

1

What Should Every Teacher Know About Early Childhood Intervention?

Ms. Dennis, a kindergarten teacher, was finding that many of the students entering her class already had mastered the content she was prepared to present. By checking with some of the parents, she discovered that the local preschool programs had adopted a firm stance on academics in response to parents' requests that they better prepare children for kindergarten. The kindergarten teacher was considering restructuring the academic year in response to this new population of students with well-developed skills.

MORE CHILDREN ATTEND PRESCHOOL

From 1987 to 2000 (National Center for Education Statistics, 2002), preprimary enrollment increased in the United States by about 33 percent for children between the ages of 3 and 5. By 2000, more than half of the children between ages 3 and 5 were enrolled in nursery school or kindergarten classes. Of this total, about

10 Working With Families and Community Agencies

43 percent of 3-year-olds, 64 percent of 4-year-olds, and 92 percent of 5-year-olds were enrolled in preprimary educational programs. In 2000–2001, 35 percent of public elementary schools offered kindergarten and over 800,000 children participated (National Center for Education Statistics, 2002). During 2000–2001 about 65 percent of all children younger than 6 years of age who were not enrolled in kindergarten regularly participated in early educational programs or some type of child care (National Institute for Early Education Research, 2002). By and large, these students are better prepared for school and are more advanced academically than students who started school five to ten years ago.

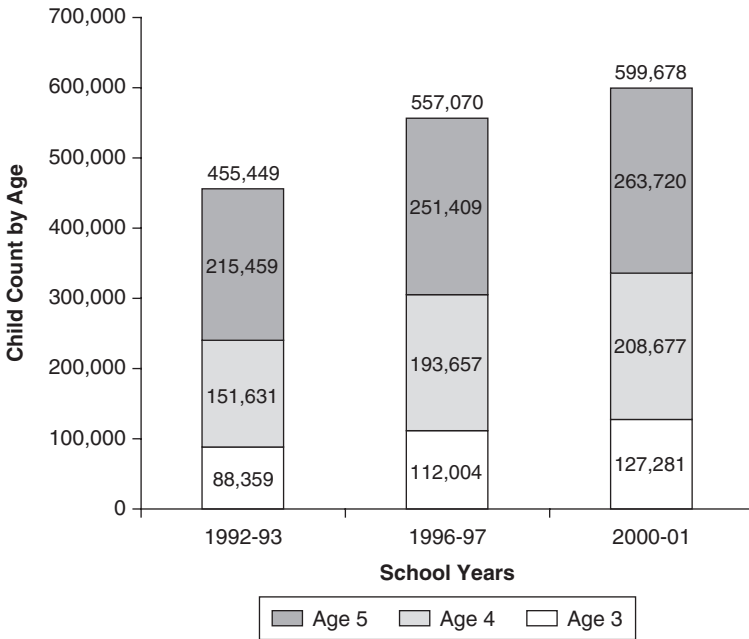
MORE CHILDREN NEED PROGRAMS

At the same time that there are more preschool programs, there are more students in need of the programs. Fetal alcohol syndrome and alcohol-related birth defects are on the rise. Babies born with AIDS are increasing in number each year, and so are babies with medical problems resulting from their mothers' addiction to cocaine. Infants who are medically fragile are surviving through extraordinary medical interventions but then may face life with significant mental and physical impairments. Even children born healthy may face poverty, homelessness, or physical abuse. It is argued that we ought to intervene early in the lives of children to prevent later problems and to enable them to enter school ready to learn. The first National Educational Goal was that by the year 2000, all children would start school ready to learn. This goal has still not been met.

MORE PRESCHOOLERS RECEIVE SPECIAL EDUCATION SERVICES

The increase in the numbers of children ages 3–5 who received special education services under the Individuals With Disabilities Education Act (IDEA; 1997) during the 1992–1993, 1996–1997, and 2000–2001 (most recent available) school years is shown in

Figure 1.1 Number of Preschoolers Receiving Services Under IDEA During the 1992–1993, 1996–1997, and 2000–2001 School Years



Source: U.S. Department of Education (2002).

Figure 1.1. Illustrated is the fact that over time, more and more preschoolers are receiving special education services.

FEDERAL LAWS AND INCENTIVES

In 1968 the Handicapped Children's Early Education Assistance Act (Public Law 90-538) was passed. It was the first law that provided federal funds for innovative programs for preschool children with disabilities. By 1973 Head Start and other federally funded programs were required to keep at least 10 percent of their spaces available for children with disabilities. The Education for All Handicapped Children Act of 1975 (Public

12 Working With Families and Community Agencies

Law 94-142) mandated services for all 3- to 5-year-olds by 1980; state law already provided services for children without disabilities in that age group. It also provided incentive grants to states for improving early childhood special education programs.

In 1984, Public Law 98-199 (Education of the Handicapped 1983) made funds available to states to develop comprehensive services for children with special needs from birth to age 5. Two years later, President Reagan signed into law the amendments to the Education for All Handicapped Children Act (Public Law 99-457). This legislation expanded services to children with disabilities who are under age 5. It mandated that schools must have on file for each preschool child with a disability an **individualized family service plan (IFSP)**. An IFSP is a kind of IEP (individualized education program) for young children.

The amendments to the Education for All Handicapped Children Act also authorized the distribution of federal funds to help states provide special education to very young children and guaranteed a free, appropriate education to all preschoolers with disabilities. This law also made special education for young children with disabilities compulsory, and parents became an important part of the educational program. The provisions of this law were incorporated into the amendments of the Individuals With Disabilities Education Act (1997).

DIRECT AND INDIRECT SERVICES

Settings for early intervention programs differ, and the nature of services provided in the settings is diverse. When the services are provided to the child, they are called **direct services**; when they are provided to another person, such as a parent, who in turn serves the child, they are called **indirect services**.

HOME-BASED PROGRAMS

Some early childhood special education (ECSE) programs are **home based**, especially for very young children (birth to age 3).

When this is the case, school personnel visit the home regularly, either to provide direct services or to educate families who in turn educate the young children. In some home-based programs, the visits occur weekly and are designed primarily to improve the families' skills in working with their children. The type of service depends on the type of disability and the willingness of the family to teach the child. Families also receive indirect services in some home-based programs. Specially trained teachers make recommendations for training, organize groups of parents with similar concerns, and help families monitor the progress of the intervention they are providing.

HOSPITAL-BASED OR CENTER-BASED PROGRAMS

In other instances the programs are **hospital based** or **center based**. In hospital settings, the services may be provided directly to the child or to hospital personnel who work with the child. In center-based programs, the family brings the child to a center for direct or indirect services. The center may be at a hospital, school, day care center, clinic or other facility. Once there, families may work with their children under the guidance of specially trained professionals, or they may observe others working with their children. In some center-based programs, groups of parents meet to share concerns and provide support for one another. Other centers are organized primarily as referral sources for services available locally.

For students who do not need to be hospitalized, the choice is between home-based and center-based intervention programs, both of which have advantages and disadvantages. At home, the child learns in a natural environment surrounded by family members who often can spend more time working with the child at home than they can at a center. Problems associated with transportation, care of other children, and general family disruption are minimized when special education is carried out at home. Home-based programs, however, have several disadvantages, including the following:

14 Working With Families and Community Agencies

Success depends heavily on the family's cooperation.

Children from homes where both parents work or homes where there is one parent and that parent works may be less likely to receive special education at home.

Being at home limits opportunities for interaction with other adults and children.

A center-based approach provides varied types of help at a central location. Professionals from several disciplines, such as medicine, psychology, occupational therapy, speech and language pathology, and education, work together to assess and teach the child. The program benefits from periodic meetings to discuss progress and plan future interventions. The disadvantages of center-based intervention include the time and expense of transportation, the cost of maintaining a center, and the likelihood of less family involvement.

Regardless of which approach is taken (and many professionals combine them), the curriculum generally is the same. We teach young children with disabilities to improve their language, motor, self-help, communication, preacademic, and cognitive skills. We also try to improve their self-concepts, creativity, motivation to succeed, and general readiness for social interaction in school.

A generation ago, families of preschool children with disabilities were offered little help. Today, public special education is available from birth to age 21, and early childhood programs are a rapidly growing part of special education.

DOES EARLY INTERVENTION HELP?

Policy reports have regularly noted the cost-effectiveness and cost benefits derived from early intervention. For example, the Committee for Economic Development (1991) stated

Quality preschool programs clearly provide one of the most cost-effective strategies for lowering the drop out rate and helping at-risk children to become more effective learners and productive citizens. It has been shown that for every \$1 spent on a comprehensive and intensive

preschool program for the disadvantaged, society saves up to \$6 in the long-term costs of welfare, remedial education, teen pregnancy, and crime. (p. 28)

Head Start

Head Start is the most widely publicized and publicly recognized early intervention for children. It is designed to be used with those who are economically disadvantaged. In a study of the extent to which Head Start helped children, Lee, Schnur, and Brooks-Gunn (1988) demonstrated that children who participated in Head Start showed significant short-term gains but were still behind their peers in absolute cognitive levels after a year in the program. Currie and Thomas (1996) showed that Head Start is associated with large and significant gains in test scores among both whites and African Americans. Yet gains are quickly lost among African Americans.

Haskins (1989) wrote a cautionary paper arguing that research had shown that model preschool programs and Head Start have an immediate impact on the cognitive test scores and social development of students but that the gains diminish over the first few years of public schooling. He argues that "There is limited but provocative evidence that model programs may have positive effects on life success measures such as teen pregnancy, delinquency, welfare use, and employment, but there is virtually no evidence linking Head Start attendance with any of these variables" (p. 274). It may be very difficult to demonstrate direct links between preschool intervention and later life success, because it would be necessary to follow students for 20 or more years to answer the necessary cost-benefit questions. Most people would rather err in the direction of providing unnecessary yet nonharmful services than wait 20 years for evidence that the services had a beneficial effect.

Ypsilanti Perry Preschool Project

One of the most extensive evaluations of early childhood services was performed by analyzing the effects of the Ypsilanti

16 Working With Families and Community Agencies

Perry Preschool Project, a service for economically disadvantaged 3- and 4-year-old children in Ypsilanti, Michigan. It was shown that a substantial proportion of the costs for providing preschool services were recovered because children did not need such extensive special education support once they entered school. In addition, none of the graduates of the Perry Preschool Project required institutional placement. Perry Preschool graduates were also shown to have higher projected lifetime earnings than similar children who did not receive the services. The evaluation showed that early intervention resulted in a savings per child of \$14,819. Berrueta-Clement, Schweinhart, Barnett, Epstein, and Weikart (1984) reported that this amounted to a 243 percent return on original dollar investment.