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ABSTRACT

Part of a volume which explores current issues in service delivery to infants and toddlers (ages birth to 3) with handicapping conditions, this chapter discusses the evolution of public policies related to early intervention services. Major milestones in federal legislation are reviewed, beginning in 1965 with Project Head Start. Current trends in federal education funding are noted, with special focus on the provisions of the Handicapped Infants and Toddlers Program established by Public Law 99-457, including a profile of state participation in implementing this law. Finally, a discussion of policy challenges for the future focuses on full participation, effective implementation, and policy evaluation and revision. References are appended. (JW)

❑ Public policy commits the government to certain goals, determines whose interests and values will prevail, and regulates and distributes resources (Seekins & Fawcett, 1986). Public policies come in the form of laws, regulations, executive orders, guidelines, ordinances, and judicial rulings, and are found at all levels of government—local, state, and federal.

Policy has enjoyed a steady growth.

Early intervention public policy is a relatively recent phenomenon. Contrary to many social developments, early intervention policy has enjoyed a steady and almost meteoric growth, as compared to the pace of typical social policy developments. In 25 years, early intervention policy has progressed from being virtually nonexistent to the establishment of legal mandates for service in many states and an expanded federal commitment to provide high-quality early intervention services to handicapped and at-risk children and their families.

This chapter discusses the evolution of public policies related to early intervention services. It reviews the past—trends in federal and state policies that have provided for funding and programming for very young children and their families. It reviews the present—the state of the art, or status, of current federal and state policies for early intervention. And finally, future policy issues are proposed.

THE PAST

❑ Major milestones in early intervention and preschool policy at the federal level began in the 1960s (see Figure 1). Federal developments at that time focused on intervening early in order to promote optimal development. They included P.L. 88-156, which expanded maternal and child health services to expectant mothers from low-income areas in an effort to prevent mental retardation, and P.L. 89-313, which provided federal education money to state-operated schools and institutions for the handicapped and which has often been used by states to start experimental early intervention services (Allen, 1984).

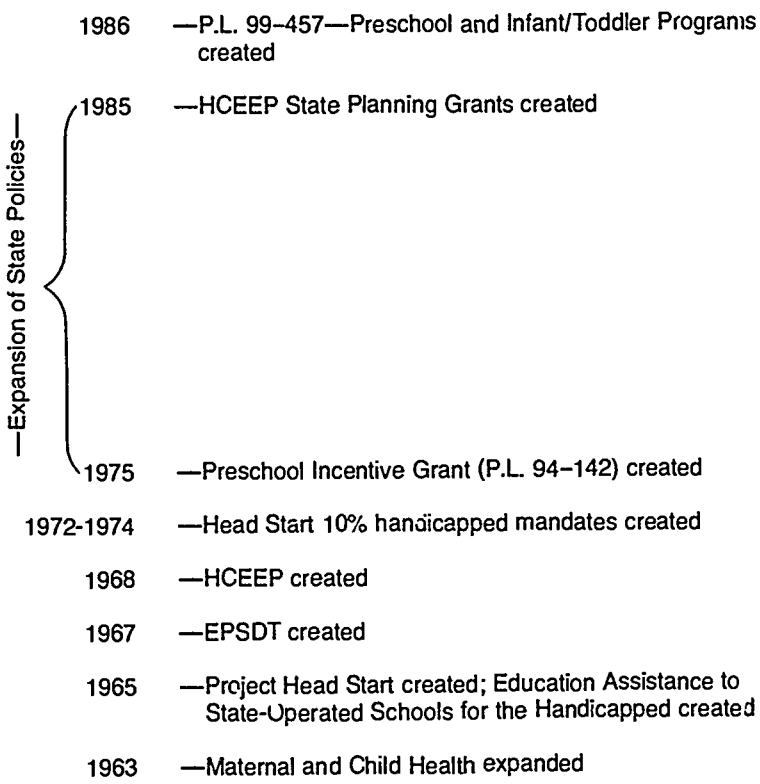
Head Start was the first nationwide attempt to intervene.

Project Head Start was the first nationwide attempt to intervene directly with the young child with the goal of improving the child's development through a variety of services—educational, medical, nutritional, and parent training. Project Head Start was launched in 1965 as part of the War on Poverty. It was designed to help economically disadvantaged preschool-aged children achieve their full potential by attempting to remedy the damaging effects of poverty on their development through early intervention.

HCEEP has provided federal support for nearly 20 years.

In the late 1960s, two major cornerstones of current services were laid. In 1967, P.L. 90-248 established the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT, a component of Medicaid, focuses on early identification and treatment as a method of preventing developmental and medical problems. In 1968, P.L. 90-538, the Handicapped Children's Early Education Assistance Act, was passed. This legislation established the landmark Handicapped Children's Early Education Program (HCEEP), which has provided federal support for 20 years for the development of effective model programs, methods, and state policies in early intervention and preschool services for handicapped children.

Figure 1. Evolution of Early Intervention Public Policy.



In 1968 few services existed, and the importance of early intervention was just emerging. Therefore, Congress passed P.L. 90-538 with the purpose of expanding the knowledge base of the potential impact of early intervention. Since 1968, HCEEP has funded over 500 projects that have demonstrated early intervention model practices, developed curricula and assessment instruments, and provided training to thousands of programs and practitioners nationwide. In addition to the development of effective models and practices, HCEEP has also provided support for research in early intervention, delivered technical assistance to projects, and encouraged state-level planning of universal services to young handicapped children (Garland, Black, & Jesien, 1986).

500 projects have demonstrated model practices.

In the early 1970s early intervention for handicapped children took a leap forward with the establishment of a new requirement that Head Start set aside 10% of its enrollment opportunities for handicapped children. P.L. 92-924 and P.L. 93-644 provided that 10% of the enrollment should be handicapped children and that these children should be provided services to meet their special needs within Head Start (Allen, 1984).

10% of the enrollment should be handicapped.

Consequently, Head Start has been the largest provider of "mainstreamed" services for preschool-aged handicapped children in the nation. In 1985, over 98% of Head Start programs enrolled at least one handicapped child. Over 60,000 handicapped children are enrolled in Head Start programs (U.S. Department of Health and Human Services, 1986).

Over 60,000 handicapped are enrolled in Head Start.

In 1975, Congress, while recognizing the importance of educational opportunities for all handicapped children, also recognized the importance

The Preschool Incentive Grant program was voluntary.

of *early* educational opportunities for preschool-aged handicapped children by passing P.L. 94-142—The Education for All Handicapped Children Act. While P.L. 94-142 fell short of mandating services for children below traditional school age, it did establish the Preschool Incentive Grant to encourage states to serve 3- through 5-year-old handicapped children. The Preschool Incentive Grant provided funds to states that elected to serve 3- through 5-year-olds. The Preschool Incentive Grant program was voluntary; however, once a state received these funds it was required to assure all the rights and services of P.L. 94-142 to the preschool child.

P.L. 98-199 established a new state planning component.

Concurrent with these federal initiatives, between 1970 and the early 1980s, state policies mandating early services increased dramatically. By 1984 over one half of the states required early services to some portion of the 3-through 5-year-old population and over 10 states began services at birth to some portion of the population (see Figure 2). However, to encourage further expansion of state policy, Congress passed P.L. 98-199 in 1984. P.L. 98-199 established a new state planning component within HCEEP—providing federal funds to states for the purpose of planning, developing, and implementing state-wide comprehensive services for handicapped and at-risk children from birth through 5 years of age and their families.

P.L. 99-457 took one step closer to services for children, birth-5.

Then in 1986, Congress passed P.L. 99-457, The Education of the Handicapped Act Amendments of 1986—capping 20 years of evolution in early intervention policy. Prior to P.L. 99-457, federal policy was focused primarily on supporting effective models and technology, providing training for professionals, and encouraging the generation of new knowledge through research and development activities. However, with P.L. 99-457, the nation took one step closer to a national policy of access to services for all handicapped and at-risk children, birth through 5 years of age, and their families.

THE PRESENT

❑ While P.L. 99-457 dominates the present early childhood policy arena, there are other important related trends and activities. This section reviews the trends in federal education funding for infant-related projects to the present, as well as an update of state early intervention policy. However, a description of the landmark legislation, P.L. 99-457, is the primary focus of this section.

Federal Education Funding Trends

Funds have increased dramatically since 1980.

❑ Federal education funds—particularly those from the U.S. Office of Special Education Programs (OSEP)—have been increasingly targeted to the birth through 2-year-old population. Funds for research, model and outreach projects, and personnel training have increased dramatically since 1980.

HCEEP model demonstration projects that focus on infant services, for example, have increased significantly since the first projects were funded in 1969. In 1969, 23 HCEEP projects were funded; five (22%) included infants. From 1982 to 1986, approximately 83% of the 131 HCEEP projects included services for infants (Suarez, Hurth, & Prestridge, 1987).

Figure 2. Age At Which States Mandate Services.

State	Birth–2	3–5
Alabama		Yes
Alaska	Yes	
American Samoa		
Arizona		
Arkansas		
California		Yes
Colorado		
Connecticut		Yes
Delaware	Yes (partial)	
D.C.		Yes
Florida		
Georgia		
Guam	Yes	
Hawaii		Yes
Idaho		
Illinois		Yes
Indiana		
Iowa	Yes	
Kansas		
Kentucky		
Louisiana		Yes
Maine		
Maryland	Yes	
Massachusetts		Yes
Michigan	Yes	
Minnesota		Yes
Mississippi		
Missouri		
Montana		
Nebraska	Yes	
Nevada		
New Hampshire		Yes
New Jersey	Yes	
New Mexico		Yes
New York		
North Carolina		Yes
North Dakota		
Ohio		
Oklahoma	Yes (partial)	
Oregon	Yes	
Pennsylvania		
Puerto Rico		
Rhode Island		Yes
Scuth Carolina		Yes
South Dakota	Yes	

(Continued)

Figure 2. Age At Which States Mandate Services (Continued)

State	Birth–2	3–5
Tennessee		Yes
Texas	Yes	
Mariana Islands		
Utah		
Vermont		
Virgin Islands		
Virginia	Yes (from 2)	
Washington		Yes
West Virginia		Yes
Wisconsin		Yes
Wyoming	Yes	

Note: From U.S. Department of Education, Ninth Annual Report to Congress on the Implementation of the Education of the Handicapped Act (1987).

Funding for training of personnel has increased.

Similarly, funding for the training of personnel to work with infants and their families has increased dramatically. Until 1987, OSEP was not required to set aside personnel preparation funds specifically for early intervention personnel training. However, under P.L. 99-457, Congress instructed OSEP to make the training and preparation of personnel to work with handicapped infants and their families a priority for the Education of the Handicapped Act (EHA) Personnel Preparation program funding.

P.L. 99-457 contains many provisions relating to handicapped children of all ages. However, the most far-reaching initiatives pertain to children in the birth through 5-year age group. The law establishes two new programs—one for birth through 2-year-olds and, one for 3- through 5-year-olds. For purposes of this chapter, emphasis is placed on the birth through 2 provisions. Briefly, however, P.L. 99-457 extends the provisions of P.L. 94-142 to all children 3 years of age by 1990-1991, and significantly increases funding for this age group.

Handicapped Infants and Toddlers Program (B-2)

❑ The landmark early intervention program established by P.L. 99-457 is the Handicapped Infants and Toddlers Program, Part H of the Education of the Handicapped Act. This section of the law creates a new federal program for handicapped and at-risk children from birth to age 3 years and their families. The purpose of this program as described by Congress is to provide financial assistance to states to:

1. Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services.
2. Facilitate the coordination of early intervention resources from federal, state, local, and private sources (including private insurers).
3. Enhance states' capacities to provide high-quality early intervention services.

While the Infant/Toddler Program is voluntary for states—that is, they may elect not to participate—if a state does choose to participate, or apply for funding under this law, it must meet the requirements of the law. In addition, to be eligible for a grant in the 5th year, the state must ensure that services are available to all eligible children.

If a state does participate, it must meet the requirements of the law.

Who Is Eligible for Services?

❑ The new Infant/Toddler Program is directed to the needs of children, birth to their 3rd birthday, who need early intervention because they:

1. Are experiencing developmental delays in one or more of the following areas: cognitive, physical, language and speech, psychosocial, or self-help skills.
2. Have a physical or mental condition that has a high probability of resulting in delay (e.g., Down syndrome, cerebral palsy, etc.).
3. At state discretion, are at-risk medically or environmentally for substantial developmental delays if early intervention is not provided.

Also, under this program the infant or toddler's family may receive services that are needed to facilitate their capacity to assist in the development of their child.

What Must States Provide?

❑ If a state applies for funds under this program, it must meet the following requirements. For the first 2 years:

1. The governor has established an Interagency Coordinating Council made up of parents, state agency representatives, personnel trainers, state legislature representatives, and others.
2. The governor has designated a lead agency (which may be the Interagency Coordinating Council).
3. The state ensures that the funds will be used to plan, develop, and implement statewide services.

The 3rd and 4th years:

1. In addition to the requirements of the first 2 years, the state must ensure that it has adopted a policy that contains the required components of a statewide system, which are as follows:
   (a) A definition of the term "developmentally delayed."
   (b) Timetables for ensuring services to all eligible children by the 5th year of participation.
   (c) Multidisciplinary evaluations of the functioning of all eligible children and the needs of their families to assist in the development of their child.
   (d) Provision of a written individualized family service plan (IFSP) for all eligible children.
   (e) Comprehensive Child Find system including a system for making referrals to providers. "Primary referral sources" must be included, including hospitals, physicians, other health care providers and agencies, and day-care facilities.
   (f) A public awareness program focusing on early identification.

(g) A central directory containing state resources, services, experts, and research and demonstration projects.

(h) A comprehensive system of personnel development, including training of public and private service providers and primary referral sources, as well as preservice training.

(i) A single line of authority in a *lead agency* designated or established by the governor to carry out the general administration, supervision, and monitoring of programs and activities; the identification and coordination of all available resources within the state from federal, state, local, and private sources and the assignment of financial responsibility to the appropriate state agency; the resolution of state interagency disputes and procedures for ensuring the provision of services pending the resolution of such disputes; and the entering into formal state interagency agreements that define the financial responsibility of each state agency for early intervention services (consistent with state law) and include, among other things, procedures for resolving disputes.

(j) A policy pertaining to the contracting or making of other arrangements with local providers.

(k) A procedure for securing timely reimbursement of funds between state and local agencies.

(l) Procedural safeguards with respect to the settlement of disagreements between parents and providers, the right to appeal, the right to confidentiality of information, the opportunity to examine records, assignment of surrogate parents, written prior notices to parents in their native language, and procedures to ensure the provision of services pending the resolution of complaints.

(m) Policies and procedures relating to the establishment and maintenance of personnel training, hiring, and certification/licensing standards.

(n) A system for compiling data on the early intervention programs (may include sampling).

2. The statewide system must be in effect no later than the beginning of the 4th year, except for the assurance of full service to all eligible children.

The 5th and succeeding years, the state must ensure that the system is in effect and full services are available to all eligible children.

Services must include multidisciplinary assessment and a written IFSP.

Early intervention services must include, for each eligible child, a multidisciplinary assessment and a written individualized family service plan (IFSP) developed by a multidisciplinary team and the parents. Services provided must be designed to meet the developmental needs of the child and be in accordance with an IFSP. They may include special education, speech and language pathology and audiology, occupational therapy, physical therapy, psychological services, parent and family training and counseling services, transition services, medical services for diagnostic purposes, and health services necessary to enable the child to benefit from other early intervention services. Case management services must be provided for every eligible child and his or her parents.

All early intervention services must be provided at no cost to parents except where federal or state law provides for a system of payments by parents, including provision for a schedule of sliding fees.

What Are the Individualized Family Service Plan (IFSP) Requirements?

❑ The IFSP must be developed by a multidisciplinary team and must contain: (a) a statement of the child's present levels of development (cognitive, speech/language, psychosocial, motor, and self-help); (b) a statement of the family's strengths and needs relating to enhancing the child's development; (c) a statement of major outcomes expected to be achieved for the child and family; (d) the criteria, procedures, and time lines for determining progress; (e) the specific early intervention services necessary to meet the unique needs of the child and family including the method, frequency, and intensity of service; (f) the projected dates for the initiation of services and expected duration; (g) the name of the case manager; and (h) procedures for transition from early intervention into the preschool program. The IFSP must be evaluated at least once a year, and must be reviewed every 6 months or more often where appropriate.

The IFSP must be evaluated at least once a year.

State Policy

❑ P.L. 99-457 does not require states to serve infants and toddlers. It does, however, provide significantly increased financial incentives as well as federal guidance and encouragement. All states are already implementing some of the provisions of P.L. 99-457.

All states are already implementing P.L. 99-457.

In a recent study of state early intervention and preschool policies, Meisels, Harbin, Modigliani, and Olson, (1987) provided the following national "profile":

- Very few states ($N = 7$) have entitlements for services to birth-3 year olds. Nevertheless, more than 80% of the states have some form of entitlement prior to school age.
- State Educational Agencies (SEAs) play an important role in administering programs for birth-6-year-olds. But Public Health and Social Services are more actively involved in overseeing birth-3 services than are SEAs.
- Funding emerges from more than 12 major public and private sources. P.L. 94-142 is a major funding mechanism, but state and local taxes are most frequently cited as fiscal support for birth-3 services. Medicaid, which is utilized by 2 of every 3 states, is the only non-education source widely used besides taxes.
- There is no single intervention service component that is universally mandated nationally. At best, two-thirds of the states mandate Public Awareness and Diagnosis/Assessment for 3-6 year olds, but only slightly more than half of the states require intervention services for 3-6 year olds. Fewer than 2 of every 5 states mandate such services for birth-3 year olds.
- All program components are in need of significant improvement in the area of interagency coordination. Case management, staff training, and diagnosis/assessment are the highest on the list of intervention components in greatest need of interagency coordination.
- Coordination among agencies faces numerous obstacles, stemming principally from low funding, inconsistent eligibility criteria, and inconsistent regulations. These problems are significantly reduced, but not eliminated, in states with mandates.

- Major problems remain to be solved in the areas of state regulations, teacher certification, and supply and demand of trained professionals. An alarming shortage of trained early childhood special educators, and physical, occupational, and speech therapists was identified—this shortage projected to continue until the end of the decade. (p. 15)

In an effort to track the early effects of P.L. 99-457 on state policy, the National Association of State Directors of Special Education (NASDSE) initiated periodic surveys of state special education directors requesting information on their states' initial responses to P.L. 99-457. Two of the issues surveyed were: (a) whether the state decided to participate; and (b) the designation of the "lead agency" for the Part H or Infant/Toddler Program. All states have entered the program and have designated a "lead agency." Figure 3 is a listing of the "lead agencies" in each state.

We have a wide variety of state policies and programs.

Thus, at present, we have a wide variety of state policies and state programs for young handicapped and at-risk children. We also have the advent of the first national initiative to provide full services to all eligible children—P.L. 99-457. Perhaps this federal guidance and incentive can help provide a unifying lead for state and local policy. The effect of P.L. 99-457 on state policy is only one of the possible challenges that lies ahead.

THE FUTURE

Data and logic have been around longer than programs.

☐ The increased sociopolitical attention to the needs of infants and their families is probably a result of research-based advocacy that built upon the logic that if intervention at age 3 had significant, positive effects, earlier intervention was even better. Indeed, the data and the logic have been around a lot longer than the programs or the policies and had a laboratory research, clinical research, *and* conceptual basis (Strain & Smith, 1986). However, even in the face of decades of research, early intervention policy development has typically been a "trickle-down" phenomenon, that is, state and federal funds have been phased in from preschool-aged services downward toward services beginning at birth. This "phase-in" is, obviously, still with us. Until the "phase-in" is complete, with *all* states providing appropriate services to *all* eligible children from birth, there will continue to be significant and emerging policy developments. These developments, hopefully, will be based on research and "best practice" and will move us forward.

Policy challenges lie ahead.

Four obvious policy challenges lie ahead for early intervention: (a) full participation by all states in P.L. 99-457; (b) effective implementation of the intent of P.L. 99-457 at state and local levels; (c) evaluation of the effects of P.L. 99-457 and state and local policies on young children and their families; and (d) revision of P.L. 99-457 based on the evaluation data.

Full Participation

☐ Just as P.L. 94-142 is a voluntary program, so too is the Infant/Toddler Program of P.L. 99-457 (Part H). States do not have to participate. However, if a state applies for Part H funds it must comply with the requirements of the law. Therefore, the first challenge ahead is to convince governors and agency administrators of the importance of participation.

Figure 3. Participation and Lead Agency Designation.

State	State Participation	Lead Agency
Alabama	Yes	Education
Alaska	Yes	Health and Social Services
American Samoa	Yes	Health
Arizona	Yes	Econ. Security—DD
Arkansas	Yes	Human Services
California	Yes	Developmental Services
Colorado	Yes	Education
Connecticut	Yes	Education
Delaware	Yes	Public Instruction
D.C.	Yes	Human Services
Florida	Yes	Education
Georgia	Yes	Human Resources
Guam	Yes	Education
Hawaii	Yes	Health (Crippled Services)
Idaho	Yes	Health and Welfare—DD
Illinois	Yes	Education
Indiana	Yes	Mental Health
Iowa	Yes	Education
Kansas	Yes	Health and Environment
Kentucky	Yes	Cabinet for Human Resources
Louisiana	Yes	Education
Maine	Yes	Interdepartmental Committee
Maryland	Yes	Office of Children and Youth
Massachusetts	Yes	Public Health
Michigan	Yes	Education
Minnesota	Yes	Education
Mississippi	Yes	Health
Missouri	Yes	Education
Montana	Yes	Developmental Disabilities
Nebraska	Yes	Education
Nevada	Yes	Human Resources
New Hampshire	Yes	Education
New Jersey	Yes	Education
New Mexico	Yes	Health and Environment
New York	Yes	Health
North Carolina	Yes	Human Resources
North Dakota	Yes	Human Services
Ohio	Yes	Health Department
Oklahoma	Yes	State Dept. of Education
Oregon	Yes	M.H. Program for D.D.
Pennsylvania	Yes	Public Welfare
Puerto Rico	Yes	Education
Rhode Island	Yes	Interagency Coord. Council
South Carolina	Yes	Health and Env. Control
South Dakota	Yes	Education and Cultural Affairs

(Continued)

Figure 3. Participation and Lead Agency Designation. (Continued)

State	State Participation	Lead Agency
Tennessee	Yes	Education
Texas	Yes	Inter Council on EC Intervention
Mariana Islands	Yes	Education
Utah	Yes	Health
Vermont	Yes	Education
Virgin Islands	Yes	Health
Virginia	Yes	Mental Health/Mental Retardation
Washington	Yes	Social and Health Services
West Virginia	Yes	Health
Wisconsin	Yes	Health and Social Services
Wyoming	Yes	Health and Human Services

Note: From National Association of State Directors of Special Education, September 4, 1987.

Research and evaluation studies will help shape challenges.

Once a state participates it faces the three remaining challenges. All three of these challenges have one fact in common—they should be driven by research efforts.

Effective Implementation

❑ One unique feature of early intervention social policy is the role that research and development activities have played in its development. One of the possible reasons for this is the fact that early intervention policy has developed concurrently with a tightening of the national economy. Over the past 20 years, policy makers have gradually lost the luxury of frivolous decisions. Each policy decision has had to be weighed against all other competing interests and values. Thus, early intervention advocates have learned to present convincing arguments based on research data and practice. Therefore, the use of research in the future challenges of selecting effective program and policy options and evaluating and refining policies does not present an unfamiliar task to early intervention advocates. The important factor will be *how* research is used to advance high-quality services to children and families.

Advocates have learned to present arguments based on research and practice.

There are four stages of policy making.

Seekins and Fawcett (1986) suggest that there are four stages of policy making: agenda formation (deciding which issues to act upon), policy adoption(making the policy itself), policy implementation (translating the policy into action), and policy review (evaluating the value and satisfaction of the consequences of the policy). Each stage dictates a particular use of research.

When one reads the House Report (99-860) (1986) accompanying P.L. 99-457, it is evident that research data played an important role in the development and adoption of the legislation. For instance, the report contains the following excerpt as the rationale for the new federal initiative:

> Because of advances in research methodology, instrumentation, and theory, educators and behavioral scientists have come to view even very young infants as capable of participating in complex interactions with the world. For example, we now believe that newborns have a functioning perceptual system capable of intersensory coordination,

that they are capable of making multiple categorizations, that they possess both central and peripheral vision at birth, can coordinate visual and auditory input by age 2-1/2 months, show evidence of recognition memory by 4 months, and are able to recognize relatively abstract two-dimensional stimuli by 5 months. . . .

Thus, the infant's developing physical, cognitive, and social competencies are very important. Because of our recognition of the early appearance of these and other competencies, infants increasingly are being viewed as active organizers of their experience and not as passive and helpless creatures. Likewise, such recognition has also made it more feasible and tenable to develop early successful intervention approaches for handicapped infants and toddlers.

Infants are being viewed as active organizers of their experience.

The Committee therefore concludes that an overwhelming case exists for expanding and improving the provision of early intervention and preschool programs. The Committee's conclusions comport with the Department's findings in its Seventh Annual Report to the Congress:

Studies of the effectiveness of preschool education for the handicapped have demonstrated beyond doubt the economic and educational benefits of programs for young handicapped children. In addition, the studies have shown that the earlier intervention is started, the greater is the ultimate dollar savings and the higher is the rate of educational attainment by these handicapped children.

More specifically, testimony and research indicate that early intervention and preschool services accomplish the following:

- Help enhance intelligence in some children;
- Produce substantial gains in physical development, cognitive development, language and speech development, psychosocial development and self-help skills;
- Help prevent the development of secondary handicapping conditions;
- Reduce family stress;
- Reduce societal dependency and institutionalization;
- Reduce the need for special class placement in special education programs once the children reach school age; and,
- Save substantial costs to society and our nation's schools. (pp. 4-5).

Research and evaluation activities will continue to play an important role. Using Seekins and Fawcett's (1986) model, early intervention policy under P.L. 99-457 is entering the latter two stages—implementation and review.

There are many provisions in P.L. 99-457 that are subject to interpretation. Some of these dimensions already have a research base that points the way to the most effective implementation. Therefore, the challenge is the dissemination and adoption of these research and model development findings. Until recently, research findings have not been readily available to or used by practitioners. Indeed, B. F. Skinner (1956) summarized the state of the art at that time when he wrote: "We are more concerned with the discovery of knowledge than with its dissemination" (p. 221). More recently there has been an increase in the attempts to have research findings accessible to and adopted by practitioners and "lay" public (Couch, Miller, Johnson & Welsh, 1986). In fact, this interest

The challenge is the dissemination and adoption of findings.

has facilitated a growth in "technical assistance" efforts aimed at translating research and development findings into practice, as well as a growing body of literature regarding factors that enhance or impede the field adoption of research findings. After reviewing the literature, Kohler (1985) developed a synopsis of 12 criteria for the effective dissemination of educational findings. According to Kohler, in order to be readily adopted, research should be

Applied: Study behaviors that society has some interest in.

Behavioral: Increase peoples' ability to do something effectively.

Compatible: Consistent with the values, past experiences, and current needs of its consumers.

Decentralized: Suitable for small-scale application.

Effective: Produce large enough effects for practical value.

Flexible: Invite consumers to create their own procedures based on original models.

Generalizable: Improvements should endure across settings, responses, and over time.

Inexpensive: Economic profitability, low initial cost, low perceived risk, and a savings in time and effort.

Simple: Comprehensible and usable.

Socially Valid: Select goals that society really wants. Use procedures that are acceptable to consumers. Produce effects that are satisfying to society.

Sustainable: Maintained by local individuals and resources.

Technological: A typically trained consumer can replicate a procedure with effective results.

Loucks (1983) proposed seven tasks that must be undertaken in order to achieve successful implementation of a model program or procedure. According to her, the researcher or model developer must

- Create awareness of the model.
- Establish a commitment from the adopting site.
- Provide and explain materials.
- Train site personnel in the model program and procedures, including follow-up training.
- Help the adopting site to plan for the implementation of the model.
- Solve implementation problems and "trouble shoot" solutions.
- Monitor and evaluate the implementation.

Using dissemination guidelines such as those just described may increase the adoption of research findings. Because of the time factor involved in studying certain program and implementation options of P.L. 99-457, attention to the "adoptability" of related studies may prove to be a critical factor in the success of this legislation.

Many dimensions or provisions, however, are not so clear. Instead, they lend themselves to the study of the most effective options. For instance, dimensions such as interagency funding and reimbursement options, effective inservice training and credentialing models, and the most effective options for implementing the case management system, because of their innovative nature, demonstrate the need to evaluate the effects of various options or services to children and families. At this stage, research is used to answer the question "how to intervene" rather than

"whether to intervene." Or as Weiss (1977) put it, there are two primary uses of research in policy making—to set the agenda (whether to intervene) or to suggest alternative policy actions (how to intervene). Indeed, Bulmer (1981) suggested that information on the effects of various options may be the most powerful type of research information for decision makers.

Research is used to answer "how to intervene."

Currently, one policy dimension presented by P.L. 99-457 that necessitates the assessment of the effects of various options is the frequency and intensity of services to be provided. Decision makers need information on the effectiveness of varying levels of service intensity and frequency on various populations of children. Information on the consequences of various models can help shape policy decisions at all levels—school/community, state, and federal. In other words, studies of the effectiveness of services delivered for a variety of days per week and hours per day, and percentage of instructional time versus program hours for groups of children of varying conditions and severity of delay are needed. Comparative results will help decision makers to provide the most effective and yet efficient quantities of service.

Information on models can help shape policy decisions.

Comparative results will help decision makers.

Policy Evaluation and Revision

Evaluative data, as described above, could prove to be invaluable to policy makers and program developers. Policy evaluation or analysis provides an important, systematic way of measuring whether or not the intent of the policy has been met and of determining how the policy needs to be changed to increase the success rate (Gallagher, 1984). However, a word of caution is needed. A high level of research validity and integrity is imperative. As stated earlier, data on the effects of program options form a powerful policy tool. Poor data can be as powerful as high-quality data. For an example of the potential negative impact data may have on program and policy, one need not look far. Brown (1985) reviewed the impact that the 1969 "Westinghouse Report" nearly had on Head Start. In his paper, Brown pointed out that although the study was flawed and the conclusions questionable at best, policy wheels were set in motion. The report concluded that the summer Head Start program was ineffective and even had a negative effect, and the full-year program had only marginal effects. Even though the report was questioned immediately and other researchers demonstrated the problems with the study, in 1971 a plan was developed to phase out Head Start. While the phase-out was eventually prevented, the negative impact of the Westinghouse report lingered for many years.

A high level of research validity is imperative.

It was not until another study was completed, according to Brown, that the negative impact was in fact, reversed. The Consortium for Longitudinal Studies (1979) conducted a "meticulous" study of the effects of early intervention and reported significantly different findings from the Westinghouse study. Since them, Head Start funding has increased dramatically and was one of few domestic programs to be placed in the Reagan budget "safety net" in 1981 (Brown, 1985).

While research and evaluation activities can facilitate the development of effective programs and implementation policies, they can also help to review the effectiveness of the policy itself. Over the next several years, systematic policy research and collection of data on the effect of P.L. 99-457 on children and families could assist in any future review and revision of state and national early intervention policies. Periodically, the

Policy research on P.L. 99-457 could assist in future intervention policies.

Congress reviews its policies. In a few years, it will review P.L. 99-457—whether the intent of the law has been met and whether there is need to revise it. High-quality evaluative data at that time will help to shape national early intervention policy for years to come.

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