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ABSTRACT

The report presents results from a survey of four states (Iowa, Maryland, Michigan, and Nebraska) regarding mandates for the provision of special education services for children below 3 years of age. An overview of each state's mandate contains a brief description of the law and how it came to be; an explanaton of the way responsibilities are shared among the state education agency, the local education agency, and any regional education units; an examination of service delivery models and a discussion of the way very young children are identified and then referred for special education; and a look at how completely the mandate is being implemented throughout the state and what difference it has made in providing services to infants. A contact person and a mailing address are listed for each state. Mandates among the states are compared in terms of historical background, administrative roles and responsibilities, funding, referral/child find, eligibility for services, service delivery models, certification, and mandate implementation. Noted among findings are that common to all states is a coalition of parents, professionals, and/or concerned citizens in developing and passing the legislation; that there are two general approaches for funding--a combination of federal, state, and local monies (in Maryland and Michigan) and federal funds used for the majority of services (in Iowa and Nebraska); and that home based programs are the predominant means for delivering services to handicapped infants in all four states. Certification of teachers, funding and administration, and eligibility for services are handled in a variety of ways by the different states. Appended is a list of the survey questions used with the four states. (SW)

Special Education Mandated from Birth

Joan D. Anderson and
Talbot L. Black

TADScripts '81

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INTRODUCTION

For many years, research and practice have shown that the earliest period of life is the best time to help handicapped children and their families through special education. Nevertheless, very few states currently have legislation that mandates special education for their youngest citizens, i.e., children in the first thirty-six months of life. In some states, legislation allows, but does not require, special education services to be provided to children below age three years. In still others, some early intervention is being provided without legislative support at the state level.

The Technical Assistance Development System (TADS) conducted a survey of four states -- Iowa, Maryland, Michigan, and Nebraska -- that have special education mandates from birth. Their efforts under these mandates are described in this report. The evolution of the mandates in each state and the ways in which each state currently is organized to carry out its mandate are covered first. Then each state's approach to serving handicapped infants is reviewed. For example: How do states decide who is eligible for services? How do they certify teachers? How do they find the children who need help? How do they coordinate the work of various agencies that help the youngsters and their families?

The purposes of the report are to compare and contrast history and current practice among the four states and to determine some of the effects that legislative mandates have had on the provision of special education to infants and their families. Readers will gain some insight, hopefully, into what issues are important when a special education mandate from birth is developed and implemented, how and why practices differ among the states, and, perhaps, how they themselves may use this information to improve early intervention for the handicapped in their own states.

How TADS Conducted the Survey

A key person in each state education agency (SEA), usually the early-childhood-special-education consultant, was contacted by TADS and asked to participate in the survey. Each participant was sent a list of questions to review in preparation for an extended telephone interview. (See the Appendix for the list of questions.) After the interviews, TADS wrote a description of each state's history and current practice, and mailed a copy to the participant who was asked to review, revise, and approve it.

Finally, the section of the report comparing the states in specific areas was prepared. The observations and conclusions made in this section are strictly the authors' and have not been reviewed and approved by the states.

The areas selected for comparison were not determined before the survey was conducted. Rather, they evolved from the four state descriptions. They were chosen because they seemed integral to understanding state mandates or they seemed particularly interesting areas of contrast. They were selected by the authors, and by no means exhaust the comparisons that could be made among the four states.

AN OVERVIEW OF EACH STATE'S MANDATE

This section contains descriptions of each state's mandate for special education from birth. Each description is divided into four parts:

1. Mandate -- A brief description of the law and how it came to be
2. Administration -- An explanation of the way responsibilities are shared among the SEA, the local education agencies (LEAs), and any regional education units (Also includes discussion of other administrative issues such as eligibility, funding, and teacher certification)
3. Description of services -- An examination of service delivery models and a discussion of the way very young children are identified and then referred for special education (Also includes number of children currently being served below three years of age)
4. Effects of the mandate -- A look at how completely the mandate is being implemented throughout the state and what difference it has made in providing services to infants

A contact person for each state and a complete mailing address are also listed.

IOWA'S MANDATE

The Mandate

Iowa's current special education legislation, which mandates services from birth to twenty-one years, became law in 1974. Before then, services to young children were permissive. The law, which does not focus exclusively on early intervention, represents a massive reorganization in the way special education is provided in the state. It divides the state into fifteen Area Education Agencies (AEAs) and gives them the major responsibility for quality special education throughout the state. The State Department of Public Instruction drafted the concept upon which the legislation is based, and the Iowa Association for Retarded Citizens gave strong support for passage of the legislation.

Administration

As set out in the law, the major coordinative responsibilities are assumed by the fifteen Area Education Agencies. Each AEA has a preschool unit composed of supervisors, consultants, teachers, and support staff (occupational/physical therapists, speech pathologist, nurse, etc.). At the SEA level, a preschool consultant relates to the fifteen AEA preschool units.

The AEA and LEA responsibilities include finding children, determining their eligibility, developing individual education programs (IEPs), providing direct services, and monitoring progress. The IEP process for infants is the same as for older children in that a teacher or support service person functions as a case manager. The AEAs are able to provide virtually all needed educational services, and subcontracting with another agency for direct services occurs infrequently except for occasional evaluations by physicians. The AEA reports the numbers and types of children being served to the SEA.

Children are judged as eligible for services by a multidisciplinary team. Some guidelines are provided by the state and, to be eligible, each child must be categorized as educationally handicapped due to a hearing impairment, emotional disability, learning disability, visual impairment, severe/profound handicap, or communication or mental disability. A provision in the guidelines also allows the team to give a child a "deferred diagnosis," meaning that the child is having difficulty and is in need of an early intervention program but that the specific handicapping condition has not yet been determined. The child can then receive services for one year without a categorical classification. The "deferred diagnosis" category can only be used to age three.

The majority of Iowa's Part B EHA* (P.L. 94-142) monies are used to

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*Education of the Handicapped Act

support special education services for children who are younger than mandated school-age. In 1975, Iowa identified these children as its largest unserved population and, therefore, directed most Part B federal monies into early childhood services. State and local monies can also be used if a center-based program is being supported. All monies are either channeled through the AEA to local school districts or used by the AEA to support direct services. This has been the funding pattern since 1975.

There are special certification requirements for teachers serving preschool handicapped children. The certification includes the basic requirements for a preschool and kindergarten teacher plus a minimum of twenty hours of course work in special education instruction. Temporary certification is available with three years to meet the requirement for full certification.

Over the past few years, a great deal of in-service training related to infants has been given to teachers and support services staff in order to improve the quality and range of services.

Description of Services

A wide array of services is provided to handicapped infants and their families in Iowa. Most infants are served through a home instruction program where a teacher visits approximately once a week to train the parents to work with their child. Some very young children attend center-based programs. Factors that influence whether or not a child is placed in a center-based program include: the unique benefits of center-based programming for the child, the parent's needs and capabilities, the child's health needs, and transportation. A range of support services -- such as occupational, physical and speech therapy, nursing, audiological and psychological services, and social work services -- is provided, as needed, under the state regulations.

Families also have access to services. In addition to home training, parents are offered opportunities for evening group meetings and training sessions conducted by teachers and support services staff. Social work services and psychological counseling are available. An organization of "pilot parents" is very strong in Iowa. This group, which is independent from -- though closely affiliated with -- the education system, provides peer counseling and support to families. All members are parents of handicapped children.

Infants are referred to AEAs from many sources. Public health nurses and parents account for most referrals, but hospitals, physicians, and departments of social services also identify and refer children. Child Find activities are handled primarily by each AEA. Billboards, radio, television, newspapers, and brochures are typical Child Find strategies. In order to establish contact, some AEAs give kits with toys to parents as they take their newborn child home from the hospital. Some high-risk registries are maintained in Iowa, focusing mainly on the hearing impaired. Referrals of infants are handled in the same way as referrals for older preschool children. They are screened by teachers or nurses and then, if appropriate, evaluated by a multidisciplinary team. Most children served below age three are moderately to severely handicapped. Approximately 700 children below age three are receiving ongoing intervention services in Iowa.

Effects of the Mandate

Iowa's goal of full services by 1980 has been achieved. Continuous and comprehensive services to children from birth to three are available throughout the state. The result is an equal opportunity for early intervention (that is free and publicly supported) for all handicapped infants as soon as they are identified. Some initial conflicts related to the mandate have been resolved among agencies, and no major problems currently exist.

When Iowa extended its mandate down to birth in 1975, the full programmatic implications of the extension were imagined only vaguely; but after six years, the system has adapted to accommodate its youngest children. A key factor contributing to that success has been having one agency responsible for services, record keeping, and program quality in each region. The fifteen AEAs constitute a manageable system that provides services to infants and their families within their local school districts.

For more information contact:

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MARYLAND'S MANDATE

The Mandate

In the fall of 1980, the final step of a planned phase-in of services to young handicapped children was taken in Maryland. Educators in Maryland promoted the passage of the legislation which provides for comprehensive educational services to all handicapped children from birth through age twenty. Prior to 1978, services to handicapped children under five were permissive and some services were provided categorically (e.g., deaf-blind). Because of various incentives, federal, state and local dollars, and the HCEEP demonstration projects and outreach activities, all but one of the local education agencies were providing some services for children under two years of age during 1979.

Administration

The Maryland law directs the state education agency to administer educational services from birth through age twenty to children having any of the eleven handicapping conditions enumerated in Maryland Bylaw, COMAR 13.A.05.01, and in the federal legislation, P.L. 94-142. At the state level, two Early Childhood Specialists in the Division of Special Education have responsibility for assuring services for the birth-to-age-five handicapped population. Each year, the state education agency monitors eight of the twenty-four local school systems for compliance with the mandate. The Early Childhood Specialists are directly responsible to the Chief of the Program Development Branch in the Department of Special Education. Each local unit has a Director of Special Education, whose responsibility is to administer programs for the education of all handicapped children. All local school systems have identified Early Childhood Facilitators who have responsibility for the coordination of services for handicapped children from birth to age five. The local Early Childhood Facilitators' duties may include interagency coordination and Child Find activities. Some facilitators provide direct services in their respective school systems.

Services for the very youngest handicapped children are paid for with state funds, Part B discretionary dollars, and local funds which also support services to older children. Part B discretionary funds are awarded to each local school system for infant services based upon a formula which considers the local school system's child count. During FY 1982, the Maryland State Department of Education has earmarked approximately $400,000 for educational services for handicapped children between birth and age three.

A State Implementation Grant (SIG) from the U.S. Office of Special Education supports the planning of services for infants and has enabled the involvement of various agencies in these planning efforts. While other agencies -- notably the Maryland State Departments of Health and Mental Hygiene and Human Resources -- are not legally responsible for implementing the state's education mandate, they do provide services at the local level. One of the difficulties in coordinating services is that each agency has different regulations regarding programs for this target audience. Contracts for services from private agencies may be negotiated by local agencies. This is done typically for severely handicapped children with diverse educational needs. State approval may be necessary, depending on the ratio of private-to-public school costs.

Description of Services

Each school system has identified a Child Find contact who receives referrals of children who may be in need of special educational services. This contact may also be the Early Childhood Facilitator. As a result of both state and local public information efforts, health departments, pediatricians, hospitals, diagnostic centers, clinics, and private citizens are referring parents of such children to Child Find coordinators. The state efforts include a toll free hotline. In each of the five administrative regions, the public television system broadcasts a local telephone number for referrals.

All services identified in the federal legislation plus additional services specified in state law are available to handicapped children from birth through age twenty. These services include parent counseling or training. All of the infant programs in Maryland serve parents in either or both of these ways.

The service delivery model is predominately home-based, with a few programs (approximately five) employing a home and center combination. The centers utilized are public school facilities -- elementary, secondary, or special schools.

Teachers of the youngest handicapped children are certified in special education and frequently are certified in a related area of exceptionality. There is a tendency for these teachers to seek additional in-service training opportunities to meet the challenges they face. The extent of the availability of auxiliary staff -- such as physical and occupational therapists, speech and language pathologists, and psychologists -- varies with the local education agency. Some ingenious interagency arrangements have been devised that share staff members (social workers, occupational/physical therapists, nurses, etc.).

Individual educational programs (IEPs) are developed by the diagnostic team and parent as required by state and federal law. Service providers in Maryland have found that IEPs require frequent review and revision due to the unique characteristics and needs of children in this age range.

Effects of the Mandate

Approximately 623 handicapped children between birth and three are presently receiving services in the state of Maryland. Reporting procedures do not reveal the numbers of children at each age; but many of the children have been observed to be between fifteen and thirty-five months of age.

The Maryland statute provides only for the provision of services to handicapped children from birth. The terms of such services are specified in Maryland Bylaw COMAR 13A.05.01. The bylaw specifies options for service delivery, how children receive services, and who can receive services. While these specifications meet the needs of school-age children well, some aspects are difficult to apply to very young children.

The Maryland State Department of Education is examining the interpretation of the bylaw for very young handicapped children in terms of: least restrictive environment, adverse effect, educational assessment, and teacher pupil ratios. Through the SIG, it is hoped that information will be developed which clarifies the intent of Maryland's Bylaw as it relates to educational services for young handicapped children.

Several factors were instrumental in the development of Maryland's program for young handicapped children. The enactment of the mandate to serve handicapped children from birth ensured the availability of services. The phasing-in of the law (by lowering the age at which children were eligible for services) permitted school systems to prepare to serve this age group. Also, available incentives provided by state and federal education agencies prior to the effective date of the legislation, paved the way for successful implementation. With the mandate have come closer working relationships among state agencies involved in providing services to handicapped children and their families.

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MICHIGAN'S MANDATE

The Mandate

As a result of the advocacy of a cross section of Michigan citizens, known as The Citizens' Committee for Special Education, Michigan led the nation in 1971 with the first legislative mandate to provide educational services from birth to handicapped persons. While the efforts were orchestrated to a great extent by university personnel and special education administrators, the Citizens' Committee also included labor unions, charitable organizations, civic groups, teachers, and parents. This committee has continued and is currently functioning as the State Special Education Advisory Committee required by P.L. 94-142.

P.A. 198 established only the right to education; further revision and restructuring of state statutes to assure the provision of programs and services was accomplished in 1977 and 1980. The 1980 rules and regulations specified how handicapped children in the pre-primary years were to be served. While there were no prohibitions against services for pre-primary children prior to 1971, there was no permissive act as such, and education for these children was sparse.

Administration

Direct services are provided by teacher-consultants who are supervised and coordinated by the local Director of Special Education. When it is more economical or efficient, services are organized at the Intermediate District (county) level. Each of the fifty-seven Intermediate School Districts (ISDs) monitors its local school districts and reports to the state the data required at the federal and state levels. The state in turn monitors approximately one-third of the ISDs each year. Presently, there is no full time position at the state level with responsibility for pre-primary special education services. It is anticipated that such a position may be funded and filled by the end of 1981. Furthermore, the Director of the state's Office of Pre-primary and Family Education, vacant due to a hiring freeze, may soon be filled. It is hoped that these two state-level positions will be complementary.

Services are also paid for at the local level with either state or local monies or a combination of the two. Pre-primary children qualify for the State Membership Reimbursement because their programs typically cover 450 hours over a 180-day period. The amount of funds from the state varies among the districts, depending on the millage (tax) assessed by the local district. The distribution of state funds is intended to be an equalizing factor, but, in fact, the amounts spent by local districts vary widely. In addition to the State Membership Reimbursement and local millage, ISDs can also elect a millage. On the average, about $1800-2000 per child for children between birth and age five (no figures were available for birth to three exclusively) are derived from these three sources.

Description of Services

Project Find Coordinators at the intermediate and local levels are responsible for referral efforts and for screening children of all ages. Activities at the state level are directed primarily at awareness and include the maintenance of a toll-free telephone number for inquiries. Local Project Find Coordinators are responsible for personal contacts with referring agencies and parents.

Eligibility for pre-primary services is based upon the Educational Placement and Planning Committee's finding that a child meets one of the following classificatory criteria: severely mentally impaired, speech/ language impaired, learning disabled, severely multiply impaired, or pre-primary impaired. The pre-primary impaired classification has recently been enacted and will become effective at the beginning of the 1981-82 school year. Children under age five who do not meet the existing criteria for inclusion in any of the four categories listed above and who manifest impairment in one or more areas of development equal to or greater than fifty percent of what is expected for their chronological age, as determined by one or more developmental scales, qualify for services as "pre-primary impaired." The regulations further stipulate that the child's impairment should not be subject to remediation by medical or nutritional intervention.

Home-based programs are the predominate means of delivering services to children under two, while school-based programs are the norm for three- to five-year-old youngsters. Some form of parent training is required by law.

Direct service providers prior to the 1981-82 school year were required to have a bachelor's degree in teacher education plus one special education approval area. Many had speech and language or special education teaching backgrounds. In conjunction with the pre-primary impaired classification for children, the state now has established certification requirements for teachers of young handicapped children. A major in early childhood education with a thirty semester-hour early childhood specialization and a "special education pre-primary approval" will be required beginning with the 1981-82 school year. Because the number of personnel so certified will not meet the need, persons currently teaching in this capacity are expected to be retained by what is commonly called a "grandparent clause."

Effects of the Mandate

In the ten years since Michigan enacted P.A. 198, the number of handicapped children under three receiving education increased from nearly 0 to 1,443. An additional 13,412 handicapped children between three and five also are served. While the right to education has long been established, programs and personnel to make that right a reality are more recent refinements. Logistical and fiscal problems remain to be resolved. Transportation needs of pre-primary programs differ from traditional classroom programs. Costs of pre-primary programs are also an issue. It is felt in some quarters that the pre-primary impaired classification may increase the numbers of children eligible for services drastically and, in turn, increase the cost of providing services. The counter-argument is that such a designation permits more appropriate services, rather than more services, because a child is not stigmatized by an inappropriate label. Further, because the pre-primary impaired designation is applied only to children under age five, the potential for a young child to move from this to the nonhandicapped category is greater. At age five, the pre-primary impaired child must meet either the criteria for one of the other impairment categories used for placement or be found "nonhandicapped." Thus, the enactment of the pre-primary impaired classification may allow early remediation of milder impairments resulting in a decrease in the amount of special education needed later and, ultimately, a savings in dollars spent on special education.

A state-level interagency effort involving the Departments of Education, Social Services, Mental Health, and Public Health is currently underway as a result of the mandate. The focus of activity at present is to develop instruments for screening infants, who are at risk for handicapping conditions, which can be used across agencies. The state-level Interagency Advisory Committee has transcended departmental jealousies to provide a working model for county and local-level agencies.

The relationship between the services provided for handicapped children by Head Start and the LEAs is currently under discussion at the state level. The Department of Education is interested in Head Start programs, because for some children the Head Start setting may provide the least restrictive environment. Some of the issues to be resolved include: personnel (Head Start teachers serving handicapped children are not required to meet the certification requirements of the state education agency) and payment for services.

Michigan's mandate to educate handicapped persons, ages birth to twenty-five, is firm. The effects of the more recent pre-primary rules, however, are yet to be ascertained. The clouded economic forecast and political climate could result in changes in the rules by which the mandate is implemented.

<u>For more information contact</u>:

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P.O. Box 30008
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(517) 373-6325

NEBRASKA'S MANDATE

The Mandate

It was actually a surprise to many people when legislation mandating special education from birth to twenty-one passed the first time it was introduced in the Nebraska State Legislature. In April 1978, the state's special education legislation (which had been passed two years earlier and was permissive below age five) was amended to create the current mandate. The law is, in large measure, the result of parents advocating for early intervention. They packed the galleries of the state legislative chambers while the proposed mandate was being debated. The state's Association for Retarded Citizens was a vocal supporter. Two key state senators, one of whom was the chairperson of the education committee, introduced the amendment. The State Board of Education, while not supporting the amendment, did not actively oppose it. A major factor influencing the passage of the current legislation was the fact that many diverse efforts were already going on in the state. There was a need to consolidate and coordinate them, so that services could be provided more efficiently and equitably.

Nebraska began moving gradually toward mandated special education from birth in 1959, the year in which services for the visually handicapped, deaf/blind, and multihandicapped were extended to birth. The acoustically handicapped (hearing impaired) were added to this group in 1963. Finally, in 1976, permissive legislation to provide special education to all handicapped children from birth was passed. In addition, Nebraska's Department of Public Institutions was granted permission to serve the mentally retarded from birth sometime in the early 1960s, and that department established several child development centers across the state.

The April-1978 law was targeted to go into effect in July 1979. It gave the primary responsibility for providing services to the 1,200 local education agencies in Nebraska. The state education agency was directed to assist in the transitions necessitated by the new law by forming regional planning groups. These planning groups, which were made up (in part) by those currently providing services in the regions, developed plans for implementation of the mandate in their regions. (These groups continue to meet once a year to review current efforts and future plans, but have no decision-making authority.)

Administration

The law and its provisions have been in full operation since the 1979-80 school year. Local school districts are responsible for providing or contracting for direct services, monitoring the quality of those services, and reporting the numbers and types of children being served to the state education agency (SEA). There are nineteen regional educational service center agencies, but they are not controlled directly by the SEA and their role in implementation of the mandate varies from region to region. At the SEA level, one individual is designated the "early childhood person" in the special education department. Since there are no regional early childhood consultants, that person relates directly with the 1,200 local school districts. Much of that interaction involves paperwork, budget concerns, and monitoring districts for compliance with the 1978 law.

Eligibility (for services) criteria for infants in Nebraska is essentially the same as for school-age children. One part of that criteria, that children score two standard deviations below the mean on diagnostic tests, has created some difficulty in judging the eligibility of infants, since diagnostic procedures often do not provide those kinds of scores. There is no provision for providing services to at-risk children. It is implied by the two-standard-deviation criteria that the handicap must be observable for services to be provided. On the other hand, the way eligibility is determined is quite flexible in Nebraska and is left to the judgment of those at the local level.

Special education to children below school age is paid for, through the local school districts, by the state on a reimbursement basis. The state currently reimburses 100 percent of the costs associated with providing services. In addition to the basic costs of teachers and other support services staff, the state also reimburses some costs for facilities and transportation (even when the parents bring their child for services). For early childhood, the state's reimbursement is concurrent with the year in which services were provided. (There is a one-year delay on reimbursement for services to school-age children.)

Currently, almost all early childhood special education is paid for with federal dollars, i.e., Part B EHA (P.L. 94-142). When the mandate was passed, state funds were appropriated for local school districts on a

90% (state) - 10% (local) cost-sharing basis. However, Nebraska (like Iowa) found it much more efficient to shift its federal monies to early childhood and use state monies to pay for school-age services. Nebraska uses its preschool incentive grant monies (P.L. 94-142) to support in-service training of local school district personnel in early education of the handicapped. These funds also are used to support some transportation costs and diagnostic evaluations.

Teachers must be certified in both early childhood and special education. Temporary certification is possible, but full endorsement (permanent certification) must be obtained within six years. The fact that Nebraska had many infant programs established prior to the 1978 mandate created some unique certification issues. The issues were resolved by a "grandparent clause" arrangement which allowed anyone who had been teaching young handicapped children in programs prior to the mandate to continue teaching without meeting the full requirements for certification. In fact, those individuals could be reimbursed as early childhood special education teachers anywhere in the state. They also received some additional in-service training through the state. The Meyer Rehabilitation Center at the University of Nebraska has provided much of the training in early education of the handicapped for the state education agency.

The development of IEPs for infants follows the same procedures as for older children. However, IEPs for children below age three are reviewed and updated every three months. Children three to four years old have their IEPs reviewed every six months.

In larger school districts, most services are provided by the district's own personnel. In smaller districts, however, purchasing a service from another agency is a frequent practice. Subcontracting with a neighboring school district, a regional service unit, or some other outside agency for support services like occupational therapy, physical therapy, and diagnostic evaluations is typical.

Description of Services

The mandate supports a wide range of instructional and related special education services. Related services include: occupational, physical, and speech therapy; diagnostic services; specialized consultations; and transportation. The instructional programs may be entirely home-based (visits occurring once or twice a week), entirely center-based, or a combination of home- and center-based. Center-based programs usually are located in an elementary school building or in another service agency facility such as a community day care center. Some center-based programs integrate (but most segregate) handicapped and normal children. Residential placements are not made for very young children.

Occupational and physical therapy usually is provided in cooperation with Nebraska's Service for Crippled Children (SCC). A recent interagency agreement spells out how these services are provided. Basically, the SCC handles everything once the referral has been made. The local school district helps in locating therapists and in integrating their services into the IEP. The state education agency reimburses the therapist directly with federal funds.

The state education agency has a rigorous Child Find operation as a part of the state's system of services. A three-person staff in the state office has developed several media and materials packages for use throughout the state. Some are particularly targeted for identifying the youngest children. For more information on Nebraska's Child Find efforts and materials contact:

Kathy Koop
Nebraska Department of Education
Child Find Office
301 Centennial Mall South
Lincoln, Nebraska 68506

In Nebraska, referrals of very young children come primarily from physicians and parents. Few referrals come through the department of public health. The processing of referrals is the responsibility of the local school district.

Currently, Nebraska reports serving 608 children below four years of age as follows:

0-12 months	30 children
12-24 months	101 children
24-36 months	160 children
36-48 months	317 children

Effects of the Mandate

The mandate from birth has improved significantly the services to children below age three in Nebraska. Its intent for those children is being realized at this point. No major problems currently exist, but during the transition period some difficult problems were encountered and subsequently resolved. The fact that much activity in the special education area was already going on in the state made the task of coordinating and establishing new lines of responsibility difficult. Creative solutions like the "grandparent clause" helped move the transition process ahead.

The major problem solved by the mandate was the lack of a clear process for acquiring special education services that were consistent and provided an equal opportunity. The mandate also created some new problems and issues for Nebraska. It raised the question: "What is special education for very young children?" It also created difficulties in applying the state's eligibility criteria to children under three years.

The major strengths of Nebraska's mandate are: 1) it places very specific direction and responsibility on the local school districts, 2) it is comprehensive, covering any and all handicapping conditions, and 3) it provides 100 percent reimbursement to local school districts.

For more information contact:

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A COMPARISON OF THE STATES

> How did the mandates come about? How are administrative roles and responsibilities structured in the four states? How is funding arranged? Are there procedures for referral and Child Find? Who is eligible for services? How do service delivery models vary from state to state? What about teacher certification? What about implementation of the mandate?

These are the questions that guided our analysis of the information the states gave us. While there were certainly many possible points of comparison among the states, we can explore only a "tip of the iceberg" for now. Subsequent studies should explore several areas in more detail. It also would be informative to ask these same questions of states with only permissive or no legislation on special education for infants. Their answers would allow an evaluation of the differences that a mandate makes in a state's ability to provide early intervention.

How The Mandates Came About

While each state had its own unique history regarding the passage of legislation, some common elements can be observed. A coalition of parents, professionals, and/or concerned citizens, for example, were prime movers in developing the legislation and working for its passage in all the states. The Association for Retarded Citizens was influential in two states (Iowa and Nebraska). Maryland's legislation was promoted primarily by educators, while a citizens committee brought together a wide range of supporters, including labor unions, civic groups, educators, and parents, in Michigan.

In two of the states, Nebraska and Maryland, the mandates came about as a result of specific efforts to extend the right to special education down to birth. In both states the prior legislation was permissive only. In the other two states, Iowa and Michigan, the mandate was only one part of a more comprehensive revision of each state's special education legislation.

Administrative Roles and Responsibilities

Each state's public education system has the responsibility of providing special education to its youngest children. This responsibility includes: finding children, determining their eligibility for special services, developing IEPs, providing direct services, monitoring compliance with state laws, coordinating interagency activities, and paying for services.

The ways in which responsibilities are shared by local, regional, and state education agencies vary. In Nebraska, most major responsibilities belong to the LEAs who relate directly to the state education agency and determine the roles of the regional education center in each region. By contrast, Iowa places major responsibilities for special education on a network of fifteen regional centers, and the SEA relates primarily to them. Maryland is divided into three broad regions; nevertheless, LEAs are responsible for most functions. In Michigan, either an LEA or an Intermediate School District (whichever is more efficient and economical in a given circumstance) shoulders most responsibilities.

Responsibilities for monitoring compliance with the law also vary. In Michigan, ISDs monitor LEAs and the state in turn monitors the ISDs. In Maryland, LEAs in each of the three regions are monitored by the state on a rotating schedule. In Iowa, monitoring is handled by the fifteen regional centers. The SEA in Nebraska monitors each LEA directly.

Three of the SEAs have at least one state-level staff position that deals exclusively with early childhood special education (Maryland, Iowa, ~~and~~ Nebraska). Maryland actually has two early childhood specialists. Michigan did not have an early childhood position at the time of this report, but anticipated establishing one by the end of 1981. Michigan also has vacant the state-level position of "Director of the Office of Pre-primary and Family Education." State personnel hope this position will soon be filled and that the two positions will coordinate their work closely.

Funding

In comparing the four states, two general approaches emerged for funding special education below the age for compulsory school attendance. In Maryland and Michigan, the education of young handicapped children is supported through a combination of federal, state, and local monies; while in Iowa and Nebraska, the majority of services are paid for with federal (P.L. 94-142) funds.

Maryland distributes its state funds and some discretionary monies from P.L. 94-142 to local education agencies who determine what portion will be used, in combination with local funds, to support infant services in their respective districts. Maryland also has had a State Implementation Grant (SIG) from the Office of Special Education to support interagency planning for infant services.

In Michigan, the state and federal monies go to the Intermediate School District level, and it is there that decisions concerning allocations for infant education are made. ISDs have the option of taxing their districts, in addition to any local school district taxes, to support needed services.

Iowa and Nebraska have found it easiest to be fiscally efficient and accountable by supporting the bulk of their early childhood special education with P.L. 94-142 monies. In Nebraska, monies go directly to LEAs on a cost reimbursement basis. In Iowa, all monies are given to the Area Education Agencies for direct services or for disbursement to the LEAs.

Referral, Child Find

In all four states, the effort to find young handicapped children in need of services is focused primarily on awareness activities and the maintenance of toll-free telephone lines for information. Referrals for screening, diagnosis, and service are handled primarily at the service-provision level, either local or area. The agencies and individuals involved in referring children vary somewhat from state to state. In general, parents and medical personnel make the most referrals -- which suggests one reason why the more severely or obviously handicapped children tend to receive services earlier in life than the more mildly handicapped youngsters.

The tendency for a particular agency to refer handicapped children to education agencies seems to depend on the referring agency's mission within the state as well as informal or formalized interagency agreements. For example, in Iowa public health agencies are a major referral source; while in Nebraska, which has a well-developed Child Find component at the state level, few referrals come through public health.

Eligibility for Services

States tend to use the same eligibility requirements for birth to three-year-old children as for older youngsters. Categorical criteria (e.g., severely mentally impaired, learning disabled, emotionally disturbed, etc.) are employed by all four of the states. Maryland, for example, uses the eleven categories specified in P.L. 94-142.

Current instruments are often inadequate for diagnosing special needs in infants. Consequently, some states have developed strategies to avoid inappropriate labeling of infants with developmental difficulties. Michigan has established a "pre-primary impaired" classification which in essence says only that the very young child has a significant developmental delay. The classification is not an option after age five, whereupon the child is diagnosed either as having a categorical handicap or not in need of special education. In Iowa, a young child may receive special education for up to one year under a "deferred diagnosis" option. Nebraska recognizes the decision of local service providers regarding the need for services when diagnostic instruments are inadequate to determine a child's status.

Severity of handicap also helps determine the need for special education. States providing special education from birth do not recognize a <u>risk</u> for handicapping conditions as sufficient grounds for offering special education, especially when the risk is due to environmental factors. But for biological risk factors (such as chromosomal syndromes), the "pre-primary impaired" classification and the "deferred diagnosis" option are vehicles for providing intervention at the earliest possible time.

Service Delivery Models

Home-based programs are the predominate means for delivering services to handicapped infants in all four states. Serving infants at home does require administrative flexibility; some school systems may not be used to having teachers traveling all day. Travel reimbursement, insurance, and workday schedules may become issues in providing home-based services. On the other hand, some difficult issues are avoided by serving children in the home, such as transporting infants to schools, providing appropriate space and equipment, and determining teacher/child ratios for infant classrooms. Family involvement -- a part of the mandates of all four states -- is, of course, much easier to encourage when most services are provided for the infant in the home.

Most of the relatively few center-based programs are housed in public school buildings and, as one would expect, are segregated (or nonmainstreaming) programs. When center-based programs are available, placement is determined by the child's health needs, the parent's needs, and the availability of transportation.

Key persons from all four states indicated that services to parents were included in their programs. These services varied at the local level, but they tended to include training parents to teach their children, counseling, resource referral, group meetings on topics of common interest, and the encouragement of peer support.

Individualized educational programs (IEPs), according to our respondents, require more frequent revision for these very young children than is required with older children. Quarterly IEP reviews are either required by law or performed as a matter of necessity in two of the four states.

Certification

Three of the states surveyed have certification requirements for teachers of birth to three-year-old handicapped children which demand combined training in early childhood and special education. To meet the need for personnel in this area, states tend to permit grandparenting (i.e., those not certified but already teaching these youngsters are exempt from the requirements) and temporary certification which is contingent upon certain requirements being met by a specified date.

In-service training in the areas of infant development and handicapping conditions was cited as both desired by the teachers and encouraged by the states. A variety of vehicles were described for meeting the in-service training needs of the teachers: e.g., university course work, special workshops, and community college classes. The states do not seem to have the personnel to provide this training, so they tend to encourage coordination among the providers and consumers. For example, Nebraska supports in-service training with its preschool incentive grant monies.

Implementing the Mandate

The presence of infant programs in sufficient numbers in a state may be necessary before a mandate for special education from birth can be established and met. In Iowa, Maryland, and Nebraska, because of permissive special education legislation and with the help of public and private agencies, a number of handicapped infants were being served before the mandates from birth were passed. This situation seems to have been an important factor in implementing the mandates. The existing service programs helped shape both the laws and the manner in which they were implemented. They demonstrated the need and the value of early intervention, and they provided key professional and parent leadership, especially in the early years of implementation.

Michigan's story supports this hypothesis. While legislation which recognized the right to special education for persons from birth to age twenty-five was established in 1971, further action to assure its implementation at the pre-primary level did not occur until 1977 and 1980. The time between passage of the state law and its full implementation was much shorter in the other states. Unlike those states, however, Michigan had no permissive legislation before 1971, and infant services were virtually nonexistent before the 1971 mandate. Many factors could have contributed to this delay, but perhaps the presence of more service programs would have tended to force more immediate attention to the implementation issues related to serving infants.

CONCLUSION

The four states we have examined are perhaps more different than similar in their treatment of special infants. In fact, only two features we have discussed were common to all four of the states: the preponderance of home-based programs and the inclusion of some type of services for parents. Certification of teachers, funding and administration, and eligibility for services were areas handled in a variety of ways by the different states.

Many issues have been raised which require further investigation. Clearly, a comparable survey of states without mandates to provide special education from birth is needed. Since three of the states we reviewed were providing some services prior to legislation, the mandate is obviously not the sole impetus for birth-to-three programs in those states. In states without mandates, are services being provided by the education agency? Are services comparable to special education being provided uniformly by other agencies?

Many advocates of intervention from birth stress the importance of interagency coordination in providing the comprehensive services needed for infants and their families. Does a mandate to the SEA tend to enhance or inhibit the effective establishment of interagency service agreements? Are interagency agreements established more readily when the provision of such services is elective?

As funding continues to be threatened in these austere times, a mandate alone does not solve the problem of costs. The commitment to provide services must also include the commitment to pay for them. To discover how states resolve the problems of funding infant programs without a mandate would be enlightening for all.

Additional issues and questions raised by the survey were suggested by the states themselves, and they deserve more in-depth study:

1. Eligibility requirements, i.e., how to determine which children receive services, are at issue. Does "deferred diagnosis" or "pre-primary impaired" encourage "false positive" admissions and strain budgets?

2. When P.L. 94-142 monies are involved in the services for the birth-to-three population on a discretionary basis, should these children not be included in the state's child count?

3. Despite the fact that the mandate specifies education from birth, the states reported most of the children served were twenty-four to thirty-six months old. What are the factors prohibiting referral earlier in the child's life?

APPENDIX
Survey Questions Used with the Four States

IMPLEMENTATION

1. What is the range of services provided to children below age three under the early-childhood-special-education mandate? Do these services include family support as well as direct services to children?

2. What models of service delivery are used for children below age three?

3. How are services paid for? Who pays at the local level? What service fees does the state reimburse and in what amounts?

4. What monies are used to pay for mandated services to children below age three? Identify federal, state (both education and noneducation), and local monies.

5. What types of professional staff typically provide direct services to the children below age three? What kind of background or training do they have?

6. How are children below age three identified? How are referrals handled at the local and regional level? Is there a state child find effort for children below three? Explain.

7. How are children below age three determined to be <u>eligible</u> for services? Are children classified? If so, how? Do eligibility criteria include "at-risk" children? If so, how are the children judged to be at risk?

8. Are IEPs developed for children below age three? If so, how and by whom? Is the IEP process different for children below age three?

9. How are services coordinated at the local or regional level? What is the primary coordinating agency?

10. Does the implementation of the mandate for children below age three involve a lot of contracting for services from other agencies and/or service providers? If so, how is the contracting process handled and by whom? Who pays for the contracted services? What types of services are provided typically through contracting and with what agencies and service providers?

11. How is your department of special education organized to deal with serving children below age three? (Is one staff person primarily responsible? Are there regional consultants who are responsible?)

12. What other state agencies are involved in planning and implementing the early-childhood-special-education mandate for children below age three?

13. Who monitors and reports to the state the numbers and types of children below age three being served?

14. How many children below age three are being served as of your latest child count? Number of children below twelve months? Number of children from twelve to twenty-four months? Number of children from twenty-four to thirty-six months?

15. At what stage is your state in implementing the early-childhood-special-education mandates for children below age three; planning stage, initial implementation stage, or fully operational? Explain.

HISTORY

16. When did your current legislation, concerning early childhood special education, become state law?

17. What were the most important factors (arguments, rationale, advocacy initiatives) that led to the development and passage of the current legislation?

18. Who were the key individuals and organizations in developing the legislation and working for its passage?

19. Were there any particularly critical events that occurred during the development and passage of the legislation? If yes, identify each event and explain why it was critical.

20. When did the legislation actually go into effect? If there was a planned "phasing in" of programs and services, how was it organized and scheduled?

21. What was the request for appropriations that accompanied the legislation? How much was actually appropriated?

22. What was your state's legislative mandate prior to the current law, and when was it established? Did it require early-childhood-special-education services for children with specific handicaps below age three?

23. Did any other laws that either required or allowed services to handicapped children below age three exist prior to the passage of the current legislation? If so, briefly explain the law(s).

OTHER ISSUES

24. What are some particularly strong or useful aspects of your state's mandate?

37

25. Are there some problems in your state's current early-childhood-special-education mandate? If so, explain.

26. What problems has the mandate solved? Not solved? Created?

27. How has the mandate affected the SEAs working relationships with other state agencies (e.g., health, developmental disabilities, etc.)?

28. Is your current mandate in jeopardy? If so, explain.

29. Do you think that the intent of the mandate in your state is being realized for children below age three (insofar as it can be at this point)?

30. Do you think that providing services to children below age three has improved significantly because of the early-childhood-special-education mandate?