been provided on a sporadic, not an ongoing basis; often they were far removed from the local communities. Moreover, in both rounds staffs said that they had been trained ad infinitum in matters that didn't much relate to the realities and problems of their serving handicapped children. They wanted more practical experience to learn how to identify, diagnose, and plan programs for children with more severely handicapped children.

Our observations revealed that such training was necessary for at least two purposes, that of developing staff skills in working with the more severely disabled and for changing staff attitude. Regarding this last point, we found that Head Start personnel basically had few problems with the notion of including children with less disabling conditions, but that most programs we visited had a great deal of anxiety and concern about serving more severely involved children. They questioned, first of all, whether they could provide the kinds of services needed by these children. Furthermore, almost all of the programs felt that it was more difficult to serve severely handicapped children. Thus, training and technical assistance, along with the desire for more staff, remained two very high priorities for Head Start teachers.

In the discussion above we have summarized key findings from our visits to 52 regular Head Start programs. There were two additional facets to the Task III evaluations, i.e., assessment of the 14 experimental projects and visits to 10 non-Head Start preschool enrichment programs. In the next two parts of this chapter, we will present the findings from these visits and their implications for the Head Start handicapped effort.

Experimental Programs

Our observations of the experimental projects focused on two central issues. The first had to do with examining the ways that the demonstration programs differed from those of the Head Start programs. The second concerned larger questions of whether and how these new developments were really leading to an improvement of services for handicapped children.

With respect to the first point, we found that the experimental programs differed from the regular Head Start programs, but that in most instances such variations were more a matter of degree than distinctions in program activities.[13] The main differences may be summarized as follows.

1. While the majority of experimental projects, like the regular Head Start programs, had disproportionately large numbers of children with mildly disabling conditions, they had enrolled more moderately and severely handicapped children. The few exceptions to this general finding were

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[13]Five projects (i.e., Anchorage, Alaska; Chapel Hill, North Carolina; Portage, Wisconsin; Seattle, Washington; St. Paul, Minnesota) were developing some uniquely different models of service delivery for handicapped children.

the regular Head Start programs in the second round which were selected for their greater enrollments of severely handicapped children.

2. The above observations may have been related to two other distinguishing characteristics of most experimental projects. In general, they had developed a more systematic approach to planning activities and implementation in the early stages of the handicapped effort. In addition, they had made more consistent contacts with community agencies for purposes of referral and identification of handicapped children.

3. Overall, the experimental projects placed a greater emphasis on screening and assessment of special needs of children. This included professional diagnoses by community agencies, but perhaps more importantly, informal evaluations by classroom teachers.

4. The experimental projects tended to affiliate more with personnel specifically trained in the area of special education. This development was evident in most programs in one or two ways. First, some of the projects had established close cooperation with special education departments of universities. Second, they often hired professional staff with backgrounds in special education. In

the latter instance, additional personnel usually exceeded numbers of staff hired this year in the regular Head Start programs. For example, in some projects we found that entire experimental teams had been added to assume responsibility for the handicapped effort.

5. Special service staffs of the experimental projects provided more on-the-spot guidance and support for teachers who worked with handicapped children than liaison persons of the regular Head Start programs who, theoretically, were hired for some of the same purposes. In addition, they served as resources for the regular Head Start teachers.

6. There was some evidence in a few of the demonstration projects that handicapped children--especially the more severely disabled--were separated from the mainstream of class activity. Though we considered the possibility that these observations may have been a function of our early visits in the fall, such circumstances did not appear to have changed very much upon further inquiry by telephone in the late spring.

7. Special project staffs and regular Head Start teachers in the experimental programs were offered more apparently relevant opportunities for training to work with handicapped children. One extremely important dimension of

these activities in several programs involved the training of paraprofessionals to deal with the problems of rural settings.

8. Finally, there were greater tendencies among the experimental projects to develop distinctive methods of service delivery to handicapped children.

Such was the status of the experimental effort in late spring. Our observations revealed that a great deal has been accomplished to date, and probably more will be attained over a longer period of time.

Turning now to the second point of our analysis we need to ask ourselves this question: What has all of this really meant to handicapped children and their families, staffs, and for overall program development? Have changes improved services? On the one hand, the demonstration effort lends just cause for cautious optimism about new resources, service delivery models, and special provisions that can be offered to handicapped children in Head Start. At the same time, there are some problems that raise considerable concern.

Most certainly, the experimental effort has provided selected programs with opportunities greatly desired by many Head Start programs. It has served as an impetus toward serving more severely handicapped children, providing

opportunities for testing new service delivery and staff training models, offering additional staff to support regular Head Start teachers, and training staffs to deal more effectively with individual needs of all children. The effort has focused directly on a wide variety of problems which programs otherwise would have had neither the time, funds, nor staffs to resolve. In almost every program, there was some evidence of breakthrough in modifying staff patterns of instruction an eveloping even more individualized class programs for children.

Given such changes, however, other observations were not as encouraging. For example, we found that the majority of experimental projects were still plagued by many of the same problems faced by the regular Head Start programs. They also had trouble recruiting severely handicapped children in the early stages of the handicapped effort. Staffs, even in the spring, continued to express needs for more and different kinds of training. Many of the programs, too, had experienced resistance initially from community agencies, and were struggling with problems of definition and concepts of handicap. Moreover, despite the marked sophistication of staffs of several programs, there were very few differences in qualities of integration across projects or between the

regular and experimental Head Start programs. In fact, as we have mentioned above, there was some evidence from our observations that the experimental projects were tending to provide special services for more handicapped children in separate settings. This last point is an extremely important one in light of the central thrust of the new Head Start handicapped effort to serve children in integrated classes.

In closing, let us summarize some key implications of our observations and emphasize a few additional points. Much of what we have discussed above seems to underscore the general conclusion that the experimental projects were making some headway in attacking major problems and concerns that are central to the Head Start handicapped effort. We certainly view these efforts to be worthy of continuation in the future, with the hope that they will eventually yield strategies that can be meaningfully implemented in regular Head Start programs.

At the same time, there is an apparent need for improvement, especially in the areas of separation of services. We have already commented on the emerging trend in some programs to serve some children apart from regular Head Start settings. Our observations disclosed another related tendency, i.e., in some programs, the demonstration effort was

partially separated from ongoing regular Head Start activities. Thus, there is a possibility that unless the special projects make more definite attempts in the future to insure that new developments interface with Head Start processes, they may become more distinct and fail to achieve their primary purpose of creating replicable approaches for the regular Head Start programs.

Exemplary Programs

Our evaluation of the 16 exemplary programs had two main purposes, i.e., to study the service delivery models and procedures developed by these programs to provide for disabled children and their families and to consider their implications for further improvement of the Head Start handicapped effort. As we pointed out earlier, all of these programs shared two common characteristics: At least five percent of their enrollments included moderately and more severely disabled children, and secondly, the programs had an integration component that involved serving typical and handicapped children in the same demonstration classrooms or placing handicapped children in regular class settings in the community. These were, of course, two characteristics that should have been evident in all Head Start programs according to the new legislation and OCD policy.

The following points summarize the main exemplary characteristics of these programs and their particular relevance for the Head Start handicapped effort.

1. The total family care models developed by some of the exemplary programs have much potential for strengthening the parent involvement component of the Head Start handicapped effort. Rather than providing separate services for parents and children, these programs have attempted to involve entire families in therapy and treatment processes. While it would probably be impossible for Head Start staffs alone to assume full responsibility for such activities, there is the potential for programs to develop stronger parent services in collaboration with community agencies that would have more available resources. Such services hold possibilities for broad impact on family problems.

2. Another key component of some exemplary programs was their intense involvement with community agencies and public schools. This characteristic was evident in two respects. First of all, diagnosis and assessment by community agencies were a meaningful part of ongoing program activity and served to broaden teacher insights about children. This marked departure from the irrelevance of much formal diagnosis in the regular Head Start programs probably can be

attributed to three factors including more highly trained preschool teaching staffs, a sense of purpose of the evaluations, and more frequent contact of agency personnel.

Second, several programs had developed relationships with public schools so that preschool staffs continued to follow-up children after they were placed in the regular classes. While such procedures did require additional staff, they ensured a degree of continuity as children moved into school settings, provided support for persisting problems and special needs of children, and helped to bring about more rapid placement in the regular grades. With few exceptions, Head Start staffs were having problems accomplishing all of these objectives.

3. Staffing, staff training, and technical assistance comprised a third major area where most of the exemplary programs have developed approaches that could improve the Head Start handicapped effort. The majority of these programs had more staff to provide one to one relationships with seriously disabled children. Staffs of most of the non-Head Start preschool programs were more highly trained than Head Start personnel and, beyond this, had the benefit of immediate training and technical assistance when needed. As we have pointed out earlier, this was one of the critical

problems of the handicapped effort whenever Head Start staffs felt incapable of dealing with severely disabled children and frustrated with limited opportunities to gain some meaningful experience with handicapped children. We think that this last point was at least partially responsible for the substantial differences in the attitudes of staffs of the exemplary programs and the majority of Head Start programs we visited.

4. There were other factors that were critical to the overall effectiveness and direction of the exemplary programs. These were the leadership and organization abilities of the program directors. We have already alluded to the importance of these qualities in previous discussion of this chapter, but they are so central to the strength of the exemplary programs they deserve to be stressed again. Basically, we found that the directors of these programs were persons who actively participated with their staffs in total program development--in terms of planning, training, community relationships, curriculum and instruction, and funding arrangements. They maintained personal contact with staffs, were personally involved in resolving problems, and overall, contributed to the sense of motivation and commitment of

program personnel. In our view, these factors were equally as important to the integrity of programs as the skills and abilities of teaching staffs.

5. We found that, in general, the exemplary programs monitored integration processes more carefully than most of the regular Head Start programs. Teachers and clinicians were more sensitive to the individual developmental needs of all children, used techniques more skillfully to enhance these processes, and in some programs were actually studying modeling behavior of the children. While our observations revealed that the integration of handicapped children into Head Start was proceeding with a good deal of success, there is still the need to examine the long-term effects of the handicapped effort on the lives of typical and handicapped children, the general well-being of their families, and teachers themselves.

6. Finally, it was not surprising to find that the exemplary programs had the benefit of a wide range of resources which provided good developmental services for all children--resources that Head Start could well use for the overall improvement of program quality.

Summarizing Statement

In the final analysis, this basic question remains to be answered: How successful has Head Start been in providing new services for handicapped children this year? The question, of course, cannot be answered simply; outcomes have been both positive and negative.

The handicapped effort has brought about some important changes this year in terms of providing services for a few more seriously handicapped children, encouraging teachers to become more sensitive to individual developmental needs of all children, getting parents a bit more involved than they have been in the past, and emphasizing the need for programs to establish meaningful relationships with community agencies and public schools. These positive accomplishments should not be minimized.

At the same time, however, the mandate has caused some serious problems. Labeling of children with minor or temporary difficulties has dramatically increased this year. Secondly, Head Start staffs now feel compelled to meet requirements that they little understand or believe they can accomplish with current staffing, training, or funding arrangements. Thus, their anxieties, concerns, and confusions

have been heightened. Moreover, the new legislation generally added another responsibility to existing commitments at a time when Head Start staffs felt that they were barely surviving.

All considered, our assessment has led us to this final conclusion: Head Start services for children with special needs have basically remained the same this year and in order to really fulfill the intent of serving more seriously disabled children, the legislation needs to be further clarified and new approaches with greater resources developed.

CHAPTER VII

CONCLUSIONS, POLICY ISSUES AND RECOMMENDATIONS

Background

For many years, handicapped children in the United States have been a large and, some would say, an expensive business. Although we have doubts concerning the accuracy of both their prevalence and expenditure data, it might be helpful to briefly summarize data reported in a recent Health, Education and Welfare study prepared by The Rand Corporation in order to illustrate the magnitude of the problem and the extent to which society has attempted to deal with it (Kakalik, 1973). This group estimated that, among the nearly 84 million youth in the United States in 1970, from birth to 21 years, approximately 9.5 million are handicapped, an overall prevalence of somewhat more than 10 percent. To serve this large and very heterogeneous group, an estimated $4.7 billion are expended annually by various governmental agencies, with federal expenditures of approximately $1.1 billion

(23.5 percent of the total amount) and non-federal expenditures of $4.7 billion (76.5 percent of the total amount).

An examination of the variety and complexity of federal, state, and municipal, as well as voluntary association, involvement in serving handicapped children today is impressive indeed. It is all the more puzzling that the national Head Start movement, until recently, has almost pointedly ignored any responsibility for the Nation's handicapped disadvantaged young children. Almost 10 years ago, a panel of experts, chaired by Dr. Robert Cooke, then Professor of Pediatrics at John Hopkins University and today Vice Chancellor of the University of Wisconsin Medical School, recommended the creation of what eventually became Head Start. Even then, the objectives of that program included provisions for a broad spectrum of services and supports to protect and nurture physical, social and intellectual development of young children (Cooke, 1965). Nowhere in this comprehensive document is there any mention of the term "handicap" or the need to provide special services for disabled children. To be sure, embedded in almost every recommendation there is the recognition that disadvantaged children suffer from blunted intellectual,

physical, and social environments and, consequently, medical assessments, dental examinations, and screening for special problems and strengths are necessary. However, it is curious that, from its inception, there appeared to be a rejection of the idea that Head Start, a movement which would eventually influence millions of people, should be directly involved in providing services for handicapped children. It seemed enough that this agency would devote itself to the disadvantaged, without the potential added burdens and encumbrances of a mission on behalf of the handicapped.

Yet, whatever the antecedents were, however they influenced current policies, however reluctantly or enthusiastically national or local Head Start leaders responded, the times eventually demanded that this movement--born of great hopes yet still today with fragile underpinnings--accept its share of the responsibility for providing young handicapped disadvantaged children with program opportunities heretofore denied them. In a major policy statement approved by its 1973 Delegate Assembly, the Council for Exceptional Children (CEC) enunciated the following principles (Council for Exceptional Children Policies Commission, 1973):

> The right to equal educational opportunity implies the obligation of the appropriate governmental units to provide free public education for all children (p. 70).
>
> The system of organization and administration developed for special education should be linked with regular education. . . (p. 70).
>
> Special education programs should be joined with other child and family assistance programs of the community in order to provide exceptional children and their families with all needed services on a fully coordinated, effective, and efficient basis (pp. 71, 72).
>
> Special education requires a broad base of participation and support from the community as well as from the educational system (p. 73).

The CEC statement, subsequently enunciated again and again--in the press, in our scholarly journals, from the podium--was one of many expressions that the handicapped have rights, not only privileges, and are best served in integrated settings. The litigation in the overlapping fields of special education and mental health exemplifies the centrality of the integration-mainstreaming issue (Syracuse University Law Review, 1972). The courts have affirmed that handicapped children have a right to a publicly-sponsored education. Further, it is no longer sufficient to offer special programs and facilities without regard to where and under what conditions services are provided. Henceforth, the courts declared that programs must be justifiable, not only insofar as quality is concerned

but also the degree to which they refrain from the unnecessary segregation of clients.

Almost concurrent with a renewed emphasis on human rights and public responsibility and the re-enunciation of concepts involving freedom of choice, options, due process under the law, and consumer protection is the equally provocative reaffirmed interest of professionals in the hypothesis that development is plastic, can be modified, is a function of motivation, practice, and training. This idea on the nature and nurture of human beings is essential to both the concept of compensatory education, i.e., one of the theoretical pillars of the Head Start movement, and special education, i.e., the intent of the 1972 Amendments to the Head Start legislation. For, if capability is plastic or educable, it is educable for <u>all</u> people--for the so-called "cultural familial" mentally retarded, the disadvantaged school failures, the back-ward severely defective resident of a state institution, the multiply handicapped neglected school-excluded child--for <u>everyone</u>, for <u>us</u>. Further, without doubt, the educability hypothesis is critically important for anyone who seeks to find more informed and helpful answers to questions concerning human development, and for anyone who seeks better treatment for our currently untreated or "untreatable" fellow humans.

Therefore, with the luxury of both retrospect and the ability to "take distance," it is not now surprising that Head Start was originally endorsed by the Congress and, eventually, more or less by the Nation; and it wasn't a surprise that in 1972 the Congress made deliberate efforts to stipulate inclusion of more severely handicapped children in Head Start programs. As implied earlier, the major surprise is that the Nation did not demand such inclusion prior to that time. For reasons that are not only congruent but inextricably interrelated, we are concerned as a Nation about the disadvantaged, the handicapped, the aged, and the "weak." Possibly, because our Nation is now sufficiently affluent to afford the "price" in caring for our disadvantaged and handicapped, possibly because we have developed a new wisdom of new morality, possibly because we can no longer bear to--or afford to--neglect such a large segment of America, we seem to behave today as if we care more and wish to do more for those in need. Possibly because we are finally or sufficiently impressed by the convictions of some of our best statesmen, political scientists, and economists that our society will no longer be able to tolerate a dependent segment which is essentially ever-populating, non-contributing, and unproductive--for whatever the reasons--it seems that we have now realized a

new responsibility. It is also possible that, in our darkest moments, some of us have imagined the Nation in 30 or 40 years, when the population has exploded and industries have become automated, and the earth will be more polluted and we will be less, not more, tolerant. During those terrible nightmares, some of us may have thought about manufacturers previously employing thousands of workers who will now require only handsful of people to produce the same quantity of goods more cheaply, more quickly, and of better quality. And, in that society, what work force will be needed for this automated revolution? Certainly, basic and applied scientists will be required to design and build machines which will produce our consumer goods. Skilled mechanics and technicians will be needed to service and repair the equipment of modern industrial complexes. There will continue to be a probable shortage of physicians, clergym dentists, accountants, lawyers, domestic servants, public service people, and generally unskilled workers. In contrast with today's labor force, a very modest number of production workers will be employed. Labor experts, sociologists, and other social planners are predicting a culture--within our lifetimes--in which fewer people will be necessary to meet production standards, in which most employment

opportunities will require advanced academic preparation.

What will become of those men, women, and children who are uneducated and untrained, or who are handicapped and in need of specialized services and facilities? What will become of those who are currently employed or employable when the new mechanized economy makes their skills obsolescent? It's possible that, in this new culture, fewer people than ever before will be forced to live in poverty and degradation. It is possible that the affluence of the economy will permit guaranteed incomes to all human beings in a manner previously undreamed of and in a way that provides basic standards of shelter, nourishment, and clothing for all. It is possible that everyone--from the person with the highest degree of professional skills to the one who is unemployable--will have to readjust this occupational philosophy, to seek other avenues for fulfillment and satisfaction, and to view work as a small, necessary part of his life. It has even been predicted by recreation leaders, as well as by those in labor fields, that a new relationship between work and recreation will be developed during the next half century. Leisure and recreation may become more than luxuries and relief from the strain of work. They may become a way of life needing no special justification.

However, one-third of America may be almost totally incapable of participating in this new culture, other than as spectators and recipients of its charity. These people--the disadvantaged, the handicapped, the aged--must not be denied opportunities for such participation; they must be encouraged to fulfill their potentials, to be as economically and socially independent as possible and, further, to continue as contributing members of society throughout their lives. Unless special measures are designed now to prepare those with special needs for participation in the coming generations differences between the advantaged and disadvantaged will become greater not smaller, differences between the rich and the poor will be more glaring than ever before, differences between "the haves" and "have-nots" will not attenuate but, rather, will greatly magnify. Ironically, we are heading toward a society of greater abundance than ever before, yet one that may prohibit large numbers of Americans from being employable and enjoying the harvest of our affluence. Ironically also, from necessity, this unemployable group may become the "leisure" class but, unfortunately, may be as unprepared to participate profitably in leisure activities as in work or intellectual activities.

Therefore, although not envisioned, or at least not articulated, by its creators, the Head Start movement

was bound to eventually accept its almost-fated responsibility for the handicapped. Inherent in its initial charge was the concept of human educability and, although it may have been understood all to naively and simplistically, and although that concept is now attacked not only in racist journals but in prestigeful centers of academe, it has both a proud heritage and is, in fundamental ways, our most promising perspective for a better future for humanity. From an affirmation of support for the hypothesis that people can change, and improve, it was only a matter of time for Head Start to be entrusted with a significant responsibility for those most desperately in need, the disadvantaged handicapped.

Consequently, the Economic Opportunity Amendments of 1972 were hailed as a significant statement of federal concern for the handicapped (LaVor, 1972). The legislation was the product of many years of Congressional support for the expansion of the Head Start mandate. In fact, the history for such support goes back decades, not only in America but in France, England, and otherwestern countries. And, when that history is completely written, it will include contributions of Montessori, Binet, Skeels and his associates, Kirk, Sarason, and that very first pioneer who

had belief in human resiliency and educability, Jean Itard (Blatt & Garfunkel, 1969).

It was not surprising to find unusually enthusiastic expectations and hopes arising from this new Congressional mandate:

> For the first time, large numbers of preschool handicapped children can learn and develop with non-handicapped children as Head Start launches a major effort to insure at least a 10 percent enrollment of handicapped youngsters in the program (Jordan, 1973, p. 45).

Great hopes were expressed for this program. The professionals viewed it as long needed and a harbinger for the future. The parents found that, finally, some agency was interested in helping their children. The political leaders observed that they had righted some serious wrongs in our federal legislation--as undoubtedly, any informed and reasonable person would agree. However, as usually happens with great expectations--as occurred subsequent to the organization of Head Start itself--the initial enthusiasms were followed by disappointments, a few denunciations, some denials, and some unfortunate conclusions. The House of Representatives' Education and Labor Committee learned of reports of mislabeling of Head Start children as handicapped and, therefore, directed OCD to "take immediate steps to

guarantee" that no child had a certified handicap (Education Daily, June 5, 1974). Similar legislative concerns were reported in a Council for Exceptional Children news report, Insight (June, 1974). And, prior to the public debate, other discussions occurred. Even "best suits" were wagered, that OCD did, or did not, meet the Congressional mandate (Education Daily, April 22, 1974, p. 3). At the present time, OCD claims that ". . . children professionally diagnosed as handicapped account for at least 10.1 percent of the children enrolled in Full Year Programs" (Office of Child Development, 1974). Therefore, OCD maintained, in its most recent Annual Report to Congress, that it had met the 10 percent mandate, explicitly, that children with milder disabilities were not included within this grouping, and that Head Start policy required that no handicapped child be excluded arbitrarily from programs because of the nature or extent of the child's handicap. Finally, Head Start grantees were required to engage in deliberate efforts to recruit handicapped children, including the more severely handicapped.

From its beginnings, evaluation studies of Project Head Start often were accompanied by ambiguities, disclaimers, differing conclusions, and debate (Datta, 1969). Added to

the general complexity attached to the study of diffuse social organizations, evaluation of special populations within such complex social organizations are difficult indeed, especially when there are many vested and interested groups hoping for, or expecting, the evaluations to "prove" something or other. It is with this certain sense, with a feeling that many interested, and few disinterested, parties will review and analyze each word in this report and, especially, this concluding chapter, that we move to specific sections on conclusions, policy issues, and recommendations. We have collected enormous amounts of data, literally thousands of pages of observations and reports. Earlier chapters in this report provide the reader with a statement of the objectives of this research, our research methodology, and analysis of our findings. It is the purpose of this last chapter to even further reduce the data discussion, to focus on the few central conclusions, policy issues, and recommendations. Lastly, before this review, it should be noted that, although the conclusions were obtained directly from the data, the policy issues and recommendations were developed jointly by the project staff and a group of distinguished Consultants to this research project. This group of Senior Consultants met for three

full two-day periods during the 1973-1974 project year. They were provided with: data reports, staff analyses, and staff recommendations. They were presented with project-problems and issues as these occurred during the course of our research. They were consulted both during our physical meeting times as well as via telephone and written communication. Some Senior Consultants even participated in the observational-data gathering stages of this project. In essence, the Consultant Group, from the very beginning, was intimately and continuously involved with this research. It would not be fair to claim that the Consultants endorse, or agree with, every one of the conclusions, policy issues, and recommendations to be presented. However, it may be appropriate to suggest that, as a group, they not only participated in the process of developing the statements but appear to support them in substance, if not also in form. Appendix C includes the summarized minutes of the three Senior Consultant meetings and, secondly, the list of all participating Consultants and their professional affiliations.

General Conclusions

Identification, evaluation, integration, and program delivery. In 1972, Cahn reported to OCD on a "Preliminary Survey of Head Start Services to Handicapped Children." The study was essentially concerned with developing a better understanding of where Head Start stood in its role in helping the preschool handicapped. To accomplish this analysis, a questionnaire was sent to local Head Start programs and, secondly, procedures to evaluate other organizations, who were then serving handicapped children in integrated settings, were developed. Very interestingly, the Cahn survey revealed findings quite similar to those of the current research. Although Cahn learned that the reported enrollment of handicapped children in Head Start projected an open and receptive policy toward the handicapped, he doubted the validity of those data. Rather, he concluded, for very much the same reasons affirmed by this study group, that many of those who were labeled "handicapped" were not truly handicapped in the sense that they were not seriously or more severely impaired. Cahn noted that Head Start reported relatively few mentally retarded children served in their programs. On the other hand, he noted that more children with visual and auditory disabilities

than existed proportionately in the population were served by Head Start. From such findings, he concluded as we have concluded, that many children who are labeled "handicapped" needed only glasses, or had earaches, or were otherwise very mildly and/or temporarily handicapped. Essentially, Cahn raised the problems and questions we raised in our Interim Report of last February, which we must continue to raise in this report--that is, identification, evaluation, and labeling are connected intimately to a social-psychological milieu, legislation, funding, and various public or private pressures. Cahn raised these questions before the mandate, possibly hopeful that the mandate would mitigate the uneasiness then. Unfortunately, it may have intensified this particular problem. It is unfortunate that one of Cahn's recommendations, that "a quota should not be set on the number of handicapped children which should be enrolled in Head Start programs," was not heeded when the federal amendments were promulgated. It is unfortunate that Cahn was not heeded when he predicted that quotas would encourage unnecessary labeling of already unnecessarily stigmatized children. His is a report that deserves rescue from the "archives." Now, let us turn to our data.

One of the strong impressions gained during the

first round of field visits concerned the attitudes of program staffs toward handicapped children in Head Start. Essentially, personnel had difficulty accepting the mandate, especially as it meant they would now be required to serve the severely disabled. This difficulty was tied to a general resentfulness toward the manner in which the mandate was thrust upon them. There was neither antagonism nor anxiety concerning the integration of mildly disabled children in Head Start programs. In fact, those children have never been really thought of as handicapped and, for the most part, Head Start programs felt a continuing responsibility to accept such children as regular participants. These attitudes are reflected in the data on the current population of handicapped children, how they were identified, diagnosed, and enrolled. Essentially, procedures for recruitment and enrollment have changed little since the mandate; if severely impaired children are now included in programs, such developments occurred coincidently to any special procedures, not because of them. Consequently, as would be expected, the majority of programs analyzed served very few or no severely impaired children and, secondly, the majority served a fair number of mildly impaired children, children of a type they have always served.

Inevitably, identification and evaluation leads to prevalence estimates and, again, returns us to the discussion dealt with at length in our Interim Report and the questions raised by Cahn. OCD has claimed that the 10 percent mandate has been met. Clearly, Head Start programs have reported in national surveys that at least 10 percent of their populations are bona fide handicapped children. We don't want to repeat the rather involved discussion of the Interim Report; it's there for readers to review. However, it would be unfair to those who haven't had the opportunity to review the report not to mention again that incidence and prevalence data are extraordinarily difficult to estimate in this field. They are tied to: definitions--which change from time to time; laws--which either encourage or discourage labeling; funding patterns--which also can discourage or encourage labeling; and other factors, some of which yet remain unknown. For example, in a recent Rand Report on handicapped youth (Kakalik et al., 1973, p. 276), the enormous range of prevalences illustrates our contention that it's almost meaningless to claim success (or failure) with the 10 percent mandate unless we are in complete agreement as to the definition of each handicapping condition and, further, that we have confidence in the unbiased nature

of the prevalence reporting. Neither of these conditions have been satisfactorily met by the Office of Child Development. Summarizing prevalence rates reported by 11 different groups, the Rand Corporation found a range: in total prevalence of handicapping conditions, from 4.08 to 24.50 percent; in mental retardation, from 1.54 to 7.00 percent; in speech impairment, from 1.30 to 5.00 percent; in emotional disturbance, from .07 to 5.00 percent; and in learning disabilities, from .03 to 7.0 percent.

Contrary to the data collected in the full-year survey of all Head Start programs reported by OCD, of the 36 programs evaluated during the second round of our visits, we found only six that were serving a number of severely handicapped children approximating 10 percent of their total enrollment. On the other hand, 23 programs reportedly were serving 10 percent or more mildly or moderately handicapped children. Data from our first and second rounds of visits led us to the unequivocable conclusion that: notwithstanding the mandate, Head Start programs were not serving the more severely impaired child; notwithstanding OCD's admonition to develop appropriate identification and recruitment programs, local Head Start agencies continued to service the same type of clients they have always served.

Insofar as classroom programming, service delivery, and facilities are concerned, our second round of visits substantiated the observations of the first round: Essentially no programs have made significant modifications in their physical facilities or programs for severely handicapped children. The majority of programs offered quite adequate resources for mildly, moderately, and a few severely handicapped children. On the other hand, in only a few instances were there deliberate attempts to individualize programs and facilities for severely handicapped children. As with the "mix" of handicapped in Head Start itself, those who were admitted and remained were, more often than not, fully integrated, but usually were not provided with any special treatments or concessions. In a way, Head Start served as a confirmation of the belief that most mildly and moderately handicapped children, and even some severely handicapped children can be enrolled with minimal difficulties or special supports in integrated settings. Unfortunately, probably those that can't--i.e., those that require very special considerations--might well have difficulty avoiding exemption or eventual program exclusion.

Family involvement and community collaboration. In their Second Annual Report to the Congress OCD claimed that

41.1 percent of parents with handicapped children enrolled in Head Start were receiving special counseling (1974). Our research generally corroborated that unusually positive claim, although our data differed somewhat between round one and round two of our observations. During our first round of visits, we found that parents of handicapped children--as of typical children--expressed favorable attitudes about Head Start and, especially, concerning the handicapped effort. Many parents were involved in formal and informal programs to provide better care and developmental opportunities for their children. Parents of the handicapped, especially, were grateful for Head Start's receptivity and concern for their children; moreover, they were as involved as those of typical children, if not more so, in the day to day operations of Head Start centers. Although data obtained on the second round of visits mitigated this very optimistic picture, those programs that maintained higher enrollments of more severely handicapped children continued to be characterized by active involvements of parents in activities of their Head Start centers.

As with the involvements of families, Head Start programs were successful in utilizing the resources of community agencies. As a result of the handicapped effort,

services provided by heretofore general community agencies have increased, due at least in part to the special efforts of many Head Start programs to coordinate community efforts on behalf of the preschool handicapped. Further, these coordinated community efforts seemed to be increasing and strengthening, as witnessed by the positive changes our own staff noted in community collaborative efforts between first and second round visitations.

Staffing, training, and technical assistance. Efforts have been made, both on the regional and local level, to provide training and technical assistance to Head Start staffs. These programs were located at centers themselves and, in a few instances, on college and university campuses. However, most staffs of the programs we visited continued to request additional training and program consultation. In all too many instances, staffs have felt that the training opportunities provided them are sporadic and ineffectual, as was the consultation. This appeared to be an area of great concern and plainly felt need of line-level staff.

To summarize these general conclusions, the following statements appear warranted: Severely retarded children comprised a very small percentage of the total enrollment of Head Start centers visited, said population significantly

less than the 10 percent Congressional demand; there was great variation among programs vis-a-vis attitudes toward the handicapped--especially the severely handicapped--and program opportunities for the handicapped. By and large, most mildly and moderately handicapped children were physically and psychologically integrated in Head Start programs, with such integration usually assured upon admission; exclusion or exemption was the more serious problem than was the integration of those admitted. The mandate appeared to have positive effects in increasing a coordinated involvement and effort with families and other community agencies. Lastly, Head Start staffs continued to feel very strong general needs for both in-service training and improved and increased technical assistance and consultation.

Hypotheses

With research of this type, there is a continual process involving the design for data gathering, the data gathering activity itself, the data coding and reduction, the analyses, and dichotomous procedures leading to conclusions and new hypotheses. A substantial part of our data gathering effort utilized techniques taken from the social

sciences, essentially: a variation of participant observation methodology, interviews, observation schedules, and other field-type data gathering tools. These efforts lend themselves more to the generation of hypotheses rather than to the testing of hypotheses. This is by way of saying that we believe the hypotheses that have been developed from this research may be as important, eventually, as the conclusions we have been permitted to articulate. Data to support these hypotheses are found in Chapters III and IV and are summarized in Chapter VI. Although several of these hypotheses are related to the aforementioned concluding statements and while we think there is evidence to support the seriousness of the hypothetical claims, there is sufficient confirmation to suggest only that these statements merit continued investigation:

1. Integration was neither a major problem nor a serious policy question. Essentially, children who were admitted to Head Start were integrated. A more compelling issue concerns those children who were excluded or exempted from program admission.

2. The model Head Start setting offered sufficient resources and capabilities to adequately serve minimally, most moderately, and even some severely impaired children.

3. The model Head Start center staff believed that integration of handicapped with typical children was beneficial for all children and, in general, staffs had positive attitudes toward the handicapped and their rights to developmental opportunities.

4. The extent of integration and the diversity of children served correlated significantly with general Head Start program quality.

5. The 10 percent mandate encouraged unnecessary "labeling" and contributed to staff and family anxiety and confusion.

6. Sufficient and appropriate support systems tended to strengthen and enhance the inclusion and integration of handicapped children in Head Start, especially the severely handicapped.

7. The handicapped effort has increased Head Start involvement with community agencies.

8. The degree to which Head Start staffs were receptive to enrolling the severely handicapped increased as contact with such children increased.

9. Head Start programs did not believe they had the resources and capabilities to serve severely handicapped children.

10. With modest additional resources and efforts, Head Start programs developed sufficient capabilities to serve the severely handicapped.

Policy Issues and Recommendations

As data collection must always lead to data reduction and analyses, analyses inevitably leads to confronting policy issues and the eventual recommendations that seek resolutions to existing problems. As we noted earlier, the development of an understanding of these issues and the subsequent refinement of the following recommendations was enhanced by a fruitful collaboration with our external Senior Consultant Group. The following were of key concern: What is the mandate? What did Congress intend, what is the target population, what is the role of Head Start with respect to the mandated population? From the legislation, from the Annual Reports of OCD, it is clear that the Congressional mandate requires that local Head Start programs attend to so-called "high risk" populations and, further, that they build strategies into the total effort to give priority to this group. Therefore, it is incumbent upon those who develop, as well as those who must eventually implement, policies to strive to guarantee that the language

of their guidelines and policies does not lead to the removal of children from programs. Head Start policies must make clear the intent to include, rather than exclude or exempt, children because of the severity of their handicaps.

It is recommended that increased program monitoring be required to guarantee the continued integration of mildly impaired children in Head Start programs. However, much greater efforts than heretofore must be exerted to include the severely disabled child, the client that Congress surely had intended to benefit directly from the 1972 mandate. In the course of this research, we found that the Congressional mandate has not been met and only special efforts will reduce current roadblocks to the successful implementation of the mandate.

Definitions, labels, and epidemiology. What children are now enrolled in Head Start? Who are excluded? and why are they excluded? Is the 10 percent mandate regressive? Does it unnecessarily label children, and is the labeling process accompanied by any redeeming value to the child or his family?

Our data lead us to conclude that the 10 percent mandate may be a regressive provision that, over time,

will only cause more mildly and moderately disabled children to be labeled as handicapped but, unfortunately, will not include more severely handicapped children in Head Start programs. As quickly as practicable, new options to this requirement for Head Start programs should be pursued, that is:

(a) Removal of the 10 percent mandate with continuing emphasis on the inclusion of severely handicapped children

(b) The establishment of a "new quota" for only severely handicapped children (approximately three to five percent)

(c) The continuation of an overall quota of 10 percent handicapped children with particular emphasis on including three percent severely disabled.

Developmental needs of eligible children. What do children need? What do their parents need? What should they expect from a humane and decent society? We believe that there are four important elements of any "exemplary" program for Head Start handicapped children: integration, parent involvement, community agency involvement, and training and technical assistance. The real intent of the mandate is clear, at least to us: Head Start children,

handicapped children, all children deserve opportunities to be integrated in normalized communities. There is an enrichment offered to those who participate in the most diverse environments. "Integration" will not provide solutions to all problems, but it is necessary for a solution to the most important problems.

Similarly, parents must be involved, not only in token ways or merely in advisory capacities, but as participants in policy development and implementation. It isn't that parents are more worldly, or wise, or trustworthy than the professionals; they have different agendas, needs, and aspirations. Therefore, we must listen to them; so, too, must other community agencies. It's a non sequitur to think of integration and mainstreaming and not give deliberate attention to one's neighbors. We are the wealthiest, the technologically most advanced, the supposedly most progressive culture on earth. Isn't it possible that such grandeur can be filtered down to the local communities and their agents? Isn't it possible that the United Cerebral Palsy agency, or the Association for Retarded Children, the Mental Health Association, the Boys' Club, the YMCA, you name it, can provide support for this Head Start mission?

Lastly, one thing clearly apparent to us concerned

the loneliness, the almost-abandonment expressed by Head Start staffs. They had a need to talk, to have someone listen seriously and singlemindedly to them, to have someone be devoted to helping them. If any of this is going to work, it will require a different way for organizing and delivering training programs and consultation to line staff.

Head Start and two major contemporary movements: Universal early education and maximizing human variance in general society. What is the future for Head Start? Is it a harbinger for universal early education? Is it an enunciation of state involvement in preschool education? Is it a "stalking horse," a front runner, for what the public wants or for what some people think it needs? Should it be held accountable to the public? And, if it should, how? The Office of Child Development and its Head Start program has provided answers to these questions for those who will seek them. It's clear to any who will analyze the data--or accept the conclusions based on these data: The Head Start movement has demonstrated that young children profit mightily from inclusion in formal programs designed to facilitate their development. Legally, the severely handicapped are no less eligible. Morally, the severely handicapped are no less worthy. And the data, the research,

indicate that the severely handicapped will profit equally from participation in Head Start. The current period will be the watershed for Head Start leadership in educating the handicapped, or it can be a new era of concern and accomplishment.

Although Congress may have missed the mark on requiring a 10 percent mandate as it usually demonstrates on the important issues, it was right on target in stipulating that all eligible handicapped children deserve to be included in Head Start programs. Every effort should be made to guarantee their participation.

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