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ABSTRACT

The report presents information gathered in a 1982 survey of over 400 public and private agencies serving preschool handicapped children in New York state. The information is organized into 60 recommendations for improving services in six key areas (sample subtopics in parentheses): (1) identification, evaluation, and placement (screening, use of labels, mainstreaming); (2) program operation (educational assessment, individualized education program development, curriculum content, individualization, evaluation of progress); (3) services for families (developing the parent individual education plan, parent role in planning and evaluation, program philosophy); (4) staff (qualifications, staff skills, adult-child ratios, inservice training); (5) interagency cooperation (advisory board, referrals, direction centers); and (6) legal considerations (length of stay, transitions to school, eligibility for services). Sample survey forms and references are appended. (CL)

STANDARDS FOR EXCELLENCE:

Recommendations for Preschool Special Education in New York State

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The content does not necessarily reflect the position or policies of the agencies which employ the contributing authors.

ABOUT THE NEW YORK STATE CONSORTIUM

In 1981, the New York State Consortium was organized to provide a forum in which professionals who work with handicapped children could exchange ideas and resources and thereby build a structure of better services for the youngsters in their care. The members of the Consortium include all persons holding Handicapped Children's Early Education Program (HCEEP) grants in the State.

It is the primary goal of the Consortium to promote the purposes of the federally funded HCEEP effort on the state level. Among these purposes are:

1. To develop a climate in which professionals can exchange information on the best ways to work with various populations.
2. To encourage local and state governments to create policies, laws and regulations favorable to the improvement of services for the handicapped.
3. To develop a network of providers of services.

In addition to these purposes, the Consortium has in its brief history been committed to determining the present level and kind of services offered in the state by various groups involved in early education. By examining current practices, the Consortium has sought to ascertain the present standards that govern services provided to special preschoolers in New York.

It has been through this examination of current practices and the hard-won, collective experience of Consortium members that a part of the Consortium's primary goal has been accomplished:

> The creation of one set of recommended standards which could be embraced by all persons working with handicapped children given adequate funding for personnel, equipment and other services.

Membership

Regional Demonstration Program for Preschool Handicapped Children (Putnam/Northern Westchester BOCES, Yorktown Heights, NY 10598)

Early Childhood Intervention (Board of Education Services of Nassau County, Salisbury Center, Valentine and The Plains Roads, Westbury, NY 11590)

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INTRODUCTION

In 1982, the New York Consortium mailed a survey (Appendix A) to over 400 public and private agencies serving preschool children in New York. (See Appendix B, List of Survey Respondents.) The survey was designed to help the Consortium identify current trends in the state and pinpoint major problem areas in delivering services to infants, toddlers and preschoolers.

The information obtained through this survey indicated that many of these programs had already developed high standards for themselves and unique programming to meet the diverse needs of their children and parents. The authors have learned from these agencies. The survey was not, nor was it intended to be, a formal research study. It was, more simply, a way to gauge the practices of service providers and the level of assistance they offer to the under-five age group.

This book is a compendium of the information gathered in the survey, the beliefs of the members of the New York Consortium, and the findings of research. The data from these three sources have been unified into sixty recommendations or standards for professionals serving preschool handicapped children.

The issues in early education for special children, identified through the survey as well as through the experience of Consortium members, are the foci of the first half of this Introduction. An examination of the recommendations and their organization within this text occupies the remainder of the chapter.

A. THE ISSUES

The results of the random survey substantiated, in large part, what researchers have identified as national trends in special education for children below age five. For example, one signal of a problem nationally and in New York is that a high number of children are labeled "speech and language impaired." This trend has developed because it is very difficult with preschoolers to go beyond easily identified communication problems and find their sources--which are frequently rooted in more specific handicapping conditions.

This problem is tied to what are perhaps the three most critical features of early special education today:

1. Evaluation - Programs are often not equipped, in terms of staff and facilities, to conduct the in-depth examination of children.

2. Funds - There is insufficient money for such evaluations.

3. Tools - Very young children who clearly need special assistance cannot be pegged into one of the traditional handicap categories with current diagnostic tools, thus they are labeled "speech impaired."

Diverse State

These kinds of issues are multiplied in a very diverse state, such as New York. Geographically, New York includes isolated mountainous terrain as well as one of the most densely populated regions in the world. It includes affluent suburbs as well as pockets of poverty.

Major ethnic groups are represented substantially within the state. For many clients of special preschool services, in fact, English is clearly a second language, if it is used at all.

To provide programs amidst such diversity requires adequate staff and resources. It also demands a legislative commitment.

Diverse Service Agencies

Our survey found the agencies serving New York's preschool population also are diverse. They receive funds from a wide array of sources. They are located in suburban, rural and urban areas. They provide services in facilities which include everything from private homes to universities. They sometimes have physicians, nurses, educators, social workers and numerous other personnel on their staffs. And they sometimes keep children, whom they cannot serve immediately, on waiting lists for over a year!

Alice Hayden (1975) wrote of special preschoolers: "To deny them the attention that might increase their chances for improved functioning is not only wasteful, it is ethically indefensible" (p. 510). To deny services even by a few months, we feel, is also indefensible.

General Difficulties

We found that the keys for understanding the reasons for long delays and other inadequacies in service lie in several areas:

1. Interagency cooperation (networking) - Most programs for preschoolers cooperate with a limited number of other agencies. But more collaboration is needed to provide all the help children require and to find the best programs for youngsters who have been found to be developmentally delayed.
2. Evaluations - A variety of professionals must work together to find the real root of each child's difficulties and to prescribe the best course of services. Initial medical and psychological evaluations provided by the physician and psychologist in a hospital child development unit may take a long time to complete.

3. Ratios - Programs must have an adequate ratio of professionals and paraprofessionals to clients if they are to meet the needs of children and to be able to accept all the youngsters eligible for their services.

Clearly, some of these dilemmas are beyond the abilities of service providers to resolve. It is difficult, for example, to create favorable ratios when the resource cupboard is bare. Similarly, it is impossible to cooperate with unwilling agencies.

Local Problems

However, some of the other major problems are within the power of providers of preschool services to address. The categories listed below represent key inadequacies in early education that frequently have been encountered by Consortium members.

1. Language and cognition - Most early education programs (especially for children younger than three) focus on motor and social emotional development and general "stimulation" activities. Yet, language and cognition begin to develop very rapidly in the first five years of life. By school age, most normally functioning youngsters can speak and understand language very well. However, since most handicapped preschoolers have language communication problems, special preschool programs should spend greater portions of each day on developing these skills. Children under age 3 need carefully reciprocated social and language intervention to stimulate cognition.
2. Five years - Children who are five years old often fall between preschool and school services. Yet they need help if they are mildly impaired. Care providers must see that such children have programs.
3. Creative service provision - Given that adequate resources (staff, funds and placement programs) are not always available, staff members of child care agencies need to adopt more creative service strategies. These include: developing arrangements with neighboring agencies to provide

needed therapy, involving parents in center activities, using more paraprofessionals, etc.

4. Fathers and Siblings - The mother is not the only person in the child's life, though she may be the primary care giver. Programs must try to involve fathers, brothers, sisters and even grandparents and other relatives in the special child's education.

5. Severe impairments - Children who have very severe handicaps need more individual attention than other children. They also require different curriculum materials, which are specific to their needs. Newer techniques such as neuro-development techniques, etc. can be very helpful.

6. Generalization - Programs tend to provide one kind of service to all clients. Certainly, children who can be placed together successfully should be served together. But all children cannot be equally served via a single curriculum format or with the same level of attention from the educator.

In the face of these problems, the New York Consortium envisioned a book of standards or recommendations that could be used by all preschool service personnel to gauge the quality of their programs and to take actions which would alleviate the more serious inadequacies.

B. THE STANDARDS

The Standards for Excellence is essentially a set of recommendations for improving services in six key areas:

1. Identification, Evaluation and Placement
2. Program Operation
3. Services for Families
4. Staff
5. Working with Other Agencies
6. Legal Considerations

The Consortium arrived at these areas by examining the responsibilities of a preschool to its clients (Figure 1). The problems preschool education faces are related to the fact that schools are unable or unwilling to fulfill some of these responsibilities adequately. Some do not plan, some do not provide sufficient in-service training for the staff, some do not initiate child identification strategies in their communities, and so forth. As a result, we have unserved or inadequately served youngsters.

FIGURE 1

KEY RESPONSIBILITIES OF PRESCHOOL SERVICE PROVIDERS

1. To plan an overall preschool program
2. To hire qualified staff and provide supplemental training as needed
3. To help find children who may need their services
4. To evaluate these youngsters thus identified
5. To accept the children into the program, if appropriate, or help place them in another program
6. To prepare an individual education plan for each child
7. To involve parents in the remediation process and overall operation of the school
8. To work with other agencies in finding children who require services and in providing those services
9. To evaluate the efforts of their program regularly

How to Resolve the Issues

The most important action that can be taken to correct the problem is the passage of a mandate by the Legislature for services to children under five in New York State. This step would clarify requirements for school operation through regulations and create more consistency in funding and identification of special children.

Parameters of the Recommendations

The recommendations do not touch directly on every issue that is important. For example, in our survey many respondents indicated a need for more space to serve the children they had accepted; many indicated problems in transporting children over long distances. These specific problems generally come under the purview of one or more recommendations and will be resolved, in large part, when the recommendations can be implemented properly.

The book also does not address many of the administrative issues involved in preschool activities. For example, when teachers must go regularly to a child's home, how should transportation, insurance and the time involved be handled? These specific details, again, have been addressed indirectly via the recommendations on planning which are woven into the fabric of each section.

The Six Key Areas

The six areas contain a total of sixty recommendations, many of which overlap with one another. The standard for screening, for example, is closely tied to all other evaluation standards. Yet, inasmuch as it is a particular facet of evaluation, it has been addressed with its own recommendation. The text which follows clarifies the content of each of the areas. (See Figure 2.)

FIGURE 2

LIST OF RECOMMENDATIONS

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55. Transitions to School
56. Criteria for Placement
57. Eligibility for Services
58. Committee on the Handicapped
59. Parent Consent
60. Parent Involvement

Section 1 - Identification, Evaluation and Placement. (See Steps 3 and 4 on Figure 1.) One whole section has been devoted to these activities because the Consortium as well as survey respondents listed very specific, unmet needs in this area. In general, the following problems were identified:

1. Identification, which involves locating children who need to be screened for developmental problems, is seldom systematic and very often inadequate.

2. Screening, which involves a quick evaluation of a large number of children to find those who need further evaluation, is uncommon except for certain anomalies, such as hearing and seeing, which are usually first identified at birth by medical staff.

3. Diagnosis, which involves an in-depth evaluation of the child's level of functioning in educational, medical and psychological areas to determine specific needs, is often performed inadequately.

Also, within this section, several considerations which should guide agency attempts to place children within adequate programs are addressed. These issues include finding suitable environments and the schedule for placing children who have been diagnosed. (The reader should review the recommendations in Section 5, Working with Other Agencies, along with recommendations in this section.)

Section 2 - Program Operation (See Steps 1, 6 and 9 of Figure 1.) The section on operating a program concerns the day-to-day matters which, if not properly planned, can affect the agency's success with the youngsters and its reputation with parents. These issues include:

1. Educational Assessment - an activity undertaken with each child to determine needs in motor, cognitive, language, social-emotional and self-help areas.

2. Individual Education Plan (IEP) - a written statement of the school's goals for the child and objectives with specific activities to reach those goals.

3. Curriculum - the content and organization of education activities.

4. Program Management - the approach to behavior problems, the use of related services (such as physical and occupational therapy or medical intervention), the individual time each child spends with the teacher, and transportation to school.

5. Evaluation of Program - a periodic, ongoing effort by the school to evaluate its work with the group of children and their parents.

Section 3 - Program for Parents (See Step 7 on Figure 1.) Each provider of educational assistance to preschoolers must have plans for including parents in the process. This section concerns the formulation of these plans and their content as well as the agency's interaction with other agencies to serve the family.

Section 4 - Staff (See Step 2 on Figure 1.) Preschoolers who are handicapped require the services of people from many disciplines. This section outlines the qualifications which these professionals should possess and the form of interaction between professionals. By form of interaction, we mean basically that all service personnel should collaborate in helping the child. Core services should be provided by a transdisciplinary team. This team is: a unit composed of a teacher, parent and other appropriate professionals charged with evaluating the child, planning a series of services for him, providing those services and altering the course of services as necessary.

This section also recommends adult-child ratios for preschools, in-service training activities for staff, and personal characteristics which help staff members perform better in preschool settings.

Section 5 - Interagency Cooperation (See Steps 5 and 8 on Figure 1.) The need for cooperation between agencies serving similar client populations is great. For some time, professionals have advocated the creation of national and statewide networks to help find, evaluate and place children who have special problems. This section recommends that advisory boards (at the school level) and Direction Centers (at the local and state levels) be used in constructing a better network of communication and assistance between agencies. It also recommends activities to help in referring children and the development of a state plan for interagency cooperation.

Section 6 - Legal Consideration (See Step 3 on Figure 1.) The survey revealed a wide range of criteria for admitting children to programs, for moving children from one placement to another, and for determining the overall eligibility of preschoolers for services. These criteria should be standardized among various kinds of programs and for all children. They also should be different for children under five who are, by reason of their age, more dependent on parents and more vulnerable to developmental problems than school-age youngsters. This section proposes standards for eligibility for services, criteria for placement, and the "length of stay" in a placement. It also addresses the need for a state mandate which would designate coordinating bodies for these standards.

Conclusions

As New York moves closer to legislating services for children birth to five, professionals in the field must begin to ask:

* What services should be available for preschoolers in the state?
* What should the goals of such services be?
* What should be the responsibilities of the state, the school district and other local agencies, and the service provider?

The answers of the Consortium to these questions are, in part, the sixty recommendations in this publication. However, preschool services are so important that all professionals serving children must offer their best advice, most creative solutions, and most earnest help in building a better level of preschool education.

SECTION 1

IDENTIFICATION, EVALUATION AND PLACEMENT

IDENTIFICATION, EVALUATION AND PLACEMENT

In the past thirty years, the process of serving the special youngsters in this country has come to consist of three major steps:

1. locating children who may need help,
2. evaluating them and
3. placing those youngsters requiring special services in appropriate programs.

In New York, as in other areas of the nation, a multitude of procedures to accomplish these three steps have evolved. But these approaches have been so varied and, with children under five, so limited that noticeable inconsistencies in service quality from locale to locale and child to child have developed.

Part of the problem is that children under five are not covered by existing legislation. Consequently, their fates often rest exclusively on the availability of programs in their communities rather than upon a consistent statewide identification and evaluation system.

This situation is unfortunate in that there is so much clear research evidence supporting the benefits of consistent early identification and placement activities. In 1979, for example, Lazar & Darlington deduced, on the basis of data from a 14 year longitudinal study of children served in preschool and infant programs, that the children: 1) required special education later on less frequently, 2) were retained in a grade less often, and 3) scored consistently higher on intelligence tests" than children who were not in such programs (Westar, 1981, pp. 7-8). Children who need assistance must be found <u>before</u> they enter school.

Another issue in identification and placement throughout the country is the nature of the handicaps for which children are evaluated. Severe physical and medical conditions that threaten development are often identified in children before three. These problems receive rapid treatment because professionals and parents recognize the need for immediate action.

But children whose problems are not obvious or life threatening are usually not screened for developmental problems before age five--after a disability, which may have been identified earlier, has become obvious and/or disruptive. The earlier that almost any condition--which will cause physical, emotional or academic problems--can be identified and treated, the better the prognosis for the child.

This section is designed to offer suggestions for remedying some of the major problems in this area of services for children: lack of clear placement and admission criteria, inappropriate labeling, inappropriate placements, too narrow a range of program options and evaluations not followed immediately by required services. It also provides, in each of these areas, a clear standard for programs and, ultimately, the state to follow. By so doing, the intention is to evaluate present New York State guidelines and provide options for more flexible acceptance of varied program strategems.

Recommendation 1: Locating Youngsters

A statewide publicity program should be implemented to help the educational community find children in need of more intensive evaluation.

The publicity should be aimed at the general population. Special campaigns should also be developed to reach: 1) medical professionals, 2) parents and 3) agencies which serve children.

Our survey respondents revealed that they regularly spend time identifying children in their geographic areas. The sources they most often listed for the children placed in their programs were:

1. Other agencies (referrals)
2. The community (advertising campaigns)
3. Pediatricians (referrals)
4. Parents of children in the program (referrals)
5. School districts (referrals)

The Critical Characteristics Inventory (1981) reported, in its survey of early intervention programs for children below three years, that the following sources of referral are most common:

1. Medical personnel
2. Social services
3. Parents
4. Education agencies
5. Friends

The medical category probably is a less frequent source of referrals as children pass the three year mark. (See Recommendation 49.)

Recommendation 2: Screening

A screening program should be available in all parts of the state to screen all children for developmental and medical problems.

Our survey revealed that most programs screen a limited number of children each year using procedures developed in the programs. All children, however, should be screened for developmental problems using one of the instruments presently available. These tests are designed to be easy to use and to evaluate a large number of children in a small amount of time at low cost.

Unfortunately, children only a few months old are less easily screened for learning problems than older children who are more responsive to their environment. However, certain medical conditions, factors at birth, and prenatal histories render children at risk, and these babies must be screened. If no need is found during the first screening but the child's background indicates that a problem is likely to develop, he or she should be rescreened at appropriate intervals.

Recommendation 3: Nature of Evaluation

The child may be evaluated by formal (instruments, tests, etc.) or informal (observations, unstructured procedures, etc.) means.

The younger the child, the more difficult it is to engage him in formalized tests and activities. Some states, nonetheless, have required children under five to meet the same service-eligibility criteria, in terms of test scores, as school-age children. One state, for example, requires infants and twenty-year-olds alike to "score two standard deviations below the mean on diagnostic tests. (This) has created some difficulty in judging the eligibility of infants, since diagnostic procedures often do not provide those kind of scores" (Anderson and Black, 1981, p. 20). Such diagnostic requirements also eliminate the possibility of serving children who are at risk for developmental disabilities.

When diagnostic procedures indicate to the examiners that there is need for intervention, appropriate services should follow for the child. If related services are indicated, they also should be provided. Reevaluations, depending on the handicap and the youngster's progress, should be undertaken periodically. These steps should be taken with children under five whether or not a categorical handicap can be identified. (See Recommendation 57, Eligibility for Services.)

Recommendation 4: Use of Labels

No youngster should be placed in a program on the basis of a specific label (e.g., "emotionally disturbed"); placement should be made on the basis of the help required.

Clearly, there is a difference between any two children suffering from the same disability: one may need very little help to thrive; the other may require inten-

sive intervention. Thus, these two children should not necessarily be placed together by label to receive assistance. Each child can be placed by the type of placement (e.g., regular classroom, transitional support services, etc.). This procedure brings together children whom the teacher can work with as a group since they have been placed by "ability to function" rather than by "handicap."

In Special Education Mandated from Birth (1981), Anderson and Black note: "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. (One state) has developed a preprimary impaired classification which (means) only that the...child has a significant developmental delay" (p. 28).

Figure 3 shows the most frequently represented handicaps in programs that responded to our survey. This order of frequency generally follows national statistics, with speech at the top of the list and blindness and deafness at the bottom.

FIGURE 3

MOST FREQUENTLY IDENTIFIED HANDICAPS

Severe speech or language impaired

Educable mentally retarded

Emotionally disturbed

Physically handicapped

Trainable mentally retarded

Learning disabled

Autistic

Hard of hearing/deaf

Visually impaired/blind

Recommendation 5: Program Admission

Each program's services should be within the reach of all eligible children and their families regardless of ability to pay.

Our survey indicated that most programs admit children on the basis of age, handicap and geographic area--not ability to pay. See Recommendation 56. The table below (Figure 4) reveals the order of the criteria used by programs responding to the survey.

FIGURE 4

HOW CHILDREN ARE ADMITTED

1. Age
2. Handicap
3. Specific geographic region
4. Results of assessment
5. Committee on Handicapped recommendation
6. Parent willingness to be involved
7. Ability to pay

Recommendation 6: Mainstreaming

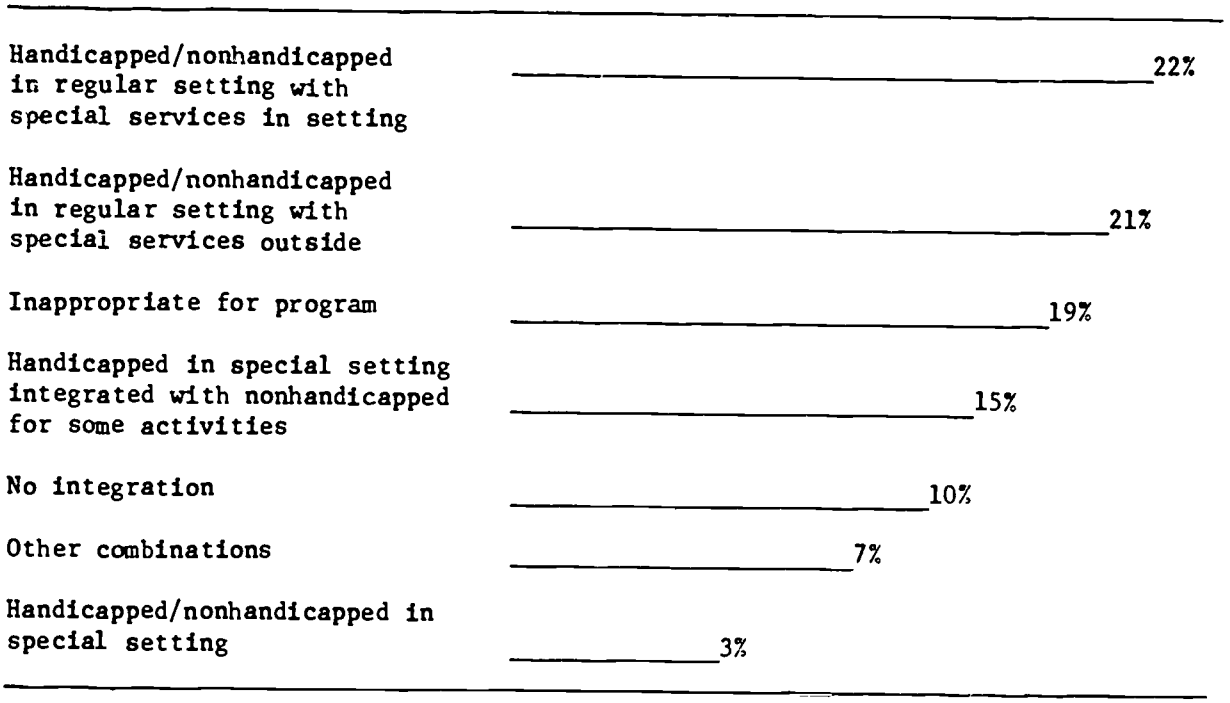
If appropriate for a child, he/she should be placed in an integrated program (special and nonhandicapped children); if not, the child should remain in a program with only special children. Mainstreaming should not be required for all children.

Approximately half the programs which responded to our survey reported that they mainstreamed their handicapped youngsters into a regular education setting with nonhandicapped children. Some of these programs, however, still removed the special youngsters from classrooms for treatments (physical therapy, speech therapy, etc.). (See Recommendation 17.)

Other facilities used reverse mainstreaming: i.e., they integrated non-handicapped and handicapped children in a "special" setting. In some programs, mainstreaming was not an issue since facilities were highly modified for special youngsters (e.g., a hospital for severely profoundly handicapped youngsters) or the facilities were segregated by philosophy, or the program was strictly home based. Figure 5 shows frequencies of different placements.

FIGURE 5

MAINSTREAMING



Recommendation 7: Continuum of Services Model

> The program chosen for each child should provide the least restrictive environment in which the child is capable of functioning.

Clearly, the least restrictive environment encourages children to function at their highest levels. Also, money is saved when supervision and less specialized facilities are required.

The continuum that should be available includes:

1. Regular Nursery Schools
2. Head Start
3. Partially and fully mainstreamed classes
4. Special classes
5. Home programs
*6. Home care centers

Head Start may provide the least restrictive placement for some three to five year olds. However, as addressed by Anderson and Black (1981), teacher certification may become an issue when this placement is considered. Also, the income eligibility provision and ten percent (10%) limitation may reduce accessibility to many youngsters. Therefore, regular nursery schools must be considered as placement alternatives for mildly handicapped youngsters. See Recommendation 6 & 8.

Recommendation 8: Variety of Program Options

A state plan should be developed to ensure that a variety of programs is available in each region of the state - e.g., Head Start, self-contained classrooms, hospital-based programs, regular nurseries and home programs.

Our survey revealed the models in Figure 6 to be the most frequent program types among those responding.

FIGURE 6

MOST FREQUENT TYPES OF SERVICE DELIVERY MODELS

1. Head Start programs
2. Self-contained classrooms
3. Hospital programs
4. Social services programs with support services
5. Home programs
6. Regular nurseries with handicapped children

*A home care center is a unit where three to five youngsters and their mothers receive specialized treatment in baby and home care.

These programs were sprinkled among urban, surburban and rural areas. The types of programs deficient in most locales were:

-Respite care arrangements

-Day treatment and therapy programs

Recommendation 9: 30-Day Placement

No child should wait more than 30 days after referral for screening or assessment; no more than 30 days after assessment for a placement.

In our survey, respondents indicated that children very often had to wait more than thirty days before they were assigned placement. The reasons for the delays were many, including: space was unavailable, parent consent was not provided, transportation was an issue, no appropriate placement was available, there was too much paperwork, a September-only placement policy existed. (See Recommendation 59.)

Infants, toddlers and preschoolers with special needs must be provided services when the need becomes apparent. They cannot afford to wait for a year to be placed in a school. In fact, they should be admitted on an ongoing basis.

Before age six, critical developments occur more rapidly than at any other time in their lives. Motor skills begin to develop before age one, language dramatically develops between ages one and two, important cognitive and social growth occurs between birth and age five. To delay services to a child who is in need even by a few months can cost the child dearly in more than just the area in which he is handicapped. If he has a problem seeing, for example, it may affect his motor development, emotional growth, speech and so on. Placement within thirty days must be the law.

Programs responding to our queries noted that they have between 0 and 100 children waiting for placement at the present time.

SECTION 2

PROGRAM OPERATION

In the maze of private, local, state and community programs currently operating, one can find a hundred and one different ways of approaching the task of providing services on a daily basis. For example: some programs develop individual education plans months after children enter classes, some develop the plans before the youngsters spend their first day at school. Some schools use the same basic curriculum for all children under five, others use five different curriculums. Some programs have two-hour days, some four. Some provide transportation for all clients; some provide it for none.

The point of listing these differences is not to prove that any program is operating incorrectly. Most schools do the best they can for their clients, and all programs have limitations--some of which are beyond their power to correct. For example: Some schools simply cannot provide transportation for all pupils, though that might be ideal. Some cannot find curriculums that are designed for the needs of the children they are serving. Some cannot, because of staff limitations, develop IEPs before the first day of instruction. But all preschools can improve, and a state mandate for services for children under five would help them make needed changes.

In this section, guidelines for operating programs for preschoolers are presented. They suggest the minimum levels of services in the key areas of: assessment, curriculum, behavior management, length of day, transportation and program evaluation. More detailed guidelines may be found in the resources listed in Appendix C.

Recommendation 10: Educational Assessments

All programs should regularly evaluate each youngster accepted in order to develop a responsive individualized plan of services for the child.

We believe that a transdisciplinary team (i.e., teacher, parent and appropriate professionals) can evaluate a child's needs more effectively than various commercial tests and assessment devices. The Critical Characteristics Inventory (1981) states (for children birth to three): "Assessments that are commercially available are not specific enough to indicate the minute progress characteristic of the severely developmentally disabled child" (p. 20).

Of course, instruments must be used to collect information about the child as the team develops the IEP. However, decisions regarding a program of activities must be worked out through discussion: tests cannot give as full a picture of a child's need as can professionals who consider the child's total needs and the way those needs conspire to alter the child's ability to function. (See Recommendation 3.)

Assessment should include the five major developmental areas (language, social-emotional status, cognition, motor and self-help abilities) and any special areas of concern medically. The team must have an objective of developing prescriptions to address specific growth needs in each of the areas.

The majority of the programs responding to our survey employed a team assessment approach.

Recommendation 11: Individual Education Plan (IEP)

> The Phase I IEP should be developed on the basis of initial evaluations prior to entry in the program; the Phase 2 IEP should be written no later than 30 days after entry.

The Phase I IEP provides a starting point for instruction. Within 30 days, the teacher or staff is in a position to develop the Phase II IEP which provides specific behavioral objectives.

Many states with services for children under three require frequent reviews of IEPs. In an informal review of four state programs, Anderson and Black (1981) reported that IEPs "require more frequent revision for...very young children than is required for older children. Quarterly IEP reviews are either required by law or performed as a matter of necessity in..." some states. An IEP review process needs to be developed for children under three years (with reviews every three months) and youngsters three to four years old (with reviews every six months).

Recommendation 12: Curriculum Approach

> The curriculum used with the special child should mesh with the rate and level of development, satisfy the need for interaction with others, and provide for any special requirements.

To meet these dictums, most programs that responded to our survey reported the use of a diagnostic prescriptive or developmental-interaction model. A few programs used Piagetian or behavioral approaches. All of these methods have research which attests to their viability with special youngsters. The diagnostic-prescriptive approach is the one most often used in programs funded by the Handicapped Children's Early Education Program (HCEEP).

Recommendation 13: Curriculum Needs

> Different curriculums should be used for the three preschool age groups: infant (0-18 months), toddler (19-36 months) and preschooler (37-60 months).

Research has shown that very specific and different kinds of developmental events occur during these three periods. Curriculums must be utilized which deal with each period to help the special child through each developmental range.

Our respondents noted specifically that adequate curriculum materials were not available: 1) for the severely handicapped youngster, 2) for the emotionally disturbed, or 3) for the multiply handicapped.

Even though the teacher must adapt any core curriculum (chosen by the transdisciplinary team) to each child's requirements, the creation of specific materials for these handicapping areas and the development of materials for the three age ranges will facilitate the process and improve services throughout the state.

Recommendation 14: Curriculum Content for Classrooms

> Center-based programs should include for all children on a daily basis: work in language, cognition, self-help skills and motor skills, a meal or snack, play time, small group work and individual work.

Most of the survey respondents indicated that their work includes all of these items. Some noted that large group work, art and playground time were important parts of their daily routines. It is important for the routine to provide opportunity for intervention in the five major developmental areas daily. See Recommendation 10.

The Critical Characteristics Inventory (1981) suggests that center-based programs are most appropriate for children more than eighteen months in age. At this age, children begin to benefit from interaction with peer groups and an extended daily training period.

Recommendation 15: Individualization

> Each session of the class program should provide each child with some individual instruction.

Even though the IEP specifies individual work for each child, it does not elaborate on the level of individual attention. The need for and effectiveness of individual work on a daily basis with special children, however, is well documented.

While school children may be able to make progress with individual work once or twice weekly, preschoolers with short attention spans and less interaction skills need daily sessions.

This recommendation primarily applies to three to five year olds who are in center-based programs. Younger children are predominantly served via home-based systems and are thereby guaranteed individual attention during the teacher's visits. However, infants and toddlers in hospitals and other institutions require individual stimulation activities as much as other youngsters. And they should receive them every time they are in a group situation.

See also Recommendation 14, Curriculum Content for Classrooms, and Recommendation 44, Adult Child Ratios.

Recommendation 16: Behavior Management

Teachers should use class rules, a structured routine, prevention techniques, and positive social reinforcement to dissipate behavior problems.

Our survey respondents primarily used these methods in their programs. Occasionally, play therapy and non-directive approaches and behavior modification techniques were also used. These latter methods should be employed only if the primary techniques listed above do not produce the desired results.

Class behavior is more easily managed when the adult-child ratio is no more than one to five. Parents and paraprofessionals can often be invaluable assets to the teacher faced with youngsters with greater than average needs. (See Recommendation 33, Parent-Teaching Activities; Recommendation 40, Qualifications for Paraprofessionals; and Recommendation 44, Adult-Child Ratios.) The preschooler, especially if he is autistic or emotionally disturbed, usually presents more management problems than the infant or toddler.

Recommendation 17: Related Services

The professional assistance needed by the special children in the program should be provided, preferably in the classroom.

Respondents to the survey indicated the use of a wide range of related services, from physical therapy to psychiatry (see Recommendation 37). However, the special work was often provided outside the classroom which means the child's daily schedule was interrupted and the teacher was not available to observe and work with the service provider. Whenever possible, assistance should be provided in the classroom environment.

Recommendation 18: Transportation

Safety features: car seats, seat belts, monitors (if required) should be mandated in buses.

Of those responding to our survey, approximately two thirds reported that students came to their programs by bus.

The perennial problem of too much time on the bus is still present. The solution must be to increase bus service so children do not spend excessive and fatiguing time on the road.

In addition, safety features must be mandated, i.e., car seats, seat belts, monitors, etc.

Recommendation 19: Curriculum Content for Home

Home-based programs should include: interaction with the parent, individual work between the child and teacher; oral and written suggestions for the parent; parent observations of teacher's work with the child; and teacher observation of the parent's work with the child.

Most of the programs responding to the survey indicated that all of these components were included in their home programs. Some felt that written homework for the parent was important when their child was severely handicapped.

In the home program, it is even more important than in the center program that the parent become versed in the needs of the child with a handicap and the pattern of development that can be expected. Often parents of special children must be taught to recognize cues from the child. A blind baby, for example, does not respond as a sighted infant to the presence of the mother. The mother, consequently, may misinterpret passiveness as rejection and fail to establish the bond that normally develops between mother and baby.

When a parent learns how to stimulate a special youngster properly, the child in turn develops the ability to respond to the parent. The cues he/she is able to give then become more plentiful and a relationship in which his/her needs can be met develops.

Parents with youngsters who cannot go to school also frequently need extra emotional support. Sometime respite care which permits the youngster to be cared for by another person for a few hours or days relieves the feeling of overwhelming burden from the parent.

Recommendation 20: Amount of Services

> In center programs, direct services to children should have at least two-and-a-half hours of intervention, 3 to 5 days per week; in home programs, the children should have at least 2 hours per week.

In most of the programs responding to the survey, these parameters were observed. Most schools, in fact, reported that children were in school as many as five hours per day, five days per week.

Recommendation 21: Evaluation of Progress

All programs should track the progress of each child to ensure the general effectiveness of the curriculum for the group of children.

This standard will help others in the state evaluate the curriculum and determine its usefulness for their clients. It will also, of course, help the educational staff make changes in the curriculum or choose a new curriculum when children are not improving at an acceptable rate.

Two kinds of evaluative data should be collected. Information about child performance must be obtained on an ongoing basis (daily or weekly) for formative evaluations and at the end of the program year for summative evaluations. The first data are necessary for making midstream modifications in procedures and curriculum; the second are important to ascertain whether the program was able to reach its goals for the group of children.

Other important evaluative considerations are:

-Criterion-referenced devices should be used to measure progress of children.

-It is important to use well-defined guides to assess the strength of the program in the service provision area.

-The data collected must be used to develop new objectives for the program to help overcome discovered problems.

-Assessment procedures for evaluation of program goals should be valid and reliable.

-Parent satisfaction data should be obtained.

-The advisory council, depending on its role, may be helpful in developing evaluative strategies (see Recommendation 48).

-Formal evaluation by an external source may prove beneficial.

SECTION 3

SERVICES FOR FAMILIES

SERVICES FOR FAMILIES

Parents have long been considered essential to the educational process with handicapped children. More than any other influence in the child's life, they can change the course of development. And, researchers argue, they can do it more economically and effectively than any school or other institution (WESTAR, 1981). All major federal legislation requires programs receiving funds to develop activities which support parents (see P.L. 94-142, etc.). Even programs operating with private money in almost all cases try to involve parents.

But what level of services should be extended to families? Some schools try to help parents with difficult day-to-day problems of poverty and illness; some try to educate parents regarding handicapping conditions; some try to give parents a respite from the unrelenting demands of a special child. In general, however, professionals agree that parents need help in three areas:

1. Knowledge--They must become versed in the process of development for normal and special children.
2. Understanding--They must come to feel that their problems with their child are understood by others in order to accept guidance from others.
3. Attitudes--They must develop positive attitudes which will enable them to nurture the growth of their child.

These three areas are the general foci of the recommendations included in this section. It is important to recognize that as the school helps the parent develop in each of these areas, it also i. making its own goals for the child more manageable because the parent is becoming a teacher in the home setting.

Knowledge. It has been noted that a biological as well as psychological system of interchange exists between a mother and her child (WESTAR, 1981). When a youngster is disabled in any way, however, two-way communication may be compromised.

The clues the disabled child gives about his needs may be so subtle or so aberrant that the parent is unable to respond appropriately. With special training, however, the mother learns to recognize and respond to various abnormal clues and, thereby, nurture the child's growth. One of the school's primary responsibilities to parents is to provide education which helps them recognize the child's signals and react appropriately so growth is stimulated.

Understanding. Before a parent with a handicapped preschooler is able to accept his or her role as the child's primary teacher, however, he/she often must conquer feelings of inadequacy or anger borne out of the situation. The school may provide individual counseling to parents and opportunities to meet with peers to help them clarify their situation and to aid them in seeing that others understand the difficulties they face. This support is often so effective that parents not only begin to work very well with their child, they also become advocates for special education in general.

Attitudes. The parent's attitude is important for the school as well as for the child. The teacher needs a cooperative mother or father if for no other reason than information. The parent is with the child all of the time, sees behavior on a moment-to-moment basis, and knows the child's medical and developmental history from birth. This information is essential when assessing the child and developing a suitable educational program.

How are attitudes formed? If the school staff members show the parent that they are dedicated to providing the child and family with the best of all possible services, and that they wish to help the family with all the problems (financial, psychological and educational) resulting from the birth of the special child, the parent is likely to regard the school as a very supportive affiliation. In short, the school's genuine concern for each preschooler must be communicated to parents in all its actions.

While the recommendations which follow only slightly touch on the role of siblings and the extended family in the special child's growth, these are persons who may profitably be included in many school activities. The more people concerned

for the child, the better the child's chances for success in learning activities.

Recommendation 22: Program for Parents

All schools involved with special preschoolers, toddlers or infants should have parent programs.

These programs, at a minimum, should include training and education regarding the child's development, emotional support for the parent, and assistance in acquiring services and financial relief.

Most programs serving special youngsters work hard to involve the parents. They frequently, however, fail to provide the counseling parents require regarding available services. This is perhaps because the programs themselves do not have enough information about the options in the community.

They also often fail to enlist the help of the fathers in the education of the child. More and more, fathers are recognized as essential in the child's early development (WESTAR, 1981, p. 12). Also, fathers may be the key to family stability. If the marital relationship is strong, the mother has emotional strength to bring to her relationship with the child. If it is weak, she may have less tolerance for the baby's needs. The "status and well-being of an infant is (often) related to the marital relationship...it has been shown that intervention is effective in mitigating at least some problems by improving the fathers' responses to their handicapped children" (WESTAR, 1981, p. 13).

Recommendation 23: Parent Individual Education Plan (IEP)

Each family should be evaluated to determine its needs and a plan prepared to meet them.

This activity should be initiated annually. The needs may be determined by

informal and formal means. Informal methods include: observation during parent-group meetings, parent-planning sessions, and other teacher and parent interchanges. Formal methods include: interviews, questionnaires, and the use of other evaluative tools. The plan itself should include activities with timelines in three areas: support needs, information needs, case management needs. (See Figure 7)

Program goals to help the family should be ones to which they aspire as well as ones that the school considers important. It may prove most efficient to include these goals in the child's educational plan and to evaluate progress toward them each time the youngster's growth toward his own goals is evaluated. But in no case should achievement be evaluated less than yearly.

Figure 7

Sample Program Goals for the Family

SUPPORT: To find respite care for the family.

1. A respite care facility will be found in the immediate area or arrangements will be made for such care.
2. The parents will meet with the facility director.
3. The child will be placed in the facility one weekend per month.

INFORMATION: The mother will learn proper handling procedures for the child.

1. A meeting will be arranged between the mother and physical therapist once per week.
2. The mother will be given handouts which show positions for feeding, lifting and toileting activities.

CASE-MANAGEMENT: All transportation needs will be arranged by the social worker.

1. The social worker will determine transportation needs for getting the child to other areas where related services are provided.
2. The social worker will determine which agencies are to pay for these services and handle arrangements.
3. The social worker will develop a schedule that meets with the parent's needs.

Recommendation 24: Parent Support Groups

Workshops and other group meetings which reflect the needs of parents with youngsters in the program should be held regularly.

Families with handicapped children often provide more emotional support for new families facing the crises of special children than professionals. They've been through the drama themselves. They know what helped, what hurt, and where the best help was finally found.

Parent groups are also an important way of communicating general information on handicaps and the development of the special child, and other kinds of information important to parents in general. Group meetings also can be used to assess the general satisfaction or dissatisfaction with the work done by the school.

Meetings should be of at least two formats. One should be an informal meeting in which parents can come together with other parents and discuss any difficulties currently being faced. Another meeting should be a regular well-planned session in which information, determined to be useful via assessment of the parents' needs and desires, is presented. See Recommendation 27.

Recommendation 25: Sibling Programs

Schools should have programs for the brothers and sisters of the handicapped.

Most programs are geared to reach parents. Of course, the parent's attitudes toward the disabled child are often reflected by the siblings. It is reported that in families "where parents shared...positive attitudes toward the handicapped child, the other siblings showed less disturbance in the home, at school and in social activities" (WESTAR, 1981, p. 14). While it is unarguable that parents must be the primary focus of family intervention efforts, it is becoming clearer

that benefits accrue when the special child's brother or sister are also counseled by the school.

Schools can help siblings accept and teach their special family member. This support in turn helps the family become more stable, thus removing a burden from the parents. In a study of programs that included the handicapped youngster's brothers and sisters in group experiences for siblings, it was reported that as a result of participation, the "siblings felt better about themselves and were able to interact more appropriately with their handicapped siblings" (WESTAR, 1981, p. 14).

If a school does not provide support for siblings, it must, as a minimum, familiarize the parents with possible problems and ways to resolve them.

Recommendation 26: Case Management

Schools should be willing to case manage in situations where families are receiving services from more than one agency.

When several agencies are charged with the care of a child, it is important that everyone involved understand the role of each agency. This knowledge prevents duplication of services and reveals gaps in the child's support network.

The school program's personnel should be the primary managers of the services received by the child since they spend more time with him than any other professionals. They can help arrange times for services convenient for the parent, help with paperwork, help with transportation, etc. This management relieves the parent of the added burden of coordinating professional assistance. Care must be taken not to take over typical parenting roles and responsibilities.

The first step in managing cases is to appoint a "case manager." The role this person plays is outlined in Figure 8. Clearly, the case manager is the person charged with coordinating service delivery for the child and family as well as interceding with others for the family.

In our survey, approximately one third of those programs responding reported that they were involved in case management for their parents.

Figure 8

Role of the Case Manager*

-Acts as liaison between family and service providers

-Acts as liaison between family and evaluators and referral source

-Ensures completion of social history forms by family (regarding: family composition, parent education and occupation, language, ethnicity, financial resources, etc.)

-Collects assessment results and recommendations from all program staff

-Schedules staff meetings to develop I.E.P.

-Meets with parents and staff to explain transdisciplinary team results and discuss recommendations

-Updates social history and notes changes that may influence child's progress

-Meets once per month with persons responsible for I.E.P. objectives to discuss parent-child progress and make adjustments in the program.

*Adapted from the Critical Characteristics Inventory (1981), pp. 31-32.

Recommendation 27: Parent Role in Planning

Parents should be involved in planning school services for their child.

First, parents should be a part of the team of professionals who evaluate their child. They can provide invaluable information on the child's medical and developmental history and behavior in the home.

Second, parents should also help develop the individual education plan. Usually, they have their own priorities regarding the skills the child should improve. Often, for example, parents want the child to learn to execute very

specific tasks in the self-help area - such as "using the bathroom without help."

Third, parents should have some part in determining the kinds of related services (physical therapy, psychiatry, occupational therapy, etc.) their child will be given and the source of those services. Since they frequently must learn to provide support activities at home, it is very important for them to understand the need for specific services.

Fourth, parents should help plan and write goals for the family. These goals may be included in the I.E.P. (See Recommendation 23.)

Fifth, parents may be involved in planning the operation of the preschool. They may have a role on the Advisory Board or other bodies charged with guiding the school's activities. "The parent is one of the two primary consumers of the center's services...(while he) should be able to...expect leadership from the staff in program decisions, the center personnel should expect valuable assistance in decision making from the parents" (Lillie and Trohanis, 1976, p. 8).

Recommendation 28: Parent Role in Evaluation

Parents should be given a role in evaluating the program annually.

This role helps build parent commitment to the program. It also helps the educational organization determine the level of parent satisfaction with its work. The role played in evaluation may be as basic as helping determine the child's performance on certain baseline skills and comparing it with initial performance at the time of program entry, or as complex as helping the staff determine the success with which overall objectives for the parent program (in the areas of information, counseling, etc.) were met.

Recommendation 29: Play and Toys

The educator should teach parents and siblings the best way to use toys and play in helping the special child.

The task can in part be accomplished through parent workshops in which teachers and psychologists help the parent understand the role of play in learning and how to select toys that help the child in different developmental areas. It can also be accomplished in private consultations with the parents or during visits to the home. In this latter situation, the teacher can demonstrate appropriate procedures with the child as the family observes and then ask the parent or sibling to repeat the procedure.

In Teaching Parents to Teach (Little and Trohanis, 1976), a procedure called the toy-lending library is recommended. "After a discussion of the developmental level and needs of the child, the parent is given an appropriate educational toy to take home to the child. Usually, instructions accompany the toy to give the parent an understanding of how it can be used for learning" (p. 9). This method of teaching the parent incorporates both a learning session with the teacher and a written text for the parent. The Special Education Training and Resource Center (SETRC) might also be utilized as a source of materials and training for parents.

Recommendation 30: Home Teaching

Home teaching should be available according to need regardless of age.

Regardless of age, the more severe the handicap of the child, the more likely the family will require in-home demonstrations and assistance.

Recommendation 31: Consultation

Individual consultation in the home or school should be available to parents.

Parents should be aware of the staff's willingness to come to their home and talk about any issues related to their child's education, handicap and development.

Recommendation 32: Written Prescriptions

Parents with children unable to attend classes should receive a written prescription of activities for their child.

When a child receives all educational services in the home, as is often the case with moderately handicapped infants, it is extremely important that the parent be involved in teaching the child at home. A written outline of activities to engage in with the child, supported by weekly visits from the school staff, will help the parent become the out-of-class teacher that he or she must be. A sample procedure to be used in home teaching is shown in Figure 9.

Approximately one third of the respondents to our survey reported that their clients were in home-based programs.

FIGURE 9

HOME TEACHING PRESCRIPTIONS*

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1. Teacher presents written prescription of an IEP goal or objectives with a sample of activities to help the child reach the goal. This should include step-by-step teaching format for the parent.

2. She or he then introduces the activity to child, following the written prescription, and records frequency of correct responses on data sheet.

*Adapted from Marsha S. Shearer in Teaching Parents to Teach (Lillie, 1976), p. 137.

3. After several trials, with the parent watching the teacher, the parent tries the activity with child.

4. The teacher offers suggestions.

5. The teacher emphasizes the importance of working with child during the week and recording frequencies.

6. The teacher leaves home or office number and encourages mother to call if questions develop.

7. After one week, the teacher returns, collects post-baseline data on the activity.

8. On the basis of this information, she alters the prescription or writes a new one. She then repeats the procedure above.

Recommendation 33: Parent Teaching Activities

Parents should regularly participate in teaching activities with the child and educator.

Whether the child is in a home or center-based program, the parent should work with the teacher at least weekly. This time helps the parent learn proper intervention techniques (e.g., how to handle a cerebral palsied child, how to stimulate language development) and it shows the child that the parent supports the school's work.

The work with an educator also enhances the parents' confidence in his or her skills and they become more competent in using routine events during the day (e.g., toileting) to teach the child language, cognitive and motor skills and self-help skills. It provides the teacher with an opportunity to observe language and social interactions between the parent and the child. These observations help in developing prescriptions that the parent can follow and in identifying activities for which the parent is by temperament or ability unsuited.

Ultimately, the parent may wish to work in the classroom with other children. Some parents make excellent classroom aides and the school experience reinforces

their work with their own children. Parents placed in classrooms as paraprofessionals should receive the amount of training (including observation by the teacher) specified for paraprofessionals in the school's employment and staff guidelines. (See Recommendation 40.)

Recommendation 34: Program Philosophy

Parents should be given a written statement of the program philosophy and goals.

The statement should be given to the parent at the time the child is enrolled. It helps the parent not only know what to expect and what benefits will be realized from the school; it helps in understanding that the school wants parents' participation and, moreover, expects commitment to the educational process.

The school's written philosophy should outline the role the program hopes the parents will accept in partnership with the preschool. It should state the level of involvement expected of parents in terms of workshops, weekly visits and at-home work with the special child. (See Figure 10.)

The written statement for parents should be concise and easily understood. Jargon should be avoided.

Figure 10

A Preschool's Activities with Parents*

-Inform parents of rights (as per P.L. 94-142)

-Support parents via regularly scheduled meetings

*Adapted from Critical Characteristics Inventory (1981), p. 35.

-Plan educational programs on subjects requested by parents

-Offer training in discipline techniques

-Train parents in positioning/handling techniques

-Offer information on developmental disabilities and normal development

-Provide training in data collection and behavior charting

-Provide guidelines to help parents choose toys

-Make available toys and printed materials for home use

-Offer training in how to cope with child in community

-Provide information concerning available community resources

-Provide individual family counseling or refer parents to outside agencies

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SECTION 4

STAFF

STAFF

Special education programs demand certain staff configurations usual to most areas of education. Special children may be seriously ill which necessitates the involvement of medical personnel. They may be physically disabled which means physical, occupational and other therapists are needed to help them learn to function better in their environment, and they may be significantly delayed in language or pre-language development. They may be very far from being able to speak; they may never hear or see; and consequently, long-term work with a speech therapist may be required. The child's disabilities may make extraordinary demands on their family's ability to hold together emotionally or to survive financially. Social workers, nurses, psychiatrists and many other professionals may be required to help the families cope as their children develop to the point their capabilities allow. Most of all, special teachers who have been trained to work with such children may be needed to provide appropriate programs for them.

The two decades since 1960 have seen a flurry of activity in the field of special education: programs have proliferated as funding became available, the number of children receiving services has increased a hundred-fold, and thousands of new professionals and paraprofessionals have entered the area of preschool services. Certainly, there has been a growing demand for knowledgeable people to serve a very great need. In almost every state, even now, newspapers are filled with advertisements from school districts in need of special educators, especially in the preschool area. Not only teachers, but administrators, therapists, resource room specialists and aides are sought.

While standards exist for the training of most of these people, they are in some instances inadequate. They are too broad to ensure the readiness of the professional for work with handicapped preschoolers. In this section, we have

offered answers to several key dilemmas:

-What should be the qualifications for each member of a preschool staff?

-What skills should he or she possess?

-What role will he or she play?

-How can professionals become better prepared for their work?

Responses to these questions are not easily devised. But the keys to most of them must be: "Develop better in-service training programs. Plan to upgrade staff skills. Develop certification criteria for professionals who work with children under age 6." By taking these actions, the overall quality of services will rise and, very possibly, more children will be served as professionals learn to work as part of a team responsible to the children and their parents.

Recommendation 35: Qualifications for Teachers

The qualifications for a preschool special education teacher should be at least equal to the certification/licensing requirement for similar teachers of 5 to 21 year old pupils in New York.

The preschool child's development in the five key developmental areas (motor, cognition, language, social-emotional growth and self-help skills) is more dramatic in content and speed than the school-age child's growth. From a being totally without competence in any of these areas, the normal baby grows into a child who, by age five, has become a moving, thinking, speaking, interactive, somewhat self-sufficient human being. If something is awry developmentally during the preschool years, it must be identified and treated quickly and skillfully: time is of the essence. When a baby is born with Phenylketonuria, for example, a delay of only a few weeks in treatment can be the difference between a lifetime of retardation and a lifetime of normalcy.

It is very important that teachers be acquainted with the appropriate options for remediating various special disabilities present in preschoolers. Because this age group is so vulnerable and so dependent, the teacher must be an expert in recognizing problems before they become crises.

In our survey, most persons responding indicated that teachers in their programs were special education certified. It is very important, however, for teachers to be trained for work with handicapped preschoolers, as well as special children in general. A strong background in normal child development is also necessary.

Recommendation 36: Qualifications of Supervisor/Administrator

> People supervising educational programs for special preschoolers should have special education or early childhood credentials and experience in working with the birth to six population, in addition to competencies in supervision and administration.

While the administrator may rarely work with the children in the classroom, he/she will often be involved in their evaluations, in interactions with agencies serving them, in consultations with their teachers, and in tasks related to evaluating the overall program for parents and families. For these reasons, we have recommended that the supervisor not only be special education certified but also have experience--as a teacher or specialist--in working with special preschoolers.

Of those programs responding to our survey, all but one had administrators holding special education or early childhood certification credentials.

Recommendation 37: Qualifications of Specialists

Professionals serving the program in staff or consulting positions should have experience with preschool handicapped children within their areas of specialization.

This category includes parent education specialists; speech, physical, occupational and recreation therapists; psychiatrists; psychologists; etc. It also includes all members of the transdisciplinary team: medical personnel, educational and therapy specialists. The reasons for team members and specialists being required to have experience with the zero-to-five population are the same as those for teachers. (See Recommendation 32.)

The following figure shows, in order, the ten most frequently hired specialists in preschool programs responding to our survey.

Figure 11

Ten Most Frequently Hired Professionals in our Survey

Teacher

Speech/language therapist

Psychologist

Paraprofessional

Social worker

Physical therapist

Pediatrician

Occupational therapist

Psychiatrist

Audiologist

Recommendation 38: Qualifications of Transdisciplinary Team Educators

Teaching professionals who work with a team in assessing child needs and diagnosing problems must have a master's degree in Special Education and experience with children under five.

On the team, the teacher's knowledge is critical in making appropriate decisions on future activities for each child. It is, in point of fact, often up to the educator to guide the team through the diagnostic and I.E.P. development process. She or he can act as a guide only if well trained and experienced.

A person with experience in supervising a program is aware of the resources available for the youngsters, knows the various staff members' roles and expertise, and on the basis of long practice, knows the best routes for solving a host of problems.

The requirement for an advanced degree in education reflects the need for a team educator who keeps abreast of the latest developments in research and has strong ties with the professional and academic communities which guide developments in the field.

Recommendation 39: Qualifications of Home Workers

Individuals who work with the child at home should have training in the areas designated for intervention on the child's IEP.

The transdisciplinary team should closely monitor the matching of home trainer and need. Paraprofessionals, as well as professionals from a variety of disciplines, may be used in this role.

Since home workers almost always have even less time to work with the children

than the classroom teachers, each minute of the work must count. This situation can only be achieved when the home visitor is well versed in the area of the child's need.

It is also important for home workers to be competent in motivating parents. They must guide the parent, as well as the child, through various teaching strategies. They often must resolve concerns that plague the parent before teaching can begin. Ross's (1964) description of a "helping person's" attributes are those which the home trainer should possess:

> They include the human qualities of acceptance, understanding and warmth; the professional attributes of objectivity, confidence and knowledge, as well as the technical skill of listening and talking to people under stress (p. 75).

Our survey indicated that most programs responding usually send either a social worker or special education teacher into the home. However, most preschools indicated a willingness to send any of their staff members when the need arises.

Recommendation 40: Qualifications of Paraprofessionals

> Standards for persons working in preschool programs without academic credentials should be determined by the program; the minimum requirement for those working with children, however, should be completion of a series of training events conducted by the staff or other education professionals.

Because funds are limited, more and more paraprofessionals are becoming a part of preschools. They have proved themselves as a group, to be invaluable in helping the teacher manage the classroom and in providing him or her with more

time for instruction. A point has been reached, however, when paraprofessional qualifications need to be spelled out for the educational community.

Paraprofessionals are frequently charged with tasks such as behavior management and small group teaching in preschools. These roles are necessary when the teacher is unavailable because of individual assessments or consultations with specialists. However, the paraprofessional should be trained by the teacher and supervised in these roles over a reasonable period of time before being entrusted with the children alone.

The fact that paraprofessionals have come to be trusted with basic classroom functions suggests that their roles can and should grow over the next few years. Therefore, to help them become productive members on the school team, they should be included in appropriate in-service training events along with other staff members. Also, they should be helped to acquire some of the staff competencies shown in Recommendation 41. The acquisition of skills is especially reasonable when the paraprofessionals are also parents in a program.

Recommendation 41: Staff Skills

> The abilities needed for the various staff roles at the preschool should be stated in writing on a list of staff competencies.

This list is important to help the staff operate smoothly. It helps everyone understand everyone else's role. It gives every member a general knowledge of the kind of skills that can be expected of every other staff member. The staff skills shown in Figure 12 are basic for all staff members in preschools. Deficiencies in any of the areas should be the focus of staff development and in-service training.

Figure 12

Staff Competencies*

Can write goals and objectives

Knows behavior modification techniques (behavioral observation, data collection, methods to increase/decrease behavior, graphing)

Can write task analysis

Can select and modify instructional materials for developmentally disabled preschoolers

Can use and adapt assessment devices

Can coordinate, plan, implement and evaluate activities to meet prescribed activities

Is knowledgeable regarding developmental disabilities, rehabilitation and their prevention

Can counsel families of handicapped infants and toddlers

Is aware of community resources

*Adapted from Critical Characteristics Inventory (1981), p. 36.

Recommendation 42: Staff, Personal Qualifications

> Program personnel should be warm, enthusiastic, and committed to working with children; and they must have good interpersonal skills for working with professionals from other disciplines, with parents, and with agencies.

Obviously, these criteria are subjective. A staff composed of individuals with these characteristics, however, functions more successfully than a staff without them. Education is a people business; special education requires its practitioners to work with a multitude of individuals who must find them credible (other professionals), committed to and enthusiastic about their work (parents, children), and efficient (agencies).

Recommendation 43: Transdisciplinary Team, Personal Qualifications

The professionals on the team should be open to collaboration with persons from other disciplines and interested in group dynamics.

All members of the team should work together in evaluating the child's behavior and performance. Mutual respect, therefore, is very important among team members. Individuals who enjoy working with other people and who are able, when necessary, to compromise are the best candidates for an evaluation team.

Persons who possess the appropriate personal qualities, however, may often benefit from staff training exercises designed to familiarize everyone with the focus and skills of each team member's discipline.

Recommendation 44: Adult-Child Ratios

There should be at least one adult for every three severely handicapped children, at least one adult for five mild-moderately handicapped youngsters.

Special children need constant attention--not all of it educational or medical. They do, however, need an adult present most of the time for supervision and personal care. The teacher need not be responsible for all care. Others can help with noninstructional work.

The higher the adult-to-child ratio, the more the teacher is able to individualize the instruction for each child. As teaching becomes more individualized, the child's rate of learning improves.

As children prepare for regular-education environments, the ratio should approach what is found in a mainstreamed classroom.

Preparation for mainstreaming is critical because the children are moving from an environment specially suited to their unique needs to one which is de-

signed for nonhandicapped children. The teacher must communicate frequently with the professionals who will work with children in the regular setting. Together they can ensure a smooth transition. Their team work, however, takes time and the preschool teacher needs extra adults present to help out with the children while transition arrangements are made, and children are prepared individually for the new demands of the regular school.

In the programs responding to our queries, ratios as high as two adults per child and as low as three adults for twenty children were reported. The teacher-child ratios ranged from one-to-one to one-to-thirty.

Recommendation 45: Staff Development Plan

An annual plan for staff development should be prepared by all preschools.

Even with sound training and experience, every professional needs to keep abreast of developments in this field. Special education and related disciplines change very rapidly in terms of the information available each year. Every program should help its staff members assess their needs for professional development and then explore options for meeting the needs. (See Figure 13.) This assessment should occur at least annually.

A majority of programs responding to our survey indicated that they are involved in identifying staff needs and developing plans to meet those needs.

Figure 13

Methods for Assessing Needs for Training*

-A written report of self-perceived needs by staff members

-A paper and pencil survey or profile of staff member's needs in particular areas

-A formal, written testing procedure to ascertain the staff's knowledge

-Recommendations for training from an advisory committee or task force

-An informal, face-to-face interview with each staff member

-Development of plans on the basis of a period of observation of the staff's behavior

*Adapted from: Trohanis, P., "Designing an In-service Training Program." In M. I. Johnson, B. A. Ramirez, P. L. Trohanis, J. L. Walker (Eds.), Planning Services for Young Handicapped American Indian and Alaska Native Children, pp. 138-140.

Recommendation 46: In-service Training

The staff should regularly be provided workshops and other in-service training experiences with the ultimate goal being to help them function better on the job.

The team of transdisciplinary professionals should be used in these staff training experiences. They have skills and knowledge that staff members need in implementing the objectives of the education plan. Most of the training sessions should be designed to improve very specific skills or to acquaint staff members with procedures or information necessary for their job in the school. (See Figure 14.)

Figure 14

Topics for In-service Training Experiences

Orientation workshop for all staff

Skills workshops in developing objectives, recording data, analysis of tasks, and so on, for I.E.P. planning and programming

Working with parent groups

Sessions to help professionals to understand differences and similarities between children with various degrees of handicapping conditions and learning problems for individual case analysis

Developing the skills of paraprofessionals

Transdisciplinary team: diagnostic evaluation orientation; skill building; etc.

Community resources and child placements

Transition from preschool to school programs

Mainstreaming

Medical procedures

Specific skill methodology, materials and techniques in specific areas of development

Sessions to help identify and work with abused and neglected children and their parents

Recommendation 47: Function of Transdisciplinary Team

The team as a unit should diagnose the child's problems, assess his learning needs, develop a learning plan (IEP), and assist in intervention.

Every person on the team has a specialty of significance for the child: the social worker knows the child's history and family background; the child's teacher knows his learning aptitude; the physician knows his medical problems; the speech therapist understands his communication needs. All relevant professionals, consequently, should work together to serve the whole child.

After the initial diagnosis, which has been determined by the group, the team's members should assist the teacher in transforming their recommendations into an educational plan for the child. After the plan is developed, they should be available as needed: to train the teacher in techniques from their disciplines that she or he will need in order to work with the child; to work directly with the child or family themselves; to work with other professionals in developing intervention strategies or finding resources for the program or its clients; to learn the techniques of other disciplines themselves to work with the child.

One of the major advantages of this team approach is that over time, professionals grow to respect one another and become advocates for the program. They begin to share their contacts with the preschool, each other and clients. This interchange of information leads to a greater network of resources for the children and families served by the program.

Our survey respondents indicated that in most cases their teams function in the following manner: each professional evaluates the child separately and then meets with other team members to review all evaluations and prepare a list of recommendations. An ideal method of team operation is: all members work <u>together</u> in evaluating the children, discuss the results together, and develop recommendations together. At least most of the programs responding to the survey <u>do</u> develop group recommendations.

SECTION 5

INTERAGENCY COOPERATION

INTERAGENCY COOPERATION

In the 1970's, the Federal Government began a program, Child Find, designed to identify special children who could benefit from preschool education programs. When this effort was abandoned in the late 1970's, federally subsidized programs were left with the full responsibility for finding their own clients. More important, many of these programs, those created under the Handicapped Children's Early Education Program (HCEEP), were charged with the task of publicizing their work in the community, and with developing an overall plan for locating children. The success of these plans, it soon became clear, rested on the degree to which cooperation could be fostered with other local service providers.

Unfortunately, territoriality often clouded various agencies' willingness to cooperate fully. It precluded asking others for help and, in turn, offering help to others.

This situation continues to exist even in the face of diminished federal resources. More than ever, some programs feel they need all the clients they can enroll, just to continue operating.

The truth of the matter is, of course, that no one agency can be all things to all clients: no school can provide all handicapped children with the range of services they may need. Many service providers are necessary to respond to the gamut of conditions seen among special children.

Programs must work together to provide services to the entire handicapped population in any given community. A harmonious group effort ideally would allow programs to gain clients they can serve well through referrals while they send clients with needs outside of their specialty to other professionals.

What can be done to instill a new sense of inter-reliance among programs in New York? Two major organizational activities are needed. First, a network of service agencies must be developed. It should be based on professional and

personal liaisons formalized in writing, designed to provide better services to children and to reduce the overall costs of intervention. Second, an atomosphere of cooperation among agencies must be created to support the network. A willingness to work with others is required both to provide help to individual children and to develop better overall services for families in a community.

The idea of a network incorporates the notion of awareness: through regular communication, each agency must become aware of what its counterparts are doing. This knowledge means that for a particular child, gaps in services will be recognized quickly and duplication of tests and services by different agencies servicing the youngster will be avoided. This awareness saves agencies money and reduces problems for clients.

The problem faced now in New York and in a large part of the rest of the nation is that there has never been a single agency given the task of creating a network. On the basis of logic, it has always been assumed that when several agencies serve one child, they will work together. The cooperation has been elusive. A state plan, which perhaps incorporates the Early Childhood Direction Centers as a key administrative group, should be devised and implemented.

Until the time when the plan is working, each agency must develop procedures to cooperate with others. Most of the federally funded programs are already required to have "networking" plans.

An advisory board may become a key element in implementing a program's plan for networking. Particularly when membership includes visible and influential persons from the community and professionals from various child-care disciplines, the board is in a position to "open doors"--to help the agency establish and maintain liaisons with other service organizations in the community. Most agencies have advisory boards, but many do not make good use of them.

Figure 15 shows the elements of a comprehensive program plan for networking. Figure 16 lists steps for better interagency cooperation and exchange.

The five recommendations in this section should be considered along with Recommendation 1: Locating Youngsters in the Services for Children section and Recommendation 26: Case Management in the Services for Families section. These recommendations deal with referrals and interagency work, respectively.

Figure 15

Elements in a Comprehensive Networking Plan*

A timeline

Procedures for: making phone contacts, visiting agencies, distributing flyers and posters, conducting workshops, keeping records of agency contact

A list of contacts to be made

A list of materials to be developed

A list of workshops to be given

Referral procedures

Staff responsibilities

*Adapted from A Guide for Creating Community Awareness and Developing Interagency Cooperation (Eagen, et al, 1981), p. 12.

Figure 16

Steps for Interagency Cooperation

Establish liaison with local and state agencies.

Participate in planning services for preschool handicapped children at community and state levels.

Refer children to other agencies.

Accept children referred by other agencies.

Manage cases for families receiving services from more than one agency.

Manage cases of children awaiting placement.

Document interagency efforts.

Develop a written interagency agreement with other agencies.

Recommendation 48: Advisory Board

Every program should have an advisory board.

The board should provide a vehicle for reaching out to the community. Its membership should be carefully chosen. It may be comprised of professionals from the following categories:

1. Community service agencies
2. Parents
3. Administrators or professors from universities and colleges
4. Community officials (government)
5. Special educators
6. Others concerned with preschool or special education

The minutes of each of the board's meetings should be recorded and made available to the program's staff, and to other agencies, the media, important local organizations, etc.

Our survey revealed that respondents provided advisory board minutes primarily to program staff. Most advisory materials contained recommendations regarding staff procedures and the provision of services. Advisory board information also was provided to: 1) the funding source, 2) the board of directors of the school, and 3) the state education department--in that order.

Other audiences for the materials were area agencies and county governments. Unfortunately, these groups received information less frequently than other groups. Yet, they represent two of the most important audiences: since they control accessible services and financial resources and are concerned with the client group served by the preschool.

Recommendation 49: Referrals

Each program should develop a statement, preferably written, which spells out in detail the kind of cases it can accept as referrals.

This statement should be distributed to all relevant community agencies along with other materials which describe the program. (See Fact Sheet, Figure 17.) This sheet should be prepared for use by other agencies that need information on the program. The referral statement should contain the following categories: age range for children accepted; financial terms; handicap(s); degree of handicap(s); and other pertinent information about the conditions for acceptance.

Eventually, written agreements between agencies to facilitate the transfer of cases may be developed. These contracts should specify procedures for referral, including: descriptive forms on client which include results of any tests or evaluative activities, present level of services, and history of intervention; agency contact person; and information regarding services desired from accepting agency. These agreements may also create a structure through which a group of agencies can hold community screenings and review the results, for each client, as a group--making placement decisions at the time of review.

Figure 17

A Fact Sheet Format for Programs in New York

1. Age Group
   Is the program for infants (0-18 months), toddlers (19-36 months), or pre-schoolers (36-60 months)?

2. Evaluation of Children
   Does the program use a team approach to determine the child's needs and the intervention services to be used? Does the program determine the nature of the curriculum to be used via these evaluations?

3. Home Program
   Are there provisions for serving certain children--who cannot or should not attend classes--in their homes?

Figure 17 (Cont.)

A Fact Sheet Format for Programs in New York

4. Class Program
Is the classroom program comprehensive in terms of daily routine? Are specific developmental areas concentrated on daily?

5. Behavior Management
Does the program use routine, rules, prevention, positive reinforcement, behavior modification, or specific kinds of therapy to maintain an appropriate classroom environment?

6. Curriculum
Does the program use one curriculum for all children or is content of the curriculum varied according to the needs of individuals in the program?

7. Length of program
How long may children remain in the program? What are the reasons for termination of services (too old, no longer handicapped, change in diagnosis, etc.)?

8. Length of Day
Does the length of time the child spends in class per day or the hours of intervention provided per week to the homebound child vary or is it set?

9. Mainstreaming
What level of integration of nonhandicapped and handicapped children is possible in the program: all of the time, only during specific activities (e.g., art), or none of the time?

10. Intervention philosophy
Does the program allow each specialist serving the child, e.g., physical therapist, occupational therapist, etc., to work in isolation with the youngster or are all professionals required to work together?

Recommendation 50: Direction Centers

The Direction Centers must provide more help in coordinating services.

Since these centers were set up for the purpose of matching the needs of preschoolers with local services, it would be easy to extend their work to include providing information regarding available community services on a regular basis to local agencies.

They could also help various agencies coordinate their work with each other. This would relieve some of the information-gathering burden on local service providers and place it with a Direction Center that is already designed to be aware of local resources. In this sense, the Direction Center would become an interagency clearinghouse that helps prevent duplication of services; helps local agencies find specialized services for their clientele; and plays a coordinating role in placement, transitions between preschool and school, and case management. The Early Childhood Direction Centers are an excellent idea that needs to be developed further.

Recommendation 51: Services Listing

> Every school should be required to provide parents with a list of available services in the geographic area at the time the child is screened.

Often agencies feel they must compete for children because of financial considerations. Some even feel that they must take clients, regardless of the appropriateness of their program for the clients. This step would reduce these problems by giving parents options that they have a right to pursue under P.L. 94-142 regulations.

Requiring schools to provide this service guarantees that they will make an effort to locate other sources of care in their communities. This effort is the first step in developing interagency cooperation. Once many agencies make the effort to locate other agencies, they will take the next step--establishing liaisons. Sources of listings for other agencies include: Direction Centers, area associations for the handicapped, day care council listings of area facilities, central county agencies, local newspapers, yellow pages in telephone books, and State Education Department libraries of child find literature.

Recommendation 52: A State Plan

A plan should be devised at the state level to foster inter-agency cooperation.

A list of methods to help agencies cooperate in serving children should be developed. It should include the requirements listed in Recommendations 48-51 as well as a detailed list of the responsibilities of each preschool, the role of local agencies (such as Direction Centers), and guidelines for the development of a clearinghouse which would maintain computerized lists of agencies and the services they provide. The clearinghouse should be open to queries from both parents and schools who are seeking services.

In many states with mandates for providing services to children under three, the state-level referral and child identification activities primarily involve "awareness activities and the maintenance of toll-free telephone lines for information". Then, depending on the state, the other interagency referral activities are "handled primarily at the service-provision level, either local or area" (Anderson and Black, 1981, pp. 27-28). In states with state-level activities for finding children, most children placed are located through these efforts; in states without such programs, most referrals of children below three years come from public health agencies. In all probability, state programs find more mild to moderately at risk children than do public health agencies which, by their nature, are most likely to identify only the most severely handicapped babies. These public health agencies are unlikely to maintain a network of referral contacts as extensive as could be developed by a state-level program.

SECTION 6

LEGAL CONSIDERATIONS

LEGAL CONSIDERATIONS

This section of the Standards concerns issues in improving early education services that must be addressed at the state level. The most central issue, around which all others revolve, is the need for a mandate to provide services to handicapped children under five, which would include funding non-profit, non-public and public agencies.

The enactment of such a law will raise certain implementation questions which must be answered with care by regulations that address the unique requirements of this special population. The central question, asked in Special Education Mandated from Birth (Anderson and Black, 1981), is "What is special education for very young children" (p. 23)? Is it simply the same as special education for school-age youngsters?

Certainly, its purposes are the same. It must be geared to finding children who need help and providing the required aid to assist them in reaching their fullest developmental capacities. A law would help accomplish this goal by providing "a clear process for acquiring special education services that (are) consistent and (that provide) an equal opportunity" to all children in the state (Anderson and Black, 1981, p. 23).

However, the question still lingers: What is special education for this population? Many babies and toddlers cannot be diagnosed as having a particular developmental handicap, but they clearly demonstrate a need for intervention. Should placement be denied these children because they cannot be slotted into one of the traditional handicap categories (blind, deaf, autistic, physically handicapped, etc.) or into the traditional program? If they are enrolled in a program, what sort of program should it be? Who will decide?

In most states with mandates for birth to five, moderately and severely

handicapped children receive most of the services. This situation developed because youngsters with mild handicaps are more difficult to diagnose and because legislatures have been reluctant to allow children at risk for developing problems (due to social or familial factors) to receive assistance. But should this be the case when the evidence from research over the last fifty years so clearly supports the earliest possible intervention as a means of resolving developmental problems?

These and related issues are addressed in this section. New York has a head start on many of these problems. For some years, there have been provisions for serving some children in this population even though a mandate has never been in place. Anderson and Black (1981) point out that in states with permissive early education legislation or in states with a history of services to citizens under five, the implementation of a mandate--when it comes--appears to occur more easily than in states where little or no groundwork for providing services has been laid. It is now the moment for services already available in New York to be organized and, if necessary, supplemented by the passing of an early education law. To do less is to ignore a segment of our youngest and neediest citizens.

Recommendation 53: A Law

There should be a mandate which provides for services to children between birth and five years.

In a position statement from the International Council of Exceptional Children (Division of Early Childhood), its authors state: "...the provision of services to handicapped children, birth through five, ...must be made a priority of the 1980's. ...The lack of such services represents the most serious impediment to handicapped children which exists today ...(given) the mounting evidence of program effectiveness for this group"(Toole, 1980, Appendix B).

The law is needed now, and it must follow the P.L. 94-142 guidelines. Its regulations should address responsibilities of state education for children under five. These include: "finding children, determining their eligibility for services, developing I.E.P.'s, providing direct services, monitoring compliance with state laws, coordinating interagency activities and paying for services" (Anderson and Black, 1981, p. 26).

Because special children under three are especially difficult to evaluate and because the services that birth to five year olds require differ from school-age children, the regulations cannot be carbon copies of these for five to twenty-one year olds. They must differ especially in eligibility criteria, parent involvement, placement procedures, and service options.

Recommendation 54: Length of Stay

Children should be able to leave a program at school age or whenever the program no longer addresses their needs.

The eligibility requirements for special education for children birth to five years must be balanced by criteria for determining when a new placement or no further special placement is indicated. While the days when a handicapped person is placed in a state or private institution without hope of reprieve are over, some programs still retain pupils who would be better off in other situations.

Our survey found that most respondents agree with this standard. They, in fact, use the following criteria for terminating services:

1. Age
2. Eligibility for regular education
3. Original condition no longer exists
4. Change in status
5. Committee on the Handicapped review
6. Assessment results

Recommendation 55: Transitions to School

Children should be allowed to stay in a preschool program once they reach five years if there is no program for five-year-olds and if the local Committee on the Handicapped agrees.

Because many special children are very late in developing normal functional skills, it is better for them to be with younger children of comparable capacity than with older children of greater capacity if a choice must be made. These decisions should not be legislated, however, but should remain the prerogative of local service providers.

Many five-year-old children with mild handicaps who are given a year of special education with others of like age and capacity are able to go to regular school at age six. This year of transition helps prepare them for the academic tone of school in a way that preschool--which usually must focus on remediating particular problems in development--does not. A year of transition gives the youngsters an opportunity to begin to integrate cognitive, social, and self-help skills under the guidance of an educator whose goal is promoting attitudes and skills necessary for first grade. This year is not required for all students, but it should be an option for those who need it. Many more transition programs are needed in the state to help five-year-olds make the passage from preschool to school more securely.

Recommendation 56: Criteria for Placement

Need for services must be the primary criteria for placement: children should not be matched with a program solely because it is within their community or funds are available for placement within a particular facility.

The definition of need is an area that requires more study. As outlined in Recommendations 3 and 57, however, children who satisfy a transdisciplinary team's criteria for special need should be placed in a suitable program within thirty days of evaluation. To place children in a program for which they are not suited simply because it is convenient or it is the only placement available creates an added burden for the staff of the program and does not resolve the needs of the youngster satisfactorily. Therefore, many programs need to provide more comprehensive services with various options in programming, scheduling and treatment.

Recommendation 57: Eligibility for Services

The transdisciplinary team should be given authority to determine the need for services.

In some cases, an infant's need for services cannot be determined via tests and instruments. These tools may not reveal the presence of an impairment, even though the transdisciplinary team feels there is ample evidence from the child's present behavior and history to indicate a need for services. In cases where a categorical classification of handicap is impossible, a "deferred diagnosis" category should be used if the child clearly requires intervention.

"Deferred diagnosis" means "that the child is having difficulties and is in need of an early intervention program, but that the specific handicapping condition has not yet been determined" (Anderson and Black, 1981, p. 6). Most states using this category require reevaluation at least yearly and disallow the classification past age five years.

Other states are using a "pre-primary impaired" designation for youngsters who do not fall into one of the handicapping categories but show an "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" (Anderson and Black, 1981, p. 16).

Both of these classifications may allow mild as well as severely handicapped children to receive services. And, most important of all, the "deferred" classification leaves judgment regarding eligibility up to the transdisciplinary team rather than to tests.

Recommendation 58: Committee on the Handicapped (COH)

> Local COH's for preschool children (separate from school age) should be established by each school district.

These Committees should be centrally involved in the placement process. They should include: a special educator, a speech therapist, a special education administrator, a psychologist, and other specialists when appropriate. It is extremely important that they focus on and be knowledgeable regarding the birth to five age group. The placement options for this group and the needs of the youngsters are quite different from the five to twenty-one year olds presently served by COH's.

Finally, these new COH's should cooperate with their school level counterparts in developing transitional placements for children who are five. This interchange will help local schools prepare for incoming special youngsters.

Recommendation 59: Consent

> Parents must give written consent for the child to undergo assessment, placement and IEP activities.

The consent form should apprise parents: 1) of what they may expect to occur during the screening, diagnostic, and assessment processes; 2) of their roles in the processes; and 3) of any obligations they may incur as a result of the overall evaluation. The parent should also be advised, at this time, of the scheduled date and time of each evaluation and asked if transportation assistance will be needed. A record of consent should be included in the child's folder.

The signing of consent forms is an excellent opportunity for enlisting parents in the service provision process. If the staff is supportive and demonstrates its competence in first meetings with parents, the subsequent encounters are more likely to be productive.

Recommendation 60: Parent Involvement

> Each preschool should be required to have parent involvement goals and should be required to document activities with parents.

The documentation should include evidence of consultations with parents, parent group meetings, home visits, team involvement and workshops. (See Recommendation 34.)

Lillie, in Teaching Parents to Teach (1976), advises:

> Evaluation involves determining whether or not objectives have been accomplished, by comparing (them) with the actual outcomes of the project. Many different evaluation procedures are available: standardized testing, criterion-referenced testing, observing and counting frequency of behaviors and testimonials are some of the more popular (p. 13).

Lillie recommends that a parent plan include goals and objectives in four areas: social emotional support, information exchange, parent participation, and parent-child interaction. The actual goals for each parent should be developed by answering (with activities) questions shown in Figure 18. Evaluation can be conducted by determining how well the "answers and the activities they suggested" were implemented.

Figure 18

Planning Parent Programs*

AREA	QUESTION	ANSWER (FILL IN)
Social and emotional support	What emotional support do parents need?	
Information exchange	What information do the parents and center staff need from each other?	
Parent participation	What are the parents' and center's needs for participation from parents?	
Parent-child interaction	What are the parents' needs to improve their interaction with their children?	

*From Teaching Parents to Teach (Lillie and Trohanis, 1976) p. 12.

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APPENDIX A

SURVEY

PRESCHOOL PROGRAM

A Regional Demonstration Program For Preschool Handicapped Children

PAUL IRVINE
Director
Special Education

AMY L TOOLE
Supervisor
Preschool Programs

Dear Director of Early Intervention Program:

The New York State Consortium is comprised of project directors and coordinators of federally funded early intervention programs in the state. In an effort to obtain data about current service delivery systems in the state, we are conducting a survey. We realize that it is rather long, however, we do feel that the results will provide us with valuable information about service delivery in this state.

The enclosed survey form has been mailed to a random sample of early intervention program directors. It is divided into two parts - the general program information is enclosed, the second part will be sent to you in May. We would appreciate your taking 20 minutes of your time to complete it and return it in the self-addressed, stamped envelope provided by April 30. The results will be collated and shared with you and program planners within the state.

We hope that this survey will provide us all with information regarding the present status of programs in the state and help us develop recommendations for future program standards.

Sincerely,

Amy L. Toole
Project Director
A Regional Demonstration
Program for Preschool
Handicapped Children

Chairperson
New York State Consortium

ALT:hd
Enclosure

NAME OF PROGRAM _____

ADDRESS _____

PHONE _____

PERSON COMPLETING QUESTIONNAIRE _____ TITLE _____

PART I - General Program Information

Please indicate answers on the lines provided. Unless indicated by "check only one," please check as many answers as apply.

1. How would you categorize the local fiscal agent of your program (please check only ONE)?

____local educational agency (LEA)

____regional or intermediate educational agency

____state educational agency (SEA)

____public agency (other than educational)

____institution of higher education (nonmedical)

____institution of higher education (medical)

____private, nonprofit organization

____health institution (e.g., hospital or non-university medical facility)

____other (please specify):

_____

2. What is your funding source?

____Federal Project

____Family Court

____Office of Mental Retardation and Developmental Disabilities

____other _____

3. Type of facility.

____church setting

____special education center

____hospital setting

____non-residential school

____other _____

____other public building

____university based setting

____residential school

____public school setting

What type of facility would you prefer for your population? _____

4. Homes of children - Geographic location

____urban

____suburban

____rural

5. Ages of children served

____0-3 ____other_____

____3-5

____0-5

6. Children with which of the following exceptionalities have been or are currently enrolled in your program or class:

____severely speech/language impaired

____emotionally disturbed

____educable mentally retarded

____trainable/severe/profound retarded

____hard of hearing

____deaf

____visually impaired

____other_____

____physically handicapped

____legally blind

____partially sighted

____autistic

____learning disabled

____gifted/talented

____none of the above

____all of the above

7. List the (3) major handicapping conditions served by your program.

1._____ 2._____ 3._____

8. Are you in favor of identifying children by handicapping conditions for program eligibility? _____yes _____no _____sometimes

If not, what system would you prefer:

____continuance of services model defining type of placement needed rather than handicapped (regular placement, transitional support services, related services, resource program, special class, special school)

____other_____

9. Please check if the following admission criteria is typically used for your agency.

____handicapping condition

____ability to pay

____specific geographic area

____parent involvement

____age of child

____results of specific assessment instrument
which instrument is used?_____

____Committee on the Handicapped approval

10. Please check if the following termination criteria is typically used by your agency.

____change in status of handicapping condition

____eligible for regular education program

____originally diagnosed handicapping condition no longer exists

____age of child ____what age?

____results of specific assessment instrument _____what instrument used?

____Committee on the Handicapped review

11. How does the program locate children for its services?

____advertising in the local area

____press

____TV and radio

____agency workshops

____interagency referrals

____community knowledge of the program

____school district source

____pediatricians

____other_____

12. What are the three major sources of referrals?

____physicians
____parents telling other parents
____nursery schools
____community agencies
____results of advertising
____school district
____other_____ _____

13. During what part of the year do you actively seek children?

_____ongoing_____in spring_____summer_____fall_____winter

14. How many children are currently enrolled in your program?_____

15. How many children are on a waiting list?_____

16. Are you able to place children within (30) days of identification of a handicapping condition? _____yes _____no If not, why?_____

_____

17. What is the maximum number of children you are able to serve each year?_____

18. If you have a maximum number, what is reason?

____budget constraints
____facility constraints
____staffing constraints
____other_____

19. Would you serve more children if the above constraints did not exist? ____yes ____no

20. How are children grouped in class?

____age of children
____transportation routes
____by level of handicap (mild, moderate, severe)
____by type of handicap (deaf, speech and language impaired, etc.)
____all children regardless of level and type

21. If children of different handicaps are grouped together, what is your rationale?

____program believes in heterageneous grouping

____not enough children identified of one handicapping condition

____other_____

22. If it is appropriate to your program, please indicate the extent to which handicapped children are involved in integration experiences with nonhandicapped children. (Check the choice which best describes those experiences.)

___a. handicapped and nonhandicapped children are fully integrated in a regular early education setting; handicapped children receive support services WITHIN that setting.

____b. handicapped and nonhandicapped children are integrated in a regular early education setting; handicapped children receive support services OUTSIDE that setting.

____c. handicapped children are served in a special setting, with nonhandicapped children fully integrated into that special setting.

____d. handicapped children are served in a special setting and integrated with nonhandicapped children for some activities.

____e. handicapped and nonhandicapped children are not integrated.

____f. not appropriate to our program. Explain:_____

_____

____g. other _____

23. Check the preschool programs which serve handicapped children which exist in your geographic area, not necessarily run by your program.

____regular nursery

____day care

____kindergarten

____respite services

____hospital treatment

____home visiting services

____group home care provider units

____therapeutic nurseries

____head start

____social services agency programs w/support services

____self-contained special classes

____other day treatment

____in-patient treatment
____a. hospital
____b. institution

____other_____

24. What services for children in your community are needed that are not presently in existence (choose from the list under question 23)_____

_____

Given the resources, could your agency provide these: _____yes _____no

What resources would be necessary?

_____financial _____facilities

_____training _____other

25. What is age range in _____classes _____homebased program

26. What is the <u>teacher</u> to child ratio? (Ex. 1:10, 1:15, etc.)_____

What is <u>adult</u> to child ratio?_____

What is adult/child ratio on full-staffed day?_____

What is adult/child ratio on least staffed day?_____

What would be the most appropriate adult/child ratio for your program?_____

27. How many hours per day do children attend center-based program?_____

Is it adequate? _____yes _____no

What would you suggest?_____

28. How many hours per week do children receive home training?_____

Is this adequate? _____yes _____no

What would you suggest?_____

29. How many days per week do children attend:

_____center-based Is this adequate?_____yes _____no _____suggestion

_____home-based Is this adequate?_____yes _____no _____suggestion

30. What means of transportation is used by children at center-based program?

_____bussing (funding source_____)

_____parent _____other_____

Is this adequate? _____yes _____no

31. What type of team approach is used by your program?

____no team is used to evaluate child

____each member team evaluates children separately and gives reports to teacher

____each team member evaluates child separately and meets as a group to report recommendations

____each team member evaluates child separately and meets as a group to develop recommendations

____team members evaluate the child at the same time and meet together to develop recommendations

Is this adequate? _____yes _____no If no, what is your preference?

_____

32. What specialists do you hire?

List training on line at right. Ex (early childhood/ special education, neurodevelopmental, behavior modification, etc.)

____Teacher _____

____Paraprofessional _____

____Social Worker _____

____Psychologist _____

____Speech and Language _____

____Audiologist _____

____Occupational Therapist _____

____Physical Therapist _____

____Recreational Therapist _____

____Psychiatrist _____

____Pediatrician _____

____Other (please list) _____

33. What changes in staffing would you like to make?

decreases_____ reason_____

_____ _____

_____ _____

increases_____ reason_____

_____ _____

_____ _____

34. Are teachers New York State certified? _____yes _____no

Are speech therapists New York State certified? _____yes _____no

Are psychologist and social workers New York State certified? _____yes _____no

Are physical therapist and occupational therapist certified in area of specialization? _____yes _____no

35. Is administrator certified as a teacher of handicapped children? _____yes _____no

36. Who makes regular home visits?

___Physical Therapist ____Social Worker

____Occupational Therapist ____Special Education Teacher

____Psychologist ____Speech Pathologist

____Paraprofessional

Would staff members other than those whom you chose be appropriate to make home visits?

_____yes _____no _____whom?

37. What professionals take children <u>out</u> of the classroom to provide services?

____Physical Therapist ____Occupational Therapist

____Psychologist ____Speech Pathoiogist

____Physical Education ____Other

What professionals serve children in the classroom?_____

38. Related to program evaluation, what design(s) or approach(es) does your project use to determine the effectiveness of child services?

Design or Approach

____a. experimental/quasi-experimental, e.g., pre/posttest, posttest only, time series, comparison with control group, etc.

____b. objective-based, e.g., determination of accomplishment of IEP objectives, program goals for children, etc.

____c. systems, e.g., Context/Input/Process/Product (CIPP), Discrepancy (DEM), etc.

____d. naturalistic, case studies, ethnographic studies or observation

____e. other (please specify):_____

____f. none

39. What audiences receive program evaluation information?

____board of directors

____community

____area agencies

____program staff

____funding source

____legislators

____county governments

____state education department

____advisory council

____other _____

Thank you for taking the time to complete this questionnaire. Your comments will be helpful.

Amy L. Toole
Chairperson
New York State Consortium

PRESCHOOL PROGRAM

A Regional Demonstration Program For Preschool Handicapped Children

PAUL IRVINE
Director
Special Education

AMY L TOOLE
Supervisor
Preschool Programs

Dear Director of Early Intervention Program:

I have received the survey which you have completed and returned to me. Thank you so much for participating in the New York State Consortium's effort to obtain data about current service delivery systems.

Enclosed is Part II of the survey form. It would be most helpful if you could complete this and return it by June 11 in the envelope provided. This part of the survey is shorter than Part I and should only take about 10 or 15 minutes of your time to complete. It is only through the analysis of both Part I and Part II of the survey that the Consortium will arrive at valuable information concerning programs in New York State.

As I mentioned previously, all of the information will be collated and shared with you and other program planners within the State. Thank you again for your time and cooperation.

Sincerely,

Amy L. Toole

Amy L. Toole, Project Director
A Regional Demonstration Program
for Preschool Handicapped Children

Chairperson
New York State Consortium

ALT:hd
Enclosure

Board of Cooperative Educational Services, Yorktown Heights, New York 10598 (914) 962-2377

NAME OF PROGRAM _____

ADDRESS _____

PHONE NUMBER _____

PERSON COMPLETING QUESTIONNAIRE _____ TITLE _____

PART II

A. ADMINISTRATION AND MANAGEMENT

Please check the appropriate column. If you feel a change is needed, please comment on the direction of the change.

Program Planning	Yes	No	Partially	Not Relevant	Desired Change
1. The program has a statement of:					
a. philosophy					
b. goals and objectives					
c. activities and time-lines					
d. organizational structure					
Program goals are revised to reflect changes in planning					
Personnel					
2. The program has a statement or clearly delineated plans & procedures for:					
a. identifying staffing needs					
b. providing staff development					
3. The program has:					
a. job description for staff					
b. organizational chart					

Advisory Board	Yes	No	Partially	Not Relevant	Desired Change
4. The program has an Advisory Board					
5. The program holds regular meetings					
6. The program has minutes of meetings					
Coordination					
7. The program has plans and procedures for:					
a. establishing liason with other local and state agencies					
b. participating in planning efforts for services to young handicapped children and their families at the community and/or state level (Ex. Regional Advisory Board)					
c. referring to other agencies					
d. accepting referrals from other agencies					
e. case managing children and families who receive services from more than one agency					
f. case managing children prior to entering another service					
g. documenting inter-agency efforts					

8. The program has a written Interagency Agreement with certain agencies
List _____

_____

9. Who of the following are the targets of the program's direct services?

_____a. both parents and child
_____b. the child
_____c. both parents
_____d. the guardian
_____e. the father
_____f. the siblings
_____g. other professionals
_____h. other (please specify):

10. What is the PRIMARY philosophical approach of your curriculum model?

_____a. experimental or traditional child-centered nursery school
_____b. Montessori-specific
_____c. Piagetian-specific
_____d. diagnostic-prescriptive
_____e. behavioral
_____f. developmental-interactive
_____g. other (Please specify):

_____

11. Which of the following developmental areas does your program have as the focus for intervention?

_____a. self help
_____b. social-emotional
_____c. cognitive-academic
_____d. sensorimotor
_____e. language-communication
_____f. other (please specify):

Given your population, which is your primary focus?_____

B. SCREENING

12. What methods are used for screening children prior to entry to the program?

_____

_____

13. List screening instruments used with the majority of children. (Include name of norm-referenced, criterion referenced, observation, parent report, other)

Full Name	Developed by Your Program	Commercially Available
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. ASSESSMENT

14. What methods are used to assess and diagnose children prior to entry into the program, once screened?

_____

_____

15. List instruments used with the majority of children. (Include names of norm-referenced, criterion referenced, observation, parent report, other)

Full Name	Developed by Your Program	Commercially Available
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Do you feel that screening and assessment tools are adequate? ___Yes ___No

17. What tools would be helpful?_____

18. Do you feel them instructional and non-discriminatory? ____Yes ____No

D. PROGRAM PLANNING

19. What methods(s) does your program use to assess the status of the child FOR THE PURPOSE OF PLANNING INSTRUCTION? (Include names of norm-referenced criterion referenced, observation, parent report, other)

FULL NAME

_____

_____

_____

_____

20. What are the name(s) of the CURRICULUM programs your program uses (i.e. Portage, Developmental Therapy, PEECH, program developed curriculum, etc.)?

FULL NAME	Check if you use daily
_____	_____
_____	_____
_____	_____
_____	_____

21. Do you feel that curriculum package and programming planning materials available are adequate? _____Yes _____No

22. What additional materials would be helpful?_____

_____

23. The daily routine for center program includes:

Check here	Check which of these you feel is essential for an early childhood program
_____large group	_____
_____small group	_____
_____individualized instruction	_____
_____music	_____
_____art	_____
_____play	_____
_____motor time	_____
_____language time	_____
_____cognitive stimulation	_____
_____self-help skills time	_____
_____meal time (including snack)	_____
_____play-round time	_____
_____rest time	_____
_____opening exercises	_____
_____end of day group activity	_____
_____other_____	_____
_____	_____
_____	_____

24. The routine for home program includes: (complete if appropriate)

Check here		Check which of these you feel is essential for a home program
_____	interaction with parent	_____
_____	parent observation	_____
_____	written parent homework (prescription)	_____
_____	evaluation of parent homework	_____
_____	individual work with child in general developmental stimulation	_____
_____	observation of parent working with child	_____
_____	oral suggestions to parent	_____
_____	lending of toys	_____
_____	toy library program	_____
_____	taking baseline data for decision making	_____
_____	other_____	_____

25. Check the forms of behavior management procedures which are used:

Check here		Check which of these you feel is essential for an early childhood program
_____	behavior modification	_____
_____	prevention	_____
_____	structured routine	_____
_____	clear classroom rules	_____
_____	aversives	_____
_____	non-directive approach	_____
_____	play therapy	_____
_____	other_____	_____

26. Please check the appropriate column on the left side. If not desirable, state why on the right side.

Yes	No		If not desireable, state why
		The District Committies of the Handicapped (DCOH) reviews and recommends placement annually.	
		The DCOH develops the Phase I IEP.	
		Assessment procedures are carried out for each child prior to entering the program.	
		An Individualized Education Plan (IEP) for each child is developed within 30 days of entry.	
		Assessment data is used in the development of annual and short term goals in the IEP.	
		A Phase I IEP is developed for each child prior to entry.	
		A Phase II IEP is developed once the child is attending the program.	
		Progress of children is documented apart from the IEP.	
		Individualized instruction time is provided with each program session for meeting IEP goals and objectives.	
		Lesson plans are kept for each session.	
		The program has a written statement of the philosophy for parent and family involvement with the program.	
		The program has a written statement of goals and objectives for the services for parents.	
		The philosophy, goals and objectives for parent and family involvement has been communicated to staff and parents.	

Yes	No		If not desireable, state why
		The program determines the needs of parents that can be addressed by the program	
		Materials necessary for implementing the activities of the services for parents have been developed and/or acquired	
		Procedures for providing information and involvement for parents as required in PL 94-142 guidelines have been implemented	
		The program assigns staff responsibilities within the services for parents	
		The program maintains records on the activities of the services for parents	
		The program documents the extent of progress (or change) in parents where appropriate	
		The program involves parents/families in the following activities:	
		- identification of needs and learning goals	
		- orientation to program	
		- classroom observation	
		- volunteering	
		- carrying out activities at home	
		- assessments	
		- parent/staff conferences	
		- parent group training meetings daytime/evenings	
		- support groups for sibling	
		- social groups	
		- individual counselling	
		- group counselling	
		- development of instruction materials	
		- formal communication: newsletters	
		notes	
		telephone	
		telephone hot line	
		- maintenance of child progress records	

Yes	No	If not desireable, state why
	- transition to next placement	
	- parents training other parents	
	- participation on advisory council	
	- advocacy	
	- provision of respite care	
	- other non-educational or therapeutic services such as	
	job placement	
	public assistance	
	- fund raising	
	- other	

Please send any brochure or descriptive information which you have available about your program with this questionnaire.

Thank you once again for your cooperation.

Amy L. Toole
Chairperson
New York State Consortium

APPENDIX B

LIST OF SURVEY PARTICIPANTS

LIST OF SURVEY RESPONDENTS

Mark Rothchild
Social Work Supervisor
H.G. Birch School for Exceptional Children
145-02 Farmers Blvd.
Springfield Gardens, N.Y. 11434
212-528-5754

Kathryn Hirsch
Coordinator
White Plains PreKindergarten Program
65 McKinley Ave.
White Plains, New York 10606
914-997-2378

Leonard Kankowski
Director
Chenango Forks Preschool
Handicapped Program
John Harshaw School
Patch Road RD #3
Binghampton, N.Y. 13901
607-648-8511

Frieda Spivack
Director
DIPHH(Developmental Infant Program in
Homes and Hospitals)
Kingsbrook Jewish Medical Center
Rutland Road
Brooklyn, N.Y. 11203
212-756-9700 X 2284

Beatrice H. Brennan
Early Childhood Supervisor
New York State Experimental Prekindergarten
Program
80 Montgomery Street
New York, N.Y. 10002
577-0212, 0211

Shirley J. Reynolds
Education Director
United Cerebral Palsy Assoc. of Western
New York
31 Rossler Street
Cheektowoga, New York 14206
716-897-1351

Dr. Rose Greenspan
Pre-K Director
Westbury Prekindergarten
Park Avenue Early Childhood Center
Westbury, N.Y. 11590
516-997-9161

Eileen Kurtz
Head Teacher
Warwick Preschool Program
Warwick Valley Central School
P.O. Drawer E
Warwick, N.Y. 10990
914-986-1163

Paul Wight
Asst. Supt./Dir. Special Education
BOCES Preschool
P.O. Box 455
Plattsburgh, N.Y. 12901
518-561-0100

Marcy Dunn
Coordinator, Direction Center
Franklin-Essex-Hamilton BOCES PreSchool
P.O. Box 28
Malone, New York 12953
800-342-7670

Anita Weinberger
Director
East Syracuse-Minoa Prekindergarten
Pre-K Office
Woodland School
Fremont Road
East Syracuse, N.Y. 13057
315-656-8271

LIST OF SURVEY RESPONDENTS - Page 2

Janice J. Kostek
Special Needs/Handicap Assistant
Bethel Head Start
1525 Michigan Ave.
Buffalo, New York
884-6631/884-4087

Michele Strobridge
Special Needs Coordinator
Washington County Head Start
949 Dix Avenue
Hudson Falls, New York 12839
518-747-2816

Elizabeth Short
Coord. of Education and
Services to Handicap
Oswego County Head Start
223 Oneida Street
Fulton, New York 13069
315-598-4711

Meg Sterling
Director
Oryden Head Start
Box 515
Dryden, New York 13053
607-844-4490

Jayne Elliott
Family Advisor
Stamford Head Start
Stamford, N.Y.
652-7472

Mary Carroll
Coordinator of Services to
the Handicapped
Lewis County Head Start
7673 State Street
Lowville, New York 13367
315-376-7531

Bertha Williams
Head Start Director
Sullivan Co. Full Year Head Start
Box 215 Main Street
Woodbourne, N.Y. 12788
434-4164

Dr. Ilana Reich
Consulting Psychologist
Quick Start Head Start
126-22 150th Street
South Ozone Park, New York 11435
212-659-6928

DeRuland
Special Services Coordinator
Schoharie County Head Start
Box 464
Cobleskill, New York 12043
518-234-7521

Barbara Krawiecki
Coord. of Special Services to the
Handicapped
Head Start
RD #5
Amsterdam, New York 12010
842-8225/842-0329

Nancy B. Pierce
Director
Dorothy Hoke, Coord. for Handicap Serv.
Essex County Head Start
14 Front Street
Keeseville, New York 12944
518-834-7171

Bonnie Wolcott
Health/Handicap Coordinator
Project Head Start
Milton Terrace Elem. School
Ballston Spa, New York 12020
518-885-4606

Karen E. Diamond, Ph.D.
Director
New Family Project
Skidmore College
Saratoga, New York 12866
518-584-5000 Ext. 120

LIST OF SURVEY RESPONDENTS - Page 3

Mark Dryden
Program Coordinator
Special Class at Low Memorial
Child Care Center
50 Monroe Place
Brooklyn, New York 11201
212-237-0958

Sara Hess
Director
South Hill Child Care Center, Inc.
110 E. Upland Road
Ithaca, New York 14850
607-257-0200

Dr. Ann Williams
Director, Program Development
Kennedy Child Study Center
151 East 67th Street
New York, New York 10021
212-988-9500

Anne Campbell
Managing Director
Handicapped Children's Assoc. of
Southern New York, Inc.
18 Broad Street
Johnson City, New York 13790
607-798-7117

Karen Lederman
Director
Pinewoods Center-Rensselaer County ARC
116 Pinewoods Avenue
Troy, N.Y. 12180
518-274-3684

Gerri Monahan
Early Intervention Teacher
Orange County AHRC Early Intervention
Mt. Hope Road
Middletown, New York 10940
914-343-0871

Joyce Golbus Poll
Acting Y.I.P. Supervisor
United Cerebral Palsy of Queens, Inc.
Young Infant Program
82-25 164 Street
Jamaica, N.Y. 10021
212-380-3000

Karen Waaland Sheen
Executive Director
United Cerebral Palsy and
Handicapped Children's Assoc. of
Chemung County, Inc. - Preschool Program
318 Madison Avenue
Elmira, N.Y. 14901
607-734-2081

Louis B. Tehan
Executive Director
United Cerebral Palsy & Handicapped
Persons of the Utica Area, Inc.
Roskoff Avenue
Utica, New York 13502
315-724-3141

Judith E. Nitchke
Director
Lord of Life Child Development Center
1025 Borden Road
Depew, New York 14043
668-8000

Kathleen Corasso
Program Director
Helping Hands Preschool
41 Werner Road
Clifton Park, New York 12065
664-5066

Andronike C. Tsamas
Director
Spence-Chapin Services to Families
and Children- The Children's House
3 East 94th Street
New York, New York 10028
212-369-0300

Mary Edwards, Coordinator
Early Intervention Center
RD #1 Box 67A
Walton, New York
607-865-7126

Elayne E. Greenberg
Asst. Dir. of Ed.
Coord. of Nursery Program
Suffolk Child Development Center
Hollywood Drive
Smithtown, N.Y. 11787
516-724-1717

LIST OF SURVEY RESPONDENTS - Page 4

Diane Cunningham
Director, Early Childhood
Center for Developmental Disabilities
Early Childhood Program
657 Castleton Avenue
Staten Island, New York 10301
212-448-9775

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APPENDIX C

LIST OF RESOURCES

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