IMPLICATIONS OF PUBLIC LAW 99-457 FOR EARLY INTERVENTION SERVICES
FOR INFANTS AND TODDLERS WITH DISABILITIES

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Public Law 99-457 (Education of the Handicapped Act Amendments of 1986) is one of the most far-reaching pieces of recent federal legislation to affect the lives of young children with disabilities and their families. This legislation has three main provisions:

1. Title I establishes a new discretionary program for states to facilitate the development of comprehensive systems of early intervention services for infants and toddlers with developmental delays or disabilities. This program is designated as Part H of the existing Education of the Handicapped Act.

2. Title II requires states by 1990 (or 1991, depending on the level of appropriated funds) to provide free and appropriate public education and related services for all eligible children with disabilities from the age of 3 to 5 years in order to receive federal preschool funds.

3. Title III reauthorizes a number of discretionary programs under the Education of the Handicapped Act, such as services for deaf-blind children, early childhood research institutes, and grants for personnel training.

This legislation was introduced during the 99th Congress in the House of Representatives by Congressman Pat Williams (D-MT) (H.R. 5520); somewhat similar legislation had been introduced previously by Senator Lowell Weicker, Jr. (R-CT) (S.2294) in the Senate. Hearings were conducted during the summer of 1986, and the final bill was signed into law by President Reagan on October 8, 1986. The Notice of Proposed Rule Making (NPRM) appeared in the Federal Register on November 18, 1987; regulations are expected to appear late in 1988. Even in the absence of final regulations, states have been developing and refining their policies related to services for young children with disabilities and their families during the past year.
While acknowledging the importance of all three aspects of P.L. 99-457, this report focuses on Title I (referred to as Part H)--early intervention services for infants and toddlers with disabilities. We discuss the context in which the legislation was drafted and enacted into law, the status of early intervention programs at the time of its enactment, and issues related to critical components of Part H. Four important aspects of the law that lack specificity and thereby permit (and impose) a great deal of decision-making and flexibility at the state level are addressed: definitions of developmental delay, the designation of "risk" groups eligible for services, the role of families, and the process of transition from early intervention into preschool. In light of the complexity of these topics, we believe they warrant careful consideration by the child development research community, whose members can both make known the relevant research base and direct their attention to the investigation of yet unanswered, policy-oriented questions.

The Context for P.L. 99-457

In many respects, it is surprising that such far-reaching legislation as P.L. 99-457 was passed at a time of so little support for expanded federal investment in education. The political survival of Part H is even more intriguing, given the strong objections raised by the Secretary of Education, William Bennett, who found the program to be "unduly prescriptive, burdensome and costly" (1986, p.2), and the opposition voiced by the Assistant Secretary for Special Education and Rehabilitation Services, Madeleine Will, who contended that insufficient information on early intervention existed to make a decision about the role of the Department of Education (U.S. House of Representatives, 1986, p.386). Despite such formidable opposition from within the federal education bureaucracy, proponents of expanded federal education initiatives countered with the help of powerful advocates within the Congress, and an extremely energetic array of consumer and professional organizations who mounted an effective lobbying effort from the early committee hearings through the final days of a possible presidential veto.

Although undoubtedly many factors account for the successful passage of P.L. 99-457, including the personal beliefs and values of many of the policymakers who endorsed its goals, much of its support was derived from the strong foundation of federal investment in the educational needs of children with disabilities. The Handicapped Children's Early Education Assistance Act (P.L. 90-538) was passed in 1968 to authorize funds for the development, evaluation, refinement and dissemination of model demonstration programs for the education of disabled children from birth through 8 years of age and their parents. Demonstration and outreach projects continue to receive federal support through the Handicapped Children's Early Education Program (HCEEP).

The most extensive federal legislation affecting the education of children with disabilities was P.L. 94-142, the Education of All Handicapped Children Act, enacted in 1975 (see Behr & Gallagher, 1981 for a review of federal educational policy for handicapped children). Despite considerable concern about the extent of its implementation (Singer & Butler, 1987), the fundamental assumption of P.L. 94-142 is rarely questioned. That assumption is that all school-age children (between 5 and 17 years) with disabilities have a right to an education appropriate to their needs. Travers and Light (1982) maintain that social legislation like P.L. 94-142 often carries with it a "climate of entitlement" that extends beyond the boundaries of the law itself. In this case, such a climate promoted the extension of entitlement to younger children.
Other forces also have directed attention to the value of intervention during the early years of life. Public dissemination of the results of evaluation research on early childhood programs, for example, has promoted widespread awareness of the benefits of such efforts. This is perhaps best illustrated by the media's response to the publication of Changed Lives, a report on a 22-year study of economically disadvantaged children who attended the Perry Preschool Project (Berneuta-Clement, Schweinhart, Barnett, Epstein, & Weikart, 1984), whose findings of wide-ranging, long-term benefits were reported through radio broadcasts, evening news programs, and syndicated columns in major newspapers. Other reports of the long-term value of early education for young children from economically disadvantaged families have added further evidence of the benefits of such investments of public resources (e.g., Lazar, Darlington, Murray, & Snipper, 1982).

In contrast to the evaluation studies mentioned above, data on the effectiveness of early intervention programs for infants and toddlers with disabilities are sparse and less well known. Although such research findings seldom have direct influence on federal legislation (Andringa, 1976), they may serve to augment lobbying efforts on behalf of certain programs (Weiss, 1986). Thus, references to a body of knowledge on the efficacy of early intervention services and to the cost-effectiveness of special education in general were sprinkled throughout the committee proceedings (U.S. House of Representatives, 1986). Congressman Pat Williams (D-MT), for example, began the hearings with the following statement:

I bet no one here today will argue when we say that early intervention is good social, as well as economic policy. It adds to the quality of human life, and it is cost-effective for society. (p.1)

Typically, researchers are reluctant to draw such unequivocal conclusions. In a recent commentary on studies of early intervention services, for example, Palmer, Capute, and Shapiro (1988) lamented that "it is of concern that the scientific study of treatment efficacy has lagged behind program development and legislative mandate" (p. 80). Multiple reviews of research on early intervention for infants and toddlers with disabilities have concluded consistently that few investigations have met reasonable scientific standards (Shonkoff, Hauser-Cram, Krauss, & Upshur, 1988). In a systematic analysis of 27 studies of developmentally delayed and/or disabled infants, Simeonsson, Cooper, and Scheiner (1982) found that statistical procedures were used to analyze data in only 59% of the reports, despite conclusions of program success in 92% of studies reviewed. Dunst and Rheingrover (1981) reviewed 49 studies of programs for infants and toddlers with organic impairments and reported that 57% of the studies failed to rule out three or more threats to internal validity.

More recent meta-analytic reviews have concentrated on a relatively select body of higher quality studies. Casto and Mastropieri (1986) aggregated data from 74 studies of programs for children with biologically based disabilities through age 5 years. Shonkoff and Hauser-Cram (1987) further restricted this data set to 31 studies of infants and toddlers (below 36 months of age) with disabling conditions or biological vulnerabilities. Both meta-analyses found effects of about one-half of a standard deviation favoring children in early intervention programs over comparison groups. Moreover, programs that aimed for high levels of parent participation appeared to be more effective in promoting developmental progress in disabled infants and toddlers (Shonkoff & Hauser-Cram, 1987).

Reviews of the efficacy of early intervention point to five critical inadequacies in the existing knowledge base. First, most studies have focused primarily on the
effects of early intervention on developmental change in children, with relatively little empirical investigation of its impacts on the adaptive characteristics of families. Second, studies have focused largely on changes in children's intelligence quotient (IQ) or developmental quotient (DQ), while neglecting other domains of competence and behavior that may be more valid ecologically and linked more closely to specific intervention objectives. Third, most research has focused on modal population characteristics (i.e., "the average child with Down syndrome" and "the typical parent"), with relatively little empirical examination of differences among distinct subgroups within these heterogeneous populations. Fourth, research has traditionally emphasized the identification of risk factors that predict poor outcome, with less attention directed to the elucidation of protective factors that predict positive adaptation for both children and their families. Fifth, most studies of service effectiveness have been cross-sectional or extended over relatively short time intervals. Poor research design, small samples, inappropriate measures, and insufficient funding may all have contributed to the above inadequacies.

As always, the development and implementation of services cannot wait for research findings to settle questions of efficacy. In fact, a growth in the provision of early intervention services was evident in some states even before the passage of P.L. 99-457.

The Status of Early Intervention Programs Before P.L. 99-457

When P.L. 99-457 was passed, the development of policy guidelines and the availability of services for young children with disabilities varied widely across the nation (Fraas, 1986; National Center for Clinical Infant Programs, 1985). Half the states offered no entitlement to services for children under 5 years of age (Meisels, Harbin, Modigliani, & Olson, 1988), while 14 states provided entitlement for children with some disabling conditions beginning at birth (Upshur et al., 1987). In a study of selected states, the percentage of the population between birth and 3 years reported to be receiving early intervention services ranged from less than .5% to almost 3%. Interestingly, the number of children served bore no relation to either the status of state entitlement or the existence of mandates for services (Upshur et al., 1987).

Types of agencies that administered early intervention programs also varied across states. Health departments were designated most often as the primary service agency for children under 3 years of age (54.9%), while education agencies had responsibility for children age 3 and over in almost three-quarters (72.6%) of the states (Meisels et al., 1988). Poor coordination of services across multiple programs and funding sources was illustrated by the existence of seven different demonstration and funding source streams at the federal level (Fraas, 1986) and the identification of as many as 12 different funding sources at state and local levels (Meisels et al., 1988). Furthermore, using an index of "optimal policies" for implementing early intervention services, Meisels and colleagues (1988) found that no state--including those with a universal mandate--met criteria for optimal policies in all seven defined categories (handicapping conditions served, overseeing agencies, intervention services, funding sources, interagency contracts, state regulations or standards, and professional certification). Such findings, many of which were presented during the committee hearings (U.S. House of Representatives, 1986), highlight the piecemeal approach to the provision of early intervention services which existed in most states prior to the passage of P.L. 99-457 and which the legislation attempts to remedy.
Critical Aspects of Part H

Early intervention services are defined as "developmental services which...are designed to meet a handicapped infant's or toddler's developmental needs in any one or more of the following areas: physical development; cognitive development; language and speech development; psycho-social development; or self-help skills" (100 Stat.1146, Sec. 672). They may include a wide array of services, such as family training or counseling, special instruction, speech pathology, and psychological services. Health services are included only to the extent they are "necessary for the infant or toddler to benefit from the other early intervention services" (Sec. 672). Interestingly, references are made in Part H to the "development" rather than the "education" of the infant or toddler with disabilities.

Although the development of a service system beginning at birth is encouraged but not required by P.L. 99-457, all states have elected to participate in Part H. Accurate estimates, however, do not exist of the number of children from birth through 2 years of age who are eligible for early intervention services nor even of those currently enrolled in early intervention programs. In October 1987, a total of 29,696 children from birth through age 2 were reported to be receiving services subsidized by P.L. 89-313, which provides grants to state educational agencies for programs for infants, toddlers, and children with disabilities and to children in state-supported institutions (U.S. Department of Education, personal communication, June 13, 1988). Sixteen states, however, have reported fewer than 10 children receiving services supported by these funds.

Federal appropriations under Part H initially will be distributed among the states based on the relative number of children under 3 years of age in each state's population (i.e., a census allocation), rather than based on the number of children being served in existing programs. The legislative intent is for federal funds to be used to establish a service system, and not to pay directly for individual services, except as a "payor of last resort." This formula was established to prevent federal education monies from replacing current sources of federal, state, and local funding for early intervention services.

As a federal initiative, P.L. 99-457 allows states a great deal of flexibility in decision-making regarding organizational structures and programmatic practices. Two key categories of decisions confront state policymakers over the next four years of legislative implementation: (1) the organizational structures to be established for the management of early intervention services, and (2) the specific programmatic elements of service provision. This report will focus briefly on the requirements of organizational structure and will then examine four aspects of programmatic decision-making, each of which has a research base in the child and family development literature.

Structural Decisions

To receive Part H funds, a state must meet certain requirements related to the development of an organizational infrastructure to support the establishment of an early intervention service system. Two of these requirements are the determination of a lead agency and the appointment of an Interagency Coordinating Council. Both attempt to prevent the kind of patchwork system of services frequently found in state systems of early intervention (e.g., Meisels, 1985).
Prior to the passage of P.L. 99-457, services for infants and toddlers with disabilities were delivered through programs supported by the U.S. Department of Health and Human Services, such as the Developmental Disabilities programs or the Maternal and Child Health Block Grant, and programs supported by the U.S. Department of Education, such as demonstration projects funded through HCIEP. Although Part H is administered by the U.S. Department of Education, each state is given the authority to designate its own lead agency. About one-third of the states have chosen departments of education as their lead agency, slightly fewer have selected departments of health, and the remainder have chosen other agencies, such as departments of mental health or human services (Garwood, Fewell, & Neisworth, 1988).

Each state also must establish an Interagency Coordinating Council to assist in the planning, development, and implementation of its statewide system. This provision was deemed necessary because, in most states, no single agency has responsibility for all appropriate early intervention services, even when a lead agency has been designated.

Coordination between health care and education agencies at both the state and federal levels will be particularly critical to successful implementation of Part H. Traditional relationships between the health care (public and private) and education communities around the care of infants and toddlers with disabilities, however, have been uneven and complex. Although physicians, particularly pediatricians, are usually the professionals most likely to identify disabling conditions in very young children (as well as those who are at risk for developmental problems), attitudes toward early intervention services within the medical community range from enthusiastic endorsement to serious skepticism (Green, Ferry, Russman, Shonkoff, & Taft, 1987). Furthermore, despite the fact that many infants with disabilities have associated health problems (e.g., seizures, sensory impairments, growth disorders) that require sophisticated medical management to assure optimal early intervention efficacy, successful medical-educational collaboration has evolved slowly and inconsistently across the country.

The jurisdictional boundaries between health care and education in the political arena served to accentuate these "turf" issues during the process of crafting the new law. As is often the case, this was particularly true with regard to concerns about the allocation of "education" dollars for "medical" services. To counteract this problem, a federal interagency group has been formed between the Bureau of Maternal and Child Health and Resources Development, Department of Health and Human Services, and the Office of Special Education Programs, Department of Education. Nevertheless, the need to develop local service systems based on functional medical-educational cooperation in the context of bureaucratic division of medical and educational resources remains a perplexing policy challenge.

Programmatic Decisions

Definition of Developmental Delay. Part H requires that each state develop a definition of developmental delay to be used to determine the eligibility of infants and toddlers for services. The new federal law does not specify criteria for defining delay, and the only guidance provided is that assessments must employ appropriate diagnostic procedures covering five areas of performance: cognitive, physical, language and speech, self-help, and psychosocial development.

The task of defining delay in young children is complex. Available assessment methods are not highly reliable, and, when deviations are not extreme, it may be difficult to differentiate normal variations in development from truly worrisome
signs during the first few years of life. In fact, research has shown that early developmental scores are not highly predictive of later cognitive functioning (Bee et al., 1982)—in part, because early test performance is overly dependent on motor skills.

Further difficulty in determining criteria for developmental delay is related to the cultural and environmental relativity of any definition. Some have argued that selecting a specific, quantitative indicator from a standardized developmental test is the most useful strategy (Zigler, Balla, & Hodapp, 1984). Others have suggested that mental retardation or delay can be understood only within the social context in which an individual is measured (Barnett, 1986). Thus, delays in some skill areas may have more importance for some families than for others. Similarly, cultural biases in conventional assessment methods may discriminate against infants and toddlers whose family environments promote adaptive and ecologically valid behaviors in areas that are not assessed directly (Ogbu, 1987).

Each state will have to grapple with determining how much delay must be evident in order to establish a child's eligibility for service, and what methods of assessment will be used. Both of these decisions will influence whether the total number of eligible infants will be large or restricted. A great deal of research is needed on assessment methods that tap subtle behaviors and abilities. Also needed are more prospective longitudinal investigations designed to follow infants with a range of early characteristics and risks to better understand which key factors will predict adaptive or poor developmental outcomes. Given the complexity of this challenge, it is not surprising that as of January 1988, only half of the states had developed a definition of developmental delay to determine service eligibility (Gallagher, Harbin, Thomas, Wenger, & Clifford, 1988).

Determination of Risk. A second major difficulty facing the states is the determination of service eligibility related to risk factors. The proposed regulations (Federal Register, 1987) define two major target groups: (1) those experiencing developmental delay at the time of referral and assessment; and (2) those who have a diagnosed condition that has a high probability of resulting in subsequent delay. This second category is commonly known as "established risk" and includes infants born with sensory impairments, errors of metabolism, or Down syndrome or other chromosomal abnormalities (Tjossem, 1976). Each state also has the option to include a third group: children "at risk of having substantial developmental delays if early intervention services are not provided" (100 Stat.1146). Children in this optional category are commonly characterized as "biologically at risk" and/or "environmentally at risk" (Tjossem, 1976). Difficulties in identifying children "at risk of delay" include the sensitivity and specificity of existing screening methods, the unconfirmed probability of a specific condition or circumstance leading to significant delay, and the potential intrusiveness of screening activities in the lives of families with very young children.

Epidemiologists disagree on the numbers of young children who have developmental, neurological, behavioral, or physical vulnerabilities; estimates range from 3% to 26% of the population between birth and 3 years of age (Haggerty, Roughmann, & Pless, 1975; Walker & Gortmaker, 1983). Furthermore, considerable research has shown that neither a history of specific biological insults nor the presence of individual socioeconomic indicators alone predicts later development. For example, while socioeconomic status is closely associated with mild mental retardation, only 2% to 10% of low-income children are mentally retarded (Ramey & MacPhee, 1986). Thus, attempts to use basic socioeconomic indicators from birth certificates to identify children with later school problems have resulted in highly inaccurate predictions (Finkelstein & Ramey, 1980).
Alternatively, a "transactional" model of risk, which postulates that multiple factors play a role in determining developmental outcomes (Sameroff & Chandler, 1975; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987), has been proposed. Factors that have been shown to be most useful as predictors include maternal mental health status, maternal education, maternal locus of control, home environment, parent-child interaction, absence of father, stressful life events, presence of social support, and expectations for the child (Bee et al., 1982; Bradley, Caldwell, Rock, Casey, & Nelson, 1987; Crockenberg, 1981; Werner, 1986).

Research on infants who are categorized as "biologically at risk" (e.g., premature babies or those who experienced a specific perinatal insult) has yielded similar findings. On the one hand, there is a high correlation between low birthweight and such conditions as cerebral palsy, mental retardation, seizure disorders, visual problems, motor coordination problems, and learning disabilities (Hayden & Beck, 1982). Such infants also demonstrate differences in temperament and arousal state when compared with babies of normal birthweight (Field, 1983). On the other hand, it is difficult to predict which individual infants among those who bear markers of biological risk will have later developmental problems. For example, Werner, Bierman, and French (1971) reported that only 15% of children who demonstrated school problems in a birth cohort followed through 18 years of age came from the group of children with high perinatal risk indicators. Recent research on premature and low birthweight infants (Greenberg & Crnic, 1988; Rauh, Achenbach, Nurcombe, Howell, & Teti, 1988) points to the importance of studying mother-child interaction to better understand which children will develop optimally. In view of the well-documented difficulty in determining the impact of "risk" on later child development, and given the potential cost implications of a larger target population, it is not surprising that, at present, only 18 states are considering the possibility of including "risk groups" under P.L. 99-457 programs, while other states have delayed the decision or decided to start pilot programs (Gallagher et al., 1988; NASDSE, 1988).

Individualized Family Service Plans. Section 677 of P.L. 99-457 requires that an individualized family service plan (IFSP) be developed by a multidisciplinary team for each child and family enrolled in an early intervention program. Based on an assessment of the child's and family's needs, the IFSP must articulate specific child and family goals, describe the criteria, methods, and timing to be used to evaluate goal attainment, specify the services needed to meet each goal, and identify the case manager who is responsible for ensuring the implementation of the plan. The child's parents or guardians are required to be members of the multidisciplinary team that initially formulates and subsequently reviews the IFSP.

At most, only five states report using an IFSP that meets the requirements of the legislation (Gallagher et al., 1988). Thus, most states will have to contend with constructing policies and guidelines for developing such plans. The IFSP's two central elements—the articulation of family service needs and the active participation of the parent(s) in the development of the IFSP—have generated considerable controversy. Alternative interpretations of its implications suggest that it can be viewed either as a natural expansion of current practice in early intervention programs or as a radical new service frontier for children with disabilities and their families.

Conceptually, the IFSP codifies the family-focused orientation to which many early intervention programs already subscribe. The IFSP is predicated on the belief that children are enmeshed within a family unit and that both the family's and
child’s needs must be met in order for their collective development to be enhanced. This redefinition of the service recipient reflects contemporary theoretical perspectives about child development (Belsky, 1981), current practices in many early intervention programs (Bailey et al., 1986; Healy, Keesee, & Smith, 1985), and empirically based findings regarding enhanced outcomes for children whose parent(s) are involved actively in their experiences with early intervention programs (Bronfenbrenner, 1974; Shonkoff & Hauser-Cram, 1987). The articulation of specific goals for the family (as well as for the child), as now required in the IFSP, simply makes the critical role of families explicit.

Further, the IFSP procedural requirements for parental membership on the interdisciplinary team draw heavily from the legacy of parental involvement embedded within P.L. 94-142. For the past decade, children receiving public special education services have been required to have an individualized education plan (IEP) that must be developed in concert with parents and that is subject to parental approval. While active parental participation in the IEP process has been found to be uneven in practice, (Goldstein, Strickland, Turnbull, & Curry, 1980), the precedent for parental involvement in the assessment of children's needs and in the prescription of specific services has existed since 1975. Thus, from a conceptual and a procedural perspective, the IFSP provisions may be viewed as an incremental, natural extension of core elements within the field of early intervention (e.g., a family focus to services) and within the field of special education (e.g., parental participation in decision-making).

The mandate of the IFSP, on the other hand, also can be viewed as a catalyst for radical change in early intervention programs. For programs that focus primarily on the child and/or that have less experience in providing parental support groups or mother-child treatment groups (the most common types of family services currently offered within early intervention programs), the IFSP may require an expansion of service options and a reconceptualization of program goals. Areas in which the most dramatic changes may be anticipated include the selection of evaluation strategies to identify family needs and the development of new training experiences for existing and future service providers to conduct, interpret, and use such assessment protocols (Vincent & Salisbury, 1988).

While there has been considerable recent interest in family assessment strategies that are appropriate for early intervention service models, few programs have incorporated systematic methods for assessing family strengths and needs or for measuring progress toward family goals (Bailey & Simeonsson, 1986; Dunst & Trivette, 1988). Given the limited range of potentially useful instruments described in the literature, most providers of early intervention services typically rely on informal impressions of family functioning and family needs based on home visits and intake interviews (Krauss & Jacobs, in press). The collection of data derived from standardized instruments that are culturally sensitive and reliable presents a formidable challenge to implementation.

While the law requires an articulation of family needs and their incorporation into the total service plan, it is silent on the specific domains of family life to be assessed. Thus, it sanctions both cursory and probing evaluations of families. This need to probe and evaluate family strengths and needs may conflict both with the training of service providers and with the preferred collaborative nature of the relationship that develops between program staff and family members (Dunst & Trivette, 1988). Some families, for example, may chafe at the realization that simply because their child has Down syndrome, or was born with a low birthweight, they, too, must be evaluated in order for their child to receive services. Similarly,
professionals untrained in family counseling and inexperienced in family assessment techniques may be uneasy about the need to make actionable judgments about family needs.

The transformation of an individualized education plan (IEP) for the child into an individualized family service plan (IFSP) that identifies the needs of all family members constitutes a major programmatic change in the field of early intervention. Consistent with knowledge accumulated from both research studies and clinical practice that points to the most effective treatment strategies, P.L. 99-457 was crafted to ensure that early intervention as a system reflects a family-focused orientation. The latitude given to individual states (and even specific programs) regarding the form of that intervention is also consistent with the fluid state-of-the-art of family assessment. The need for experimentation, cross-disciplinary communication, and collaboration among programs in the development of appropriate and informative family assessment approaches is obvious. The opportunities for clinical and academic researchers to inform and be informed by programmatic experiences are equally compelling.

Transition from Early Intervention to Preschool. The transition across service systems at age 3 years represents another emerging challenge in the implementation of P.L. 99-457. The proposed regulations state that the IFSP must include a description of the steps to be taken to support the transition of the service responsibility from the early intervention system to a preschool program (Federal Register, 1987, Sec. 303.68) and that a case manager must be responsible for facilitating the development of such a plan (Sec. 303.6). Although the importance of planning for such a transition is acknowledged in the proposed regulations, information about how such planning should be accomplished is meager.

In those states that have not chosen their department of education to coordinate the early intervention system, families negotiating a change in the primary service agency when the child turns 3 years of age will encounter a number of challenges (Garwood et al., 1988; Harbin, 1988). Disputes over the determination of appropriate educational plans, delays in starting services, and disagreements about whether a child even qualifies for special education programs have all been reported under the current system of service delivery (Association for Retarded Citizens, 1986). Procedures will have to be established to help children and families enter new systems, and the new systems will have to be prepared to provide appropriate services.

Information sharing among agencies with conflicting mandates related to record keeping and confidentiality has been shown to be a major problem (NASDSE, 1988), one that is likely to be magnified during transitions from one service system to another. Diverse provisions of the new law with regard to children under age 3 years (Title I) and those over age 3 years (Title II) may further complicate the transition process. Differences in the definitions of children to be served and in the range of allowable services, particularly for families, are especially problematic.

Although little research has been done on the specific effects of program transitions on children and families, research on family functioning has demonstrated increased stresses related to particular events in the course of family life (Turnbull, Summers, & Brotherson, 1986). Wikler, Waslow, and Hatfield (1981) contend that transition points highlight uncertainties about the future and are times of particular stress for families. Such transition points act as reminders to parents that their children are not developing in the same way as their nondisabled peers.
Other studies have noted that the transition from family-oriented, home-based services (typical of early intervention) to child-oriented, classroom-based services (typical of preschool services) requires a major adjustment for parents of children with disabilities (Bernheimer, Young, & Winton, 1983).

Studies of child and family transitions around school entry have focused almost exclusively on the transition from preschool to kindergarten, or from kindergarten to first grade (Ladd & Price, 1987). One investigation of nondisabled toddlers and preschoolers found stress reactions associated with a change in day care or nursery school classrooms (Field, Vega-Lahr, & Jagadish, 1984). Studies on children with disabilities have tended to concentrate on "best practices" and emphasize the type of planning, coordination, and family involvement that should take place (Diamond, Spiegel-McGill, & Hanrahan, 1988; Johnson, Chandler, Kerns, & Fowler, 1986). As we move toward implementation of more extensive early childhood and preschool services, careful planning for transitions and further systematic evaluation of the process itself will be needed.

Conclusions

The passage of P.L. 99-457 was propelled by a confluence of public policy goals: to equalize access to preschool special education programs for 3- to 5-year-olds with developmental disabilities and/or delays; to arrest the uneven development nationally of early intervention services through the establishment of a coherent and consistent system of programs; and, to extend the rights of families of young children with developmental disabilities and/or delays through the prescribed requirements and protections of an IFSP. For most states, P.L. 99-457 requires a fundamental change in special education services (by extending the age of eligibility) and promotes the development of an entirely new service structure for children under the age of 3 years with disabilities and their families. While the logic and structure of the extension of special education services for children from 3 to 5 years of age is drawn heavily from P.L. 94-142, provisions for early intervention systems and program standards break new federal ground.

From a policy implementation perspective, P.L. 99-457 represents a bold initiative and raises formidable issues. Each state must make independent decisions about the definition of developmental disability, the service eligibility of children at-risk for developmental delays, the criteria and methods to be used for family assessment, and the strategies needed to facilitate a smooth transition of children and families from early intervention programs to preschool special education services. How these decisions are reached—whose views are solicited by state policymakers, how research is used to inform and defend specific decisions, and how the impacts of existing state practices are assessed—will require the participation of diverse constituencies from the academic, policy, and service delivery arenas.

Research findings alone rarely determine the outcomes of such policy debates. Moreover, research studies seldom converge on a simple set of findings related to issues as complex as those raised by P.L. 99-457. The research community, however, can wield considerable influence by ensuring that the standards and methods for defining key concepts (e.g., developmental delay, at-risk, family needs) reflect the best available knowledge and that the results of all policy decisions are evaluated for both their intended and unintended consequences.
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Sources of Further Information

Agencies and Professional Organizations

The Council for Exceptional Children (CEC), Division for Early Childhood (DEC), 1920 Association Drive, Reston, VA 22091. Contact: Carl J. Dunst, Ph.D., DEC President, 300 Enola Road, West Carolina Center, Morgantown, NC 26555 (704-433-2661); or Crystal Kaiser, Ph.D., DEC President-Elect, East Tennessee State University, Center for Early Childhood, Box 15, 520A, Johnson City, TN 37614-0002 (615-929-5615).

National Association of State Directors of Special Education, Inc. (NASDSE), 2021 K St., NW, Suite 315, Washington, DC 20006 (202-296-1800). Contact: Sharon Walsh, M.A., or Patti Place, Ph.D.

National Center for Clinical Infant Programs (NCCIP), 733 Fifteenth St., NW, Suite 912, Washington, DC 20005 (202-347-0308). Contact: Eleanor Stokes Szanton, Ph.D., or Carol P. Berman, M.A.


Documents

The Carolina Policy Studies Program (CPSP), University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center, Suite 300 NCNB Plaza, #322A UNC Campus, Chapel Hill, NC 27599-8040. For information on a series of descriptive and explanatory studies on the policy development and implementation of P.L. 99-457, contact James Gallagher, Ph.D., Director (919-962-7374).


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