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ABSTRACT

Despite the availability of relevant knowledge to guide policy formulation, and in spite of financial resources appropriated to support the developmental process, policies and procedures related to child identification in Public Law 99-457 (Part H), state plans are inconsistent with both contemporary research and Congressional expectation. Eleven factors in this problem are identified, including: (1) absence of financial resources is not the most significant impediment to implementing coordinated programs for children and families; (2) capacity to generate knowledge exceeds ability to apply it; (3) knowledge regarding the prevention of disability and vulnerability is underutilized; (4) formal structures for promoting and facilitating knowledge application in decision making do not exist; (5) administrative structures supporting coordinated health, education, and social service programs do not exist; and (6) policy and funding decisions are only marginally affected by knowledge bases. An aggressive, multifaceted initiative is needed which can make available accurate and germane information about children and their families, broaden the agenda and arena of debate around existing systems, and promote alternative ways of nurturing children and families. Specific actions are recommended. (Approximately 50 references.) (JDD)

FEDERAL POLICY IN HEALTH AND EDUCATION AS A STIMULANT FOR A COMPREHENSIVE EARLY INTERVENTION SYSTEM: MYTH OR REALITY?

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Despite the affluence and superior technological standing in the United States internationally, the perilous conditions which confront many children and families in this country are enormous. More specifically, recent data (Children's Defense Fund, 1990) indicate:

- That 7% of the infants born in the United States are low birthweight (LBW) and 28 countries, including Hong Kong and East Germany, have fewer LBW newborns
- That 13 of every 1,000 children die before their fifth birthdays, which places this country 22nd worldwide–behind nations such as Singapore and Japan
- That one year old children in the U.S. have lower immunization rates against polio than children in 14 other countries
- That the overall infant mortality rate lags behind 18 other nations; in fact, an African-American child born in Boston has less chance of surviving during the first year of life than a child born in Panama, Korea, or Uruguay
- That the United States has the highest adolescent pregnancy rate among seven industrialized nations (France, England, Wales, Canada, the Netherlands, and Sweden)
- That America and South Africa are the only industrialized nations which fail to provide universal health coverage, child care, and parental leave for child rearing

While it has been argued that such alarming trends are a direct consequence of underinvestment in children's programs, the United States does indeed expend a substantial portion of its Gross National Product (GNP) on health care and public education. In fact, America ranks seventh worldwide in expenditures on public education (Children's Defense Fund, 1990). Although it is indisputable that additional financial resources would, in all likelihood, produce a favorable impact on education and health care, the problem is rooted in several other important areas as well which have neither been acknowledged nor thoughtfully addressed.

The Mandate for Early Identification in Health and Education Policy

Examination of Federal policy, particularly in health care, reveals a rich history of commitments to children and families which originated over 50 years ago. More specifically, the Maternal and Child Health Block Grant Program, created in 1935, was enacted to ensure that low income families had access to quality maternal and child health services. In addition, specific provisions required that children in need of special health care services were identified, and furthermore, were provided with access to medical and other supportive services and care.

With remarkably similar intentions, the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) was created to provide preventive and habilitative services to all children whose families are eligible for Medicaid. EPSDT was launched in 1967 as part of a national commitment to enhance the health and welfare of families in poverty. In 1989, OBRA included unparalleled enhancements to this system by: (a) requiring comprehensive screening services, including assessment of developmental status, at periodic intervals; and (b) mandating that necessary healthcare, diagnostic services, and treatment to ameliorate illnesses and conditions revealed by the screening process must be provided regardless of whether such services are covered by the state Medicaid plan.

Despite such impressive requirements, recent evaluative studies reveal significant disparities between the mandate and reality. For example, studies indicate that only 25-30% of eligible children ever receive the benefits of EPSDT (Children's Defense Fund, 1990). More importantly, for those children who do participate, services are incongruent with the mandate. In a study of 281 Medicaid eligible, disabled children, Meisels and Margolis (1987) reported that the EPSDT program performed neither its early identification nor treatment function. Specifically, EPSDT and non-EPSDT groups did not differ on indicators of timeliness or effectiveness of early screening. Moreover, the two groups were nearly identical relative to age at diagnosis and source of diagnosis. While several reasons have been advanced regarding the apparent ineffectiveness of the EPSDT mechanism (1987b), the fact remains that EPSDT, despite its enormous potential as a preventive initiative, has fallen short of its intended outcomes.

Within the field of education, an equally impressive body of mandates exist pertaining to early identification and intervention. For example, P.L. 99-457 (Part H) includes stipulations which require states to: (a) locate and identify all disabled children and (at the state's discretion) children at substantial risk for poor health and educational outcomes; (b) coordinate such efforts with Title V and EPSDT to identify eligible children; and (c) provide appropriate interventions which fully respond to identified needs. As a result of a three year planning and developmental effort underwritten by a 200 million dollar Congressional appropriation, 45 states have submitted "fourth year" plans which include formal policies and procedures for the above mandates.

Examination of the screening and early identification component only of these plans reveals several interesting findings. More specifically, Kochanek (1992) conducted a brief analysis of all material within approved plans which pertained to the "child find" and screening requirements of the statute. Evaluative criteria used to conduct this analysis included standards recently developed by an inter-disciplinary team of professionals (Meisels & Provence, 1989). Such quality assurance standards included that:

1. Screening should be a universal, population-based enterprise.
2. Screening should be viewed as the initial encounter to service provision, and not simply the collection of information on children and families.

3. Screening procedures should involve both multiple sources as well as informants of data around child and family status.

4. Screening should be conducted at periodic intervals for all children and families.

5. Screening measures and procedures must be reliable, valid, and psychometrically sound.

6. Screening should perceive families as major informants in data collection and decision making processes.

7. Screening should be cultural and ethnically sensitive to the populations engaged.

8. Screening should be integrated into other existing child identification efforts (e.g., EPSDT, Title V).

Of the 45 state policies reviewed and appraised according to the above standards, no state fully represented all criteria. While 8 states (17%) reflected 5 of the above factors (i.e., multiple information sources, periodicity, cultural sensitivity, coordination with other screening initiatives, families as major informants and decision makers), the majority of approved policies did not provide meaningful and clearly stated procedures through which the above quality assurance standards would be met. In short, despite the availability of relevant knowledge to guide policy formulation, and in spite of financial resources appropriated to support the developmental process, policies and procedures related to child identification in P.L. 99-457 state plans simply are inconsistent with both contemporary research and Congressional expectation.

The Problems

1. Absence of financial resources is not the most significant impediment to implementing coordinated programs for children and families.

In examining comprehensive services (i.e., health care, education, social service programs) for children and families, it is apparent that the United States has made a multibillion dollar commitment to programs. For example, in response to calls for educational reform in the last decade (National Commission on Excellence in Education, 1983), virtually every state increased its appropriation to public education; adjusting for inflation, expenditures increased by 25% from 1983 to 1986 (Odden, 1987). Despite such increases in not only educational programs but other health care programs and social service programs as well, duplication and fragmentation continue to prevail, and as a result, some families receive multiple services concurrently while others are denied access to necessary, single services.

2. Our capacity to generate knowledge exceeds our ability to apply it.

Numerous impressive documents (Institute of Medicine, 1989; Institute of Medicine, 1991; Baumeister, Dokecki, & Kupstas, 1987; National Conference of State Legislatures, 1990; National Commission on Children, 1990) have recently been prepared which accurately summarize contemporary knowledge and perspectives on several important human service problems (e.g., prevention of developmental disabilities; investment strategies for the developmentally disabled; intervening with children reared in abusive/neglectful environments or who are victims of substance abuse or serious emotional problems). Despite this knowledge base, and in certain instances the political will for action, successful, large scale implementation strategies have not been developed (Schorr,1989).

3. Knowledge regarding the prevention of disability and vulnerability exists but is underutilized.

Our ability to prevent disease and disability has dramatically increased in recent years. Despite impressive achievements in understanding the epidemiology of poor outcomes in children, only a small segment of this knowledge base is used. While a comprehensive array of cost effective programs in education and health care have been reported (Select Committee on Children, Youth, and Families, 1988), uniform adoption and implementation of such programs is a rarity. Even in instances where there is unanimity on the need for immediate, widescale intervention, the elapsed time between identification of a solution and its universal implementation is unimaginably lengthy. For example, it is incomprehensible that while Edward Jenner discovered a vaccination for smallpox in 1796, it was not until nearly 200 years later that the Global Commission certified that smallpox had been eradicated worldwide (Hopkins, 1983). In stark contrast, the elapsed time between discovery and large scale market availability of significant technological inventions (e.g., the VCR, microwave oven, and computerized tomographic scanning) in the private sector is approximately 20 years (Nayak & Ketteringham, 1986).

Schorr (1989) has convincingly summarized volumes of research which have verified that the origins of damaging outcomes in children are clear, and furthermore, that the interventions needed to reduce the occurrence of such outcomes have been identified. While this knowledge is available and indisputable, statewide systems founded upon such knowledge are nearly non-existent. Moreover, middle management staff in state agencies oversee substantial expenditures on young children and families, yet do not have full and ongoing access to contemporary knowledge which should influence decision making.

4. Formal structures for promoting and facilitating knowledge application in decision making do not exist.

Despite the fact that universities have historically built their reputations on conducting scholarly inquiry of emerging and epidemic problems, formal structures do not exist which permit and facilitate the translation of this information into public affairs. In fact, state legislators are more receptive to information from their own staff or select lobbyists and advocates than from expert university faculty (Cohen, 1985; Fuhrman & McDonnell, 1985). Furthermore, a remarkable feature of education policy reform within the last five years is that it has been prompted and shaped by governors and legislators rather than by educational specialists (McDonnell, 1988).

In states where Policy Analysis Centers have been created, their impact has been disappointing. This is true because: (1) centers have had no structural linkage to key policymakers (e.g., Governors, Legislators, State Agency Department Directors); (2) policymakers have relied upon information providers whose base is largely political rather than empirical; (3) centers have been more involved with evaluating outcomes of programs and not with policy formulation; and (4) the process of information transmission and translation has been poor, and as a consequence, policy and funding decisions are made in response to crises, emotionally driven arguments, and public concerns and pressures.

5. Administrative/management structures which support coordinated health, education, and social service programs do not exist.

The majority of states retain a strong orientation to single agency structures (e.g., health, education, child protective services, juvenile justice) for the organization and management of children's services. Despite an absence of evidence regarding the effectiveness of such intra-agency models, they are: (1) administratively convenient; (2) reinforced by discreet Federal funding streams; and (3) create the illusion of responsiveness to identified problems. As such, prenatal cocaine exposure is viewed as a health problem; child abuse and neglect is perceived as a protective services problem. Consequently, solutions to problems assume the character, parameters, and limits of the agency to which they are assigned. Furthermore, including language in Federal policies which recommends or even requires inter-agency planning and intervention is too meager an antidote to overcome the strength of the prevailing system.

6. Governors and legislators are most persuaded by dividends on short-term investments.

Unfortunately, the literature on the long term benefits of prudent investments in young children and families is scant. However, even in those instances in which solid data are available, efficacious programs have not been made universally accessible. As an illustration, the adverse outcomes of low birthweight are well documented (Institute of Medicine,1985). Low birthweight infants are three times as likely as normal birthweight children to have neurodevelopmental handicaps. Despite the fact that an array of preventive initiatives have proven to be cost effective in reducing the incidence of low birthweight (e.g., maternity benefits for all pregnant women; risk scoring methods for the identification of high risk deliveries), such programs are not readily available to all women. In fact, in 1984, approximately one out of every four pregnant women did not receive prenatal care during the first trimester of pregnancy.

Attempting to convince Executive and Legislative staff of a delayed yield on investment is simply inconsistent with the length of office of such public officials. While these individuals are certainly concerned with effectively using already scarce dollars, assuming that commitments exist to initiatives whose effects may not be realized for over a decade is naive and unrealistic.

7. Although effective programs for disabled and vulnerable children and families require access to integrated health, educational, and social service programs, administrative/ management structures which promote programs to be created and interventions provided in such an integrated manner do not exist.

The service delivery system for young disabled children and their families is comprised of a myriad of programs, each with their own unique set of eligibility criteria, policies, and funding streams. Inter-agency coordination, therefore, became a centerpiece within P.L. 99-457 with the assumptions that: (1) coordinated, integrated services are more effective for families and cost efficient for governmental agencies; and (2) truly interagency based intervention models are feasible to design and implement. Based upon available literature, it is apparent that these beliefs are more philosophical than empirical. More precisely, attempts at service integration were reported nearly a century ago in which community organization societies were considered to be the remedy for fragmented and disorganized family welfare activities (Morris & Lescohier, 1972). Despite the perennial interest in the topic and its simplistic, enormous appeal, effective models continue to elude our grasp.

Gans and Horton (1975) reviewed 30 special projects underwritten by the Federal Government to support new, experimental models of service integration. Although some gains were reported, the authors concluded that the conversion of a fragmented and diffused system into a unitary, integrated system may not be an attainable goal. In a similar study of 22 Services Integration Target of Opportunity Projects (SITO), Mittenthal et al. (1974), concluded that no program produced an integrated "system" but a variety of administrative reorganizations and reconfigurations.

Finally, Heintz (1976) reviewed 26 Comprehensive Human Resource Agencies (CHRA) and concluded: "it is now generally agreed that no substantial advantage or savings can be realized through the creation of a CHRA." In short, despite the long standing interest and apparent commitment to services integration, the creation of an accessible, coordinated, cost effective, and responsive system of care for children and families continues to elude specificity. As such, new experimental models are required which must develop strategies to deal with issues such as agency rigidity (Pollard, Hall, & Keeran, 1979), absence of leadership (Hayes, 1982), protection of turf and power (Leach & Barnard, 1983), competition for finite financial resources (Colby, 1987), and conflicting state and federal policies (Steiner, 1976).

8. Striving to eliminate duplication and fragmentation may not be an attainable or desirable goal.

The preponderance of intra-agency initiatives in human services are characterized by intense enthusiasm, passion, and pride. In fact, most of the efficacy literature is derived from programs which have been underwritten and sponsored by a single agency. Despite the superficial appeal and alluring quality of inter-agency collaboration around identified, focal problems, it is not uncommon for inter-agency initiatives to be plagued by competition, jealousy, and resistance to relinquish previously held beliefs, assumptions, and procedures.

Despite the earnest attempt of many projects to promote inter-agency initiatives, their success is infrequent. Furthermore, inter-agency perspectives may compromise the passion and commitment of individual professionals and may ultimately result in a program of poorer quality and marginal impact.

9. Policy and funding decisions are only marginally affected by knowledge bases.

Analysis of recent reform initiatives (National Governor's Association, 1990) in education includes an expression of impressive, lofty goals, however, also reveals inadequate attention devoted to underlying knowledge and supportive research. As an illustration, "school readiness" has recently ascended into a prominent policy issue in public education (National Governor's Association, 1990). This is true due to increased concern with declining test scores, increased numbers of school dropouts, higher rates of illiteracy, and unfavorable comparisons with students from other countries. In fact, the first of six National Education goals states that "By the year 2000, all children in America will start school ready to learn" (National Governor's Association, 1990).

In reviewing policy and program initiatives nationally which pertain to this goal, four responses are most prevalent: (1) raising the age at school entry; (2) retention; (3) extra year early childhood programs; and (4) parents selecting to delay school entry for their children until six years of age (Meisels, 1990). Despite the widespread popularity of these movements, available research evidence indicates that each of these options in contraindicated. For example, a review by Proctor, Black, and Feldhusen (1986) found few negative effects and several positive consequences of beginning school entry early rather than late. Furthermore, Smith and Shepard (1987) discovered that although oldest and youngest children are separated by nine percentile ranks on Grade One reading tests, oldest and youngest children are indistinguishable by third grade. Overall, there appears to be little or no evidence to justify policies which raise the mandatory age for kindergarten enrollment.

With regard to retention policies and practice, research consistently demonstrates that the effects of retention are unjustifiable and discriminatory (Abidin, Golladay, & Howerton, 1971). Moreover, research shows that retention is the single most sensitive indicator of dropout potential in high school

(Kreitzer, Maudaus, & Haney, 1989). Beyond its adverse consequences in human terms, retention is also prohibitively expensive. For example, Florida expended approximately 144 million dollars in 1989 for children not promoted in the primary grades (Florida Center for Children and Youth, 1990). Nevertheless, kindergarten retention continues to take place in significant numbers (Bryant, Clifford, & Peisner, 1989; Howes, 1987), despite the fact that "it would be difficult to find another educational practice in which the evidence is so unequivocally negative" (House, 1989).

Finally, with respect to extra year programs (e.g., developmental kindergartens, transitional K-1), recent findings (Eads, 1990) indicate that no advantage was evident by an extra year in any of the above environments. In short, Meisels (1990) concludes that such programs, despite their sound intentions, masquerade iatrogenic effects; that is, unintended negative consequences. The evidence is clear that continued use of all of the above interventions should cease immediately.

Within the area of children's mental health, similar disparities between research and practice are evident. For example, extensive resources in many states are consumed by placements in residential treatment centers and psychiatric hospitals (National mental Health Association, 1989). In fact, recent reports indicate that 261 million dollars are being spent nationally on psychiatric hospitalization of children (Fox & Yoshpe, 1987). Despite such utilization, research on outcomes of such treatment is virtually nonexistent (Saxe, Dougherty, Cross, & Silverman, 1987; Institute of Medicine, 1989; Friedman & Street, 1985). Simply stated, there is no efficacy research base, and very little program evaluation, to support the observed growth in inpatient psychiatric hospitalization of children within the past decade (Kiesler & Simpkins, 1991).

10. <u>Information is not made available to policymakers in appropriate, usable forms.</u>

Policymakers are desperate for concise, unbiased, and accurate information about their investment in children's services, and on the impact and cost effectiveness of these programs. Despite this critical need, recent studies (Hetrick & Van Horn, 1987) have indicated that in most states, a mature "system" for information transmission is non-existent, and furthermore, available data are perceived as irrelevant, excessively detailed, untimely, and not consonant with existing, community based practices. Clearly, an acute need exists to develop more effective methods of "research brokering" in order to reduce the gap between research and practice.

One of the greatest challenges for policymakers is to ensure that decisions are based upon available knowledge and the merits and limitations of various policy options. While it is unreasonable to expect that educational and social service empiricism will influence policy in a manner similar to the way in which physics can precisely determine the calculation for a lunar orbital flight (Shavelson, 1988), there is room for considerable growth in the extent to which research impacts on interventions with children and families.

11. Non-compliant, risk taking, and thrill seeking behaviors are not prevalent enough in state governmental agencies.

Collaborative programs are effective when the individuals involved feel confident with their knowledge and expertise, and are eager and courageous to apply their competency to challenging issues in conjunction with new partners. Such courageous behavior can be promoted by administrators who encourage thoughtful risk taking actions on behalf of children and families. Due to a wide range of factors, risk taking investments in state agencies are an infrequent occurrence. As a result, programs are managed with a view toward security, safety, and protection, and the unfortunate consequence is a powerful self-perpetuation of what currently exists.

What is Needed

In order to more effectively utilize existing knowledge and capacity to improve the well-being of children and families, and to assist in untangling the perplexing network of health and education programs designed to reduce and resolve affliction, what is needed is an aggressive, multifaceted initiative which can make available accurate and germane information about children and their families, broaden the agenda and arena of debate around existing systems, and promote alternative ways of nurturing children and families. Specific actions recommended are as follows.

1. Evaluate rigorously the benefits and costs of existing health care and education initiatives. Programs which are neutral or negative events should be discontinued.

An urgent need exists to identify the outcomes of the extant system; that is, what works, for whom, under what circumstances, and at what expense. Despite the apparent simplicity of this objective, surprisingly little is known about numerous, highly significant programs and financial commitments.

As an example, the EPSDT program, despite its existence for nearly three decades, has rarely been subjected to systematic evaluation (Meisels, 1984). Goggin (1987) has viewed the implementation of the program in five states with indifferent results, but the findings do not seem to have affected any programmatic modifications. The need to evaluate is strong and the need to pay attention to the results of the evaluation is even stronger.

In spite of the multi-billion dollar commitment made to EPSDT over time, and despite electronic data processing capability to request accurate information (which is unparalleled in human history) on issues such as (a) the number of children enrolled in this program, (b) ongoing services received, and (c) the cost of such services, the program is seen by many as the educational equivalent of the "Star Wars" initiative in the Department of Defense. The capability and expertise currently exists to determine the relative value of existing programs such as EPSDT; this evaluation should be initiated immediately.

2. Create alternative, experimental structures which can broker contemporary information and wisdom to policymakers, the human service community, and families.

Models which promote knowledge application must assume equal prominence to those which advance knowledge development. New structures must be launched which serve as independent, non-partisan, research based information and technical assistance centers. Ideally, such models would represent a broad coalition of public and private institutions (e.g., colleges and universities, private corporations) and, additionally, would actively engage varied areas of expertise (e.g., education, medicine, psychology, economics, anthropology). Unique features of such structures would include:

- Independence and political neutrality.
- Linkage with executive and legislative branches of government.
- Immediate, product oriented response capability.
- Linkage with directors of child serving agencies.
- Research and information brokering with policymakers around target issues. Capability to create inter-agency data bases and address service duplication and fragmentation.
- Capability to generate solutions which transcend any single state governmental agency.
- Capability to promote and ensure the application of development of new interventions and treatment models.
- Capability to link and merge disparate programs and funding streams across agencies.
- Capability to link interests and commitments of the private sector with state governmental initiatives.
- Capability to conduct short term and sustained investigations of children's services.
- Capability to introduce expert, objective testimony into legislative hearings and investigations.
- Capability to develop experimental models and service configurations which are not bound by existing regulations and statutes.

Overall, such experimental structures would assist in defining problems, analyzing options and effects, providing facts and arguments on all sides of an issue, and generating cost-effective solutions. In implementing such a structure, several key questions and challenges become apparent. For example, the physical location of such an institute is critical in order to ensure integration into decision-making in governmental agencies, yet also guarantee uncompromised independence of stated positions and recommendations. Alternative locations include: a governor's office, the private sector, an institution of higher education, or a separate, free-standing, non-profit agency. Depending upon the context and political landscape of a state, certain options may be more desirable and feasible than others.

Secondly, with respect to funding, acquiring a balanced base of support which includes both public and private sources is essential. However, such a proposed institute would need to guard against being compelled to constantly pursue diverse "requests for proposals" and, thus, not have the opportunity to conduct sustained inquiry on select topics, or not develop a strong identity within a focused area.

Finally, the governance structure of such an institute will exert enormous influence on the agenda and workscope addressed and, moreover, on the capacity of the institute to use and apply information to influence decision-making in governmental agencies and community-based programs. Although the mission of the institute is to assist states in solving problems and using available resources most effectively, creating a management structure which includes only public officials compromises the independence and agenda of the institute, particularly if public funds constitute a major portion of the funding base. While all of these issues are not insurmountable, thoughtful consideration on the organization, operation, governance, and funding of such a structure would greatly enhance its capacity to achieve previously stated goals.

3. Create community based, experimental programs which view children and families, not epidemic problems or service agencies, as the target(s) of intervention.

An extensive body of literature which has reviewed the effects of programs for both disabled and high risk children consistently indicates that attempts to influence child outcomes must occur within an ecological context which regards the family system as the focal unit of intervention (Farran, 1990; Halpern, 1990; Guralnick & Bennett, 1987). Effective programs are those which include components that foster child developmental competence, parental well-being and competency, and opportunities for family security and independence (Bryant & Ramey, 1987).

Funding programs which are directed to epidemic problems or existing agencies does not always allow for the use of this information base and as such, interventions are formulated which we know in advance will be ineffective. Alternatively, new community based models must be funded which enjoin families (i.e., values, cultural uniqueness, priorities, needs), service providers, and knowledge bases in order to craft interventions which are meaningful, fully responsive to identified child and family needs, and inclusive of and sensitive to the existing system.

4. Create community-based, experimental programs within the context of the existing health and educational system.

Reviews of programs which appear to hold considerable promise for reducing the probability of adverse outcomes in children (Ramey, Bryant, Sparling, & Wasik, 1985; Infant Health and Development Program, 1990) have reported annual program costs to be approximately $10,000-12,000 per child/family. These costs are derived from program models which were implemented as separate, free standing interventions, apart from the existing child and family care system. While the immense preventive potential of these models is indisputable, given the current economic recession and climate nationally, the probability of universal adoption for all eligible and needy children and families is highly unlikely. There is a need to create a second level of demonstration. To take the results from the ideal and expensive demonstration that showed what could be done under the most favorable circumstances, and apply them in a more ordinary setting with reasonable economic costs. It is only then that we will convince decision-makers that these new ideas are worth practical consideration. Furthermore, replicating models apart from what exists is economically irresponsible, insensitive to the commitments and beliefs of the current system, and is sure to be met with resistance and hostility.

As such, new programs must be funded which: (1) identify and apply the essential principles, methods, and approaches of proven programs; and (2) re-conceptualize the existing child and family care system, including all existing funds which support it, to incorporate and fully represent the rich knowledge base concerning primary, secondary, and tertiary prevention of developmental disabilities in children.

In summary, effective translations of health and education policies require an array of new initiatives and investments which are committed to enlightenment, problem definition, and solution searches. To perform these functions successfully will require a new partnership between those who generate knowledge and those who consume it in order to make sound investment decisions for children and families. While there is no guarantee that research findings and contemporary wisdom will prevail in a political and economically stressful environment, the price of not pursuing thoughtful knowledge application is that we are forced to accept solutions from those least familiar with children and families. The waste and tragedy which result from this course are clear and should no longer be tolerated.

Summary

Examination of federal policy in health care and education reveals a rich history of commitments to children and families. Several programs have been enacted which require not only the early identification of special health and developmental needs of children but also mandate that the services necessary to ameliorate identified illnesses and conditions be provided. Despite such impressive requirements, recent evaluative studies reveal significant disparities between mandates and reality. More precisely, community based programs are, in many instances, inconsistent with contemporary research as well as Congressional expectation.

In order to narrow the gap between policy, knowledge, and community practice, several conditions are critical. They include: (a) evaluating rigorously the benefits and costs of existing programs and discontinuing those which are ineffective; (b) creating structures which can broker contemporary research to policymakers, the human service community, and families; and (c) creating community based, experimental programs which view children and families, not epidemic problems or service agencies, as the target of interventions.

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