

IV. RESULTS

**Characteristics of Children and Families Entering Early
Intervention**

High School Graduation

State Improvement and Monitoring

Characteristics of Children and Families Entering Early Intervention

In 1986, P.L. 99-457 created the Early Intervention Program for Infants and Toddlers with Disabilities, now contained in Part C of the Individuals with Disabilities Education Act (IDEA), as amended in 1997. The ensuing years have seen steady growth in the number of infants and toddlers served under Part C, increasing from an estimated 128,000 in 1988 (U.S. Department of Education, 1990) to almost 200,000 in 1997 (U.S. Department of Education, 1998). Yet very little is known about the characteristics of these children or their families, about the services they receive, or about the outcomes they achieve.

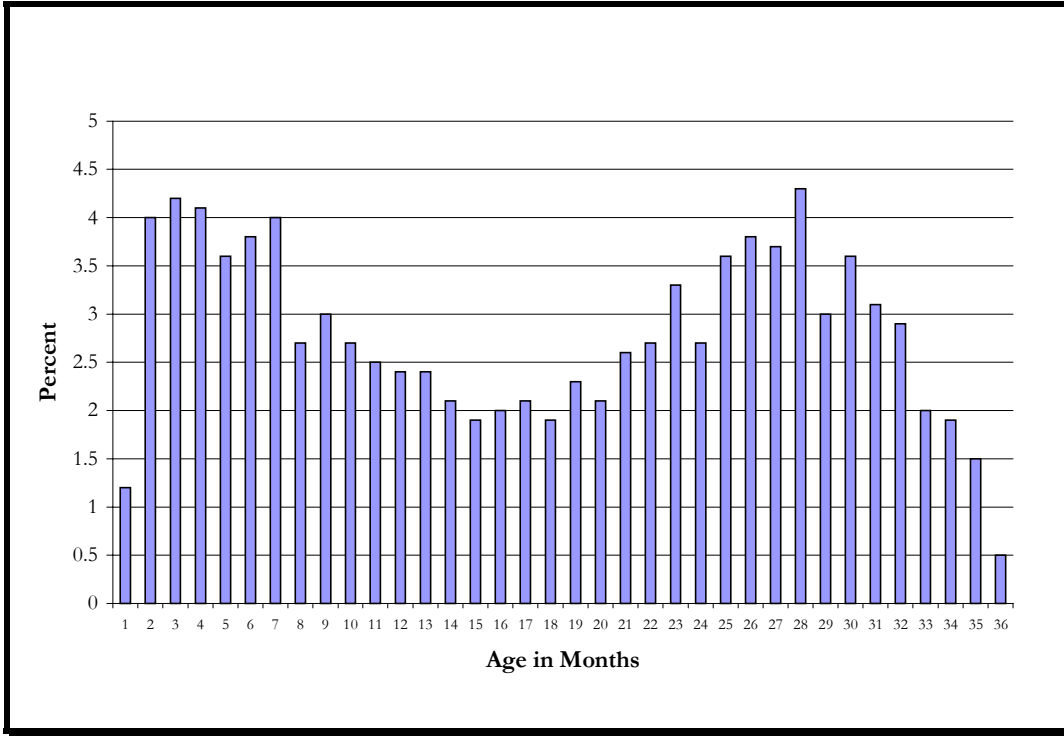
To meet the need for more and better information about Part C and its participants nationally, the Office of Special Education Programs (OSEP) commissioned the National Early Intervention Longitudinal Study (NEILS). NEILS began in 1996 with a design phase; data collection began the following year. NEILS findings are based on a nationally representative sample of children and families who were recruited into the study as they entered early intervention. Study recruitment extended from September 1997 through November 1998. Information will be collected repeatedly about participating children and families through their early school years.

The following pages present preliminary descriptive information from NEILS about the children and families entering early intervention services. These data address the reasons for which they are receiving early intervention services, the ages at which children are entering early intervention, and some demographic characteristics of this population. The data presented here are based on a one-page form that early intervention program staff completed on all children and families who entered early intervention for the first time during the study recruitment period ($n=5,668$). Additional information about the study methodology is available in Hebbeler, Wagner, and Spiker (2000).

Age at Entry and Reasons for Receipt of Early Intervention

The philosophical and empirical basis for early intervention is that providing appropriate services early is of potentially greater impact than beginning services later. Accordingly, an important policy goal is to identify and serve children with developmental problems in programs as early as possible. The average age at which

Figure IV-1
Age at Time of Individualized Family Service Plan (IFSP)



Source: National Early Intervention Longitudinal Study.

children were referred for early intervention was 15.5 months (S.E.=.66¹). Average age at the completion of the individualized family service plan (IFSP) was 17.1 months (S.E. =.72).

Average age tells only part of the story. Children entered early intervention at every month between birth and 36 months, but there are particular months at which children were more likely to enter. Figure IV-1 shows the distribution of the ages in months of children at the time of the IFSP. Each bar shows the percentage of all entering children under 36 months who were a given age at entry. As the graph illustrates, more children entered early intervention in the first and third year of life than in the second. More than 38 percent of children entering early intervention for the first time did so between birth and 12 months; in fact, more than one in five entered early intervention in their first 6 months. Another 28 percent entered in their

¹ The S.E. or standard error indicates the precision of the estimate. To determine the precision of a particular percentage or mean, the reader can construct a confidence interval for the estimate by multiplying the standard error by 1.96. The result is the range around the estimate within which the true measure would be found 95 out of 100 times.

second year, and more than one-third of children entered early intervention after their second birthdays.²

IDEA stipulates the parameters for who is to receive early intervention services. A child is to be provided early intervention services because s/he “(i) is experiencing developmental delays in one or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or (ii) has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.” The Federal law also allows States to serve children considered to be “at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual” (20 U.S.C. §1432, as amended by the Individuals with Disabilities Education Act of 1997).

Early intervention program staff were asked to describe the nature of the disability, delay, or risk condition for which the child was eligible for early intervention. Staff provided descriptors such as “motor delay” or “intraventricular hemorrhage.” This information was provided for 93 percent of the children. A total of 305 different terms were provided. The average number of different descriptors for children with at least one descriptor (n=5,293) was 1.5; the range was 1 to 11. These descriptors were then coded as a developmental delay, an established condition, or a risk condition using a classification scheme developed by the research team.

As shown in table IV-1, the most frequently reported reason for receipt of early intervention was a speech/communication impairment or delay. Providers indicated that 41 percent of the children were eligible for early intervention for problems related to speech or communication. The reader is advised that these data are limited by what providers choose to write down about a child. For children with multiple delays or impairments, some providers probably opted to write down the one or two primary reasons for receipt of services. The percentages are thus conservative estimates of presenting problems and are probably more accurately thought of as minimums. The finding is that *at least* 41 percent of the children entering early intervention had speech or communication problems.

² Figure IV-1 shows a noticeable dip around the age of 15 months because children tend to be identified for early intervention services at two key points: at birth, when some congenital disabilities are immediately apparent and, in the second year, when children fail to meet some crucial developmental milestone.

Table IV-1
Frequency of Reasons for Receipt of Early Intervention and Age at IFSP
(n=5,293)

	Reason for EI		Age at IFSP		
	Percentage	Standard Error	Average Age (Months)	Standard Error	N
Delayed development (global)	12.24	1.15	17.64	.97	701
Physical growth abnormality ^{a/}	1.58	.36	15.34	1.91	87
Sensory systems impairment	3.27	.39	15.73	.89	167
Vision impairment ^{a/}	1.07	.13	11.92	1.18	61
Hearing impairment ^{a/}	1.92	.41	15.89	.48	91
Motor impairment or delay	17.49	1.81	15.16	.33	934
Physiological or neurological system impairment	2.22	.45	10.84	.94	123
Intellectual/cognitive impairment or delay	7.18	1.36	22.72	1.00	380
Social/behavioral impairment or delay	3.74	.64	22.15	.70	209
Speech/communication impairment or delay	41.07	3.9	24.87	.29	2,153
Delay in self-help skills	2.55	.74	20.19	.99	151
Congenital disorders	8.90	.94	7.86	.69	502
Down syndrome ^{a/}	4.31	.48	5.80	.80	252
Prenatal/perinatal abnormalities	18.92	2.62	8.21	.59	1,020
Low birth weight ^{a/}	10.99	1.64	7.17	.79	588
Prenatal exposure to drugs/alcohol ^{a/}	2.08	.60	11.46	.82	97
Illness or chronic disease	1.85	.31	13.56	1.59	91
Musculoskeletal disorders	1.96	.23	8.9	.96	98
Central nervous system disorders	6.53	.56	12.2	.51	339
Cerebral palsy ^{a/}	2.19	.28	17.03	1.19	118
Receiving medical treatment, disorder not identified	1.39	.35	9.13	1.5	73
Social environment risk factors	3.90	1.11	15.20	1.4	172

Note: Children could have more than one reason for the receipt of early intervention.

^{a/} Indented categories are also included in the superordinate category above them.

Source: National Early Intervention Longitudinal Study.

Other frequently reported reasons for the receipt of early intervention included prenatal/perinatal problems (19 percent), with the most frequent of these being low birth weight (11 percent of children in early intervention), motor delays (17 percent), and an overall delay in development (12 percent).

Children entering early intervention for different reasons entered at different ages. Table IV-1 also presents the average age at IFSP for different types of disability, delay, or risk conditions. There are highly significant but not surprising differences in the ages at which children with different conditions are entering early intervention. Children with congenital disorders were the youngest group at entry to early intervention with an average age at IFSP of 7.9 months. Many of these conditions are identifiable at birth, and these children therefore should be entering early intervention very young. Children with prenatal and perinatal abnormalities also entered early intervention young relative to other conditions, with the average age at IFSP being 8.2 months. Children with physical growth abnormalities, sensory impairments, or motor delays entered at around 15 months on average. Children with motor, intellectual, social or speech/communication delays or impairments began early intervention around age 2.

Another way to examine the relationship between age at entry and disability is to look at the percentage of children who enter in the first, second, or third year of life with particular conditions. For children who began early intervention at less than 12 months of age, the most frequent reason for receiving services was perinatal/prenatal abnormalities (at least 40 percent of those who entered at less than 12 months), with low birth weight being the largest type of perinatal/prenatal abnormality (28 percent of children younger than 12 months). The second most common reason for receipt of services for this age group was for motor delays or impairments (20 percent).

The pattern is quite different for older infants. For children who began services between the ages of 12 and 24 months, the most frequent reason for receipt of early intervention was a speech/communication delay or impairment (49 percent), followed by motor delay (22 percent) and global developmental delay (15 percent). For the oldest children entering early intervention, those over 24 months, three-fourths (75 percent) of the children entered early intervention with speech/communication delays. The next most frequent conditions were intellectual/cognitive delays (12 percent), global developmental delay (12 percent), and motor delays (11 percent).

Reasons for eligibility for early intervention can also be examined with regard to the three eligibility categories in IDEA. Grouping the various disability descriptors into

Table IV-2
Frequency and Average Age at IFSP for Developmental Delay, Diagnosed Condition, and At Risk (n = 5,293)

	Frequency		Age at IFSP		
	Percentage	Standard Error	Average Age (Months)	Standard Error	N
A developmental delay	64.10	4.62	21.25	.43	3,425
A diagnosed condition	20.37	2.15	10.71	.44	1,078
Being at risk of developmental delay	15.53	2.72	8.45	.73	790

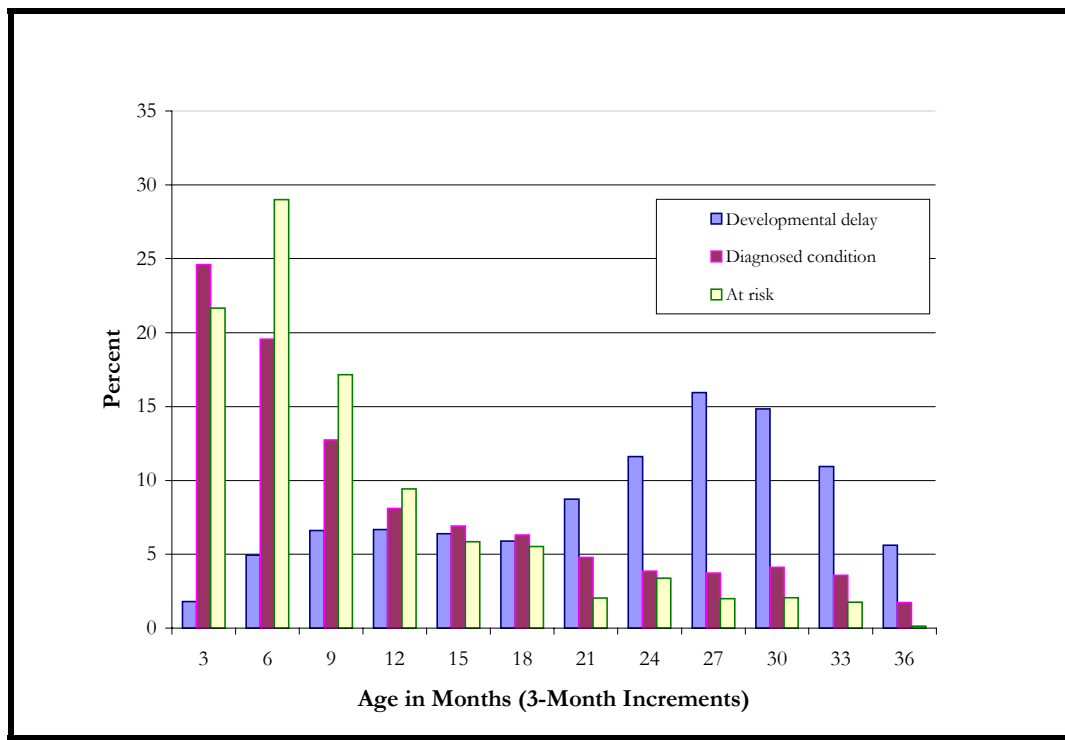
Source: National Early Intervention Longitudinal Study.

the three eligibility classifications in the law shows that most children were eligible for early intervention because of a developmental delay (64 percent), a lesser proportion had a diagnosed condition (20 percent), and far fewer were being served because they were at risk (16 percent)³ (see table IV-2). Children with more than one of these were coded into one category, giving priority to the order in which the terms were just listed (e.g., developmental delay co-occurring with a diagnosed condition was coded as developmental delay for the 4 percent of children with both.)

The average age of children at IFSP differed markedly across the three reasons (see table IV-2). Children who were eligible for early intervention primarily because of a developmental delay were significantly older on average at entry (21.3 months) than children entering because of a diagnosed condition (10.7 months) or being at risk of delay (8.5 months) (for all comparisons, $p < .05$). This is not surprising because developmental delays can only be diagnosed when children are old enough to be expected to have developed particular skills and have not yet done so. Some common diagnosed conditions, in contrast, are evident at birth (e.g., Down syndrome, spina bifida) as are some factors that put children at risk for delay (e.g., drug or alcohol exposure, low birth weight).

³ Seven of the 20 States in the study sample were serving at-risk children under Part C at the time these data were collected. Not all of the children classified by the NEILS' categorization scheme as having risk conditions were residents of States that served at-risk children. This apparent anomaly occurs because the dividing line between established conditions and risk conditions is not well defined in practice, with the same conditions being seen by some States as established conditions and other States as risk conditions. Low birth weight is one example of such a condition.

Figure IV-2
Age at IFSP by Reasons for Eligibility



Source: National Early Intervention Longitudinal Study.

Figure IV-2 illustrates the different patterns of age at IFSP for the three groups. Each bar shows the percentage of children eligible for that reason who entered early intervention in the 3-month age grouping (e.g., birth to 3 months). Children with diagnosed conditions or risk conditions entered in greater numbers in the first year of life, while children with developmental delays were more likely to be identified in the later part of the first 3 years of life. Of children who were eligible for early intervention primarily because of a diagnosed condition, 44 percent entered early intervention in their first 6 months of life, as did 51 percent of those who were eligible primarily because they were at risk of delay. By contrast, only 7 percent of those who were eligible for early intervention because of developmental delay were younger than 6 months old at entry. Forty-seven percent of children with developmental delays entered early intervention between 24 and 31 months of age, compared to 17 percent of children with diagnosed conditions and 10 percent of children who were at risk.

Table IV-3
Demographic Characteristics of Children Entering Early Intervention

	Percentage	Standard Error	N
Gender			5,663
Male	60.91	1.09	
Race/ethnicity			5,376
African American	21.49	1.23	
American Indian or Alaska Native	.48	.20	
Asian or Pacific Islander	4.84	1.86	
Caucasian	55.60	1.98	
Hispanic	15.19	2.30	
Mixed race or "other"	2.41	.47	
Socioeconomic status			
Received public assistance	42.20	1.76	5,180
No working telephone at home	5.48	.52	5,631
In foster care	7.03	.58	5,636

Source: National Early Intervention Longitudinal Study.

Demographic Information

As part of sample recruitment for NEILS, minimal demographic information was collected on all children and families who enrolled in early intervention during the timeframe. Much more demographic information will be available on the children and families who enrolled in the study, but even these minimal data provide interesting information about who is receiving early intervention services.

Gender

Six of 10 children entering early intervention were boys (see table IV-3), a higher rate than their prevalence in the general population of children less than 3 years old (51 percent, U.S. Bureau of the Census, 1998). The disproportion of boys was strongest among those with developmental delays; 65 percent (S.E.=1.79) of these children were male compared to 52 percent (S.E.=1.95) for children with diagnosed conditions and 54 percent (S.E.=3.51) for those at risk of delay ($p<.001$). The overrepresentation of boys in special needs populations has been noted among older children as well (U.S. Department of Education, 1998). Among those with

developmental delays, males were older on average than females at entry to early intervention (22.1 months, S.E.= .38 vs. 19.6 months, S.E.=.51, $p<.001$).

Race and Ethnicity

Children of color were represented in the early intervention population more heavily than in the general population. Whereas 37 percent of the general population of children ages birth to 3 in 1997 were minority, 44 percent (S.E.=1.98) of children entering early intervention during the study period were minority. Most of the disproportion of children of color results from a higher percentage of African American children (21 percent, S.E.=1.23) entering early intervention relative to their numbers in the general population of young children (14 percent). The percentage of children of Hispanic⁴ origin entering early intervention approximated the percentage in the current population: 15 percent (S.E.=2.30) of those entering early intervention were Hispanic, compared with 18 percent in the general population. Asian/Pacific Islander children were 4.8 percent (S.E.=1.86) of those entering early intervention, compared with 4.3 percent of the general population of children birth to age 3. American Indian/Alaska Native children made up less than 1 percent of both the population of children in early intervention and the general population (.5 percent vs. .9 percent, S.E.= .2).

Receipt of Public Assistance

Childhood poverty is associated with a variety of detrimental effects on children's development, including physical health, cognitive ability, school achievement, emotional and behavioral outcomes, and later teenage out-of-wedlock childbearing. Poverty that occurs earlier in children's lives and extends over more years has been found to have particularly negative effects (Brooks-Gunn & Duncan, 1997). Poverty occurring in families with young children also can place considerable stress on the families raising them; in fact, poverty has been the one factor most consistently related to child abuse and neglect (Sedlak & Broadhurst, 1996).

Although the enrollment information does not contain a direct measure of poverty, early intervention professionals did report whether the families whose children were entering early intervention received any kind of public assistance (e.g., Temporary Assistance to Needy Families (TANF), food stamps). A large proportion of children entering early intervention were in families who received some kind of public

⁴ Children were classified as Hispanic apart from the racial classification. In reducing these two variables to a single variable, Hispanic children were classified as Hispanic regardless of race whereas other children are classified by the racial category.

assistance (42 percent, S.E.=1.76).⁵ This is significantly higher than the rates at which children in the general population received Aid to Families with Dependent Children (AFDC) or general assistance (13.4 percent in 1995; U.S. Department of Health and Human Services, 1999) or food stamps (20.3 percent in 1995; U.S. Department of Health and Human Services, 1999). Children from families in early intervention receiving public assistance were more likely to be minority than children in families not receiving public assistance; 62 percent (S.E.=4.54) of the families receiving public assistance were minority families compared to 30 percent (S.E.=2.3) of those not receiving public assistance.

Children from families receiving public assistance and not receiving public assistance differed in their reasons for eligibility for early intervention. Fewer children in families receiving public assistance were eligible for early intervention because of a developmental delay (61 percent, S.E.=4.73) compared to 67 percent (S.E.=4.48) of families not receiving public assistance ($p<.001$). More children in families receiving public assistance were eligible because of a risk condition (19 percent compared to 12 percent for children in families not receiving public assistance, S.E.s=3.66 and 1.84, respectively).

Children with developmental delays in families receiving public assistance were younger, average age of 19.3 months (S.E.=.58), at entry to early intervention than children with developmental delays in other families, who averaged 22.6 months (S.E.=.37, $p<.05$). This could be because their delays were more serious, because they may be seen by pediatricians and other service providers more often or who were more attuned to possible delays, or a combination of these.

Almost 6 percent (S.E.=.52) of families had no working telephone at home. The lack of a telephone probably means these families have a more difficult time communicating with early intervention professionals about their child and their services which could translate into less service (e.g., missed home visits) or less effective service for these families.

Foster Care

The frequency of foster care placements for children in this country has increased in recent years, from approximately 262,000 children in 1982 to 483,000 in 1995 (U.S.

⁵ Early intervention professionals were asked to indicate whether anyone in the household “received any kind of public assistance. Public assistance can include food stamps, public housing, welfare benefits (AFDC, TANF), etc.” The kind of public assistance received was not recorded. Additional information about the type of assistance received by families in early intervention will be forthcoming from other NEILS data.

Department of Health and Human Services, 1999). More than half of children in foster care are placed there to protect them from adults in their own homes (Tatara, 1990). Seven percent of children entering early intervention were in foster care, a rate about 10 times the rate at which children in the general population are in foster care (7.3 children per thousand, U.S. Department of Health and Human Services, 1999).⁶ Although the magnitude of this finding is somewhat surprising, its occurrence is not. The same unfortunate life circumstances that have resulted in children being in foster care (e.g., maternal drug abuse, poverty, neglect) may also have significantly impaired their development and certainly place children at risk for developmental problems. Foster care children entering early intervention present a particularly urgent demand for coordinated services across multiple systems, often including child welfare, public health, mental health, and early intervention.

Children in foster care were less likely to receive services for a diagnosed condition (13 percent, S.E.=2.12, compared to 21 percent, S.E.=2.23) than children not in foster care ($p<.001$) and more likely to receive services for a risk condition than children not in foster care (22 percent vs. 15 percent, S.E.s=6.55 and 2.47). Early intervention recipients in foster care were overwhelmingly African American (60 percent, S.E.=4.9). By contrast only 20 percent (S.E.=2.96) of children in early intervention and foster care were Caucasian. With 45 percent of the children under 18 in foster care being African American, there are also a disproportionate number of African American children in foster care in the general population (U.S. Department of Health and Human Services, 1999).

Children in foster care also were significantly more likely to be living with families receiving public assistance. Three-fourths (74 percent, S.E.=5.29) of families with foster children were receiving public assistance compared to 40 percent (S.E.=1.92) of families of children not in foster care ($p<.001$). It is not clear, however, if this means 75 percent of the families with foster care children were low-income families. Service providers might have indicated the family was receiving public assistance because they were receiving public funds for the foster child. Additional information on this point will be available through the family interviews.

⁶ Early intervention professionals who enrolled children were asked to report if the child is cared for by someone in a foster care arrangement (e.g., placed with a family by a social services agency), whether or not the child has a legal foster parent. The difference between the foster care placement rate of children entering early intervention and that for the general population may be affected to an unknown degree by the difference in age between the two groups. The early intervention population is children younger than 3, whereas the figure for the general population includes all children younger than 18.

Summary

Who are the children and families entering early intervention? Preliminary data from NEILS indicate that most children are eligible for early intervention because of a developmental delay, and these children are likely to enter early intervention later than children with a diagnosed condition or a risk condition.

Children enter early intervention at every point throughout the first 3 years of life, but there are time points at which children are more likely to enter: in the first year and third year of life. Children with diagnosed conditions and risk conditions constitute the majority of children entering before the first birthday. Children with developmental delays are the majority of those entering after their second birthday. The primary reasons for eligibility for those who begin services as infants are prenatal or perinatal abnormalities, followed by motor delays or impairments. Older children are most likely to be eligible because of a speech/communication impairment or delay. Motor delays continue to be identified through toddlerhood.

These initial findings on the demographic characteristics of children in early intervention have shown that they are not a representative cross-section of the birth to 3 population. There are more males in early intervention. Families in early intervention are more likely to be receiving some form of public assistance.

The findings reported here are based on the first data from NEILS, and considerably more information will be available in the future. Analyses of data from the family interviews will provide more data on the characteristics of children and families receiving early intervention, such as information about the children's functioning and their families' initial experiences with early intervention. Detailed information about the nature, amount, and location of services will be forthcoming from data collected from service providers. Program directors and program providers were also surveyed, and those surveys will provide profiles of the types of programs serving young children and their families as well as information about who is providing those services. Finally, NEILS will also collect data on the costs of early intervention services and will relate those costs to the benefits achieved.

References

- Brooks-Gunn, J., & Duncan, G.J. (1997). The effects of poverty on children. *The future of children*, 7, 55-71.
- Hebbeler, K., Wagner, J., & Spiker, D. (2000). *Characteristics of children entering early intervention*. Menlo Park, CA: SRI International.
- Sedlak, A.J., & Broadhurst, D.D. (1996). *The Third National Incidence Study of Child Abuse and Neglect*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children, Youth, and Families.
- Tatara, T. (1990). *Characteristics of children in substitute and adoptive care: A statistical summary of the VCIS National Child Welfare Data Base*. Washington, DC: American Public Welfare Association.
- U.S. Bureau of the Census. (1998). *Money income in the United States*. Washington, DC: U.S. Department of Commerce.
- U.S. Department of Education. (1990). *Twelfth annual report to Congress on the implementation of the Education of the Handicapped Act*. Washington, DC: Author.
- U.S. Department of Education. (1998). *Twentieth annual report to Congress on the implementation of the Individuals with Disabilities Education Act*. Washington, DC: Author.
- U.S. Department of Health and Human Services. (1999). *Trends in the well-being of America's children*. Washington, DC: Author.

High School Graduation

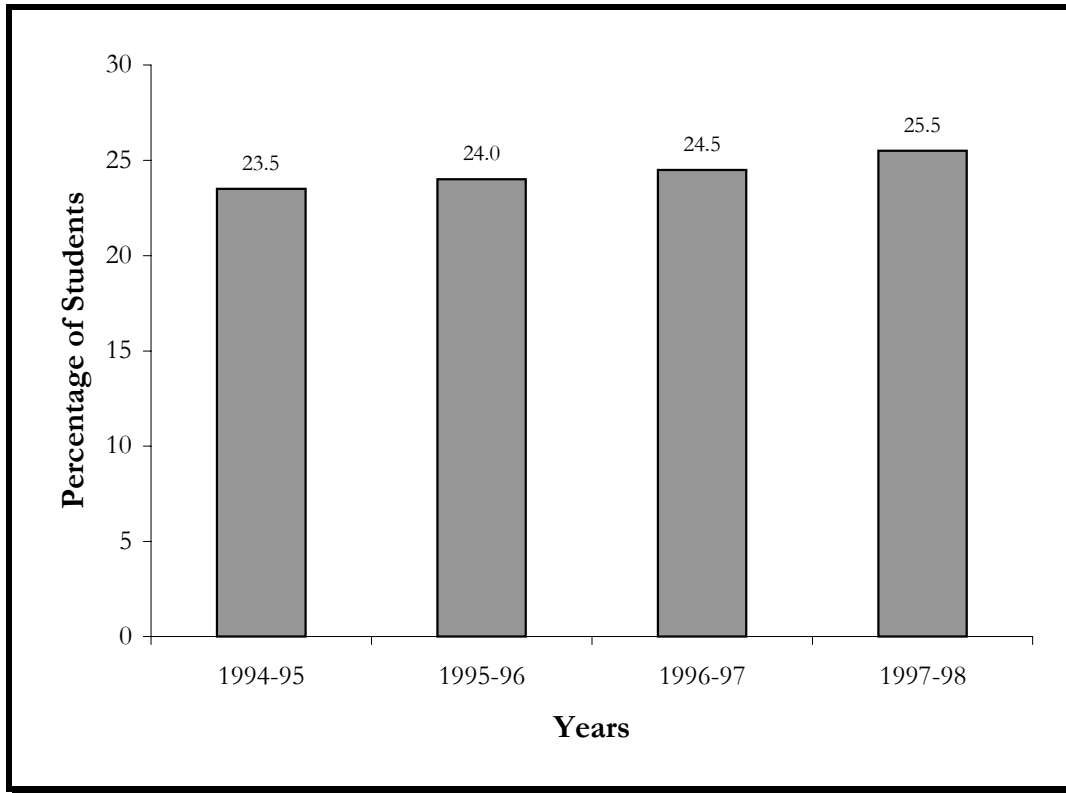
High school graduation is a critical indicator of educational achievement both for individuals and for educational agencies. The importance of the high school graduation rate as an indicator of educational progress is stressed in several pieces of national legislation. The Individuals with Disabilities Education Act (IDEA) Amendments of 1997 require States to establish goals for the performance of students with disabilities and indicators to measure progress toward those goals. At a minimum, indicators must include high school graduation rates, dropout rates, and performance on assessments (20 U.S.C. 1412(a)(16)). The Government Performance and Results Act (GPRA) requires Federal agencies to evaluate their programs. For its GPRA evaluation of IDEA, OSEP selected increased graduation rates and reduced dropout rates as indicators of improved educational results for children with disabilities.

This focus on high school completion is driven by research showing that students with disabilities who complete high school are more likely to be employed and to enroll in postsecondary education and training and earn higher wages (Wagner, Blackorby, Cameto, & Newman, 1993). Unemployment rates for dropouts with disabilities are up to 40 percent higher than rates for high school graduates with disabilities (Marder & D'Amico, 1992).

The National Education Longitudinal Study of 1988, Third Follow-up (NELS:88/94) looked at high school completion rates for students with disabilities and their nondisabled peers. When parents of NELS participants who were eighth graders in 1988 were surveyed again in 1994, 75 percent of the students with disabilities had earned a high school diploma. Another 2 percent had completed a GED or equivalent, while 6 percent were still enrolled in high school or were working toward a GED or equivalent. Ten percent of the students with disabilities had dropped out of high school (Horn & Berkold, 1999). Many students in the potential NELS:88/94 sample were excluded from the study, however, and the sample cannot be considered representative of the students served under IDEA.¹

¹ The sample of eighth graders in NELS:88/94 excluded about 5 percent of the potential sample. The sample excluded "1) students with severe mental disabilities; 2) those whose knowledge of English was not sufficient to complete the tests; and 3) students with severe physical or emotional problems that would have made it difficult for them to participate in the survey" (Horn & Berkold, 1999, p. 4). The NELS sample was therefore more representative of students with less severe disabilities than of all students served under IDEA.

Figure IV-3
Percentage of Students Ages 17 Through 21⁺ with Disabilities Graduating with a Standard Diploma: 1994-95 to 1997-98



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Given the importance of high school graduation as an indicator of educational achievement, each year, States are required to submit data on the number of students with disabilities who complete high school or exit special education through other means. In 1997-98, 147,123 students ages 17 through 21 with disabilities graduated with a standard high school diploma (see table AD3). This represented 25.5 percent of all students with disabilities ages 17 and older and 61.6 percent of students with disabilities exiting the educational system (i.e., graduating, receiving a certificate of completion, reaching the maximum age for services, and dropping out) (see table AD3). The percentage of students with disabilities graduating with a standard diploma has increased gradually, but consistently, since 1994-95, from 23.5 percent to 25.5 percent (see figure IV-3).

Table IV-4
Number and Percentage of Students Ages 17 and Older Graduating with a
Standard Diploma: 1997-98 ^{a/}

Disability	Number	Percentage
Specific learning disabilities	99,640	30.5
Speech or language impairments	4,099	35.0
Mental retardation	15,268	13.8
Emotional disturbance	13,861	22.3
Multiple disabilities	2,061	10.3
Hearing impairments	2,761	29.0
Orthopedic impairments	2,037	25.8
Other health impairments	5,052	29.6
Visual impairments	1,157	30.6
Autism	384	8.4
Deaf-blindness	132	39.2
Traumatic brain injury	671	27.7
All disabilities	147,123	25.5

^{a/} The percentages in this table were calculated by dividing (1) the number of students age 17 and older in each disability category who graduated with a diploma by (2) the total number of students with disabilities age 17 and older in each disability category.

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Graduation Rates by Disability

High school graduation rates for students with disabilities vary considerably by disability, as shown in table IV-4. In 1997-98, more than 30 percent of students with deaf-blindness, speech or language impairments, specific learning disabilities, or visual impairments received a standard diploma. The variability in graduation rates for students with deaf-blindness may be a function of the relatively small number of students in that disability category; it reflects 132 graduates nationwide. The percentage of students with deaf-blindness who graduated in previous years has been considerably lower (e.g., 14.2 percent in 1996-97). Among those least likely to graduate in 1997-98 were students with mental retardation (14 percent), multiple disabilities (10 percent), and autism (8 percent).

The gradual 4-year improvement in graduation rates for students with disabilities overall (shown in figure IV-3) holds true for most of the individual disability categories as well. Graduation rates for students with hearing impairments, speech or language impairments, visual impairments, emotional disturbance, orthopedic impairments, other health impairments, specific learning disabilities, multiple disabilities, and autism all increased slowly, but consistently, over the 4-year period. Over that same time span, graduation rates for students with mental retardation remained stable, and rates for students with traumatic brain injury fluctuated slightly. Graduation rates for students with deaf-blindness were most unpredictable, varying considerably from year to year.

Graduation Rates by State

The percentage of students with disabilities graduating with a standard diploma also varied considerably by State, with a low of 6.8 percent and a high of 45.4 percent. This variation may be a factor of State graduation requirements, the characteristics of students receiving special education services, or other differences in State policies and procedures. For example, research suggests that students with disabilities, particularly those with mental retardation or speech or language impairments, were significantly less likely to graduate with a standard diploma if they were required to pass a high school exit examination (Westat, 1998). Students with disabilities may also exit special education before graduating from high school.

Because different States identify different percentages of students as eligible for special education, there may be differences in those student populations that affect graduation rates. Hawaii, for example, serves 7.1 percent of its resident population of 6- through 21-year-olds in special education, while Rhode Island serves 12.0 percent of its student population (see table AA13). It is likely that Rhode Island's higher percentage of students served includes more students with mild disabilities and that these students may be more likely to graduate.

State graduation policies for students with disabilities also vary considerably, and these variations may contribute to differences in graduation rates. Nine States require students with disabilities to meet all diploma requirements in order to graduate; 9 require students with mild disabilities to meet diploma requirements; 11 States allow local education agencies (LEAs) to determine diploma requirements; and 6 States allow individualized education program (IEP) teams to establish diploma requirements for students with severe disabilities (National Association of State Boards of Education, 1997). Roughly 40 States offer an alternate or modified diploma, and most States that do not offer flexibility in standard diploma requirements offered one or more alternate exit documents for students with disabilities, such as a certificate of completion (Thurlow, Shin, Guy, & Lee, 1999).

States with the largest percentage of students with disabilities who graduate with a standard diploma included New Jersey (45.5 percent), Connecticut (38.7 percent), and Minnesota (38.5 percent). States with the smallest percentage included Mississippi (6.8 percent), South Carolina (10.4 percent), and Alabama (13.0 percent).

OSEP Efforts To Study and Enhance Graduation Rates

OSEP undertakes a variety of activities to uncover factors associated with high school completion and strategies for promoting graduation. For example, in 1999, OSEP began designing its second longitudinal transition study of secondary-aged students with disabilities. The study will track a nationally representative sample of students with disabilities as they leave secondary school and engage in postsecondary activities, such as employment and postsecondary enrollment. It will explore factors predicting high school graduation for students with disabilities and the consequences associated with graduation. OSEP expects to begin data collection in 2001.

OSEP also funds several discretionary grant projects that address issues of high school graduation and dropout prevention. For example, the University of Minnesota is field testing the Check and Connect procedure, a research-validated dropout prevention program for youth with disabilities. Under Check and Connect, a monitor works with groups of adolescents and their families from 9th through 12th grade. Monitors facilitate communication, promote access to services, and monitor students' educational progress. This project, which serves an estimated 100 students, will run through September 2000 (Council for Exceptional Children, 1999).

In a dropout prevention and recovery program called TRAILS--Transition: Responsible Actions for Independent Living Success, which was funded by OSEP and administered by the Ohio Valley Educational Cooperative, project staff used a functional curriculum for students with mild disabilities to help them make successful transitions to postsecondary settings. The curriculum involved a strong partnership with businesses, an emphasis on self-advocacy, and followup of graduates through support groups and home/workplace visits. The goals of the program were to increase (1) the percentage of students earning high school diplomas or general equivalency diplomas, (2) the number of alternative program options, (3) the frequency of student participation in transition planning conferences, (4) the percentage of students who achieve their educational and transition goals, and (5) the percentage of students who successfully transition from school to adult environments (Ohio Valley Educational Cooperative, 1999).

Results indicated that dropout rates for participants were lower than for non-participants, alternative program options in participating districts increased, participating students in one of two districts were more likely to have transition

plans, and participating students in both districts were more likely to attend transition planning meetings. The TRAILS project evaluation did not find significantly higher achievement of transition goals or better community transitions, in part because many project participants were still in school when the evaluation was completed (Ohio Valley Educational Cooperative, 1999).

In an OSEP-funded program administered by Fairfax County Public Schools and George Mason University, project staff will develop, implement, evaluate, and disseminate strategies for students with disabilities who are at risk of dropping out of high school. The program promotes resilience among youth with disabilities by providing opportunities for successful experiences and positive adult relationships. Students receive individualized instruction and support services to move toward a successful transition from high school to adult life. These services include counseling, social skills training, career exploration, goal setting, parenting skills, and guidance (Council for Exceptional Children, 1999).

OSEP also supports a Secondary Transition Technical Assistance Center which, at the time of this writing, was housed at the University of Illinois at Urbana-Champaign. The center conducts numerous activities to promote the successful transition of students with disabilities. These activities include research, technical assistance, and information dissemination (TRI, 2000). The grant to operate this center is being recompeted in 2000.

Summary

In 1997-98, 25.5 percent of students ages 17 and older with disabilities graduated from high school with a standard diploma. This marked a continuation of the gradual increase in graduation rates over the past 4 years. Graduation rates varied by disability and by State. Students with deaf-blindness, speech or language impairments, or visual impairments were most likely to graduate. States with the highest graduation rates included New Jersey, Connecticut, and Minnesota. Recent improvements in graduation rates held true for most of the individual disability categories, with the exception of students with mental retardation, whose graduation rates have been stable, and students with traumatic brain injury and deaf-blindness, whose rates have been variable. OSEP efforts to understand factors influencing graduation rates for students with disabilities include funding for a second national longitudinal transition study, which will provide information on associations among high school completion, student characteristics, and educational services.

References

- Council for Exceptional Children (CEC). (1999). *OSEP discretionary grant projects database*. Retrieved February 15, 2000, from the World Wide Web: <http://www.cec.sped.org/cgi-bin>
- Horn, L., & Berkold, J. (1999). *Students with disabilities in postsecondary education: A profile of preparation, participation, and outcomes*. NCES 1999-187. Washington, DC: National Center for Education Statistics.
- Marder, C., & D'Amico, R. (1992). *How well are youth with disabilities really doing? A comparison of youth with disabilities and youth in general*. Menlo Park, CA: SRI International.
- National Association of State Boards of Education. (1997). *Students with disabilities and high school graduation policies*. Alexandria, VA: National Association of State Boards of Education. (ERIC Document Reproduction Service No. ED 407 785)
- Ohio Valley Educational Cooperative. (1999). *Project TRAILS. Transition: Responsible actions for independent living success, final report*. Shelbyville, KY: Author.
- Thurlow, M., Shin, H., Guy, B., & Lee, S-Y. (1999). *State graduation requirements for students with and without disabilities*. Minneapolis: National Transition Network. (ERIC Document Reproduction Service No. ED 431 284)
- TRI. (2000). Transition Research Institute. Champaign, IL: Author. Retrieved April 15, 2000, from the World Wide Web: <http://www.ed.vivc.edu/sped/tri>
- Wagner, M., Blackorby, J., Cameto, R., & Newman, L. (1993). *What makes a difference? Influences on postschool outcomes of youth with disabilities*. Menlo Park, CA: SRI International.
- Westat. (1998). *An exploration of the relationship between high school graduation requirements and graduation rates for students with disabilities*. Rockville, MD: Author.

State Improvement and Monitoring

One of the primary purposes of the Individuals with Disabilities Education Act (IDEA) is to assess the impact and effectiveness of State and local efforts to provide early intervention and educational services to infants, toddlers, children, and youth with disabilities. Primarily through OSEP, the Department of Education assists States, local early intervention providers, and school districts in implementing IDEA's provisions by making grants pursuant to congressional appropriations and providing technical assistance, policy support, and monitoring oversight.

OSEP works in partnership with: (1) States, early intervention services providers, families of infants and toddlers with disabilities, institutions of higher education, advocacy groups, and others to ensure positive results for infants and toddlers and their families and (2) States, parents, school districts, school administrators and teachers, institutions of higher education, students with disabilities and their families, advocacy groups, and others to ensure positive educational results for students with disabilities. OSEP uses research, dissemination, demonstration, systems change, and other technical assistance strategies to provide State and local early intervention providers and educational agencies with tools to assist them in improving results.

OSEP has been working with States, parents, and other advocates over the past 5 years, and with even greater intensity since the enactment of the IDEA Amendments of 1997, to shape OSEP's accountability work in a way that drives and supports improved results for infants, toddlers, children, and youth with disabilities without sacrificing any effectiveness in ensuring that the individual rights of children with disabilities and their families are protected. In order to ensure compliance that supports strong results for people with disabilities, OSEP has used a multifaceted process that has included the following:

- Providing ongoing technical assistance to States regarding legal requirements and best practice strategies for ensuring compliance in a manner that ensures continuous progress in results;
- Reviewing each State's statutes and regulations and other policy and technical assistance documents, and documentation of the State's exercise of its general supervision responsibilities, including monitoring and complaint resolution;
- Conducting onsite visits and other activities to ensure *implementation* of policies and procedures that are consistent with the requirements of IDEA and that support reform and strong results;

- Ensuring correction of noncompliance in a manner that supports improved results and reform; and
- Engaging in ongoing communication with States, national and State organizations, parents and advocates, and other constituents.

On February 17, 18, and 19, 1998, OSEP hosted a working meeting with diverse representation from stakeholder groups, including State coordinators of early intervention services and directors of special education, Parent Training and Information Centers, Regional Resources Centers, the National Early Childhood Technical Assistance System (NECTAS), and parent and child advocacy groups. OSEP asked the participating stakeholders to help it define a vision for compliance with certain results-oriented requirements and to develop monitoring strategies to determine the level of implementation of the requirements. Finally, OSEP asked the participants to propose a monitoring system that would incorporate the results-oriented monitoring strategies. OSEP used the input from this very productive stakeholder meeting to design its Continuous Improvement Monitoring Process, which is built around the following critical themes:

Continuity. An effective accountability system must be continuous, rather than episodic, clearly linked to systemic change, and integrate self-assessment and continuous feedback and response.

Partnership with Stakeholders. OSEP must be a partner with parents, students, State and local educational agencies, and other Federal agencies in a collaborative process in which stakeholders are part of the entire process, including the setting of goals and benchmarks; the collection and analysis of self-assessment data; the identification of critical issues and solutions to problems; and the development, implementation, and oversight of improvement strategies to ensure compliance and improved results for children and youth with disabilities.

State Accountability. States must assume accountability for measuring and reporting progress, identifying weakness, and identifying and implementing strategies for improvement.

Self-Assessment. Each State must work with stakeholders to design and implement an ongoing self-assessment process that is focused on improving results for children and youth with disabilities and that facilitates continuous feedback and use of information to support continuous improvement. OSEP will periodically visit programs in the State to verify the self-assessment.

Data Driven. The continuous improvement monitoring process in each State will be driven by data that focus on improved results for children and youth with disabilities. Each State will collect and use data on an ongoing basis, aligned with the State's performance goals and indicators, with regular OSEP review. States and OSEP will compare data across States, school districts, and early intervention service providers to identify needs and strategies for improvement. Some of the available data which can be critical to the self-assessment and validation process include those regarding graduation and dropout rates, performance of students with disabilities on state- and district-wide assessments, rates at which children with disabilities are suspended and/or expelled from school, and identification and placement of students from minority backgrounds.

Public Process. It is important that the self-assessment and monitoring process be public and that self-assessment results, monitoring reports, and improvement plans be broadly disseminated.

Technical Assistance. Because the focus of the monitoring process is on continuous improvement, technical assistance is a critical component. Therefore, OSEP will prioritize the provision of such assistance as a component of its onsite work in each State. States will be encouraged to include a technical assistance plan as part of their correction/improvement plan and utilize the Regional Resource Centers and NECTAS to provide and broker technical assistance throughout the continuous improvement process. A key component in technical assistance will be the identification and dissemination of promising practices.

OSEP customizes its continuous improvement monitoring process to meet the needs in each State. In States where there is evidence of substantial compliance with IDEA requirements, OSEP's focus is on the identification and implementation of promising practices. In States that are not demonstrating compliance, OSEP works with the State to develop improvement strategies. States that fail to correct identified deficiencies may be subject to enforcement actions such as special conditions on grant awards, compliance agreement, or withholding of funds.

The continuous improvement monitoring cycle is ongoing and consists of the following phases:

Self-assessment. The State works with a steering committee of stakeholders who represent diverse perspectives to develop and implement a self-assessment to evaluate the State's effectiveness in achieving compliance and in improving results for children and youth with disabilities and their families.

Validation Planning. The steering committee, made up of representatives of stakeholder groups and selected by the State education agency (SEA) and lead agency, works with OSEP staff to plan strategies for validating the self-assessment results, including, if appropriate, onsite collection of data. The validation planning stage includes meetings to obtain focused public input, review the self-assessment, and develop a monitoring plan, which can include offsite and/or onsite strategies.

Validation Data Collection. During this phase, OSEP collects validation data, presents those data to the steering committee in a structured exit conference, and works with the steering committee to plan the reporting and public awareness processes. OSEP's data collection may include data collection at both the State and local levels.

Improvement Planning. Based upon the self-assessment and validation results, the steering committee develops an improvement plan that addresses both compliance and improvement of results for children and youth with disabilities and includes timelines, benchmarks, and verification of improvement. OSEP encourages States to include their Regional Resource Center and/or NECTAS in the development of the improvement plan, in order to facilitate the effective inclusion of technical assistance in both planning and implementation of the improvement plan.

Implementation of Improvement Strategies. The State implements and evaluates the effectiveness of the improvement plan.

Verification and Consequences. Based upon documentation that OSEP receives from the State and steering committee, OSEP verifies effectiveness of the actions taken in implementing the improvement plan. Where the State has been effective in achieving verifiable improvement, positive consequences may include public recognition. If a State does not implement the improvement plan, or implementation is not effective, OSEP may need to impose sanctions, which could include OSEP's prescription of improvement actions, a compliance agreement, or other enforcement actions.

Review and Revision of Self-assessment. Based on the results of the previous improvement planning cycle, the State reviews, and as appropriate revises, the self-assessment.

OSEP has focused its continuous improvement monitoring process on those areas that are most closely associated with positive results for children with disabilities. To help OSEP and States focus on those areas, OSEP has clustered:

1. Part C (services for children ages birth through 2) requirements into five major areas:
 - General Supervision,
 - Child Find and Public Awareness,
 - Early Intervention Services in Natural Environments,
 - Family-Centered Systems of Services, and
 - Early Childhood Transition.
2. Part B (services for children ages 3 through 21) requirements into four major areas:
 - Parent Involvement,
 - Free Appropriate Public Education in the Least Restrictive Environment,
 - Secondary Transition, and
 - General Supervision.

In order to assist States in the self-assessment of their systems for early intervention and special education services, and to guide OSEP's review of those systems, OSEP developed "cluster charts," that included results-focused State and local indicators for each of the nine clusters listed above. The self-assessment and monitoring process incorporates use of the cluster areas through the following steps:

- Identifying indicators for measuring progress in the implementation of IDEA;
- Identifying potential data sources and gathering data pertinent to the indicators;
- Analyzing the data to determine the positive and negative differences between the indicators as stated and their status; and
- Identifying promising practices and developing improvement and maintenance strategies.

Table IV-5
Schedule of 1998-1999 Continuous Improvement Monitoring Reviews

North Dakota August/September 1998	Utah October/December 1998	New York February/April 1999
Nebraska August/October 1998	Arizona October 1998/January 1999	Montana March/April 1999
Washington August/October 1998	Wisconsin November 1998/February 1999	South Dakota March/May 1999
New Mexico October/December 1998	Massachusetts November 1998/February 1999	Bureau of Indian Affairs (Data collected during North Dakota, New Mexico, and South Dakota visits)

Source: U.S. Department of Education, Office of Special Education Programs, Division of Monitoring and State Improvement Planning.

OSEP conducted 12 continuous improvement monitoring reviews during the 1998-99 school year. During the 1999-2000 school year, OSEP conducted six reviews, as well as the validation planning visit component for two additional States. OSEP will conduct the validation data collection visits for those two States at the beginning of the 2000-01 school year. In addition, in 1999-2000 OSEP made a visit to Illinois for Part B focus and Part C follow up, and two CAP visits to California. Table IV-5 shows the schedule of the 1998-99 school year reviews; table IV-6 lists the 1999-2000 reviews.¹

OSEP's monitoring reports for the 1998-99 and 1999-2000 school year reviews are, like the self-assessment, validation planning, and data collection processes, focused around the five Part C and four Part B clusters described above. The following is a summary of the strengths and areas of noncompliance that OSEP identified in the monitoring reports that it has issued based upon visits in the 1998-99 school year.

Part C: General Supervision and Administration

The State lead agency is responsible for developing and maintaining a statewide, comprehensive, coordinated, multidisciplinary, interagency early intervention system. Administration, supervision, and monitoring of the early intervention system are essential to ensure that each eligible child and family receives the services needed to enhance the development of infants and toddlers with disabilities and to minimize

¹ Monitoring reports are available online at <http://www.ed.gov/offices/OSERS/OSEP> or by writing to the OSEP director at the Department of Education.

Table IV-6
Schedule of 1999-2000 Continuous Improvement Monitoring Reviews

Illinois September 1999 (Part B focus/C follow-up)	Colorado November 1999/January 2000
Ohio August/October 1999	Florida December 1999/February 2000
Maryland September/October 1999	New Jersey February/September 2000
Louisiana November 1999/February 2000	Pennsylvania March/October 2000
Arkansas November 1999/January 2000	California January/April 2000 (CAP visits)

Source: U.S. Department of Education, Office of Special Education Programs, Division of Monitoring and State Improvement Planning.

their potential for developmental delay. Early intervention services are provided by a wide variety of public and private entities. Through supervision and monitoring, the State ensures that all agencies and individuals providing early intervention services meet the requirements of IDEA, whether or not they receive funds under Part C.

While each State must meet its general supervisory and administrative responsibilities, the State may determine how that will be accomplished. Mechanisms such as interagency agreements and/or contracts with other State-level or private agencies can serve as the vehicle for the lead agency's implementation of its monitoring responsibilities. The State's role in supervision and monitoring includes: (1) identifying areas in which implementation does not comply with Federal requirements; (2) providing assistance in correcting identified problems; and (3) as needed, using enforcing mechanisms to ensure correction of identified problems.

During Part C monitoring, OSEP identified strengths in the General Supervision Cluster in the following areas: (1) Interagency Coordinating Councils with strong parent representation and active participation by agencies involved in providing services for infants, toddlers, and their families and (2) an efficient Interagency Coordinating Council resulting in creative practices in the areas of personnel preparation, effective interagency agreements, and innovative and family-centered practices leading to improved results for infants, toddlers and their families. In addition, OSEP discovered that some States have sophisticated data collection systems that provide them with information to effectively plan in all areas of the early intervention system to ensure appropriate family-centered services. One State has implemented a joint monitoring process that minimizes duplication of effort and

promotes efficiency. These interagency monitoring activities have been effective in identifying and correcting deficiencies in the Part C program.

Areas of noncompliance identified by OSEP included States that do not have an effective or complete monitoring system to ensure compliance with all Part C requirements. There is wide variation in States' monitoring activities and in the components that are covered in a State's monitoring system. Some States have not yet conducted a systematic monitoring and evaluation of their Part C program. Other States that have conducted monitoring activities have not included important components of Part C, such as monitoring for natural environments and family-centered practices; ensuring that eligible children and families are receiving all needed services, timely evaluation and assessment activities, and individualized family service plan (IFSP) development; ensuring distribution of public awareness materials by primary referral sources; and a variety of other aspects of Part C requirements. States that identify noncompliance issues frequently have ineffective improvement actions or enforcement strategies, as the same issues recur in subsequent monitoring by the State and were also identified during OSEP's monitoring activities. Furthermore, some States are neglecting to ensure that all programs and agencies providing early intervention services are in compliance with Part C, especially if the service provider is another State agency.

Part C: Child Find/Public Awareness

The needs of infants and toddlers with disabilities and their families are generally met through a variety of agencies. However, prior to the enactment of Part C of IDEA, there was little coordination or collaboration for service provision, and many families had difficulty locating and obtaining needed services. Searching for resources placed a great strain on families. With the passage of Part C in 1986, Congress sought to ensure that all children needing services would be identified, evaluated, and served, especially those children who are typically underrepresented, (e.g., minority, low-income, inner-city, American Indian, and rural populations), through an interagency, coordinated, multidisciplinary system of early intervention services.

Each State's early intervention system must include collaborative child find and public awareness activities that are coordinated with all other child find efforts in the State. Part C recognizes the need for early referral and short timelines for evaluation because development occurs at a more rapid rate during the first 3 years of life than at any other age. Research in early brain development has demonstrated what early interventionists have known for years--that children begin to learn and develop from the moment of birth. Therefore, the facilitation of early learning and the provision of timely early intervention services to infants and toddlers with disabilities are critical.

OSEP observed areas of strengths in States' public awareness campaigns. For example: (1) An effective statewide multimedia public awareness campaign is reaching urban areas; (2) State early intervention staff participate in statewide early childhood initiatives to promote awareness of Part C; (3) program materials are available in multiple languages and easy-to-read formats; (4) funds are provided to reservation tribes for development of materials to foster child find activities for Native American children. OSEP noted strengths in States' comprehensive child find systems: in one State, legislation is in place that provides the right to an evaluation for all children ages birth to 5 years. Children do not need to be suspected of a developmental delay to receive this evaluation. Another State has an early childhood tracking system that is effective in identification of at-risk children. Under this system, parents register, beginning at the child's birth, and complete a monthly questionnaire that, in turn, is reviewed by child development specialists. In a third State, screening activities are broadly advertised, and creative public awareness materials are used to encourage parents to attend screening activities.

OSEP identified the following areas of noncompliance in the Child Find and Public Awareness cluster:

- Part C requires States to establish a public awareness program that focuses on the early identification of eligible children and that informs the general public how to make referrals and access evaluations and services. OSEP found that public awareness programs typically are not adequate to inform the general public about the provision of early intervention services; materials are not being disseminated broadly enough to reach the general public; and materials are not appropriate or easily understood for rural parents and tribes residing on reservations. These problems exist because of lack of an ongoing, systemic campaign of public awareness activities.
- Part C requires States to implement a coordinated, comprehensive statewide child find system with all other relevant major State agencies (education, health and social services programs), and tribes and tribal organizations. OSEP found that States typically do not have State or local systems to coordinate and support a coordinated child find system to locate and identify children and not duplicate efforts unnecessarily. In addition, child find is not being coordinated with tribes and tribal organizations receiving funds under Part C. These issues are occurring, in part, due to lack of clear guidance and procedures from the State lead agency.
- States must have an effective method for primary referral sources to make referrals and to ensure that referrals are made no more than 2 working days after a child has been identified. OSEP found that many primary referral sources, including the medical community and other public and private

agencies, either do not understand the appropriate referral procedures when referring a child suspected of developmental delay and in need of early intervention services, are not aware of the early intervention system, are not referring children to the system, or the eligibility criteria prevent referral. These problems exist, in part, due to lack of effective outreach and communication methods to the medical community and public and private agencies.

- Part C requires that, within 45 days of receiving a referral, a State must ensure the completion of a comprehensive, multidisciplinary evaluation and assessment of the child's strengths and needs and identify services to meet those needs through the IFSP process. OSEP found that delays are occurring in the initial evaluation and assessment of children referred to the early intervention system and that not all required services are being identified within the 45-day timeline. Delays are occurring for a variety of reasons, including personnel shortages, lack of timely assignment of an initial service coordinator responsible for ensuring completion of the evaluation, and travel requirements to reach families residing in rural communities. OSEP also found that all required services are not being identified because the initial evaluation is not sufficiently comprehensive to identify services to meet the child's needs.

Part C: Early Intervention in Natural Environments

In creating the Part C legislation, Congress recognized the urgent need to ensure that all infants and toddlers with disabilities and their families receive early intervention services according to their individual needs. Three of the principles on which Part C was enacted include: (1) enhancing the child's developmental potential, (2) enhancing the capacity of families to meet the needs of their infant or toddler with disabilities, and (3) improving and expanding existing early intervention services being provided to children with disabilities and their families.

To assist families in this process, Congress also required that each family be provided with a service coordinator, to act as a single point of contact for the family. The service coordinator assures that the rights of children and families are provided, arranges for assessments and IFSP meetings, and facilitates the provision of needed services. The service coordinator coordinates required early intervention services, as well as medical and other services the child and the child's family may need. With a single point of contact, families are relieved of the burden of searching for essential services, negotiating with multiple agencies, and trying to coordinate their own service needs.

Part C requires the development and implementation of an IFSP for each eligible child. The evaluation, assessment, and IFSP process are designed to ensure that appropriate evaluation and assessments of the unique needs of the child and of the family related to enhancing the development of their child are conducted in a timely manner. Parents are active members of the IFSP multidisciplinary team. The team must take into consideration all the information obtained through the evaluation and child and family assessments in determining the appropriate services needed to meet the needs.

The IFSP must also include a statement of the natural environments in which early intervention services will be provided for the child. Children with disabilities should receive services in community settings and places where normally developing children would be found, so that they will not be denied opportunities that all children have to be included in all aspects of our society. In 1991, Congress required that early intervention services be provided in natural environments. This requirement was further reinforced by the addition of a new requirement in 1997 that early intervention can occur in a setting other than a natural environment only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment. In the event that early intervention cannot be satisfactorily achieved in a natural environment, the IFSP must include a justification of the extent, if any, to which the services will not be provided in a natural environment.

OSEP identified strengths in the Early Intervention Services in the Natural Environments Cluster in a number of States. Examples of promising practices that OSEP found in a variety of States include: (1) the formalized coordination of the social services, health, schools, Indian health services, and service provider agencies in each local area of a State to ensure coordinated services to infants and toddlers and their families; (2) coordination with Medicaid to institute a differential funding formula for Medicaid reimbursement for services that are conducive to providing early intervention services in homes and child care settings; and (3) development of a sophisticated system of identifying competencies and degree requirements for service coordinators, professionals, and paraprofessionals who work with infants and toddlers to ensure a holistic approach to early intervention and integration of services for this population.

In the area of noncompliance, OSEP found a variety of service coordination violations of the regulations. Not all States appoint a single service coordinator to complete all of the services coordination duties specified by the regulations, thus requiring families to continue to identify some of their own resources and services. In some States, service coordinators are not assisting families in the identification of family needs and the supports and services needed by families to address those needs, and, in cases where services for families are identified, these services are not included on the IFSP.

In some States, OSEP found that evaluations and assessments are not completed within the timeline required, and some evaluations and assessments are delayed for several weeks to several months, creating a delay in needed services. Multidisciplinary evaluations are not completed in all developmental areas, and frequently, there are not enough service providers to complete evaluations in a timely manner. OSEP found that several States are not using the IFSP process to make individual determinations for eligible children and families concerning natural environments for provision of services; some States are still providing services in segregated centers, without justification in the IFSP, where children without disabilities would not normally participate. In addition, some States do not include all the services an eligible child and family needs on the IFSP, only including those services that are available. Some States fail to include on the IFSP other non-early intervention services that the child needs, as required by Part C to make the IFSP a comprehensive document.

OSEP found that not all services listed on IFSPs were actually being provided. In some instances, services are reduced or not provided in the summer months for reasons unrelated to a child's needs. In some States, eligible children are not receiving services due to the failure of the State to provide transportation to families in need of this service. Finally, OSEP found that in several States, the IFSP team process was not being used to determine services.

Part C: Family-Centered Services

Research has shown that improved outcomes for young children are most likely to occur when services are based on the premise that parents or primary caregivers are the most important factors influencing a child's development. Family-centered practices are those in which families are involved in all aspects of the decision-making, families' culture and values are respected, and families are provided with accurate and sufficient information to be able to make informed decisions. A family-centered approach keeps the focus on the developmental needs of the child while including family concerns and needs in the decision-making process. Family-centered practices include establishing trust and rapport with families and helping families develop skills to best meet their child's needs.

Parents and other family members are recognized as the lynchpins of Part C. As such, States must include parents as an integral part of decision making and service provision, from assessments through development of the IFSP, to transition activities before their child turns 3. Parents bring a wealth of knowledge about their own child's and family's abilities and dreams for their future, as well as an understanding of the community in which they live.

In 1986, Part C of IDEA was recognized as the first Federal legislation to specifically focus attention on the needs of the family related to enhancing the development of children with disabilities. In enacting Part C, Congress acknowledged the need to support families and enhance their capacity to meet the needs of their infants and toddlers with disabilities. On the cutting edge of education legislation, Part C challenged systems of care to focus on the family as the unit of services, rather than the child. Viewing the child in the context of her/his family and the family in the context of its community, Congress created certain challenges for States as they designed and implemented a family-centered system of services.

OSEP found that States used a variety of methods to ensure and enhance family participation in the provision of early intervention services for infants and toddlers. Several states have organized and systematized programs for parent involvement, including local family liaisons, parent-to-parent support networks, programs to assist parents in navigating the system, and a program to train parents to be advocates and to participate on local and State government committees. In these States, parents assist in the development of training materials and public awareness materials. The State Interagency Coordinating Council moves its meetings to various locations around the State to allow more parents to attend and participate in the activities of the Council. These States also provide information in family friendly language and in a variety of dialects to assist families to be able to participate.

OSEP included findings related to this Cluster in the Early Intervention Services in Natural Environments section of this report.

Part C: Early Childhood Transition

Congress included provisions to ensure that preschool or other appropriate services would be provided to eligible children leaving early intervention at age 3. Transition is a multifaceted process to prepare the child and the child's family to leave early intervention services. Congress recognized the importance of coordination and cooperation between the educational agency and the early intervention system by requiring that a specific set of activities occur as part of a transition plan. Transition activities typically include: (1) identification of steps to be taken to prepare the child for changes in service delivery and to help the child adjust to a new setting, (2) preparation of the family (i.e., discussions, training, visitations), and (3) determination of other programs and services for which a child might be eligible. Transition planning for children who may be eligible for Part B preschool services must include scheduling a meeting, with approval of the family, among the lead agency, the educational agency, and the family, at least 90 days (with parental permission up to 6 months) prior to the child's third birthday. Transition of children who are not eligible for special education also includes convening a meeting to assist

families in obtaining other appropriate community-based services. For all Part C children, States must review the child's program options for the period from the child's third birthday through the remainder of the school year and must establish a transition plan.

Strengths identified during OSEP's monitoring activities in the Transition Cluster for Part C included activities leading to smooth transitions for children and families. Some States have established a committee to develop interagency plans for transition, developing local and State interagency agreements and memoranda of understanding, especially where the SEA is not the Part C lead agency. States have developed a variety of interagency training techniques for providers and parents regarding transition, including specific training for parents and joint training for staff of each agency. Transition guides have also been developed to assist parents and providers in the transition process.

OSEP also identified noncompliance issues during the monitoring visits for Part C. Some States do not hold the transition meeting at least 90 days before the child's third birthday, sometimes waiting until only a few weeks before the child turns 3. Other States do not hold a transition meeting at all for those children who are eligible for Part B or for those who will transition to community services. This practice results in failure to provide services by the child's third birthday and, in some instances, failure to provide services until the child is 4. Some States do not include transition plans in the IFSP, or, for transition planning, the IFSP only states that the child will transition, without the appropriate steps to prepare the child and the child's family for transition out of Part C.

Part B: Parent Involvement

A purpose of the IDEA Amendments of 1997 is to expand and promote opportunities for parents and school personnel to work in new partnerships at the State and local levels. Parents must now have an opportunity to participate in meetings with respect to the identification, evaluation, and educational placement of their child and the provision of a free appropriate public education to their child. Parental involvement has long been recognized as an important indicator of a school's success, and parent involvement has positive effects on children's attitudes and social behavior. Partnerships positively affect achievement, improve parents' attitudes toward the school, and benefit school personnel as well.

With the enactment of the IDEA Amendments of 1997, OSEP's work in shaping its accountability in a way that drives and supports improved results for infants, toddlers, children, and youth with disabilities intensified. In order to ensure compliance with the amendments, which support positive results for people with

disabilities, OSEP designed a multifaceted process. Among the Part B requirements that provide the strongest links to improved educational results for students with disabilities are those addressing the participation of parents and students and general and special education personnel in the development and implementation of educational programs for children with disabilities. One of the four major areas in which Part B requirements are clustered for children ages 3 through 21 is parent involvement.

Since the enactment of the IDEA Amendments of 1997, OSEP has identified specific strengths in the Part B Parent Involvement Cluster in a number of States. OSEP's review of States using its new continuous monitoring process found the following examples of these promising practices: (1) joint training in some States where States and parent groups collaborate with Parent Training and Information Centers on the 1997 amendments, (2) jointly developed training materials for use by parents and personnel, and (3) the successful use of mediation as a process for conflict resolution where parents report that they feel heard and valued as partners in mediation. In a number of instances, OSEP found that parents and communities provide strong support to the educational process, with families very involved in the educational programs for their children and, reciprocally, the schools actively involving parents in meetings concerning their child's special education.

Issues of noncompliance identified by OSEP include findings that in some States, parents are not part of the group that reviews existing evaluation data to determine whether a child has a disability. In these cases, parents are also not part of the reevaluation process to determine whether the child continues to have a specific disability, and parents are not included on the multidisciplinary team that makes the placement decision for the child.

Part B: Free Appropriate Public Education in the Least Restrictive Environment

The provision of a free appropriate public education in the least restrictive environment is the foundation of IDEA. The provisions of the statute and regulations (evaluation, individualized education program (IEP), parent and student involvement, transition, participation in large-scale assessment, eligibility and placement decisions, service provision, etc.) exist to achieve this single purpose. It means that children with disabilities receive educational services at no cost to their parents and that the services provided meet their unique learning needs. These services are provided, to the maximum extent appropriate, with children who do not have disabilities and, unless their IEP requires some other arrangement, in the school they would attend if they did not have a disability. Any removal of children with disabilities from the regular educational environment occurs only when the nature or

severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

The Committee Reports of the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Education and the Workforce for the 1997 amendments emphasized that too many students with disabilities are failing courses and dropping out of school. Those reports noted that almost twice as many children with disabilities drop out as compared to children without disabilities. They expressed a further concern about the continued inappropriate placement of children from minority backgrounds and children with limited English proficiency in special education. The Committees stated their intention that “once a child has been identified as being eligible for special education, the connection between special education and related services and the child’s opportunity to experience and benefit from the general education curriculum should be strengthened. The majority of children identified as eligible for special education and related services are capable of participating in the general education curriculum to varying degrees with some adaptations and modifications. This provision is intended to ensure that children’s special education and related services are in addition to and are affected by the general education curriculum, not separate from it.”

OSEP identified strengths in the Free Appropriate Public Education in the Least Restrictive Environment Cluster in a number of States. Several States were commended for the activities they had developed to ensure that appropriately trained administrators, teachers, paraprofessionals, and related services personnel are located and available to meet the identified needs of all children with disabilities. Efforts taken to retain personnel after they have been hired were also recognized. Examples of these activities include the creation of a recruitment website to assist local districts in locating qualified personnel, upgrading of the special education teacher certification requirements, development of minimum competencies for paraprofessionals, and the development of unique approaches to secure qualified staff in rural areas. Other examples of staff development include the creation of an inclusive education training project for school districts to assist them in initiating and implementing inclusive educational practices and the development of an educational interpreter certificate project which utilizes distance learning and summer programs to deliver instruction to educational interpreters. In one State, new endorsement requirements were implemented for teachers who had requested endorsement for birth through age 8 programs that would require coursework focusing on the unique needs of students within this age range.

Particularly noteworthy were the initiatives taken by some States to address the needs of students with behavioral disorders. The creation of statewide projects and other mechanisms, such as the use of assessment instruments, to provide comprehensive

staff development to improve the capacities of schools and communities are among the initiatives taken to address the needs of this population.

A few States were recognized for the steps taken to address the needs of students from birth to age 9. One State expanded the developmental delay category to age 9, giving school districts the option of providing services to younger children without having to lock the child into an eligibility category which may be inappropriate or incorrect. Another State increased the size of the State staff responsible for providing linkages to other State level transition services for young children and their families.

Other strengths which demonstrate the variety of State-level initiatives for providing a free appropriate public education in the least restrictive environment include the following:

- Data gathering instruments, such as the development of a single State-level student information management system to collect data across programs and the development of a system that allows the State to collaborate between various programs to collect suspension/expulsion data for all students, including students with disabilities;
- Close working relationships with the State Advisory Panel to formulate policy and guidance for implementing the 1997 amendments;
- Creation of a financial safety net in the special education funding formula to ensure that all eligible children and youth with disabilities receive a free appropriate public education by providing State funds for students requiring high-cost services and to districts receiving less State special education revenue than the previous year;
- Proactive steps to increase the involvement of children with disabilities in state- and district-wide assessment programs.

The areas of noncompliance that OSEP identified within the Free Appropriate Public Education in the Least Restrictive Environment Cluster focused on requirements in the following areas:

- Removal of children from regular education settings only when the nature and severity of disability is such that education in regular classes, with the use of supplementary aides and supports, cannot be achieved satisfactorily.

Lack of supplementary aids and services, inadequate number of appropriately trained staff, and an inadequate supply of qualified staff are factors that affect decisions about removal of students from regular education classes. Students with emotional disturbance or intellectual or multiple disabilities tend to be inappropriately placed in segregated classes most often. In some instances, placement decisions continue to be based on the intensity of service level and disability category rather than on the unique needs of the child.

- Transition from Part C to B.

Some States did not consistently ensure that public agencies carry out a smooth and effective transition to Part B services. For example, collaboration among local staff is limited, and communication often results in philosophical disagreements about evaluations, untimely or no transition meetings, and inappropriate breaks in services for young children. In some cases, school staff does not consistently participate when invited to transition planning meetings. In other instances, transition for all children occurs at the beginning of the school year, regardless of the child's birthday, resulting in some children not receiving their needed services until after they turn 3 years of age.

- Extended school year services.

Students in some States are not receiving extended school year services, in accordance with an appropriate IEP. This violation seems to be related to a lack of understanding about this requirement and a need for additional training about the process and criteria for receiving extended school year services.

- Qualified staff to provide special education and related services.

States did not consistently ensure that public agencies have an adequate supply of qualified special education and related-services personnel necessary to carry out the purposes of IDEA. This is especially true with teachers qualified to serve students with severe behavior disorders, as well as related-service providers such as speech therapists, physical therapists, occupational therapists, and individuals qualified to provide psychological counseling. These shortages result in students not receiving needed services; delays in the provision of services; failure to provide students access to the general education curriculum due to lack of supports, including behavioral supports; provision of poor-quality services because services are provided by unqualified and untrained staff; provision of services on a consultative base in order to "stretch" staff availability; and discontinuance of direct services to allow time for conducting evaluation.

- Related services--psychological counseling.

Findings related to the provision of psychological counseling indicated that the type and amount of these services are limited in that they are often based on the category of disability or the grade level, rather than on the individual needs of the child. In some cases, parents pay for these services even when they are determined necessary by the IEP team for the child to benefit from special education. When psychological counseling is provided by an outside agency, it is rarely integrated into the student's IEP.

Part B: Secondary Transition

The National Longitudinal Transition Study found that the rate of competitive employment for youth with disabilities out of school for 3 to 5 years was 57 percent, compared to an employment rate of 60 percent for youth in the general population. The study identified several factors that were associated with post-school success in obtaining employment and earning higher wages for youth with disabilities. These include completing high school, spending more time in regular education, and taking vocational education in secondary school. The study also shows that post-school success is associated with youths who had a transition plan in high school that specified an outcome, such as employment, as a goal. The secondary transition requirements of IDEA focus on the active involvement of students in transition planning, consideration of student's preferences and interests by the IEP team, and the reflection, in the IEP, of a coordinated set of activities within an outcome-oriented process which promotes movement from school to post-school activities. Through parent and student involvement, along with the involvement of all agencies that can provide transition services, student needs can be appropriately identified and services provided that best meet those needs.

Strengths identified by OSEP in the Secondary Transition Cluster in a number of States include: (1) State education agency (SEA) funding of transition coordinator positions; (2) increased interagency collaboration with other agencies likely to provide transition-related services, including the local vocational rehabilitation agency; (3) partnerships with industry and school-to-work initiatives; (4) development of State Transition Coordinating Councils and Transition Task Forces to address transition from secondary to postsecondary education; (5) SEA grants to expand self-advocacy, job training, and postsecondary program admission; (6) an SEA follow-up longitudinal study; and (7) linkages with institutions of higher education.

Consistent with monitoring findings from previous years, OSEP found that in some States, there seems to be little movement in resolving noncompliance in the

following areas: (1) lack of student and other agency participation in the development of transition plans due to the failure of the local education agency to invite and ensure participation of the student and other agency representatives; (2) failure to consistently notify parents regarding the IEP meeting for which the purpose is the discussion of transition services, causing parents to be unprepared to discuss transition needs and options at the meeting; (3) lack of statements for students, beginning at age 14, of needed transition services to begin at age 16 (or younger if determined appropriate by the IEP team); and (4) a lack of understanding of the transition requirements, specifically interests and preferences of the student, related services, and course of study.

In addition to these areas of noncompliance, OSEP also identified suggestions for improved results, including determination of appropriate agency linkages; development of interagency agreements/memoranda of understanding; increased collaboration with other agencies; provision of training on the implementation of transition requirements to parents, students, and service providers; increased understanding of, involvement in, and availability of independent living centers; increased availability of community experience of Native American students residing on reservations; and the development of culturally sensitive transition plans to meet the needs of these students.

Part B: General Supervision

IDEA assigns responsibility to SEAs for ensuring that its requirements are met and that all educational programs for children with disabilities, including all such programs administered by any other State or local agency, are under the general supervision of individuals in the State who are responsible for educational programs for children with disabilities and that these programs meet the educational standards of the SEA. State support and involvement at the local level are critical to the successful implementation of the provisions of IDEA. To carry out their responsibilities, States provide dispute resolution mechanisms (mediation, complaint resolution, and due process), monitor the implementation of Federal and State statutes and regulations, establish standards for personnel development and certification as well as educational programs, and provide technical assistance and training across the State. Effective general supervision promotes positive student outcomes by promoting appropriate educational services to children with disabilities, ensuring the successful and timely correction of identified deficiencies, and providing personnel who work with children with disabilities the knowledge, skills, and abilities necessary to carry out their assigned responsibilities.

OSEP identified strengths in the General Supervision Cluster in a number of States. Examples of promising practices include statewide training opportunities through

the SEA, the establishment of interagency collaboration to benefit children and families, intervention through an early assistance program to intervene in disputes prior to filing a complaint or due process hearing, a regionalized personnel development system, school district accountability for results for children with disabilities, access to a “safety net” fund that may be utilized by school districts to offset high special education costs, and a data collection system on LEAs that can provide a wide array of information.

OSEP also identified noncompliance in the General Supervision Cluster in States that were monitored. Examples of noncompliance include the SEA not ensuring that school-aged incarcerated individuals with disabilities are identified and provided special education services, a monitoring system that was ineffective in identifying and correcting noncompliance in some public agencies, and the completion of due process hearings outside the required 45-day timeline.

References

- U.S. Department of Education. (1998). *Twentieth annual report to Congress on the implementation of the Individuals with Disabilities Education Act*. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Education, National Center for Education Statistics. (1998). *The digest of education statistics*. Washington, DC: Author.
- U.S. Department of Education, Office of Special Education Programs (OSEP). (2000). *OSEP monitoring reports*. Retrieved July 25, 2000, from the World Wide Web: <http://www.ed.gov/offices/OSERS/OSEP/osep.html#MONITOR>