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ABSTRACT

The paper explores policy options for beginning, expanding, or establishing services for disabled and at-risk infants and toddlers in a state. An initial section outlines characteristic advantages and drawbacks of options in three areas: legislative action (mandatory, phase-in, and non-mandatory legislation), executive action, and interagency agreements. Considerations in policy planning are examined, including the population to be served, agency responsibilities, personnel, and procedural safeguards and accountability. Questions are posed regarding the planning process as well as the content of policy and/or legislation, with suggestions offered to avoid common pitfalls. Appended materials include a reference list, a profile of states' mandated age of eligibility for preschool elementary school special education services, a matrix summarizing state legislation, a chart of state agencies responsible for educational services to handicapped preschool children, a chart summarizing the current status of all states on major special education dimensions (including state consultant names and phone numbers), and a synopsis of states by federal program networks. (CL)

# THERE OUGHT TO BE A LAW?

*Ensuring state-wide services for disabled and at-risk infants and toddlers*

1985

**NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS**

An exploration of issues based on a meeting sponsored by Project Zero to Three A Special Project of Regional and National Significance supported by the Division of Maternal and Child Health, Grant NO. MCJ 113271-01-1, published by the National Center for Clinical Infant Programs.

# FOREWORD

"We've *had* the demonstration projects. Now how can we take what we've learned and get services to all disabled and at-risk children in our state who need them—starting from birth?"

"Our state's system of perinatal care is saving newborns who never would have survived a few years ago. But how can we make sure these babies get key follow-up care? How can the school system keep track of them and plan to meet their needs when they start school years from now?"

"How can we convince state legislators that early intervention is effective? What do we say when they ask what 'early intervention' means? What do *we* mean by 'effective'?"

Practitioners, parents and policymakers across the country who are concerned with the needs of disabled and at-risk infants, toddlers and their families are struggling with a set of questions like these, questions related to the broader issue of how we can establish permanent programs for this vulnerable population. There is growing commitment to serve handicapped children from birth to three. But this commitment must be reflected in support for services that remain in place year after year, services that families can count on. Such an ongoing system must reflect accurately the need for services, ensure that agencies live up to delegated responsibilities, and include a mechanism for evaluating both the integrity of service programs and the quality of services offered in the light of new research in the field.

Because administrators at the state level are frequently in the lead in examining these issues, the Division of Maternal and Child Health began in 1983 to fund the National Center for Clinical Infant Program's Project Zero to Three, an initiative which brought together ten states (Maine, New Jersey, Maryland, North Carolina, Ohio, Iowa, Texas, Utah, Washington and Hawaii) well along in the process of building comprehensive service systems for disabled and at-risk children in the first three years of life. As representatives from these states voiced their concerns, plans were made to hold three meetings during the summer of 1984 to discuss:

1) Legislative mandates for serving disabled and at risk children from birth to three—What are the advantages, barriers, pitfalls and alternatives?
2) Systems for identifying and tracking high-risk (high priority) infants—What kinds of systems are most useful? How can improvements be made?
3) Program evaluation—What are the purposes of assessing the effectiveness of programs? How are these goals best accomplished?

"There Ought To Be A Law?" is a synthesis of the discussion which took place in Washington, D.C. on June 6-7, 1984 and included resource people Barbara J. Smith, coordinator of the Early Childhood Coordination Project for the Easter Seal Society of Alaska; Pascal L Trohanis, Director of the Technical Assistance Development System (TADS) Project of the Frank Porter Graham Center; Nina Carran, Director of the National Consortium of State Education Agency Early Childhood/Special Education Coordinators; Phyllis Magrab, Director of the National Network Project and the Georgetown University Child Development Center; representatives from the states of Maryland, New Jersey, Ohio and Washington and staff from the division of Maternal and Child Health, the Administration on Developmental Disabilities and the National Center for Clinical Infant Programs. NCCIP is currently preparing publications based on the two later meetings.

Thanks for ongoing, invaluable encouragement and support for this publication, as well as for every aspect of Project Zero to Three, go to Vince Hutchins, Merle MacPherson and Camilli Cook of the Division of Maternal and Child Health, Bureau of Health Care Delivery and Assistance. Project Zero to Three committees in all ten states were not only responsible for framing the question but also provided perceptive comments and suggestions as "There Ought To Be A Law?" was prepared.

# SUMMARY

A number of policy options exist which may further the goal of beginning, expanding or establishing services for disabled and at-risk infants and toddlers in a state. These options, each of which has characteristic advantages and drawbacks, include:

- Legislative action, including mandatory, non-mandatory, and phase-in legislation
- Executive action, including executive orders and regulations
- Interagency agreements

Whatever options are chosen by policy planners, certain factors should be considered in developing any established system of services to very young disabled and at-risk children and their families. Among those are:

- The population to be served
- Delineation of services
- Agency responsibilities
- Fiscal resources
- Personnel and
- Procedural safeguards and accountability

The experience of states which have begun to implement legislation mandating services for disabled and at-risk children under three and of states working with other mechanisms suggests pitfalls to avoid in both the planning process and in the content of legislation. Those in the planning process should be wary of:

- Insufficient information for decision making
- Excluding important groups from the process and
- Failure to monitor the progress and implementation of policy

Those drafting legislation or other agreements should be sure to avoid overspecificity of language and to address the need for:

- Technical assistance to intervention programs
- Specific mechanisms for interagency collaboration at the state and local level
- Access to services
- Appropriate program evaluation requirements
- Appropriate compliance provisions and
- Incentives to delineate and strive toward "best practices" rather than accept minimum quality standards

# CHOOSING POLICY OPTIONS

The task of beginning, expanding or establishing services for disabled and at-risk infants and toddlers in a state requires evaluations and choices every bit as difficult as the clinical decisions required to work with extremely vulnerable children. A number of policy options exists, each with characteristic advantages and drawbacks. These include legislative action, executive action and interagency agreements.

## LEGISLATIVE ACTION

### Mandatory Legislation

A law requiring that services be provided to a certain population represents a powerful formulation of a state's commitment to services on an ongoing basis and, perhaps most meaningful, establishes the *right* of the target population to service.

- Mandatory legislation gives to a population which might otherwise be underserved priority and recognition which will last over time.
- Mandatory state legislation also tends to increase equity over geographic boundaries and disability groups.
- Provisions of the law itself or accompanying regulations typically institutionalize standards of care, credentials of service providers and training programs for personnel.
- Well-drafted mandatory legislation will hold some body accountable for implementation of its provisions, whether this be a lead agency, a consortium, or a specially constituted interagency organization.

The promise of mandatory legislation may prove illusory, if

- Agency responsibility is confused with the right of an individual to service, particularly when funding levels are inadequate. Legislation may require that a certain agency be the one to provide services for a particular population, yet appropriate funds adequate to meet the needs of only a small percentage of this group.
- Prescribed *minimum* standards for service become the norm or even the maximum available in the state. "Best practice" documents should be available to encourage programs to go beyond the requirements of the law.
- Eligibility requirements exclude large numbers of children and families in need of care but outside the boundaries of a specifically targeted group or reflect outdated diagnostic formulations.
- Personnel and technical assistance resources are less than satisfactory.
- Legislated assignment of responsibility fails to encourage needed interagency cooperation or upsets a previously existing useful balance.
- Compliance mechanisms are insufficient or inappropriate.

All these drawbacks may be modified or remedied. Amendments can be made to existing law and "fiscal notes" which authorize or appropriate funds can be attached to legislation. But if possible, drawbacks are best avoided, for once mandatory legislation is in place, even supporters who recognize the need for improvements may be reluctant to bring a law under scrutiny, lest opponents seize the opportunity to call even the basic features of the legislation into question.

### Phase-In Legislation

Expanding services to disabled and at-risk children from birth to three in an orderly but gradual fashion may be a wise approach for many states. Legislation may be drafted which is mandatory for a portion of the target population or which is permissive at first but provides a set time or other criteria (age, degree or type of handicap, numbers of children) for making services mandatory.

- Phase-in legislation can take into account resources already in place. For example, if good programs exist for pre-school children and personnel trained to work with toddlers are available in a given state, lowering eligibility for services to age two may make sense as a first step.
- The drafting of phase-in legislation encourages policy-makers to plan an orderly process and to think

carefully about priorities of need and the resources likely to be available to meet them.

- Phase-in legislation provides an opportunity to compare outcomes for groups served earlier and those served later.

Disadvantages to phase-in legislation also exist.

- If implementation of the legislation is made contingent upon some unlikely event—a surplus in the state budget, for example—lip service may be the only service provided to children.
- Decisions about which groups to serve first will be ethically and politically difficult for legislators and advocates.

### Non-Mandatory Legislation

Non-mandatory legislation may be thought of as an end in itself or as a step toward a mandate. If a state's resources, or the legislature's willingness to use them on behalf of handicapped children, are so limited that serving all eligible children in a meaningful way is seen as impossible, non-mandatory legislation may still be a useful vehicle for improving the *system*. Non-mandatory legislation may encourage such activities as:

- allowing (rather than requiring) public agencies to serve disabled and at-risk infants with public funds
- establishing a grants program which allows agencies to apply for funds to serve disabled and at-risk infants and which may thereby provide incentives for local participation
- employing available funds to train personnel and develop resources within the state or
- setting up a task force to assess need or formulate a statewide plan for service.

While a state with a combination of non-mandatory legislation, a committed executive branch, and reasonably adequate resources may offer its disabled and at-risk infants and toddlers services which are comparable to those provided by states with mandatory legislation, non-mandatory legislation has drawbacks also.

- Non-mandatory legislation tends to offer less accountability than a mandate, and, by definition, does not *assure* services to children and families.
- Non-mandatory legislation may maintain or even exacerbate inequity: well-off or well-organized communities may be much better able than needier areas to develop proposals, raise matching resources, or otherwise take advantage of opportunities which require local initiative.
- Non-mandatory legislation may also postpone mandatory legislation.

## EXECUTIVE ACTION

### Executive orders

An executive order issued by a concerned governor can both focus attention on the needs of disabled and at-risk infants in a state and provide a prelude to more extensive and/or integrated service delivery. More flexible than legislation, an executive order can introduce a variety of initiatives, such as:

- collection of data
- interagency teams at the local level
- inclusion of private service providers in community planning
- case management systems

While it may be an extremely effective temporary measure, an executive order is unlikely to remain a satisfactory long term mechanism for organizing services and resources.

- An overly close identification with a particular administration may make services to young disabled children a partisan political issue
- No formal enforcement mechanisms would be available
- Inclusion in the governor's administrative budget is likely to limit the growth of activities—governors are understandably reluctant to ask a legislature for large discretionary sums no matter how worthy the cause.

### Regulations

Regulations clarify legislative language to help administrators meet the intent of the law; it is often in regulations that the practical implications as well as the subtle nuances of the legislation are contained. With legislation concerning services to disabled and at-risk infants and toddlers, regulations might address such crucial issues as:

- quality standards for programs which can be funded
- models to be followed by service programs or criteria which will guide requests for proposals
- issues of assessment and diagnosis
- the specific mechanisms for achieving interagency collaboration
- agency responsibilities, new councils or committees, membership on such bodies, etc.

In the absence of legislation focusing specifically on the 0-3 population, executives in some states may be able, under existing education or health legislation, to use discretionary funds to request and fund proposals for needs assessment, studies of personnel preparation and similar activities. Regulations in this instance would govern *how* funds were spent, even though they could not authorize funding.

Regulations can be redefined, changed or abolished more easily than legislation. That this is so provides an opportunity for planners and advocates to encourage desired modification but also imposes a need for constant monitoring to be sure that legislative gains are reflected in the rules which determine to such a large degree how programs really work.

## INTERAGENCY AGREEMENTS

State agencies with some current responsibility for serving young disabled and at-risk children and their families may, of course, agree among themselves to increase collaboration and integration of services, a process which may effectively expand services to children.

- State-level interagency groups may be particularly useful as a model for local case management: infants and families are likely to be well served by a system which can be individualized enough to allow different agencies to take lead responsibility for a child as the most pressing needs shift, for example, from medical treatment to habilitation to education.
- Interagency agreements may also be helpful in clarifying, within the framework of existing state laws and regulations, what services are to be provided to whom and through what mechanism. The very exercise of examining agencies' authority and responsibility may uncover areas where legislation could be helpful.
- In states which still lack widespread public commitment to serving disabled and at-risk children from birth to three, the relatively low visibility of an interagency agreement may be an asset. Once agencies have established a record of effective collaboration and efficient use of available resources, they may together be better able to weather the controversy which may accompany legislative initiatives.

It should be noted that interagency agreements can be a supplement as well as an alternative to legislation. Crucial issues, such as the provision of services to children in transition from hospital to home or from early intervention program to pre-school may be highlighted in legislation but addressed substantively through an interagency agreement.

The limitations to interagency agreements are several.

- Funding for interagency activities is likely to be scarce and unreliable.
- When one or more participating agencies are "more equal" than others, approaches to serving disabled children and their families which would alter traditional areas of responsibility may receive less attention than they deserve.
- The reservoir of trust and history of successful personal collaboration which often make interagency groups singularly effective may not last beyond the tenure of the particular participants originally involved.

### What Are States Doing Now?

Confronted with the possibility of options ranging from legislative mandates to informal agreements, policy planners may well ask what the experience of other statse which have chosen various options has been. Unfortunately, attempts to catalog, much less evaluate, the mechanisms under which states and territories provide services to disabled and at-risk children from birth to three defy easy analysis.

A recent survey of 48 of the United States' 57 states and other political jurisdictions (Trohanis, 1984) found wide variation in the handicapping conditions addressed, much diversity in the definition of such basic terms as "intervention," and equally wide-ranging approaches to statewide planning, service delivery systems, standards of care, and quality control. Most summaries of current state laws dealing with handicapped and at-risk children from birth to three years of age tend to emphasize activities under the aegis of state education agencies. Comparable state by state comparisons of mandates for early intervention by health care and social service agencies do not appear to exist, although the Intergovernmental Health Policy Project prepares annual summaries of state laws on a variety of issues, including handicapped home health and maternal and infant care. That project also has prepared a state by state analysis on laws to reduce infant mortality. A combination survey including services for healthy and high risk children in the first three years of life (as provided through a *variety* of governmental agencies) would be useful to planners seeking to design comprehensive approaches to disabled and at-risk infants, toddlers and their families.

Summaries of existing state mandates and service plans, prepared by the Technical Assistance Development System (TADS), the Consortium of the State Education Agencies, and the National Associations of State Directors of Special Education (NASDSE) are included here as appendices.

It should also be noted that change seems to be the one constant element in the array of state approaches to systematizing services to this population. States with legislative mandates are likely to be modifying regulations or implementation procedures in response to new needs assessment and evaluation data or to take advantage of opportunities afforded by new federal legislation. States with non-mandatory laws may be moving toward phase-in or mandatory legislation. Mandatory legislation may have been repealed or interagency agreements dissolved. In sum, readers of this document should verify the current status of policy before making decisions or planning strategy.

# A WORD ABOUT POLICY PLANNING

The opportunity for representatives from states with legislative mandates and from states which are considering legislation and other policy options to talk with each other, at length and in detail, was an important feature of the June Project Zero to Three meeting. Dialogue revealed that each state faces a unique political, economic, and demographic set of circumstances: an "Individualized Legislative Plan" for a state may be as crucial as an Individualized Educational Plan for a disabled child.

Although there seems to exist no fool-proof formula for early intervention legislation, some consensus does seem to prevail concerning the crucial ingredients of a comprehensive state policy designed to meet the needs of disabled children in the first three years of life. The critical ingredient for success, according to meeting participants, is high-quality planning.

Planning to begin, expand or secure services for disabled and at-risk children from birth to three years of age can take place around a kitchen table, in televised hearings of a specially appointed gubernatorial commission, or in a range of settings in between. The planning process can *itself* be planned, with carefully timed and orchestrated surveys of best practices, needs assessments, consensus building and involvement of many constituencies at appropriate stages; at the other extreme, planning may take place, if necessary, in the few short weeks of a legislative session. Speaking from their own substantial experience in developing and administering state legislation for handicapped infants, participants in the June, 1984 meeting agreed that the quality of planning and the effectiveness of ensuing legislation are intimately related. They also recognized that, like expectant parents, policymakers can never be completely prepared some reserves of flexibility—a character trait fortunately common among those who work with children and families—will inevitably be needed to adapt to the realities of the political process and the challenge of administrative pioneering.

The policy features which should be considered by any group planning public policy concerning statewide services for disabled infants, toddlers and their families have been discussed in several publications by Barbara J. Smith (1980, 1982, 1983) on which the following discussion in partly based.

### The Population to be Served

In order to assure their identification and access to services, legislation or other policy statements must clearly define the target population, addressing both age and condition. If the population is defined too broadly and resources are limited, legislation may seem to be only empty promises. Too narrow a definition may result in an inflexible policy which excludes many children needing services. Of course, the more broadly this population is defined, the more costly the program will seem, although early intervention services provided to larger numbers of children may effect substantial savings of public funds in the long run. As was mentioned earlier, the definitions used by states which currently have legislation vary widely. Categorical definitions, such as mental retardation or cerebral palsy, may be used, or a non-categorical definition such as developmental delay or deferred diagnosis, which, however, is still a "label." Determining eligibility for services through a process which moves from assessment to referral to services planning may be the most appropriate way of serving very young children and their families.

Perhaps the largest issue in population definition is that of "risk." Clinical experience suggests that, particularly when very young children are involved, preventive work can reduce the need for more costly, and often less effective, remedial efforts. But are children to be served if they are "at-risk" for physical disability only? For developmental delay? What shall be the criteria for defining the level of risk necessary for eligibility? And, most perplexing of all, how can one provide help to the infant whose greatest "risk factor" is his own environmental situation?

It is also important to decide who other than the disabled and at-risk infants as eligible for services services. Although the well-being of all family members is intimately connected to the welfare of the "target child," states seldom consider parents or siblings of disabled and at-risk infants are eligible for services directly responsive to their own needs.

Keeping in mind the continuum of services already available for children and families in a state is crucial when defining a target population for new services. Advocates in one state, for example, helped pass legislation providing services for handicapped children from birth to three without realizing that state pre-school programs served children only from age four on. Defining the population as disabled children "from birth up to the age of pre-school eligibility" would have avoided the gap in service that resulted from the poorly drafted provision.

### Delineation of Services

The services to be provided under legislation or other policy will be partly determined by the definition of the population to be served and partly by the resources available. That disabled and at-risk infants and toddlers need *comprehensive* services, delivered through a coherent system, needs to be clearly spelled out. Family involvement in services and decision making is another basic principle, as is a commitment to interagency collaboration among providers of medical, allied health, mental health, education and social services.

Standards for services which deal with such specifics as staffing patterns and hours of service may be better addressed through regulation or interagency agreements than in legislation. Legislation can describe areas of service and require that services be delivered by qualified professionals while leaving the definition of professional qualifications issues up to the agencies concerned.

Participants in the meeting emphasized that access to service can be as crucial as the availability of services themselves. Planners need to consider how children and families will first get involved with the service system; what information and referral systems are in place; to what extent transportation needs to be provided; what case management services will be available to children and families with multiple, changing needs; and how "follow along" services can help at crucial periods of transition—from hospital to home, or from infant program to pre-school.

### Agency Responsibilities

While it is crucial to delegate ultimate responsibility for ensuring that programs and services are available to some specific agency or organization, planners need to proceed with care when assigning agency responsibility. Any given state should take into account its own historical circumstances and the particular capacities of its own institutions in picking a "lead"; it should build on what already exists.

Given the desirability of a comprehensive approach, including a wide variety of services for children from birth to three and their families, no one agency is likely to be able to do everything. While following the model of P.L. 94-142 and giving sole responsibility to the state education agency may increase the acceptability of services to some parents, this route may be inappropriate for addressing the multiple needs of infants and toddlers. Health, mental health, mental retardation and social service agencies have resources and experience which should be mobilized as well.

A state's constitution and existing legislation should be reviewed as well. In one state, services provided through the educational system must be free of charge while there is a charge for medical serivces. The implications of such constraints on proposed legislation and on third party payors, including private insurors, as well, must be carefully analyzed by planners. Otherwise major problems may emerge over the long run despite the best intentions of the initial framers and supporters of legislation. Another funding issue which will have to be addressed involves the major changes now occurring in the funding of "generic" health care, which could have a significant impact on children with disabilities.

A number of approaches to the allocation of agency responsibility is possible. What is crucial is that every agency's *specific* responsibility be clearly delineated in the policy. Approaches include:

- Sole state agency responsibility, designating one existing agency as responsible for all services or creating a new agency or organization, such as an Administration on Children.
- Creating an interagency or interdepartmental cluster for service provision and case management. Legislation in one participating state had mandated interagency cooperation between or among specified agencies serving the young disabled population, with good results. Lead agency responsibility may be assigned according to the needs of the child, taking into account historic service delivery systems. One agency may be assigned a "broker" role, assembling the resources of several agencies.
- Shared agency responsibility, depending on the age of the child. For example, health and/or social service departments might have responsibility for children from birth to three, with the state education agency assuming responsibility from age three on.

### Fiscal Resources

Without adequate funding, the most enlightened or comprehensive *sounding* legislation may prove to be a cruel illusion. Participants in the June meeting stressed the importance of assessing a state's resources as well as the needs of the state's disabled and at-risk young children as policy options are being considered. With most existing early childhood programs already receiving funds from federal, state and local governments; private sources; and users fees, planners need to consider even broader bases for sharing fiscal responsibility. These might include earmarked sources of revenue such as the state Children's Trust Funds currently allocated to child protection services, or "luxury" taxes on cigarettes, liquor, etc. or coverage of preventive and other health services by private insurors.

**Personnel**

The effectiveness of any human services program ultimately depends on what goes on between service provider and program participant. This is no less true in the field of early intervention with disabled and at-risk infants, toddlers and their families The emergence of new patterns of disability, rapid improvements in clinical approaches to very young children and their families, and the multidisciplinary nature of the field make it difficult to assess current, much less future, personnel needs.

When planning for services to very young children, policymakers need to give careful thought to the age group experience as well as the professional expertise of service providers. Infants and toddlers are different from older children, and those working with them need both formal training and personal qualifications appropriate to the age group concerned.

The mix of professionals and paraprofessionals to be used in service programs, the state certification requirements for various disciplines, recruitment of personnel, and the availability within a state of appropriate training for people planning to work with infants and toddlers are important and not easily resolved issues. Meeting participants suggested that, in fact, public battles over personnel questions could threaten proposed legislation's chances for passage. They recommended that universities and other training facilities be brought into any planning process as early as possible and that policymakers try to create a process which tries to take into account such facts of life as acute shortages of trained personnel but which encourages progress toward programs staffed by competent people. Professional certification based on demonstrated competence may be appropriate. In-service as well as pre-service training should also be planned for.

**Procedural Safeguards and Accountability***

Assuring the rights of disabled and at-risk young children and their families to a continuum of services and quality providers is, of course, a major reason for advocating early intervention legislation as opposed to other policy options. Legislation should include provisions for review of decisions by service providers, case managers and others. Parent participation in every phase of screening, assessment, diagnosis and intervention should also be insured.

An early intervention program, whether community-based or statewide, should be accountable to the children and families it serves, to its own staff, and to the larger public which endorses its operation and provides material support. Too often service programs for disabled and at-risk children have failed in this regard; they may be unclear or unrealistic in setting or articulating their program objectives or may use "outcome measures" which happen to be handy (like IQ scores) but which bear little relevance to the work (such as intensive intervention with the family as well as with the disabled or at-risk child) actually undertaken by the program in question.

Meeting participants stressed the importance of informing legislators or other funding sources in a straightforward, realistic manner about anticipated benefits from proposed legislation. A dramatic advocacy effort involving state capital corridors full of parents and disabled infants can be effective in promoting the passage of legislation—but if legislators vote for a bill in the misguided belief that "early intervention" will lead to the speedy "cure" of all disabled and at-risk infants in the state, their support may turn to opposition when miracles fail to occur. Stating goals in terms of reduced need for special education and related services in the school years for some children; increased, if still limited, independence for others; and increased ability of families to meet the needs of the disabled or at-risk child and other family members may not only educate funder but also provide a framework for useful program evaluation.

Bearing in mind the adequacy of funding and training to the task mandated by legislation is also important. To expect, for example, that a service program, designed for multiply disabled infants, many of whom are living in multi-risk families, and funded at 50% of the level recommended by program planners, would benefit 50% of the enrolled children is simplistic. Just as likely would be an outcome in which an inaccessible or inappropriate service program, understaffed by poorly trained personnel, failed to provide meaningful help to anyone.

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*The issue of evaluation of programs serving disabled and at-risk infants, toddlers and their families is such an urgent and complex one that a Project Zero to Three meeting was held on this subject alone Program evaluation will be the focus of a pamphlet similar to this one.

# AVOIDING PITFALLS

The state representatives and consultants who participated in the June meeting drew on their experience to list common pitfalls awaiting unwary planners of services for disabled and at-risk young children. By asking some hard questions during the process, planners can avoid considerable grief in their efforts to establish and implement policy. These questions relate both to the planning of policy, and the content of legislation itself.

## The Planning Process

*1. Do we have the information we need?*

Although having complete information about the needs of disabled and at-risk infants, toddlers and their families in the state in question would be ideal, that is not always possible. Better tracking and data collection may, indeed, be an expected outcome of legislation rather than a prerequisite to its enactment. What does seem crucial is making sure that information about needs is accompanied by data about existing resources and services and about potential sources of funding for new programs. While legislators often respond more readily to constituent pressure than to research findings, it is more effective, in the words of one participant, "to sit on the Capitol steps *with* good data than without it."

Good information about attitudes prevailing in the state is also important. Are services delivered under the aegis of the educational system likely to be more easily accepted by parents? by policymakers? Or is there a sense in the state that education is for children over five in classrooms? Is it necessary to address the attitude that the needs of very young children should be the responsibility of families alone, without support from public agencies, before planning can proceed further?

Careful reading of a state's constitution, relevant legislation and judicial opinions can also yield crucial information. As mentioned earlier, it was reported that one state's constituton mandated that all educational services be provided free of charge; this provision was interpreted to mean that the education department which had been given the lead in interagency collaboration, could not accept payment for services from third party payors. In another state, statutes requiring fees for medical services provided by county health departments but prohibiting fees for education services complicate service provision to infants and their families.

*2. Have we included everyone who should be in the planning process? At the appropriate stage?*

Private sector health care providers should be involved early in planning policy initiatives or legislation. Creating and/or maintaining good referral and follow-up networks which include both private providers and publicly funded programs will be important for optimal service to young children and families. While many professional organizations collaborate actively at the national level to improve services to disabled and at-risk infants and toddlers, their state and regional chapters are frequently not approached by planners and advocates. Similarly, because legislation which mandates services but fails to address the issue of training program personnel will fall short of its goals, educators of professionals working with the birth to three population should be included.

The timing of involvement of legislators and their staffs in planning is also important. It may be wise to achieve consensus among advocates on needs and priorities before bringing the legislature into the process. In at least one state, an over-zealous legislator rushed to introduce a bill which would have been considerably strengthened by further discussion and revision before it was brought up for scrutiny by a legislative committee. In another state, a pending lawsuit concerning the rights of a disabled infant to services helped provide an impetus for legislative action.

*3. Are we prepared for disagreements?*

Members of a planning group should feel free to disagree with each other within the group but able to put disagreements aside once consensus is reached. If certain members find that they cannot support the final consensus, they should be willing to refrain from active opposition.

*4. Will the planning group monitor and follow up on legislation and other agreements?*

The enactment of a bill into law can involve complex and far-reaching negotiations which often take place quickly, with little notice, and at peculiar hours. Planners need to be alert in order to assure that the bill actually passed resembles the products of their deliberations.

The actual implementation of a law through regulations or the working of an interagency agreement are also ongoing processes, which require monitoring (including recognition of individuals and groups responsible for achievement) if they are to be effective.

## The content of policy and/or legislation

*1. Is the language of legislation too specific?*

While planners may attempt to provide for every contingency in legislative language, such an effort may be handled more easily in regulations than in a statute.

- Questions of which professionals provide which services and credentialing of professionals are apt to engineer discussion not suitable for the eyes and ears of a legislature. After legislation is safely passed, negotiation can proceed in a less public arena.
- Diagnostic categorization included in a statute is likely to restrict eligibility. Regulations, however, may make constructive use of differential diagnosis in the development of individual service plans.
- An enumerated list of services required by statute may be intended by planners to represent the minimum acceptable response to the needs of the target population. In practice, however, such a list is likely to be interpreted as the *maximum* deserving public support. Any policy statement, including legislation, should contain guidelines or other language which provides opportunities to expand services—for example, to meet the needs of new categories of disabled infants—and move toward best practices without requiring a reauthorization of the entire statute.

*2. Does the policy provide sufficient resources, including technical assistance, to accomplish its goals?*

Particularly when new service programs will be needed to meet the requirements of statewide legislation, technical assistance may be essential to assure the most effective possible implementation of legislative aims. This may take the form of short-term staff training or consultation concerning responsibilities under the new law, particularly those regarding interagency collaboration. A designated agency or other mechanism to provide the assistance, allowance for staff time to take advantage of it, and sufficient funding are all important.

*3. Does the policy articulate a mechanism for interagency cooperation?*

Effective interagency collaboration comes about as a result of specified roles, practices, procedures and behaviors. Does the proposed statute, regulation or agreement state clearly what people are required to *do*? In one state participating in the meeting, legislation mandating interagency cooperation among specified agencies servicing the young disabled population yielded excellent results.

*4. Does the policy address access issues?*

As has been mentioned earlier, access to service can be as important as the existence of services, particularly for very young children and their families. Without provision for—and funding to maintain—information and referral services, easy points of entry into the service system, and mechanisms for assuring smooth transition between one service system and another, legislation or other agreements may substantially reduce their impact. Meeting participants noted that cutting funds for transition services is a frequent response of legislators faced with dwindling resources; they cautioned that such a policy disrupts continuity of early intervention care and may prove extremely costly in the long run.

*5. Are program or evaluation requirements outlined in policy appropriate?*

The importance of clearly defining the goals of services to disabled children under three and their families has been stressed before. Do evaluation requirements reflect these aims?

*6. Are compliance provisions included in policy?*

Child advocates have noted that the numbers of disabled children served in states with and without relevant legislation are often similar. They see this finding not as an argument against legislation but rather as a strong indication that a mandate must include enforcement provisions. Furthermore, such provisions must apply not only to intervention services but also to "child find" or other case-finding mechanisms included in the law. At the same time, policy language and procedures should be established with the goal of facilitating service delivery rather than emphasizing punitive measures. A mechanism for approval of early intervention plans at the local and county levels as well as at the state level might be effective.

## CONCLUSION

Parents, practitioners, researchers, policymakers and members of the general public are becoming increasingly aware of new opportunities for working together to help disabled and at-risk children and their families develop their capacities to the fullest, beginning in the earliest moments, months and years of life. They are also coming to understand that advances in treatment techniques bring with them new challenges to meet the needs of children and families coping with disabilities never before encountered in community settings.

To take advantage of the opportunities and to meet the challenges in ways that treat children and parents as individuals, support family strengths, ensure fairness in access to high quality services, and make wise use of limited resources, requires some form of thoughtful, well-articulated public policy statement. Maybe "there ought to be a law" mandating services for disabled and at-risk children from birth onwards. Perhaps, as has been suggested in this paper, other forms of legislation or policy statements may be appropriate in many jurisdictions.

As practitioners, planners, advocates and administrators whose ideas are reflected in this paper have discovered, the process of establishing services for the very young disabled children on a permanent basis is a complex and sensitive one. This document is intended to be a beginning guide to some aspects of that process but cannot hope to take the place of in-depth discussion and sharing of experience. The staff of the National Center for Clinical Infants Programs and the many individuals working in the ten states affiliated with Project Zero to Three welcome inquiries about legislative mandates and other policy options concerning disabled and at-risk infants, toddlers and their families. Contact National Center for Clinical Infant Programs, 733 15th Street, N.W., Washington, D.C. 20005, tel: (202) 347-0308.

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Developed by Barbara J Smith, Easter Seal Society of Alaska, Anchorage, Alaska 1984.

*Those with an asterisk follow as appendices.

# APPENDIX

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## PROFILE OF STATES' MANDATED AGE OF ELIGIBILITY FOR PRESCHOOL ELEMENTARY SCHOOL SPECIAL EDUCATION SERVICES

| *Mandated Service from age* | |
|---|---|
| 0 | Iowa Maryland Michigan Nebraska New Jersey South Dakota |
| 2 | Virginia |
| 3 | Alaska California Connecticut (from 2.8 years) Hawaii Illinois Louisiana Massachusetts New Hampshire Rhode Island Washington** Wisconsin Texas* (from birth for VI, HI, and DB) |
| 4 | D C Minnesota Delaware* (from age 3 for TMH, SMH, and PI; from birth for HI, VI, DB, and A) Oklahoma* (from birth for VI, HI, and severely handicapped) Tennessee* (from age 3 for D) |
| 5 | Colorado Florida Georgia Idaho Kentucky Maine Missouri Nevada New Mexico New York North Carolina Ohio Utah West Virginia |
| 6 | Alabama Indiana Kansas Mississippi Montana North Dakota Oregon Pennsylvania Vermont Wyoming Arkansas* (from age 5 if LEA offers K) South Carolina* (from age 4 for HI and D) |

*Exceptions to preschool age mandates (for example, in Texas all handicapped children age three and older are eligible for special education and related services; in addition, services are mandated from birth for all children who are visually impaired, hearing impaired or deaf-blind).

A=autistic
D=deaf
DB=deaf-blind
EMH=educationally mentally handicapped
HI=hearing impaired
K=kindergarten
LD=learning disabled
PI=physically impaired
SEM=socially or emotionally maladjusted
SI=speech impaired
SMH=severely mentally handicapped
TMH=trainable mentally handicapped
VI=visually impaired

**Preschool services in Washington are currently mandated from age 5. In the 1984-85 school year, preschool services will be mandated from age 4 and in the 1985-86 school year, preschool services will be mandated from age 3

SOURCE: Data obtained from SEAs and a review of the 1984-86 Annual Program Plans
Reproduced from the above referenced Special Net bulletin board with permission of the National Association of State Directors of Special Education (NASDE), 2021 K Street, N.W., Suite 305, Washington, DC 20006.

## NATIONAL DIRECTORY OF EARLY CHILDHOOD/SPECIAL EDUCATION MATRIX (Nina B. Carran)

| | *Mandated Svcs.* | | | | | | *Permissive Svcs.* | | | | | | *Guidelines Standards Regs., Etc.* | | *Interagency Agreements* | | *Teacher Cert.* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *States* | 0 | 1 | 2 | 3 | 4 | 5 | 0 | 1 | 2 | 3 | 4 | 5 | Yes | No | Yes | No | Yes | No |
| Alabama | | | | | | | | | | | | X | X | | | X | X | |
| Alaska | | | | X | X | X | X | X | X | | | | X | | | X | | X |
| American Samoa | X | X | X | X | X | X | | | | | | | | X | | X | | X |
| Arizona | | | | | | X | | | | | | | | X | X | | X | |
| Arkansas | | | | | | X | X* | X* | X* | X* | X* | | X | | X | | X | |
| California | | | | | | X | | | | X | X | | X | | X | | | X |
| Colorado | | | | | | X | X | X | X | X | X | | X | | | X | | X |
| Connecticut | | | | X | X | X | X | X | X | | | | | X | X | | X | |
| Delaware | X* | X* | X* | X* | X* | X* | | | | | | | | X | X | | | X |
| Dis. of Columbia | | | | X | X | X | | | | | | | | X | X | | | X |
| Florida | | | | | | X | X | X | X | X | X | | | X | X | | | X |
| Georgia | | | | | | | X | X | X | X | X | X | X | | X | | X | |
| Guam | X | X | X | X | X | X | | | | | | | | X | | X | | X |
| Hawaii | | | | X | X | X | X | X | X | | | | X | | X | | X | |
| Idaho | X* | X* | X* | X* | X* | X* | | | | | | | | X | X | | | X |
| Illinois | | | | X | X | X | X | X | X | | | | | X | X | | X | |
| Indiana | | | | | | | | | | X | X | X | | X | | X | | X |
| Iowa | X | X | X | X | X | X | | | | | | | X | | | X | | X |
| Kansas | | | | | | X | X | X | X | X | X | | X | | X | | | X |
| Kentucky | | | | | | | | | | | | X | | X | | X | | X |
| Louisiana | | | | X | X | X | X | X | X | | | | X | | X | | X | |
| Maine | | | | | | X | | | | X | X | | | X | | X | | X |
| Maryland | X | X | X | X | X | X | | | | | | | | X | X | | X | |
| Massachusetts | | | | X | X | X | X | X | X | | | | X | | | X | | X |
| Michigan | X | X | X | X | X | X | | | | | | | X | | X | | X | |
| Minnesota | | | | | X | X | X | X | X | X | | | X | | | X | X | |
| Mississippi | | | | | | | | | | X | X | X | | X | | X | | X |
| Missouri | | | | | | X | | | | X | X | | | | | | | |
| Montana | | | | | | | X | X | X | X | X | X | | X | | X | | X |

*See specific state for clarification

| | *Mandated Svcs* | | | | | | *Permissive Svcs* | | | | | | *Guidelines Standards Regs. Etc.* | | *Interagency Agreements* | | *Teacher Cert* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *States* | 0 | 1 | 2 | 3 | 4 | 5 | 0 | 1 | 2 | 3 | 4 | 5 | Yes | No | Yes | No | Yes | No |
| Nebraska | X | X | X | X | X | X | | | | | | | X | | X | | X | |
| Nevada | | | | | | X | X* | X* | X* | X* | X* | | X | | X | | | X |
| New Hampshire | | | | X | X | X | | | | | | | | X | X | | | X |
| New Jersey | X | X | X | X | X | X | | | | | | | X | | | X | | X |
| New Mexico | | | | | | X | | X | X | X | X | | | | | | | |
| New York | | | | | | | X | X | X | X | X | X | | X | X | | | X |
| North Carolina | | | | | | X | X | X | X | X | X | | X | | X | | | X |
| North Dakota | | | | X | X | X | X | X | X | | | | X | | | X | X | |
| N. Mariana Is. | | | | | | | | | | | | | | X | X | | | X |
| Ohio | | | | | | X | | | | X | X | | X | | X | | | X |
| Oklahoma | X* | X* | X* | X* | | | X | X | X | X | | | X | | X | | | X |
| Oregon | X | X | X | X | X | X | | | | | | | | X | | X | | X |
| Pacific Islands | | | | | | | | | | | | | | X | X | | | X |
| Pennsylvania | | | | | X* | X | | | | X | | | | X | | X | | X |
| Puerto Rico | | | | | | X | | | | X | X | | X | | X | | | X |
| Rhode Island | | | | X | X | X | | | | | | | X | | | X | | X |
| South Carolina | | | | | X* | X | X | X | X | X | | | | X | | X | | X |
| South Dakota | X | X | X | X | X | X | | | | | | | | X | X | | | X |
| Tennessee | | | | | X | X | | | | | | | | X | | X | | X |
| Texas | X* | X* | X* | | | | X | X | X | | | | | X | | X | | X |
| Utah | | | | | | X | | | | X | X | | | X | | X | X | |
| Vermont | | | | | | | | | | | | | X | | X | | X | |
| Virgin Islands | | | | | | X | | | | X | X | | | | | | | |
| Virginia | | | X | X | X | X | X | X | | | | | X | | X | | X | |
| Washington | | | | X | X | X | X | X | X | | | | X | | X | | | X |
| West Virginia | | | | | | X | | | | X | X | | X | | | X | X | |
| Wisconsin | | | | X | X | X | X | X | X | | | | X | | X | | X | |
| Wyoming | X* | X* | X* | X* | X* | X* | | | | | | | | X | | X | | X |

## SUMMARY OF STATE AGENCIES RESPONSIBLE FOR EDUCATIONAL SERVICES TO HANDICAPPED PRESCHOOLERS, FEBRUARY, 1985 (Linda J. Sohner)

| | 0-2 | | 3-4 | |
|---|---|---|---|---|
| *State* | *Mandated* | *Permissive* | *Mandated* | *Permissive* |
| Alabama | | | | Education |
| Arkansas | | Human Services | | Education |
| Connecticut | | Education<br>MR/DD<br>*(0-3) | Education | |
| Florida | | Education<br>Dept. Health & Rehab. Serv. | | Education |
| Hawaii | | State Health Dept. DD Branch<br>* (0-3) | Education | |
| Kansas | | Education | | Education<br>Community MR Centers |
| Kentucky | | Education<br>MR/DD | | Education MR/DD |
| Louisiana | Dept. Hlth & Human Srv. (0-3) | Education | Education | |
| Maine | | MH/MR | | MH/MR |
| Maryland | Education | | Education | |
| Massachusetts | Dept. of Health | | Education | |
| Minnesota | | Education<br>Welfare | Education | Welfare |
| Montana | | Education | | Education |
| Nebraska | Education | | Education | |

| | 0-2 | | 3-4 | |
|---|---|---|---|---|
| *State* | *Mandated* | *Permissive* | *Mandated* | *Permissive* |
| New Hampshire | | Education<br>Division of Mental Health (?) | Education | |
| New Jersey | Education | | Education | |
| New Mexico | | Health | | Health |
| New York | | Education | | Education |
| North Carolina | | MH/MR Health<br>Education | | MH/MR Health<br>Education |
| Ohio | Dept. of Mental Retard. & Developmental Disabilities | | Dept. of Mental Retard. & Developmental Disabilities | |
| Rhode Island | Dept. of Mental Health, Retardation | | Education | |
| Tennessee | | MH/MR Health | 4+ - Education | MH/MR Health |
| Texas | | Interagency Council | | Education |
| Utah | | Dept. of Social Services Health, Education | | Dept. of Social Services, Health, Education |
| Vermont | | Social/Rehab. Services<br>Education | | Social/Rehab. Services<br>Education |
| Washington | | Social & Health Services | | Education<br>Social & Health Services |
| Wisconsin | | Education<br>County Handicapped Childrens' Ed Board | Education | |
| Wyoming | Dept. of Health & Human Services | | Dept. of Health & Human Services | |

# Status in States of Early Childhood Special Education
# Across Twelve Dimensions

and

# State Participation in Five Federal Program Networks

Kathy Spence
Pascal Trohanis

January 14, 1985

Note: This information reflects feedback to START/TADS from states as of November 1984. We welcome changes in this information and its format in order to update and improve this document on a periodic basis.

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Alabama[e]<br>Freda Judge<br>205-261-5099 | Alaska[e]<br>Christine Niemi<br>907-465-2970 | Arizona[a]<br>Sara Robertson<br>602-255-3183 | Arkansas[e]<br>Lena Fulmer<br>501-371-2161 | California[a,d]<br>Betsy Qualls<br>916-323-6673 | Colorado[a,d]<br>Elizabeth Soper<br>303-534-8871 |
|---|---|---|---|---|---|---|
| Legislation:<br>Mandated<br>Permissive | 6-21<br>5 | 3-19<br>B-2 | 5-21<br>- | 5-21<br>no<br>DB 0-5 | 3-21<br>0-3 (partial mandate) | 5-21<br>B-5 |
| Statewide Comprehensive Plan | no | yes | no | no | no | no |
| Statewide Planning Advisory Group | no | no | yes | no | yes | yes |
| Statewide Needs Assessment | yes | yes (partial assessment in 1982) | yes | no | yes | no |
| Early Childhood TA/ In-service Training | yes<br>materials: no | yes<br>materials: no | yes<br>materials: no | no | yes<br>materials: yes | yes<br>materials: no |
| Early Childhood Teacher Certification | yes | no | no | no | no | yes |
| Interagency Agreements | no | developing | no | no | 6 | 5 |
| Early Childhood Guidelines | no | no | yes | no | yes | yes |
| Early Childhood Rules/ Regulations | no | yes | no | no | as apply to all handl. children | no |
| Statewide Tracking System | developing | no | no | no | no | no |
| SEA Distribution of Materials | no | yes | no | no | yes | no |
| Efficacy Data | no | no | yes (limited) | no | yes | yes |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

[b] U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP

[c] former MCH/BEH Six State Collaborative Project

[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

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|---|---|---|---|---|---|---|
| gislation:<br>Mandated<br>Permissive | 3-21<br>B-3 | B-2=D,B,DB, Autistic<br>3=OH,SMH,TMH<br>4-5=other<br>no. permis. | Bd of Ed Rules<br>3-21 years | K-grade 12<br>B-K | 6-18<br>0-5 | 3-5 consent agr<br>under 3<br>Dept. of Heal |
| tatewide Comprehensive Plan | yes | no | no | no | no | yes |
| tatewide Planning Advisory Group | yes | yes | no | no | no | yes |
| tatewide Needs Assessment | yes | yes | no | no | no | yes |
| arly Childhood TA/ In-service Training | yes<br>materials: yes | yes<br>materials: no | yes | yes<br>materials: yes | yes<br>materials: no | yes<br>materials: yes |
| arly Childhood Teacher Certification | developing | yes | yes | no | yes | yes: under revision |
| nteragency Agreements | 2 | 1 | yes | 3 | 2 | 6 |
| arly Childhood Rules/ Regulations | yes | no | no | no | no<br>in process | yes |
| arly Childhood Guidelines | yes | yes | no | no | no<br>in process | yes |
| tatewide Tracking System | no | no | no | yes | no | yes |
| EA Distribution of Materials | yes | no | yes | yes | no | yes |
| fficacy Data | no | no | no | no | no | developing |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

[b] U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP

[c] former MCH/BEH Six State Collaborative Project

[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Idaho[e]<br>Paul Swatsenburg<br>208-334-4181 | Illinois[e]<br>Lynn Moore<br>217-782-6601 | Indiana[e]<br>Sara Clapp<br>317-927-0216 | Iowa[a,b,c,d]<br>Joan Turner Clary<br>515-281-3176 | Kansas[e]<br>Lucile Paden<br>913-296-3866 | Kentucky[e]<br>Betty Bright<br>502-564-2067 |
|---|---|---|---|---|---|---|
| Legislation:<br>Mandated<br>Permissive | 6-21<br>kindergarten optional) | 3-21<br>B-3 | 6-18<br>3-5 | B-21<br>- | 5-21<br>B-4 | 6-18<br>5 |
| Statewide Comprehensive Plan | yes | no | no | yes | yes | no |
| Statewide Planning Advisory Group | no | yes | yes | yes | yes | no |
| Statewide Needs Assessment | yes | no | yes | yes | yes | no |
| Early Childhood TA/ In-service Training | yes<br>materials: no | upon request | yes<br>materials: no | yes<br>materials: yes | yes<br>materials: yes | yes<br>materials: yes |
| Early Childhood Teacher Certification | no | yes | no | yes | yes | no |
| Interagency Agreements | 4 | no | no | 1 | 17 | 2 |
| Early Childhood Guideline | no | no | no | yes | yes | no |
| Early Childhood Rules/ Regulations | no | yes<br>in-state | yes | yes | yes | no |
| Statewide Tracking System | yes | no | no | yes | developing | no |
| SEA Distribution of Materials | yes | no | yes | yes | yes | yes |
| Efficacy Data | no | no | no | no | developing | in process |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

[b] U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP

[c] former MCH/BEH Six State Collaborative Project

[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Louisiana[a,c,d]<br>Ron Lacoste<br>504-342-1641 | Maine[a,b,d]<br>Susan Mackey<br>207-289-3451 | Maryland[a,b,d]<br>Lin Leslie<br>301-659-2498 | Massachusetts[e]<br>Rosalie Norman<br>617-770-7479 | Michigan<br>Marvin McKinney<br>517-373-8215 | Minnesota[d,e]<br>Ann Bettenburg<br>612-297-3619 |
|---|---|---|---|---|---|---|
| gislation:<br>Mandated<br>Permissive | <br>3-5<br>B-2 | <br>5-20<br>3-5 | <br>B-20<br>- | <br>3-21<br>0-3 | <br>B-26<br>- | <br>4-5<br>B-3 |
| atewide Comprehensive Plan | no | yes | yes | yes | yes | no |
| atewide Planning Advisory Group | yes | yes | yes | yes | yes | yes |
| atewide Needs Assessment | yes | yes | yes | yes | yes | no |
| rly Childhood TA/ In-service Training | yes<br>materials:<br>yes | yes<br>materials:<br>no | yes<br>materials:<br>yes | yes<br>materials:<br>yes | yes<br>materials:<br>no | yes |
| rly Childhood Teacher Certification | yes | no | yes | yes | yes | yes |
| nteragency Agreements | 3 | no (only informal) | 3 | 1 | 1 | yes |
| rly Childhood Guidelines | no (in process) | no | no | no | no | no |
| rly Childhood Rules/ Regulations | yes | developing | no | yes | yes | yes |
| atewide Tracking System | no | no | yes | no | no | no |
| A Distribution of Materials | yes | no | yes | yes | yes | no |
| fficacy Data | no | developing | no | developing | no | no |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

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[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Mississippi[e]<br>Alice Hobson<br>601-359-3490 | Missouri[d,e]<br>Karen Campbell<br>314-751-2965 | Montana[a]<br>Michael Hagen<br>406-657-2312 | Nebraska[e]<br>Jan Thelen<br>402-471-2471 | Nevada[e]<br>Sharon Palmer<br>702-885-3140 | New Hampshire[a]<br>Barbara Bourgoine<br>603-271-3741 |
|---|---|---|---|---|---|---|
| Legislation:<br>Mandated<br>Permissive | <br>6-20<br>3-5 | <br>5<br>3-4 | <br>6-18<br>B-5 | <br>B-21<br>- | <br>5-<br>B-VI & HI 3 for MR | <br>3-21<br>- |
| Statewide Comprehensive Plan | no | no | yes | yes | yes | no |
| Statewide Planning Advisory Group | no | no | yes | no | yes | yes |
| Statewide Needs Assessment | no | yes | no (developing) | yes | yes | yes |
| Early Childhood TA/ In-service Training | yes materials: no | yes | yes | yes materials: yes | yes materials: yes | yes materials: no |
| Early Childhood Teacher Certification | no | no | no | yes | yes | no developing |
| Interagency Agreements | no | no | 4 | 2 | 1 | 1 |
| Early Childhood Guidelines | no | no | no | no | yes | developing |
| Early Childhood Rules/ Regulations | yes | yes | no | yes | as apply to all handi. | as apply to all handi. 3-21 |
| Statewide Tracking System | no | no | no | yes | no | yes |
| SEA Distribution of Materials | no | no | yes | yes | yes | developing |
| Efficacy Data | no | no | no | no | no | no |

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[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

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## STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | New Jersey[a,b,d]<br>Jane Hochman<br>609-984-5994 | New Mexico[d]<br>Ruth F. Brown<br>505-827-6541 | New York[a,d]<br>Michael Plotzker<br>518-474-8917 | North Carolina[a,b]<br>Janis Britt<br>919-733-6081 | North Dakota[a]<br>Shelby Niebergall<br>701-224-2260 | Ohio[b,d,e]<br>Jane Weichel<br>614-466-2650 |
|---|---|---|---|---|---|---|
| gislation:<br>Mandated<br>Permissive | B-5<br>- | 5-21<br>1-4 | -<br>B-5 | 5-17<br>B-4 | 3-5<br>B-2 | 5-21<br>3-4 |
| atewide Comprehensive Plan | yes | yes | yes | no | yes | yes |
| atewide Planning Advisory Group | no | yes | yes | yes | yes | yes |
| atewide Needs Assessment | no | no<br>in process | yes | for 3-4 only | yes | yes |
| rly Childhood TA/ In-service Training | yes<br>materials:<br>yes | no | yes<br>materials:<br>yes | yes<br>materials:<br>yes | yes<br>materials:<br>no | yes<br>materials:<br>yes |
| rly Childhood Teacher Certification | no<br>proposed | no | no | no | yes | no |
| nteragency Agreements | 3 | 2 | 4+ | 1 | 2 | 3 |
| rly Childhood Guidelines | yes | no<br>under another agency | yes | yes | yes | no |
| rly Childhood Rules/ Regulations | yes | no<br>under another agency | no | as apply to all handi. children | yes | as apply to all handi. children |
| atewide Tracking System | no | no | no | no | no | yes |
| A Distribution of Materials | no | no | yes | yes | no | yes |
| ficacy Data | no | no | no | no | no | in process |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

[b] U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP

[c] former MCH/BEH Six State Collaborative Project

[d] MCH and Georgetown University "Network" Project states

[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Oklahoma[e]<br>JoAnn Gordoni<br>405-521-2312 | Oregon[c,d,e]<br>Terry Kramer<br>503-373-3782 | Pennsylvania[e]<br>William Ohrtman<br>717-783-6913 | Rhode Island[e]<br>Susan Raisner<br>401-277-3505 | South Carolina[d,e]<br>Millie Fournier<br>803-758-7432 | South Dakota<br>Amy Hamborg<br>605-773-3678 |
|---|---|---|---|---|---|---|
| Legislation:<br>Mandated<br>Permissive | B-3=DB,Failing to Thrive&4-21<br>B-3 | B-21<br>- | 4.7-5<br>3-5 | 3-5<br>- | 4=VI & HI 5-18<br>B-4 | B-5<br>- |
| Statewide Comprehensive Plan | no | no | no | no | yes | no |
| Statewide Planning Advisory Group | yes | no | yes | no | yes | yes |
| Statewide Needs Assessment | in process | no | yes | no | yes | no |
| Early Childhood TA/ In-service Training | yes<br>materials: no | no | no | yes<br>materials: no | yes<br>materials: no | yes<br>materials: yes |
| Early Childhood Teacher Certification | no | no | no | yes | no | no |
| Interagency Agreements | 1 | 4 | 2 | no | 4 | 4 |
| Early Childhood Guidelines | no | yes | no | no | no | yes |
| Early Childhood Rules/ Regulations | yes | yes | no | yes | yes | yes |
| Statewide Tracking System | no | no | yes | yes | no | no |
| SEA Distribution of Materials | no | no | yes | no | yes | no |
| Efficacy Data | no | no | no | no | no | no |

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[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Tennessee[a]<br>Pamela Frakes<br>615-741-5274 | Texas[b,d,e]<br>Joene Grissom<br>512-834-4421 | Utah[b,c,d,e]<br>Mae Taylor<br>801-533-5982 | Vermont[e]<br>Kristin Hawks<br>802-828-3141 | Virginia[e]<br>Andrea Lazzari<br>804-225-2873 | Washington[a,b]<br>Joan Gaetz<br>206-753-0317 |
|---|---|---|---|---|---|---|
| egislation: | | | | | | |
| Mandated | 4-21 | B-2=VI,HI,DB<br>3-21 | 5-21 | 6-22 | 2-5 | 3-5 |
| Permissive | - | B-2 | 3-5 | 0-5 | B-2 | B-3 |
| tatewide Comprehensive Plan | no | yes | no | no | yes | yes |
| tatewide Planning Advisory Group | yes | yes | yes | no | no | yes |
| tatewide Needs Assessment | yes | no | no | no | no | yes |
| arly Childhood TA/ In-service Training | no | yes<br>materials: yes | yes<br>materials: yes | no | yes<br>materials: yes | yes<br>materials: yes |
| arly Childhood Teacher Certification | no | yes | no | yes | yes | no |
| nteragency Agreements | no | no | yes | 3 | 2 | 2 |
| arly Childhood Guidelines | no | yes | no | yes | yes | yes |
| arly Childhood Rules/ Regulations | no | yes | no | yes | yes | yes<br>revising |
| tatewide Tracking System | no | yes | developing | no | no | no |
| EA Distribution of Materials | yes | no | some | no | no | yes |
| fficacy Data | no | yes | no | no | no | yes |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

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[e] U.S. Department of Education HCEEP State Plan grants as of October 1, 1984

STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | West Virginia[a]<br>Ghaski Lee<br>304-348-7805 | Wisconsin[a]<br>Betty Rowe<br>608-266-6981 | Wyoming[a]<br>Armena Taylor<br>307-766-5103 | Bureau of Indian Affairs<br>Charles Cordova<br>202-343-6675 | Guam<br>Steve Spencer<br>Int.-472 8906 |
|---|---|---|---|---|---|
| Legislation:<br>Mandated<br>Permissive | 5-23<br>3-4 | 3-5<br>B-2 | B-5=H&SS<br>school age-21<br>no permis. | 5-21<br>3-4 | B-5 |
| Statewide Comprehensive Plan | no | yes | no | no | no |
| Statewide Planning Advisory Group | yes | yes | yes | yes | no |
| Statewide Needs Assessment | yes | yes | yes | yes | no |
| Early Childhood TA/ In-service Training | yes<br>materials:<br>no | yes<br>materials:<br>yes | no | yes<br>materials:<br>no | no |
| Early Childhood Teacher Certification | yes | yes | no | no | developing |
| Interagency Agreements | 1 | 2 | 1 | yes | 4 |
| Early Childhood Guidelines | no | no | no | no | developing |
| Early Childhood Rules/ Regulations | yes | yes | no | developing | developing |
| Statewide Tracking System | no | no | no | no | yes |
| SEA Distribution of Materials | no | yes | no | yes | yes |
| Efficacy Data | no | developing | no | no | yes |

[a] U.S. Department of Education State Implementation Grant Funding thru OSEP as of October 1, 1984

[b] U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP

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STATE STATUS AND STATE EC CONSULTANT

| EC/SE DIMENSION | Puerto Rico<br>Awilda Torres<br>809-764-8059 | Trust Territories of the Pacific<br>Winney Kuartel<br>Int.-670 9312 | Virgin Islands<br>Ellie Hirsh<br>809-773-7997 | American Samoa[e]<br>Jane French<br>684-633-4789 | Northern Mariana Islands[e]<br>Bobbi Figdor<br>Int.-670 9956 |
|---|---|---|---|---|---|
| egislation:<br>Mandated<br>Permissive | <br>5<br>3-4 | <br>-<br>- | <br>5<br>3-5 | <br>B-5 | <br>-<br>- |
| tatewide Comprehensive Plan | yes | yes | no | no | no |
| tatewide Planning Advisory Group | yes | yes | yes | no | no |
| tatewide Needs Assessment | no | yes | in process | in process | in process |
| arly Childhood TA/ In-service Training | yes | yes | yes | yes | no |
| arly Childhood Teacher Certification | no | no | no | no | no |
| nteragency Agreements | 5 | 7-9 | yes | 1 | 5 |
| arly Childhood Guidelines | no | no | no | no | no |
| arly Childhood Rules/ Regulations | yes | no | no | no | no |
| tatewide Tracking System | yes | no | yes | no | no |
| EA Distribution of Materials | yes | no | no | no | no |
| fficacy Data | no | limited | no | no | no |

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## SYNOPSIS OF STATES BY TYPE OF FEDERAL PROGRAM NETWORKS

### U.S. Department of Education HCEEP State Implementation Grants (SIG) as of October 1, 1984 (24)

- Arizona
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Iowa
- Louisiana
- Maine
- Maryland
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- North Dakota
- South Dakota
- Tennessee
- Washington
- West Virginia
- Wisconsin
- Wyoming

### U.S. Department of Health and Human Services/Maternal and Child Health (MCH) 0-3 Projects with NCCIP (10)

- Hawaii
- Iowa
- Maine
- Maryland
- New Jersey
- North Carolina
- Ohio
- Texas
- Utah
- Washington

### Former MCH/BEH State Interagency Collaborative Projects (6)

- Connecticut
- Hawaii
- Iowa
- Louisiana
- Oregon
- Utah

### MCH and Georgetown University "Network" Project States (21)

- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Hawaii
- Iowa
- Louisiana
- Maine
- Maryland
- Minnesota
- Missouri
- New Jersey
- New Mexico
- New York
- Ohio
- Oregon
- South Carolina
- Texas
- Utah

### U.S. Department of Education HCEEP State Plan Grants as of October 1, 1984 (27)

- Alabama
- Alaska
- American Samoa
- Arkansas
- District of Columbia
- Idaho
- Illinois
- Indiana
- Kansas
- Kentucky
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- Nebraska
- Nevada
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Texas
- Utah
- Vermont
- Virginia
- Northern Mariana Islands

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