FINAL REPORT
of the
MINNESOTA OCD-BEH COLLABORATIVE PROJECT FOR HEAD START CHILDREN WITH SPECIAL NEEDS

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(3) July, 1976 (4) 268 p. in v. p.

Although our colleagues, Dave Garwick, M.A., and Jon Boller, Ph.D., had left the Project staff prior to the preparation of this final report, we wish to acknowledge their equal participation in the majority of activities on which this report is based.

Also, in some instances, the written contents of this report are adapted, or taken verbatum, from materials which they had previously written.

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This Project was funded by the Department of Health, Education and Welfare, Office of Child Development, Grant No. 5118. Opinions expressed here do not necessarily reflect the official position of the Office of Child Development.

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SECTION I
INTRODUCTION

The purpose of this introductory section is twofold: 1) to provide some background to circumstances surrounding the origin of the Minnesota OCD-BEH Project; and 2) to trace the Project's early development and initial efforts to conceptualize a model of a statewide service delivery system.

ORIGINS OF THE PROJECT

A discussion of the OCD-BEH Project's origins and early development is presented not only to provide a frame of reference but also to afford the reader an opportunity to examine and evaluate the planning and decision-making process, and the outcomes of that process, which led to the models that were ultimately conceptualized, implemented, and evaluated. The effort to resolve the practical and conceptual problems which confronted the Project staff early on was a valuable learning experience for the staff, one that may have a good deal of relevance for others who find themselves facing similar situations. This is not to imply that the decisions made and the directions taken by the Project staff were necessarily the most appropriate. The reader must make this judgment and retain what seems useful while discarding or further evaluating that which is questionable.

Prior to 1972, Project Head Start and other programs (e.g., Home Start, Parent and Child Centers) under the auspices of the U.S. Office of Child Development did not have specific recruitment guidelines for the inclusion of handicapped children. Although some Head Start programs had enrolled handicapped children, it appeared that programs typically had not made a conscious effort to recruit children with severe handicapping conditions. In 1972, the U.S. Congress amended the Economic Opportunity Act with the mandate that Head Start must make no less than ten percent of its enrollment available to handicapped children. In order to monitor this nationwide enrollment figure, the Office of Child Development first mandated that each of the Office of Child Development regions throughout the country was to meet the "ten percent" figure. The interpretation currently is that each state Head Start/Home Start network must have at least ten percent of its enrollment comprised of handicapped children.

The intent of this legislation was that handicapped children were to be served in the same setting as non-handicapped children and that Head Start was to work in close cooperation with community based organizations in developing plans to expand Head Start services to preschool handicapped children. Handicapped, as defined in the legislation is, "...mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education and related services".

In June 1972, following the congressional mandate to Head Start, the Director of the Office of Child Development announced an experimental effort, "New Approaches to Providing Services to Handicapped Children", to begin in 1973. Subsequently, fourteen experimental projects located in different parts

of the country were funded by OCD. The overall goal for these projects was the development of replicable approaches or models for the integration of handicapped children into Head Start programs. The objectives for the accepted project proposal for the OCD-BEH Collaborative Project in Minnesota were developed through the combined efforts of the Minnesota Governor's Office of Economic Opportunity, the Minnesota Head Start Training and Technical Assistance Committee, an ad hoc advisory committee and with assistance from the Region V Office of Child Development and the UNISTAPS Project (an existing BEH Project in Minnesota). The Project was entitled the OCD-BEH Collaborative Project for Head Start Children with Special Needs. The BEH collaboration was to be with the UNISTAPS Project based in the Twin Cities.

The then Governor's Office of Economic Opportunity (SEOO), located in St. Paul, was named the grantee for the OCD-BEH Project. This office was also the grantee for the Minnesota Head Start Training and Technical Assistance Program which had been invited by the National OCD and National BEH to assume responsibility for developing the OCD-BEH Project in Minnesota. It was assumed that this combining and centralizing of programs would provide more coordinated, consistent delivery of services to the local Head Start programs. This assumption proved to be an extremely valid one as time went on.

The accepted project proposal generally reflected the experimental goals and objectives suggested by the National Office of Child Development. Basically, it outlined approaches for delivery of direct clinical services to handicapped Head Start children and their parents, and training/consultative services to Head Start personnel throughout the state. The proposal identified five types of handicapped children as the primary targets of the Project's services; these were---"speech impaired, hard of hearing, deaf, mentally retarded and seriously emotionally disturbed". The selection of these types of handicapping conditions had apparently been based mainly on an informal needs assessment by Minnesota Head Start directors. The directors and members of the committee who developed the proposal felt that children with these handicaps were most prevalent among enrolled handicapped children, and would be most prevalent if provisions were made for enrolling more handicapped children in Head Start.

The first three target types of handicapped children, i.e., speech impaired, hard of hearing, and deaf were to be provided direct services throughout Minnesota by two speech pathologists. Retarded and emotionally disturbed children in Minneapolis and St. Paul Head Start programs were to be served full time by one psychologist and part time by another psychologist who would also have administrative duties as the director of the OCD-BEH Project. The proposed direct service duties would have given the two Project speech pathologists each a caseload that was roughly estimated to be 130 children (and their parents) who would be attending Head Start programs scattered throughout all geographic areas of Minnesota. The two Project psychologists would share a caseload of approximately 25 Twin Cities Head Start children and their parents.

Although direct services (e.g., screening, assessment, treatment) to handicapped youngsters was to be the primary function of the four Project staff members, training and consultative services to Head Start personnel and parents, as well as coordinating efforts with other resource agencies were additional responsibilities of the staff. It was indicated that the psychologists should serve as consultants to outstate programs as time allowed and as problems

appeared in these programs. Other resource agencies were to be mobilized to provide direct service to Head Start children and training to staffs as situations demanded and service was available. Agencies suggested for this purpose were the Minnesota Department of Education, the UNISTAPS Project, Minnesota Department of Public Welfare, Minnesota Easter Seals, area mental health programs, and the Department of Public Health. To facilitate coordination, several of these agencies were to have representation on an advisory council for the OCD-BEH Project. (Head Start staff personnel and parents would also have representatives on the council, along with State Head Start Training and Technical Assistance Program representatives).

A final component of the Project staff's duties was evaluation. Evaluation was to be performed in two different ways : first, to determine achievement of objectives as written in the proposal and second, to assess the value of this overall approach to programming in meeting the needs of the handicapped child. It was implied that the latter type of evaluation would be conducted by independent evaluators, with input from Project staff and Minnesota Head Start personnel.

In making final comments on the duties of Project staff the drafters of the proposal did allow for some flexibility in terms of the actual means adopted to implement the proposed project---"specific methods of operating or meeting the goals of the program will also be determined by the staff that is recruited, utilizing their expertise in the most efficient manner".

This, then, was the charge to the four OCD-BEH Project staff members ultimately hired: to carry out (and evaluate) the above kinds of activities designed to accomplish objectives related to the overall goal of integrating handicapped children into regular Head Start programs. The focus of the activities was to be on provision of direct services to speech impaired, hard of hearing, deaf, mentally retarded, and seriously emotionally disturbed Head Start children. An estimated minimum of around 300 children would comprise the target population. Also considered as part of the total population were the parents of handicapped children and the staffs from the thirty-five Head Start programs (200 centers) in Minnesota. In numerical terms, the inclusion of these people in the target population multiplied several times the number in the total target group. Another relevant factor was that the people who made up a major portion of the proposed target population, i.e., speech and hearing impaired children, their parents and teachers, were predicted to be fairly evenly distributed geographically across hundreds of miles in Minnesota. The Project was to be truly a statewide effort.

EARLY DEVELOPMENT

The proposal for the OCD-BEH Project was approved and funded by the U.S. Office of Child Development in April of 1973. Project staff were hired at different intervals during the ensuing months, and year one, the planning year of the three year effort, was begun.

The staff's early days and weeks were devoted to studying the Project proposal; learning about the philosophies, goals, and organization of Head Start; getting to know Head Start personnel and children; investigating potential resources that might be mobilized for Head Start; and closely inspecting the map to get a feel for the logistics involved in implementing the plan

called for in the proposal. As this process progressed, the wisdom of housing the Project staff with the State Head Start Training and Technical Assistance staff soon became apparent. The knowledge and insights of this staff, were, and continued to be, invaluable to the Project personnel. In addition, the opportunity afforded for, and the necessity of, coordination of activities conducted by both groups was evident early on.

On-site services to Head Start programs were first provided to the two programs in Minneapolis and St. Paul. This was a somewhat fortuitous circumstance since the first staff member to actually begin working for the Project happened to also be the psychologist who was to work full time with the Minneapolis and St. Paul programs. This circumstance is mentioned because it had some bearing on the directions which the Project eventually took.

In addition to becoming acquainted with Twin City Head Start personnel and program operations, the initial activities of the Project psychologist focused to a great extent on resource mobilization. This was seen as an attempt to play a supportive and facilitating role with the two Head Start programs which had already begun to seek out additional resources to help meet the handicap mandate. As other Project staff were hired, some of their first experiences were also involved in this effort. These experiences enabled the staff to begin assessing the amount and type of service that would be required of Project staff versus the amount and type of service that could be provided by other resource agencies in the metropolitan area. Because it appeared that many previously untapped resources could be mobilized by Head Start and that service which had been obtained in the past could be expanded, this effort continued with the metropolitan programs throughout the first year of the Project. Increasing numbers of psychologists, social workers, speech clinicians, nurses, special educators and other clinical specialists from a variety of agencies provided a wide range of direct, training, and consultative services to the metropolitan programs during the first year.

While continuing to facilitate greater resource mobilization, the Project psychologist who worked with the Twin Cities Head Start programs began to assist one of these programs in developing a case management team approach to working with special needs children. Some staff members of this program expressed the concern that because of the broad-based nature of the program there was a need for greater communication and organization among staff when attempting to meet the individual needs of children and their families. In this particular program there was, in addition to the director, a coordinator for each of the four program components universal to all Head Start programs, i.e., education, health service, social service, and parent involvement. The coordinators, plus a staff speech pathologist and the program's teachers were all included on the team.

The case management team approach was viewed as a method of using existing staff to mobilize services from community resources, to accomplish the screening of children, to make appropriate referrals for diagnosis and treatment, to plan the overall management of a child's program, and to help ensure that all people directly involved with a child and his/her family knew what was happening with that child at all times. By way of this process, it was assumed that the ultimate objective of "classroom integration" would be better achieved. With assistance from the Project psychologist, this case management team approach began to evolve and show promise during the first year.

Other early developments paralleled those described above. As the Project staff went through the process of becoming familiar with the organization of Minnesota Head Start and its operations, explanations regarding the Project's plans were sought by statewide Head Start committees, councils, and associations. Agencies which were involved in the original grant proposal (e.g., Crippled Children Services and Minnesota Easter Seal Society) asked for updates and explanations of plans. The initial efforts of staff to explain the Project model to these, and other agencies, as well as advocacy with professional groups, eventually led to the awareness that Project staff would need to continue relating to many people outside of Head Start. Such activities had potential as a means by which the staff could advocate for additional services for Head Start children, families, and staff.

As the first year progressed, more and more requests were made by Head Start programs for training from the Project staff. A decision was made to begin offering workshops to Head Start personnel around the state. The rationale for this decision was that conducting workshops would be an appropriate response to requests for training and, at the same time, be a means by which Project staff could become acquainted with Head Start personnel throughout the state. This would also provide an opportunity to begin assessing how Head Start teachers, other staff, and parents perceived their own needs related to understanding, and working with, handicapped children.

Two series of cluster workshops were conducted during January and March of the first Project year. The first series was conducted in eight different locations in Minnesota, as was the second series which dealt with different content material. Because of the type of training which had been requested, both the speech pathologists and psychologists joined in the planning and presentation of the workshops. The appropriateness of this decision became evident in small group workshop activities where the participants' questions reflected at least as many concerns with behavior and emotional problems of children as with speech/language related problems. These workshop experiences and other discussions with Head Start personnel raised questions about the validity of the informal needs assessment findings which apparently had served as much of the basis for designing the original Project proposal. It appeared that the incidence of various handicapping conditions was somewhat more evenly distributed among enrolled Head Start children in outstate and metropolitan areas than the informal needs assessment had indicated. Certainly the concerns of teachers and other staff did not support the notion of distinctly different types of handicapping conditions.

Consequently, the Project staff began to reconsider the design of the original proposal, both in terms of services to be provided and staff to be deployed. Also contributing to this re-thinking of service provision and staff deployment was the fact that the number of Head Start programs, staffs, and children was much greater outstate than in the Twin Cities. If the Project actually was to explore ways of serving the entire state, as seemed to be one intent of the individuals who drafted the original proposal, the uneven distribution of outstate versus Twin Cities programs,as well as travel factors, would have to be taken into account.

INITIAL EFFORTS TO CONCEPTUALIZE A STATEWIDE SERVICE DELIVERY SYSTEM

As the planning year progressed, several key issues/questions confronted the staff:

-Given the unrealistic expectation that two speech pathologists could provide direct services to speech/language impaired Head Start children throughout Minnesota, what kind of service delivery model would be a viable alternative?

-Given the reported statewide needs for Head Start staff training and other kinds of service, not only in speech/language areas, but in many other areas as well, what kind of role should the Project psychologists assume in helping to meet these needs?

-Given the positive response of Head Start participants to the statewide cluster workshops, should this training vehicle be retained during the ensuing two years of the Project?

-Given the demonstrated potential for increased mobilization of specialists' services should the Project staff attempt to facilitate an increase in services in other areas of the state?

-Given the promise of the case management team concept evidenced in one Head Start program, could the Project staff utilize this concept in its efforts to work with other Head Start programs?

These questions and related issues were carefully considered and analyzed by the Project staff, with input from the Project's Advisory Council, several Minnesota Head Start personnel, regional and national OCD personnel and State Head Start training officers. As a result of this analysis, a rudimentary model was conceived describing a system by which a small interdisciplinary group of clinical specialists, physically housed in one location in the state, could provide training, consultative, and advocacy services to Head Start and Home Start programs throughout the entire state. The primary focus of these services would be on the development of supportive service systems for children, parents, and teachers at each Head Start/Home Start program. More specifically, the staffs of these programs would receive training and consultation in methods of organizing case management teams and mobilizing the services of clinical specialists in the community or surrounding areas. The system also provided for teacher and parent training dealing with specific handicapping conditions but this training would receive less emphasis. An additional component of the system called for the Project staff to make advocacy contacts with professional individuals and groups and to develop linkages with other centralized coordinators of statewide service systems to help bring about increased local specialist services to Head Start/Home Start programs.

The conceptual framework of this system was derived to some extent from the work of Tharp and Wetzel (1969). The Project did not employ a systematic behavior modification approach as did Tharp and Wetzel. However, it did adopt an organizational structure similar to the one described by these investigators.

Their training-consultative "triadic" model was viewed as a more viable alternative to the dyadic model in which the professional specialist interacts directly with the child (or other targets of behavioral change). As the specialists on the Project staff conceptualized the triadic organization, the majority of their training and consultative efforts would be directed toward a small group of coordinator level personnel in each Head Start/Home Start agency and, to a lesser degree, toward teachers and parents. The coordinator level personnel would be trained in case management team techniques and would then act as "mediators"* to effect the management and integration of special needs children. The mediators would draw upon local and regional resources for direct services and additional training and consultative services. Part of the rationale for adopting this type of approach was similar in many respects to that offered by Tharp and Wetzel and others (e.g., Schofield, 1964), i.e., extremely poor Project staff-to-child (and teacher) ratios, prohibitive travel factors, equivical evidence regarding generalization of behavioral change from the therapeutic dyad setting to the natural environment, etc.

RATIONALE FOR THE MEDIATOR TEAM CONCEPT

The promise demonstrated in first year pilot efforts to mobilize resources and develop the case management team approach provided empirical support for this aspect of the service delivery approach. Beyond the data obtained from pilot efforts, the decision to focus on case management team development and specialist service mobilization found support in the special education literature (e.g., Hobbs, 1975, Kaufman, Semmel and Agard, 1973). Simply placing a handicapped, or special needs, child in a setting with normal children does not guarantee that the child will experience successful integration. Kaufman, et.al., suggest that there must also be provision for planning between regular teachers and special education personnel, and there should be a special education support system to help insure that handicapped children are successfully maintained in regular educational settings. Even in situations where the handicapped child relates well to his normal peers and engages in many of the on-going activities of the entire group, it is important that a process or system be available which allows for the child's special needs and strengths to be periodically assessed by appropriate clinical specialists. The child's teacher and parent should also receive specialist support and guidance in planning and implementing educational and other programs for the child. (The Minnesota Department of Education, Special Education Section, has recently (1975) published guidelines for services to handicapped preschool children which also reflects the rationale outlined above).

It was believed that the establishment of a support system for special needs children, their parents, and teachers should have a firm organizational base within the Head Start program itself. The case management team, i.e., the "Mediator Team", comprised of both coordinator level staff and teachers would provide this base, with consultative and direct services from local specialists completing the support system. Several factors contributed to the rationale for this approach. First, it appeared to the Project staff that Head Start and Home Start staffs typically were unfamiliar with systematic methods of case management of children and its many facets, e.g., making appropriate referrals, insuring follow-up by clinical specialists, developing efficient and helpful record keeping procedures, etc..

*The term "mediator" does not have the same definition as used by Tharp and Wetzel, although there are similarities. "Mediator Team" was the designation chosen for the Head Start case management team concept.

Second, despite the fact that various professional specialties (e.g., nursing, special education, early childhood education, etc.), were often represented on coordinator level Head Start/Home Start staffs, it seemed that the job descriptions of these people usually allowed little time for on-going advisory or consultative contacts with teachers. Thus, the case management team was viewed as a vehicle that could facilitate greater utilization of the expertise available within programs. The enhancement of communication, generally, was also seen as a need that could be met to a greater extent by the team process.

Third, it was considered unlikely, at that point in time, that many resource facilities outside of Head Start/Home Start, e.g., mental health centers, public schools, hospital clinics, etc., would be inclined, or able, to assume responsibility for helping to develop case management systems which would be designed primarily for use with Head Start and Home Start staff. It has often been the case that Head Start and Home Start programs are asked to sit in on team staffings conducted by individual resource agencies, but this system, although potentially valuable, may do little to assist programs in developing their own organizational structure for on-going management and service to all special needs children and to their families.

Fourth, the case management team approach was seen as a vehicle that could assist programs in better organizing and implementing such things as systematic screening programs for all children, educational programming for all children, procedures for transferring information to a child's next educational setting, programs for parent involvement, in-service training programs, etc. In sum, it was felt that the case management team approach could potentially help programs to be more effective in their efforts to meet the performance standards established by the National Office of Child Development.

It should be pointed out that some of the above factors were not completely evident by the end of the Project planning year. Certain aspects became more apparent as the demonstration process began and the Mediator Team model continued to evolve.

This, then, was the overall system or model of service delivery which the OCD-BEH Project staff set out to demonstrate in Minnesota during the Project's second year, 1974-75. The staff would attempt to work with all 35 Head Start/Home Start programs in the state, including the six Indian Community Action Agencies that had Head Start programs. The major focus would be on training and consulting in the area of case management and its corollary function, mobilizing specialist services. Complementing this effort would be Project staff's advocacy activities with potential service providers at local, regional, and state levels. Finally, some cluster workshop training about specific handicapping conditions would be offered to program staff and to some parents.

The ultimate target group for these services would not be limited to just those children with certain types of handicapping conditions. Rather, the goal was to help programs find methods of providing comprehensive health, educational, and social services to special needs children, regardless of the type of disability or degree of severity. This is not to say that the intent

of the Handicap Mandate was to be minimized. It simply reflects the conviction held by Project staff that all special needs children could potentially benefit if program personnel acquired new or improved skills in the areas of resource mobilization and case management.

Although many questions remained unanswered at this point, the Project staff felt that this type of delivery system held promise. It seemed that such a system could enable the small Project staff to have a significant impact on many Minnesota Head Start/Home Start programs, and hopefully, would result in viable models and materials that would have relevance for service providers and Head Start/Home Start programs elsewhere.

Certainly, other directions might have been taken. Different models could have been demonstrated, and, perhaps, a smaller number of programs could have comprised the target group. However, despite the fact that Project staff made substantial alterations in the design outlined in the original proposal, the staff and others (i.e., the Head Start Training Officers, the Advisory Council members, state Head Start personnel, and representatives from regional and national OCD) felt that the statewide focus should be retained -- hence, the evolution of the proposed statewide service delivery system. In the spring of 1974, a work plan describing the new directions was approved by OCD, and the Project staff prepared to embark on the second year demonstration activities.

SECTION II
DEMONSTRATION ACTIVITIES IN MINNESOTA--PROJECT YEAR 2

The intent of this section is to give the reader a general understanding of the nature of activities engaged in by Project staff to demonstrate the statewide service delivery system and the Mediator Team model in Minnesota.

As the second Project year began, the staff had two closely related, broad objectives which, if accomplished, would presumably help contribute to the overall goal of successful integration of special needs Head Start/ Home Start children into settings with normal children. These objectives were; 1) improvement in case management procedures among program personnel and 2) increased specialist services to special needs children, their parents, and their teachers. More specific objectives were as follow:

1) establishment of case management teams by Head Start/ Home Start programs

2) demonstrated improvement, both quantitative and qualitative, in programs' case management procedures in the following areas:

   a) obtaining comprehensive screening of all children

   b) obtaining comprehensive professional assessments of all suspected special needs children

   c) obtaining appropriate supportive services for teachers in planning and implementing educational/integrated experiences for special needs children

   d) making arrangements to ensure continuity of services to special needs children when they go to their next educational setting

   e) securing greater involvement of parents in decision-making, planning, and intervention processes

3) delivery of services to programs by increased numbers of clinical specialists

4) delivery of a broader range of services to programs by clinical specialists

5) delivery of increased services by clinical specialists on-site at centers and/or children's homes

It should be pointed out that the Project staff hoped the programs would come to realize the value of organizing a case management team approach to better meet case management and resource mobilization objectives. However, rejection of this organizational vehicle would not preclude assistance

by Project staff. Programs would still receive training, consultative, and advocacy services related to case management and resource mobilization objectives 2-5.

In pursuit of the above objectives, the Project staff established several process objectives to be met while carrying out demonstration activities during year two:

1) to develop a handbook that would describe concepts and approaches related to case management and resource mobilization

2) to offer an intensive workshop on case management, resource mobilization, and related areas to representatives from all 35 Minnesota Head Start/ Home Start programs

3) to make at least three full-day, on-site consulting visits during the year to each of the 35 programs--the purpose of these visits would be to help establish and guide the case management team process

4) to follow-up on consulting visits with phone and/or written communication to programs

5) to make advocacy contacts with potential service providers (at local, regional, and state levels) when appropriate and as time allowed

6) to offer two cluster workshop series, at various locations in the state, for Head Start/Home Start teachers, other staff, and parents--the content of these workshops would adhere to previously expressed needs of participants, but would also address the case management team concept and parent involvement

7) to keep all internal Head Start/Home Start organizations and advisory groups informed of Project activities and objectives

8) to offer a second workshop, toward the end of the program year, to all 35 programs--this workshop would deal with arranging the transition of special needs children from Head Start/Home Start to the next educational setting

9) to initiate efforts to evaluate the demonstration outcome objectives

10) to contract with an independant agency for an evaluation of the integration of special needs children into Minnesota Head Start programs

At this point, Project staff activities during year two will be presented in chronological order. However, training and consultative activities will first be described, with advocacy efforts being presented separately.

Unfortunately, detailed discussion of every activity engaged in by the staff is beyond the scope of this report. The intent here is to give the reader some understanding of how the statewide service delivery system, with its training, consultative, and advocacy components, was implemented.

Project Year Two--Summer, 1974. The staff's first major activity involved the conceptualizing and writing of a document entitled the Mediator's Handbook. Based to a great extent on staff experiences with the two Twin Cities Head Start programs, this Handbook described methods by which Head Start/Home Start programs could organize a case management team, carry out case management procedures, mobilize community resources, and engage in other functions relevant to serving special needs children and their families. (To obtain a clearer picture of the staff's conceptualization of possible team structures and functions at this point in time, the reader is referred to the first 42 pages of the original Mediator's Handbook.)

The Handbook and its contents were first introduced to Head Start/Home Start programs at a three-day workshop with statewide participation. (The planning and facilitating roles played by the Head Start State Training Officers were particularily helpful in this first major training effort.) Despite the fact that the Project staff had no authority to require program personnel to participate and the fact that the workshop was held in the middle of summer vacation, 24 programs had representatives in attendance. It appeared that the decision to offer cluster workshops throughout the state during the previous project year had paid off in terms of public relations. The response of participants to the workshop presentation was basically positive, and the Project staff were further encouraged about the potential of their service delivery model. (For a more detailed description of the workshop presentation and evaluation, see Appendix 1.)

Another relevant training activity during the summer of 1974 was a one day workshop presentation to the state Head Start Parent's Organization. The main purpose of this presentation was to familiarize the entire parent organization with the Project and its proposed approach to working with programs across the state.

Finally, the staff taught two courses for some Head Start and Home Start teachers at the University of Minnesota at Morris during the summer of 1974. Although the courses did deal with special needs children, the staff had questioned the appropriateness of this activity in relation to the overall plan for service delivery to the entire state. However, staff members were ultimately convinced by State Training Officers and others that, from a public relations standpoint, it was important to honor the request to teach these courses. This point is mentioned simply to illustrate the fact that Project staff had to be concerned about public relations and had to relate to, and rely on, several people in order to gain insights into this issue, as well as many others.

Also related to this point is the fact that, in retrospect, it seems that there was always some confusion about what constituted an appropriate activity for an experimental, demonstration Project versus an appropriate activity for a strictly service providing agency. It would probably be accurate to say that the distinction between these two types of activities

was never completely clear in the minds of consumers, staff in the grantee agency which housed the Project, representatives of regional and national OCD, and Project staff, themselves.

Fall, 1974. Consistent with the Project's objective to make three consulting visits to each program during 1974-75 the first round of visits was initiated in late September, 1974 and completed by November, 1974.

The purpose of the first visit was to assist programs in their efforts to establish a case management team, i.e., "Mediator Team", and carry out the "initial functions" which were outlined in the Mediator's Handbook (see pages 12-30 in the original Handbook--also see Appendix 2 for a copy of the form sent to all programs indicating the areas to hopefully be covered during the first consulting visits). Those eleven (11) programs which had not attended the summer workshop and, therefore, had not received a Handbook were sent Handbooks prior to the opening of centers in the fall. It was hoped that these programs would be willing to work with Project staff to utilize the Handbook even though they had not been present at the introductory workshop.

The Project staff was divided into teams of two, one psychologist and one speech pathologist on each team. Each team visited one half of the programs, one team visiting those programs in the southern half of the state and other team visiting those programs in the northern half. Based on previous experience and on evidence accumulated by others (e.g., Davis and McCallon, 1974), this team approach seemed to offer promise of more effective consultation visits than did visits by a single staff person. Because there was so much to accomplish and so many people to deal with during visits, it was felt that "two heads would be better than one". Also, it was hoped that the two staff members could provide a model of teamwork which would have some impact on program personnel (this, in fact, was frequently perceived and commented upon by several people). It was not always possible for both team members to make visits, but this arrangement held in the majority of cases.

In order to give direction to the consultation and to provide some continuity between the approaches of the two Project teams, data forms were developed (see Appendix 3). These forms were used to guide discussions with program staffs and to document information obtained from the discussions. Recommendations were also written on these forms and copies were left with programs.

Since there were so many programs to visit and such great distances to travel, programs often had to be asked to re-arrange their schedules to meet the travel schedules of Project staff. Therefore, it was often not possible to meet with entire staffs or entire Mediator Teams (if they had been formed). The staff usually met with only a few coordinator level personnel and usually with the same people who had attended the summer introductory workshop. As time went on, it became obvious that these were not optimum circumstances for consultation, but it was often difficult to alter the situation. This issue will be addressed later in the report.

The major training activity in the fall of 1974 was the first of two workshop series which had been planned for the year. From the end of November until the middle of December nine one-day workshops were presented in strategic locations throughout the state. Workshop sites were chosen so that the

majority of people would have to travel no more than 70 miles.

Teachers, other staff, and parents of special needs Head Start/Home Start children were invited to these workshops. Program personnel were strongly encouraged to bring parents. Based on the workshop experiences from the previous year, it was felt that combined staff and parent participation was workable and afforded opportunities to facilitate greater parent involvement and improved staff-parent relations. (See Appendix 4 for a copy of the letter announcing this workshop.)

This first workshop series focused on various uses of developmental behavior checklists and prescriptive teaching programs. After the round of consulting visits, it appeared that an introduction to these kinds of tools might be one way of addressing the expressed needs of programs for more systematic methods of identifying special needs children, determining instructional levels of these children, developing intervention programs, and giving direction to parents of special needs children. The somewhat limited objective of the Project staff for this workshop series was to familiarize participants with available behavior checklists and prescriptive teaching programs and the possible uses of these tools. (See Appendix 5 for a copy of the handout materials given to participants)

Whenever possible during these workshops the Project presenters (these workshops were also conducted by two or more staff) would relate the presentation or discussion to case management and the Mediator Team concept. This was the first opportunity for staff to describe the Mediator Team approach to many teachers and parents who had not been present at the summer workshop, the parent's organization workshop, or at consulting visits. It later became evident that this exposure seemed to be a factor in some programs moving more rapidly toward full implementation of the team approach--teachers and some parents in those programs pushed for it!

Before further describing training and consultative activities, it should be mentioned that numerous follow-up contacts, phone and written, were made with several programs after the first consulting visits and throughout the remainder of the year. It was clear that this was a crucial activity, both in terms of providing assistance per se and in demonstrating to program personnel that Project staff were committed to helping and would be available to deal with problems even if they weren't able to be physically present very often.

Winter, 1975. The second round of consulting visits began in mid-January and ended at the end of February (incredibly enough, the Minnesota weather caused postponement of only a few visits). The major thrust of these visits was to give further direction to the Mediator Teams (where they existed) in conducting team meetings and to generally help programs carry out the various case management functions outlined in the original Handbook. (See Appendix 6 for a copy of the letter sent to programs prior to the second visit and Appendix 7 for a copy of the form which Project staff used to guide their discussions, document information obtained, and write recommendations to be left with programs.)

The second workshop series for teachers, other staff, and parents was conducted during March of 1975. This series dealt with the hearing impaired child and "hyperactive" child. These topics were chosen because of the numerous questions related to these areas that had been raised during consulting

visits. As in the first workshop series, efforts were made to point out the role of a Mediator Team in providing appropriate services to children with special needs, in this case, hearing impaired and highly active children. (See Appendices 8 and 9 for copies of the letter announcing the workshops and handout materials given to participants.)

Project staff had arranged with various educational institutions to offer academic credit to those workshop participants who were enrolled in the institutions' CDA programs. Participants had to attend both the fall and winter workshops to obtain one credit.

An additional major activity engaged in during this time period was the staff's contribution to the planning and conducting of a statewide workshop dealing with topics related to the health component of Head Start/ Home Start programming. This was viewed primarily as an advocacy function and will be further described in that part of the report dealing with advocacy activities.

Spring, 1975. The third, and final, round of consulting visits took place from the middle of April until the end of May. These visits were devoted to 1) consultation regarding methods of arranging for a successful transition of Head Start/Home Start special needs children to their next educational setting; 2) reviewing the overall case management of special needs children; and 3) obtaining data related to service delivery by local clinical specialists. (See Appendices 10 and 11 for copies of the letter announcing the visit and forms used by Project staff to guide discussions and gather data.)

Although the staff had planned to conduct its second statewide workshop earlier in the spring, time did not permit this to occur. Therefore, the issue of transition of special needs children to their next educational setting, which had been the proposed workshop topic, had to be addressed primarily during the third round of consulting visits. The statewide workshop could not be held until the first part of June when most programs had closed their centers for the summer. Thus, the content to be presented was altered.

Another factor contributing to the change in content was the fact that the Project had been given very different directions for the upcoming year, project year three, by regional and national OCD. With the exception of only a few programs, the Project staff would no longer be working with Minnesota programs during the third year. Consequently, this final workshop for all 35 programs was partially viewed as an opportunity to review the year-long demonstration effort in Minnesota, to present some evaluation findings, and to commend the program staffs for their cooperation and achievements during the year of working with the Project.

The Project staff did also address "transition" and the broader issue of improving relations between Head Start/Home Start and public schools. To this end, state Department of Education personnel, special Education Regional Consultants, and public school people were invited to participate in the various workshop activities designed to explore possible methods of enhancing Head Start-public school relations.

This completes the description of training and consultative activities carried out during the second Project year. Advocacy activities will be presented next.

Advocacy Activities, 1974-75. Before moving directly into the advocacy activities of the second year, a brief overview of this component of the statewide service delivery systems will be presented.

During the entire course of the Project, liaisons were developed and maintained with numberous public and private agencies, advocacy bodies, and professional groups. Initially, an overriding feature of agency and professional contacts was the raising of consciousness that Head Start was a large, viable network of preschool programs in Minnesota. It appeared that the demise of several Office of Economic Opportunity projects had led many people to generalize that Head Start was also being phased out. It was obvious that these people were in positions or locations where they had not come in contact with Head Start personnel for some time or had never been in contact. In addition to this general consciousness raising, it was necessary to inform various potential service providers about the federal mandate that Head Start was to provide a minimum of ten percent of its enrollment slots to handicapped children. Some of these people did know about the mandate and seriously questioned the wisdom of it. When this issue was raised, Project staff usually acknowledged that some reservations about the mandate were probably valid. However, staff also expressed their conviction that many Head Start/Home Start programs would be appropriate placements for children with handicapping conditions and less severe special needs, who could benefit from experiences with normal children, particularily when no other programs were available.

There were two basic levels of advocacy activities. One level involved direct recruitment efforts with individual professionals, professional groups, and agencies who might provide new or expanded direct services to Head Start/Home Start programs at little or no cost. (Unfortunately, when the mandate was first made, Congress did not allocate extra monies to implement it. Thus, programs were to continue to rely on securing in-kind services from other community agencies. This had always been one of the fundamental percepts of the drafters of Head Start philosophy and policy, but Project staff heard sometimes that people outside of Head Start thought that these "federally funded" programs would have ample money to pay for services.)

The other type of advocacy involved working with state agencies, planning groups, and advocacy councils which were charged with responsibilities such as 1) identifying handicapped children (e.g., Early and Periodic Screening, Diagnosis, and Treatment); 2) Supervising and coordinating direct services (e.g., Division of Special and Compensatory Education, State Department of Education), or 3) acting as a broad based advocacy body for all handicapped individuals and their parents or guardians (e.g., Minnesota State Council for the Handicapped).

Initially, this scope of advocacy was not foreseen by the Project grant writers or the Project staff. It was not until the staff began first year pilot efforts to assist the Minneapolis and St. Paul Head Start programs in their attempts to recruit specialist services that the potential benefits of a significant advocacy effort began to be realized. Another

set of factors also prompted Project staff to place a high priority on advocacy. Because of the Project's collaborative involvement with the BEH-UNISTAPS Project (described later in this section) a Project staff member was invited to be a member of the UNISTAPS Advisory Council. The collaborative effort was subject to the review of that advisory council and, thereby, was brought to the attention of several august members of the special education community in Minnesota. The Project's own advisory council was composed of special educators as well as other education personnel. All of these inter-connections led to several invitations to Project staff to become members of planning, advisory, and advocacy councils. Inherent in the acceptance of these invitations was the expectation that Project staff would have an opportunity to be a "voice" for Minnesota Head Start/Home Start special needs children, their families, and the programs serving them.

The outline below reflects some of the specific types of advocacy activities engaged in by Project staff during year two to compliment the training and consultative component activities of the statewide service delivery system. In some instances, observable outcomes of an activity are mentioned. Resource mobilization outcomes will be discussed in much greater detail in Section III.

1) Submitted articles to journals and newsletters of state professional associations. These articles introduced the Project, discussed the Handicap Mandate, and called for increased services from the members of the professional organizations. (See Appendix 12 for an example of one of these articles.)

2) Met with local service providers whenever possible during on-site consulting visits to Head Start/Home Start programs. These contacts took place in the presence of program personnel or, with their permission, were made independently by Project staff. These service providers came from settings such as public schools, mental health centers, hospitals, rehatilitation centers, etc. The specialists were asked to provide services to programs and to consider expanding their services beyond the traditional one-to-one diagnosis/treatment role. As illustrated in the original Mediator's Handbook (see pp. 13-27), they were encouraged to come on-site and observe, consult with teachers, perform screening and diagnostic roles, consult with parents, provide in-service training meet with the Mediator Team, etc. A good deal of attention was also devoted to suggesting ways in which specialists could provide these services despite their other committments and time constraints. On-site services were emphasized during these advocacy visits, as they were when training the Head Start/Home Start staffs, because of the Project staff's conviction that such services would result in a stronger support system for a program's children, parents and teachers.

3) Made numerous phone and written contacts with potential service providers when face-to-face meetings were not possible or when follow-up to meetings was required.

4) Participated on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Advisory Council. One observable outcome of the participation on this Council was that Head Start coordinator staffs were specifically invited to join in the planning of EPSDT clinics in several counties in different areas of Minnesota. Head Start children will be among the first to benefit from these clinics.

5) Made numerous direct contacts with State Department of Health personnel in units other than EPSDT. These were Crippled Childrens Services and the Vision and Hearing Screening Program. These contacts facilitated specific arrangements between the Department of Health personnel and individual Head Start/ Home Start programs.

6) Held a general meeting with administrative and consultant personnel in the Minnesota Department of Education, Special and Compensatory Education Section. From this meeting the Project received endorsement and backing to aggressively request that public school special education personnel provide services to eligible Head Start/ Home Start children. Even though state law mandated many special education services to most handicapped four year old children, many eligible Head Start children had not been receiving these services prior to the 1974-75 program year.

7) Made a presentation at a meeting of supervisors of all clinical speech programs in Minnesota public schools. This presentation had resulted from the contacts with the Special Education Section mentioned above.

8) Invited public school special educators, and other specialists, to attend Project workshops. For instance, Special Education Regional Consultants and other Department of Education consultants were invited to participate in the two large, statewide workshops for Head Start/Home Start staffs. Local specialists also attended several of the cluster workshops held in various locations in the state.

9) Contributed to the organization and presentation of a "Health Roundtable", a two day workshop for Head Start/Home Start directors and health coordinators. Contributors brought to the Roundtable included: a Region V American Acadamy of Pediatrics Consultant; a Region V Dental Consultant; others from Minnesota agencies such as Day Care Licensing, Maternal and Child Health, Early and Periodic Screening, Diagnosis and Treatment, and Crippled Childrens Services.

10) Facilitated some local collaborations between Head Start and Day Activity Centers. This was accomplished by individual and group sessions between the Project staff and staff of the Minnesota Association for Retarded Citizens. The result of this effort was a "sharing" of some developmentally disabled children by the Day Activity Centers and Head Start programs and a sharing of some specialists who were directly involved in making educational and treatment plans for these children. The children involved were deemed ready for some exposure to an integrated setting in regular classrooms.

11) Conducted a special workshop with Head Start teachers ans speech clinicians from the local school district in which the Head Start program was located. The purpose of this workshop was to explore the goals and the clinical and teaching roles both groups do or could assume. The process resulted in a proposed expansion of roles for both teachers and speech clinicians. (See Appendix 13 for an in-depth outline of the process.)

12) Participated on the Minnesota State Council for the Handicapped, which has the functions of determining the needs of handicapped individuals of all ages in Minnesota and then making legislative and policy recommendations to the Governor. Other staff members participated on task forces (Task Force on Communicative Disorders; Task Force on Service Delivery Systems). These efforts undoubtedly had more long range effects rather than the specific effect of recruitment of specialists to work with Head Start. One future effect of the Council's task force efforts will be mandatory special services by school districts to all handicapped children beginning at age four, as opposed to the previous exclusion from services of four year olds with certain types of handicapping conditions.

13) One staff person also participated for a time on the state Development Disabilities Planning Council which collaborates with the Minnesota State Council for the Handicapped to make recommendations to the governor.

14) Supervised school psychology graduate students from the University of Minnesota who had practicum placements in one metropolitan Head Start program.

15) Published a newsletter, the "Mediator Media", which was mailed to all regional special education consultants and local directors of special education, other types of service providers, and Head Start/Home Start personnel. This newsletter described, among other things, the types of collaboration and delivery of service which were taking place around the state. One intent of the newsletter was exchange of information among Head Start/Home Start personnel, but

it also served the function of illustrating to service providers that various kinds of new or expanded service were possible. (See Appendix 14 for copies of the "Mediator Media".)

16) Involvement in a joint effort between the Minnesota Association for the Education of Young Children and the Center for Early Education and Development at the University of Minnesota to begin the task of coordinating training for early childhood educators in Minnesota. One of the priority issues was the need for developing and coordinating training related to working with handicapped children.

The above outline does not contain an exhaustive listing of the advocacy functions performed by Project staff during 1974-75, but the reader should be able to derive a feeling for the rather extensive scope of this component of the statewide service delivery system.

Summary of demonstration activities, 1974-75. At the end of Project year two, staff members felt that the majority of objectives which they had established for themselves had been satisfactorily met. Although the spring workshop was conducted later than planned, all of the proposed workshops had been given and some additional ones had been added. Of 105 possible consulting visits to programs (three visits to each of the 35 programs) 100 were actually accomplished. This figure does not include additional visits, i.e., beyond the initial three, which were made to some programs. Advocacy activities were engaged in to an even greater extent than had been foreseen by staff at the beginning of the second year. At least 450 person days had been spent directly involved in these three component activities, and the combined distances traveled by staff totalled many thousands of miles.

Evaluation of demonstration outcome objectives had also been initiated as planned (the approaches to evaluation will be described further in the sections on outcomes). However, as the Project staff attempted to monitor and evaluate both its own activities and those of the immediate target group, i.e., the Head Start/Home Start staffs, the difficulties of conducting a large scale demonstration effort and simultaniously engaging in rigorous evaluation research became increasingly apparent. This was particularly evident when Project staff made on-site consultation visits to programs. Although a great deal of planning went into determining the types of data to be obtained and how to collect it, the staff usually found that there was not enough time available for both extensive, systematic data collection and consultation during on-site visits to programs. The "press" to provide assistance regarding the implementation of the Mediator Team and related matters was simply too great. Yet, despite these difficulties in evaluating some aspects of the year long demonstration effort, data which were obtained yielded positive results in several areas. These results are presented in following sections on outcomes.

Unfortunately, upon receiving new directions for Project year three from OCD, the staff realized that the opportunity to go beyond these first attempts to demonstrate and evaluate the statewide system would be greatly diminished. Future demonstration and evaluation would have to focus largely on the Mediator Team model only and not on the broader service delivery system.

It also should be mentioned here that an independent agency was given a contract to evaluate the process of integrating handicapped children into Minnesota Head Start programs. Findings of this evaluation are presented in Section VI.

Collaboration with the BEH-UNISTAPS Project. Before moving to the sections on evaluation results, the collaborative efforts between the Project staff and the Twin Cities based BEH Project, UNISTAPS, will be described. A few of these activities have already been touched upon but have not been specifically identified as collaborations with UNISTAPS.

As the National Office of Child Development conceived the experimental/demonstration effort, "New Approaches to Providing Services to Handicapped Children," a collaborative effort was begun between the Office of Child Development and the Bureau of Education for the Handicapped. A few of the projects which were accepted under the experimental/demonstration effort were funded jointly by OCD and BEH. Although the Minnesota OCD-BEH Collaborative Project title contains the names of both agencies, in fact the collaboration was not financial. National OCD and BEH officers asked that the collaboration come abouth through joint work efforts between the OCD-BEH Project and the BEH funded UNISTAPS Project located in the Twin Cities.

By way of description, the UNISTAPS Project operates at two different levels. One level of operation is within the Special and Compensatory Education Section of the Minnesota Department of Education. In this Section, the UNISTAPS Director has the roles of consultant and planner for special education services to preschool age children. A colleague in the Section has the role of interagency coordination and advocacy for preschool handicapped children. The second level of UNISTAPS operation is a laboratory program located within the Minneapolis Public Schools to provide services to noncategorical, low incidence handicapped children and their families.

OCD-BEH/UNISTAPS Collaboration, year one. The specifics of the OCD-BEH/UNISTAPS collaboration were not spelled-out in the original proposal and first year work plan. The Project did invite the director of the UNISTAPS Project to be a member of its advisory council. Project staff and the UNISTAPS laboratory program staff did meet towards the end of year one and composed a list of eleven specific suggestions for collaboration. However, by the end of year one, only one of these items was made operational:

> The coordinated purchase and exchange of video tapes regarding speech and language development.

Also, attendance at UNISTAPS sponsored workshops had been open to Head Start/Home Start staffs during the first year.

There were several reasons why the Year One collaborative efforts were minimal. Two reasons stand out. First, the Project staff were still going

through the functions of learning about Head Start and determining what the exact "model" for the Project would be. Second, most of the specific agreements made with the UNISTAPS laboratory program staff were somewhat difficult to relate to the OCD-BEH Project's statewide focus. Without having these factors resolved, it was difficult for Project staff to suggest specific collaborative efforts to the UNISTAPS director, and vice versa.

By way of outcomes, the video tapes which were purchased and exchanged were used by the UNISTAPS laboratory program for parent education/discussion sessions. The OCD-BEH Project used selected tapes during a workshop for Head Start teachers and parents to demonstrate certain principles of working with hearing impaired preschool children.

Collaboration, year two. Consultation and planning continued between the UNISTAPS Project director and OCD-BEH Project staff. Midway through year two (January, 1975) the two projects entered into a formal contract to provide:

1. A workshop for approximately ninety participants including public school, Head Start, and State Department of Education personnel, to formally address the transition of Head Start special needs children into the public education system, and working relationships that might be developed or strengthened to guarantee appropriate follow-up services to these children;

2. Purchase of third party consultation for (selected) Head Start programs in the state, covering case management, demonstration teaching, and assistance to teachers, staff, parents and children of Head Start;

3. Site visitations for Head Start/Home Start staff and parents to the UNISTAPS laboratory program (Minneapolis Public Schools).

The dollar value placed on this collaboration by the UNISTAPS Project director was $4,500.

The topic of transition of special needs Head Start children to their educational setting was addressed by Project staff during the third on-site visit to most Head Start/Home Start agencies and in the Project's newsletter, the "Mediator Media". Following these on-site visits, a statewide workshop was held in June, 1975. A significant portion of this workshop did speak to transition issues and the broader issue of Head Start/public school relationships regarding service to special needs children. Attending the workshop were Head Start/Home Start administrators, coordinator staff, teachers, and parents--and the UNISTAPS director, special education regional consutants, and a school district special education director. A total of 120 people attended this workshop.

Third party consultation needs to Head Start/Home Start teachers, parents, and children were assessed by Project staff largely during the third on-site visit. The final selection of consultants and recipients was made jointly by Project staff and the UNISTAPS director. In a wide geographic distribution throughout Minnesota, the selected consultants provided on-site (home/classroom) services to twelve(12) special needs children, their families, and teachers. Some consultant services were delivered in the form of training to Head Start teachers and parents. For instance, a speech pathologist provided training at one agency

regarding speech and language development, some specific concerns of staff and parents, and some prescriptive teaching techniques. A psychologist went on-site to two classrooms in another agency, using video taping/playback as a means to assess teacher/child interactions and to suggest ways of structuring the classroom behavior of several highly active children.

Site visitations to the UNISTAPS laboratory program were made on behalf of four children. Two children were actually transported to the laboratory site for a day, where they were observed as they interacted with other special needs children. The parents and teachers of two children also observed and were involved in consultation with UNISTAPS staff. The teachers of the two other children observed UNISTAPS children for a day and consulted with UNISTAPS staff regarding some principles, techniques, and materials for working with hearing impared and low-incidence handicapped children.

Site visitation was also expanded to include similar visits by four families/teachers of Down's Syndrome children to the EDGE program (Expanding Developmental Growth through Education) at the University of Minnesota in Minneapolis.

One addition was made to the year two OCD-BEH/UNISTAPS collaboration in the form of a separate contract between a Head Start agency and a mental health center. The contract called for the training of staff and parents in the use of the PACT program (Parents and Children Together), a prescriptive teaching program involving a token economy, contingency reinforcement system. The teaching and follow-up program was to be provided by the mental health center over a nine month period, with sixty children and their families benefiting from the services.

Finally, although not part of the formal contract between the Project and UNISTAPS, attendance at various UNISTAPS sponsored workshops was open (and encouraged) for Head Start/Home Start personnel as had been the case during Project year one.

SECTION III
OUTCOMES--RESOURCE MOTILIZATION IN MINNESOTA--YEAR 2

Because mobilization of specialist services is so crucial to the development of support systems and the success of case management processes, evaluation findings in this area will be presented first. Hopefully, this will provide the reader with an overall picture of the amount and types of services provided to Minnesota Head Start/Home Start programs during the second Project year, 1974-75.

Data collection. Data related to the resource mobilization objectives were obtained in two ways. On the third round of consulting visits during the spring of 1975, Project staff asked program personnel a series of questions related to resource mobilization. The first question was "Who were the specialists who provided some type of service to your program this year, 1974-75, and for what agency did the specialist work?" The names, professions, and employing agencies of these specialists were documented on a form developed for this purpose (see Appendix 11). Then, for each specialist's name written down, the following question was asked, "Did this person or another person of the same profession from the same agency provide service to your program last year?" Baseline data had not been obtained for all Minnesota programs during the previous year, 1973-74, and it was hoped the responses obtained from this question would provide data with which to compare the 1974-75 resource mobilization outcomes. Because several program staff members were usually present when the questions were asked, it was felt that concensus responses about whether or not an individual provided service a year earlier were highly reliable.

Data were collected in this manner from 29 programs. In the cases of the other six programs, either no third consulting visit was made or time did not permit this information to be obtained. It should also be pointed out that the data which was gathered from the 29 programs was not completely exhaustive. There were several activities which had to be accomplished during the consulting visits and this sometimes reduced the time available for data collection. Data were not exhaustive in another sense. No specific inquiry was made about medical and dental services or about services provided by the state's Crippled Children's Services. This was done intentionally, mainly because Project staff had been informed that this information was available from other sources. In addition, Project staff were primarily interested in those services that might have been provided on-site at centers and/or children's homes. Although the two speech clinicians who worked full-time for Crippled Children's Services did provide some on-site services, this did not appear to be the case for most services provided by this agency nor those provided by most physicians and dentists. It is imperative to point out, however, that Crippled Children's Services and local medical and dental professionals have always, and continue to, serve Head Start/Home Start children, families, and staff in invaluable ways. The Project staff was merely looking at other types of service.

The other method of data collection involved sending questionnaires, developed by Project staff (see Appendix 15), to a group of 120 randomly sampled nurses, psychologists, speech clinicians, and social workers who had provided service to the 29 programs during 1974-75. Unfortunately, the number of these specialists who responded to the questionnaires proved to be small in comparison to the total number who had actually provided service.

Project staff had done the random sampling at program sites because they wanted staff to also complete a questionnaire (see Appendix 16) on the same specialists who would be receiving a questionnaire. It was not until Project staff returned from the consulting visits and had an opportunity to look at the combined data that they realized more specialists should have been sampled and sent questionnaires. As it was, 120 questionnaires were sent to specialists and given to program staffs. Completed questionnaires were received from a combined group of 60 nurses, psychologists, speech clinicians, and social workers. Only these professional groups were sampled and sent questionnaires because it had seemed that there were few individuals in any other professional group who had provided service on-site at programs. In fact, this proved to be the case when the combined data were later examined.

The 29 programs from which data were obtained were scattered geographically throughout Minnesota in rural, urban, and rural-urban mixed settings, with most programs covering at least two counties. At that time, most programs operated exclusively under the center-based model; fewer used the home-based model exclusively; and fewer yet used both models at different locations within the geographic boundaries of the program. The total number of children in the individual programs ranged from 11 to roughly 220, with the number of centers per program ranging from 1 to 12. Total staff size in the programs ranged from 3 to approximately 50.

Outcomes. Prior to the intiation of statewide demonstration activities during 1974-75, Project staff were confronted with several issues/questions related to resource mobilization outcomes;

-Despite the success of resource mobilization during pilot activities in the Twin Cities, would Head Start/Home Start staffs throughout the state be willing to engage in similar efforts to a significant degree?

-Would more resources than currently being utilized be available?

-Would current and potential service providing agencies respond favorably if approached to expand or initiate services?

-Would more clinical specialists be willing to provide on-site services at center and/or children's homes?

-Would program staffs be willing to request this kind of service?

-Would more specialists be willing or able to provide on-site services on a fairly frequent, regular schedule?

-Would specialists be willing to engage in professional roles other than, or in addition to, screening, diagnostic testing and one-to-one therapy?

Although the answers to these questions were by no means clear at the beginning of Project year two, the staff established the following three major objectives which they hoped would be met through the influence of their year long training, consultative and advocacy activities:

1) delivery of services to programs by an increased number of clinical specialists

2) delivery of increased services by clinical specialists on-site at centers and/or children's homes

3) delivery of a broader range of services to programs by clinical specialists

The data in Figure 1 (page 27) obtained from the questions asked on the third consulting visit, indicate that the increase in the number of specialists who provided some type of service to Head Start/Home Start programs was very substantial. Comparing the 1973-74 school year with the 1974-75 year, there was a 75% increase in the number of various types of clinical specialists who provided some service to the 29 Minnesota programs from which data were obtained (246 specialists in 1973-74, 186 additional specialists in 1974-75). The most dramatic increase in specialists providing services for the first time (189%) came from speech clinicians (44 speech clinicians in 1973-74, 83 additional speech clinicials in 1974-75), but there were substantial increases across all specialist categories (see Figure 1). The category "other specialists" in Figure 1 and Figures 2 and 3 includes a wide range of specialists, e.g., SLBP teachers, teachers of the deaf, audiologists, elementary counselors, hearing consultants, physical therapists, mental retardation specialists, etc.. These specialists were grouped into one category because there were few of any one type who had worked with the 29 programs.

Figure 2 (page 28) shows the types of resource agencies employing the various specialists. It can be seen that the public schools provided by far the largest total number of specialists. The category "other agencies" in Figure 2 includes several types of agencies, e.g., welfare departments, hospitals, day activity centers, other preschool programs, etc.. The frequency of any one of these agencies being mentioned was low. Limited time for obtaining the data during the consulting visit may have been a partial reason for low frequencies in some instances.

The data in Figure 3 (page 29) indicate that 50%, or more, of the specialists in each category did provide some on-site services at centers and/or in childrens homes. The program staffs were not asked if individual specialists were coming on-site for the first time, but given the large number of new specialists and the fact that many of these people worked on-site, it can be concluded that the number of on-site services increased over the previous year. The data in Table 2 (page 34), based on the questionnaire responses of specialists, also indicate that there was an increase in the number of specailists coming on-site, both due to "new" specialists doing this and due to "old" specialists doing this for the first time in 1974-75.

Figure 4 (page 30) presents some evidence regarding the frequency of on-site visits. Of the 44 randomly sampled nurses, psychologists, speech clinicians, and social workers who provided on-site service, 18 (41%) indicated on questionnaire items that they visited centers and/or children's homes once a month or more frequently. Although 57% of the specialists sampled provided on-site service less than once a month, there was still a substantial number who visited centers and/or homes fairly frequently.

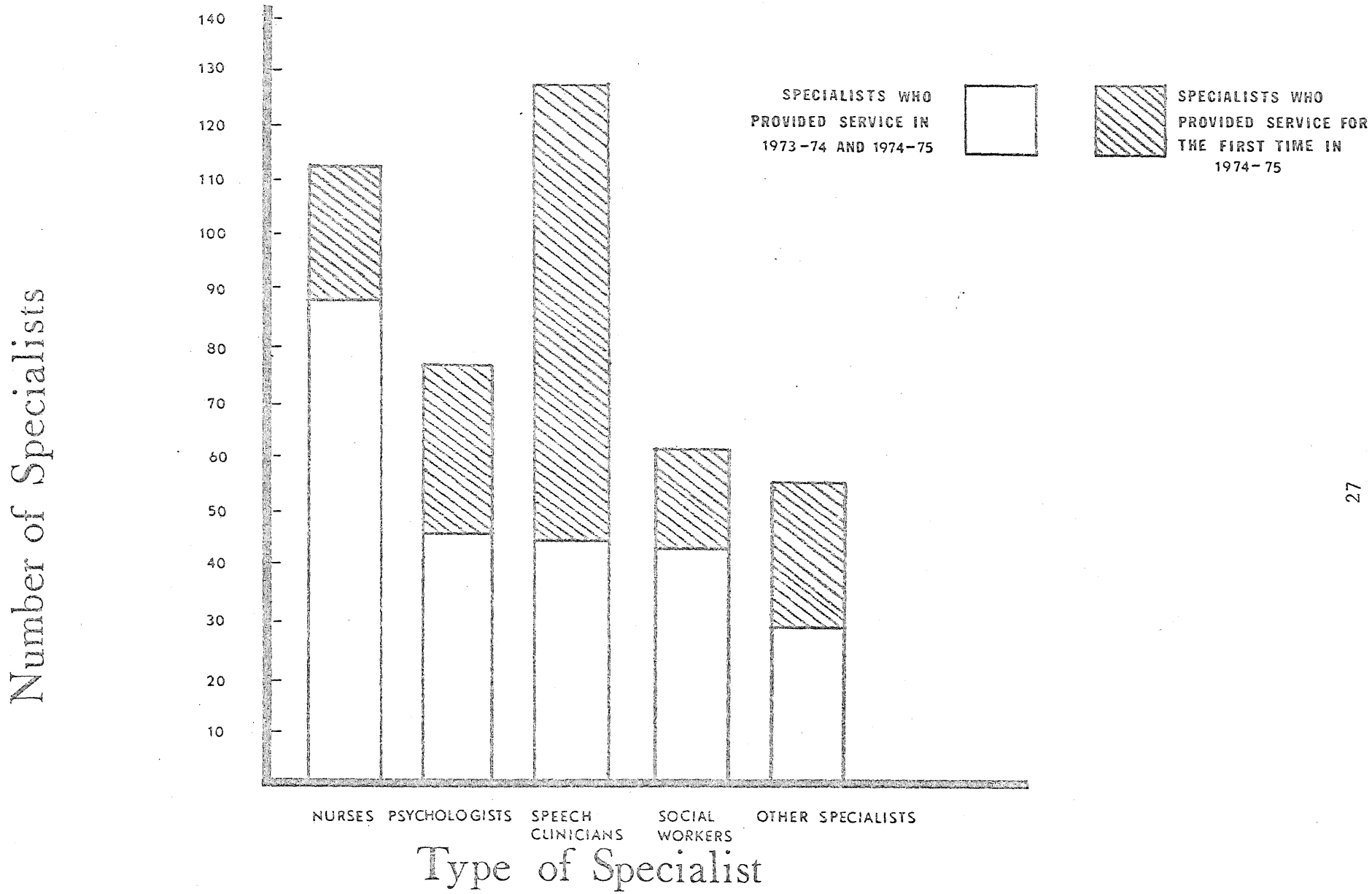


FIGURE 1 : Number of nurses, psychologists, speech clinicians, social workers, and other specialists who provided some type of service to twenty-nine Minnesota Head Start/Home Start programs in both 1973-74 and 1974-75, and the number who provided service for the first time in 1974-75

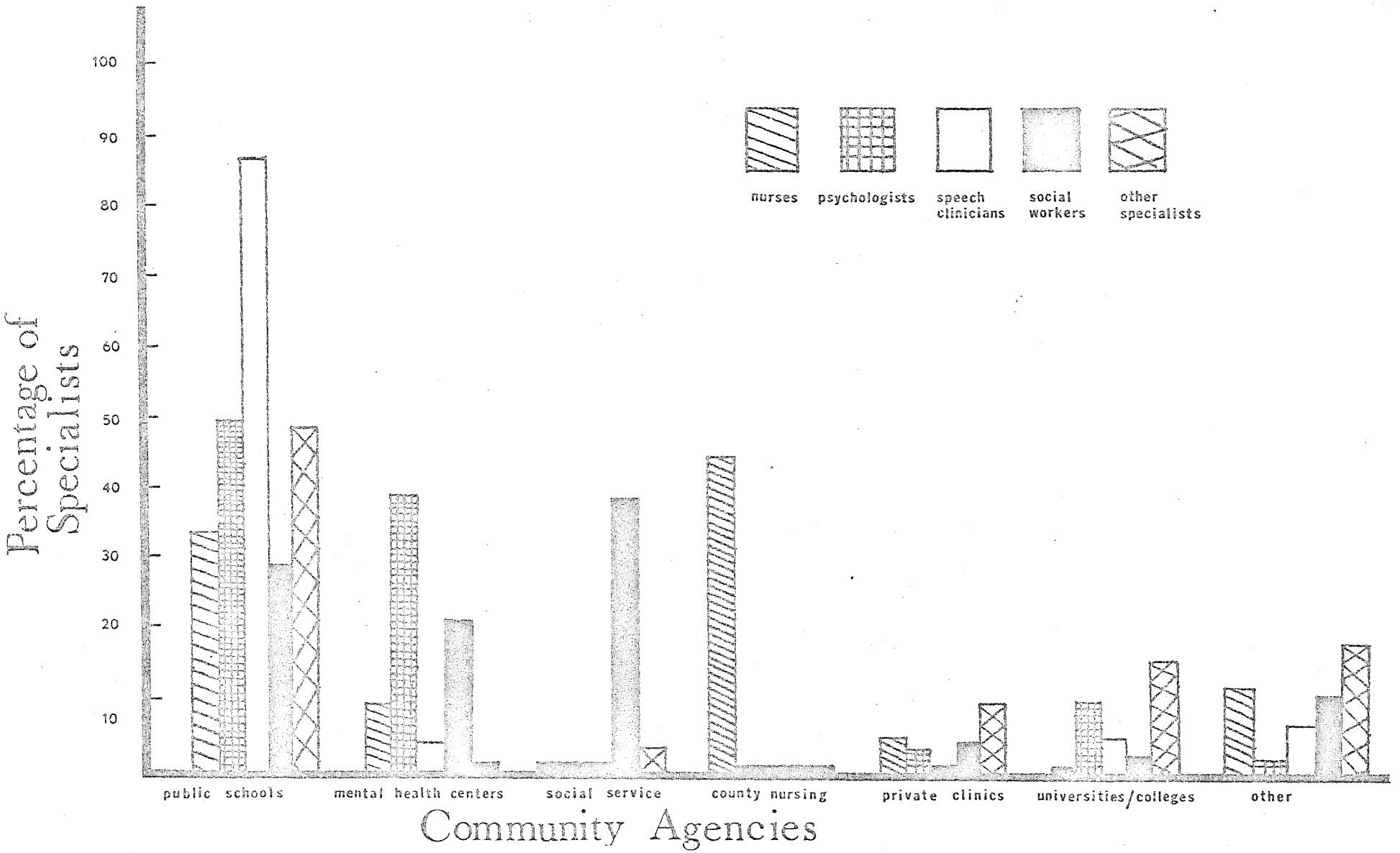


FIGURE 2 : Percentage of nurses, psychologists, speech clinicians, social workers, and other specialists from each type of community agency that provided service to twenty-nine Minnesota Head Start/Home Start programs during 1974-75.

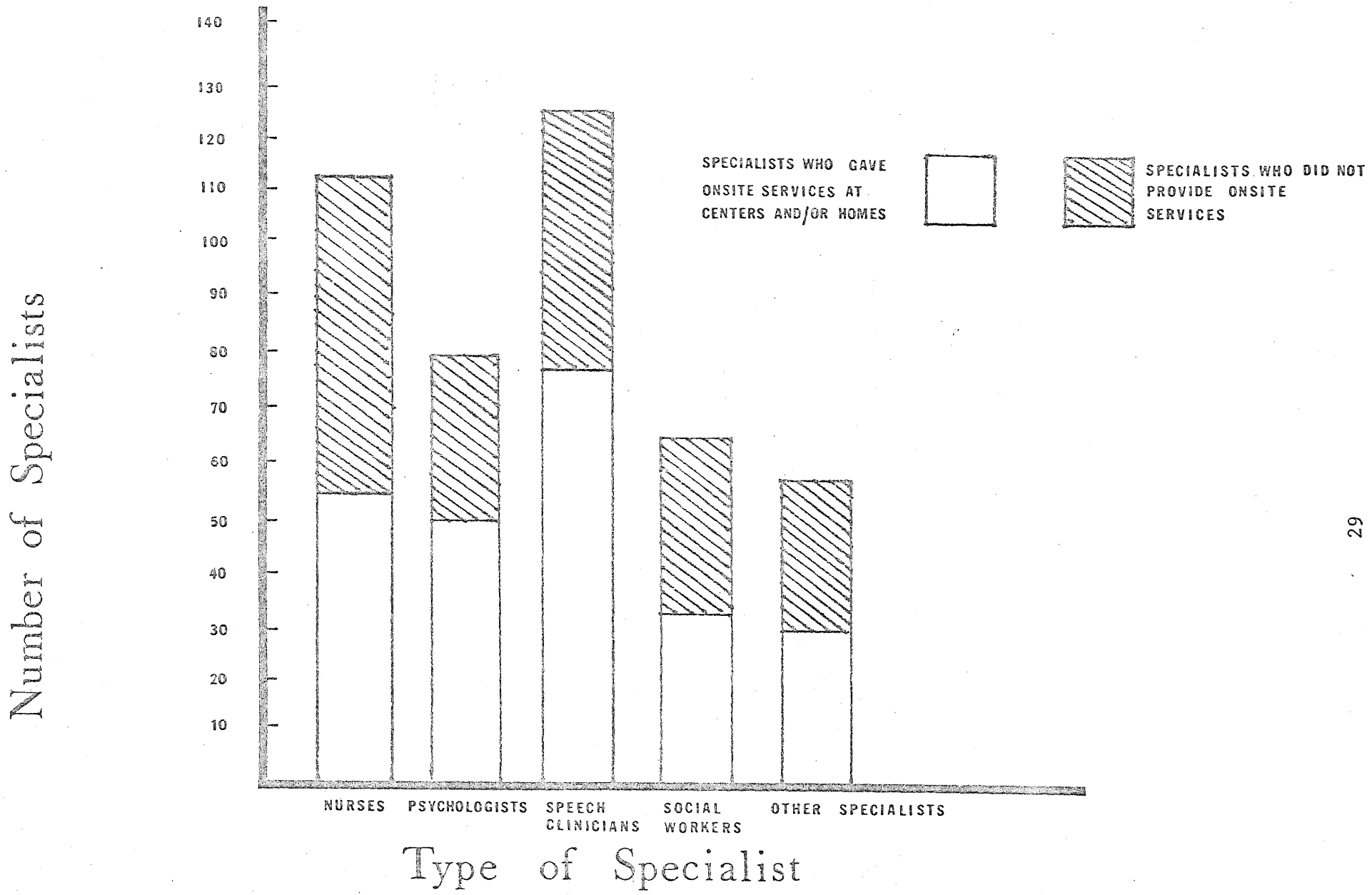


FIGURE 3: Number of nurses, psychologists, speech clinicians, social workers, and other specialists who provided some type of onsite service at twenty nine Minnesota Head Start programs during 1974-75, and specialists who did not provide onsite service

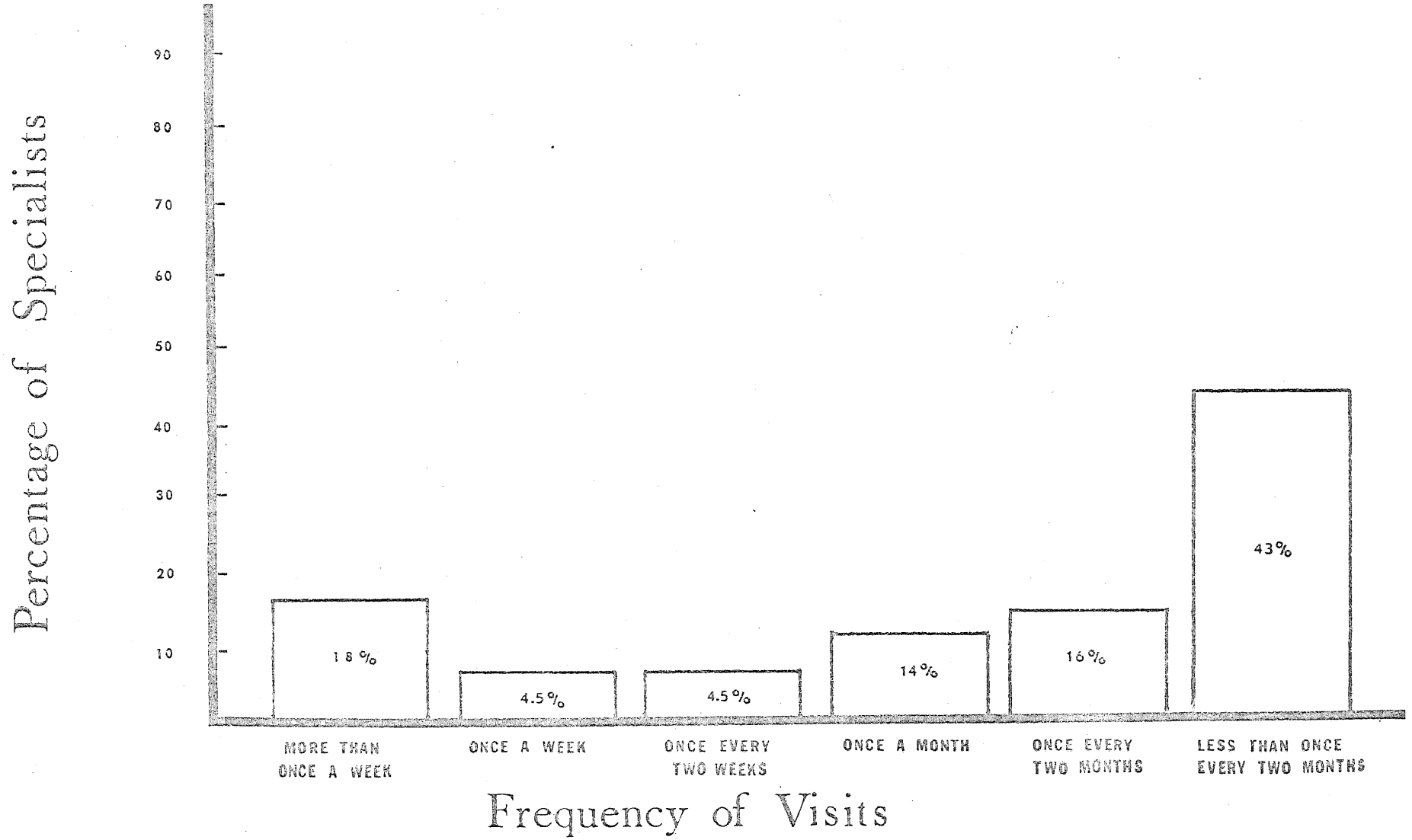


FIGURE 4 QUESTIONNAIRE DATA: Percentage of 44 randomly sampled nurses, psychologists, speech clinicians, and social workers who made onsite visits of varying frequency to Minnesota Head Start/Home Start centers and/or children's homes during 1974-75. Note: of the entire group of 60 randomly sampled nurses, psychologists, speech clinicians, and social workers, 44 indicated that they had provided some onsite services.

The specialists who visited on-site once a month, or more frequently, provided proportionately more different types of services than those specialists who visited less than once a month. (See Table 1, page 32). The 18 specialists who visited at least once a month provided, as a group, 128 of these various types of service (out of 198 possible, i.e., all 18 specialists each providing all 11 services), while the 26 specialists who visited less often provided only 148 (out of a possible 286) of these services (X^2 (1)=7.94, $p < .005$). These data do not indicate how often these kinds of service were provided, merely whether they were ever provided at any time. Although data on the frequency of each type of service was not obtained, it seems reasonable to assume that the specialists visiting most frequently would have provided a given service most often. If this were the case, these specialists would not only have provided a broader range of services, which the present data do indicate, they would also have more frequently provided each service.

Additional tentative evidence regarding the range of services provided to Minnesota programs can be found in Figure 6 (page 33) and Table 2 (page 34). There was a broad range of services provided by the randomly sampled group of nurses, psychologists, speech clinicians, and social workers. The data in Table 2 indicate that of the 45 randomly sampled specialists who said they had provided service to programs in the previous year, 1973-74, 22 (49%) indicated that they provided new services during 1974-75. Nine specialists, who came from agencies where some other person of the same profession had provided service the previous year, did not know if their services were different from the year before. Thus, at least half of the specialists were engaging in new roles. Fifty three (53) new services were provided by the 22 specialists. Of these, 35 (66%) services were other than direct service to children, i.e., screening testing, diagnostic assessment, or therapy. However, direct service was certainly not ignored or minimized. To the extent that these findings can be generalized to the services provided to Head Start/ Home Start programs by other specialists, it would appear that a much broader range of services were provided to Minnesota programs during 1974-75 than during 1973-74. Therefore, not only were more people serving programs, apparently there were also more types of services given.

Although Project staff had constantly promoted on-site services, primarily because this would presumably result in more direct consultations with teachers, it was not known if this approach was preferred by most teachers. It was possible that teachers might prefer that the specialist work alone with the child to effect some improvement. To obtain information about teacher preferences, two open-ended questions were included in the questionnaire sent to the teachers whose children had received some type of service, at centers or elsewhere, from the random sample of specialists (75 teachers returned this questionnaire). The two questions were: "What kinds of things did this specialist do that you found most helpful?" and, "Could the specialist have done other things that would have been helpful to you?"

The various responses given were categorized by Project staff into the categories presented in Table 3 (page 35). There were 113 responses made to the first question by 65 teachers (10 teachers made no response and several made more than one response). As can be seen from Table 3, the most frequent responses (24.8%) fell into the category "consulting with teacher regarding individual children". Although many responses (37.9%) referred to more "traditional" roles, i.e., screening, diagnosis, therapy, and parent counseling, more responses (45.8%) referred to some kind of direct assistance given to teachers.

Table 1. Questionnaire Data: Services Provided by Clinical Specialists Who Visited Centers and/or Homes Once a Month or More Frequently Versus Services Provided by Specialists Who Visited Less than Once a Month.

Frequency of Specialists' Visits		Services												
		Observation of children	Consultation re: individual children	Consultation re: overall classroom management	Consultation mainly by phone and written communication	In-service training	Screening Testing	Diagnostic Assessments	Individual therapy with Children	Parent Counseling	Consultation to the Mediator Team	Recruiting other Specialists	Total Number of Services Provided	Total Number of Specialists in each frequency-of-visit category
Nurses	Once a month or more	5	5	0	1	1	4	1	5	4	1	4	31	5
	Less than once a month	5	5	2	0	2	4	2	5	4	1	3	33	6
Psychologists	Once a month or more	4	4	3	0	4	3	4	3	4	3	3	35	4
	Less than once a month	9	10	4	1	7	5	6	5	8	2	5	62	12
Speech Clinicians	Once a month or more	7	6	1	1	2	7	7	7	6	1	3	48	7
	Less than once a month	4	4	1	0	3	3	3	2	2	0	1	23	4
Social Workers	Once a month or more	2	2	2	0	0	1	1	2	2	1	1	14	2
	Less than once a month	4	5	1	0	1	4	1	3	4	3	4	30	5
Combined Specialists	Once a month or more	18	17	6	2	7	15	13	17	16	6	11	128	18
	Less than once a month	22	24	8	1	13	16	12	15	18	6	13	148	26

FIGURE 6 QUESTIONNAIRE DATA: Percentage of 60 randomly sampled nurses, psychologists, speech clinicians, and social workers who provided various types of services, onsite or not onsite, to twenty nine Minnesota Head Start/Home Start programs during 1974-75

Table 2. Questionnaire Data: Number of Clinical Specialists Responding that They Had Provided New Types of Services to Head Start/ Home Start Programs in 1974-75 which They Had Not Provided in 1973-74.

Specialists	New Services: Provided new services in 1974-75	Did not provide new services in 1974-75	Did not know if services were new	Did not respond to questionnaire item	Observation of children	Consultation re: individual children	Consultation re: overall classroom management	Consultation mainly by phone and written communication	In-service training	Screening	Diagnostic Assessments	Individual therapy with children	Parent counseling	Consultation to the Mediator Team	Recruiting other specialists
Nurses	3	6	1	1	0	0	0	0	0	0	1	2	0	1	0
Psychologists	7	3	4	1	0	0	2	0	2	1	0	1	1	1	1
Speech Clinicians	7	3	2	0	2	4	1	1	3	2	4	2	2	1	1
Social Workers	5	0	2	0	2	2	1	1	1	1	1	3	1	2	2
Combined Specialists	22	12	9	2	4	6	4	2	6	4	6	8	4	5	4

Table 3. Questionnaire Data: Frequency and percentage of response made by 75 Minnesota Head Start/Home Start teachers to the questions: 1) "What kinds of things did this specialist do that you found most helpful?" and 2) "Could the specialist have done other things things that would have been helpful to you?"

Type of Response	Question #1		Question #2	
	Frequency of response (N = 113)	Percentage of response	Frequency of response (N = 84)	Percentage of response
Consulting with teacher re: working with families	0	0	2	2.4%
Consulting with teacher re: individual children	28	24.8%	12	14.3%
Consulting with teacher re: overall classroom management and curriculum	2	1.7%	2	2.4%
In-service training for teachers	2	1.7%	3	3.6%
Supplying or recommending materials,books, etc., to teacher	7	6.2%	0	0
Providing written reports to teacher	3	2.7%	2	2.4%
Keeping records and making them available to teacher	2	1.7%	0	0
Screening children	6	5.3%	0	0
Diagnosing children	10	8.8%	1	1.2%
Providing therapy or treatment to individual children	15	13.3%	7	8.3%
Placing children in other programs	2	1.7%	0	0
Providing parent counseling	10	8.8%	1	1.2%
Providing parent education	0	0	1	1.2%
Making home visits	0	0	1	1.2%
Observing children	4	3.5%	3	3.6%
Recruiting other specialists	6	5.3%	0	0
Consulting with Mediator Team	0	0	2	2.4%
Referring children to Head Start/ Home Start	2	1.7%	0	0
No response	10	8.8%	17	20.1%
Negative comments	4	3.5%	3	3.6%
Sufficient service provided	-	-	13	15.4%
Sufficient service provided given limited time available	-	-	9	10.7%
More service desired (but no description of services)	-	-	5	6.0%

Miscellaneous positive comments: (next page)

Table 3. (continued)

Question #1--"excellent in his field - I trust his judgment"; her whole approach and attitudes were the most meaningful"; "he was truthful--we knew where we stood"; "he listened to me--gave me encouragement"; "consistent help"; "general support to teachers"; "grateful for speech therapy done"; "gave me helpful tips"; "easy to work with"; "he works well with children and can win their confidence"; "made the breakthrough in communication with a mother"; "if we needed his help he provided it"; "she was a great help".

Question #2--"she is an excellent speech therapist and a beautiful, warm, understanding and intelligent person"; "he is always willing to help"; "she couldn't have been more helpful"; "I was most thankful for the time she gave us"; "being the first year and limited time, she did the best job possible"; "the nurses are overworked"; "he was overworked-I could have used more of his time"; he was extremely helpful in this situation"; "she was by far the most helpful specialist for me"; "because of time, I feel she did the best she could under the circumstances"; "she was helpful and generous with her time to us"; "I was well-pleased with the consultation with her - I feel better informed now"; "because of his heavy schedule, we felt he did well to work with the children at his office as often as he did which was every morning for about 15-20 minutes per child"; "I know she is available to me if I find something that I can't handle"; "I wish he had more time to spend with us in the classroom"; "could have benefited from more training sessions with her".

There were 84 responses made to the second question, with 17 teachers making no response (this was the most frequent "response"). Of the responses obtained, "consulting with teacher regarding individual children" was mentioned most often (after "sufficient service provided") as being the kind of service that would have been helpful. Only 10.7% of the responses mentioned screening, diagnosis, therapy, or parent counseling, while 27.5% referred to services that involved direct assistance to teachers. 26.1% of the responses indicated there was "sufficient service provided" or "sufficient services provided given limited time available".

Based on these questionnaire responses, it appears that more of the teachers sampled preferred to receive direct assistance, themselves, from specialists and/or wanted to receive more of this type of service than service provided directly to the child. The unsolicited positive comments presented in Table 3 suggest that very good working relationships had developed between many of these teachers and the specialists with whom they worked.

Summary of resource mobilization outcomes. Looking at all 29 programs from which data were obtained, it can be concluded that the first major outcome objective was very successfully achieved; the number of specialists delivering some type of service almost doubled during the 1974-75 program year. There was evidence to indicate that the number of specialists providing on-site services and offering a broader range of services also increased substantially from one year to the next.

There was variability among programs in terms of the number and types of services received, but the variable of geographical location, which might have been assumed to be critical, did not seem to account for a great deal of this variability. That is, increases in the number of specialists providing service per se and increases in on-site services and in the range of services occured in rural and semi-rural areas to about the same extent as in more densely populated areas. The variables of program staffs' motivation for recruiting services, and aggressiveness in doing so, along with the responsiveness of service providers, appeared to Project staff to be the most important determining factors. Both extremes of these variables were found in rural and more urban areas. Another factor that must be mentioned is that some programs had utilized existing resources to high degree prior to 1974-75, but, again, geographical location did not predict which programs had done so.

The Project staff also felt that the value of more on-site services and more supportive services to teachers had been confirmed. The data obtained supported the assumption that on-site services by specialists would result in delivery of a broader range of services, including more direct service to teachers, and in the enhancement of working relationships between program personnel and service providers. Undocumented feedback from program staffs and specialists also confirmed the value of these types of services. Particularily in those instances where specialists came on-site fairly frequently, greater trust and mutual respect was often established. This brought about not only more services to children, parents and staff, it also frequently resulted in programs obtaining another advocacy "voice" in the community. Given the previous lack of close working relationships between Head Start/Home Start programs and other community agencies in some areas, this was no small accomplishment!

It is difficult to specify the exact influence of the Project staff's training, consultative, and advocacy activities on the realization of these outcome objectives. Certainly, much of the credit must be given to the program staffs who actually sought, and the specialists who provided, the services. It might be concluded that the Handicap Mandate, itself, was the major impetus behind this mobilization of resources. However, the fact that the Mandate had been in effect for almost two years prior to the initiation of the Project's statewide demonstration activities suggests that the staff's efforts did have some catalytic effect on the substantial increase in service delivery during 1974-75.

There are three major areas of activity which the staff perceive as being their most significant contributions. First, program personnel were carefully informed of the state's special education law regarding mandated service to four and five year old children. This was done during the first intenstive workshop in the summer of 1974 and was continuously repeated throughout the program year. When first questioned about the law at the summer workshop, not one participant (out of 70) correctly answered all of the questions relating to the types of handicapping conditions which would make a child eligible for public school services at given ages. By making people aware of the law, and the appeals process, they were much better prepared to state their rights (the children's and parent's rights) when negotiating for services from public schools. Fortunately, it seemed that many special education directors and specialists in public schools were simultaneously developing plans to provide more extensive services to preschool children in their communities. At the same time, there was greater emphasis placed on preschool services by the Special Education Section of the State Department of Education. Guidelines for services to preschool handicapped children were developed and disseminated by the UNISTAPS Director, who is also a consultant in the Special Education Section, during the 1974-75 school year. All of the above factors appear to have converged at the right time and contributed to the public schools being the largest single provider of services ("new" and "old") to Head Start/Home Start programs in 1974-75.

The second area of activity perceived as critical by Project staff was the constant direction, support, and encouragement given to program personnel throughout the entire year at workshops, consulting visits, and any other opportunity that presented itself. Methods of obtaining services were repeatedly suggested to programs. In many instances, this issue received more emphasis than any other. The importance of the supportive role played by staff cannot be minimized. Many people were discouraged by past failures to obtain services, some were perhaps intimidated by the "professionals" in various resource agencies, and other were distrustful of these agencies and the people employed there. Despite the fact that there was undoubtedly validity to some of these attitudes, Project staff attempted to convince the program personnel that they had a right to request services, that it was important for children, parents, and staff to receive various kinds of service, and that, generally, it was worth the effort to try to secure new services and expand old ones. Remarks such as "you kept after us all year to talk to that special education director and we finally did--with good results", were fairly commonplace and attested to the importance of the on-going encouragement given to programs. Of course, in same cases, individuals could not be convinced, or further recruitment attempts continued to meet with failure.

Finally, it is known that many of the advocacy efforts engaged in by Project staff, either with program personnel present or independently, did directly result in numerous new or expanded services to programs. It was somewhat revealing to find that some specialists held attitudes toward Head Start/Homes Start similar to those expressed by Head Start/Home Start personnel toward some specialists, i.e., discouragement that offers of, or at least interest in, provision of service had not been responded to favorably, a kind of feeling of intimidation, and feelings of distrust. Project staff often found themselves playing a mediating type of role when meeting with both parties together and when meeting with one party or the other separately. Adopting this type of role frequently paid off in the sense that both parties acquired some different perceptions of one another and began to develop working relatiohships. In several instances, it appeared that the two parties involved had simply not talked with one another for some time, or at all, and had been harboring negative feelings based on past experiences or on distorted information.

Despite the fact that there were many identifiable outcomes that resulted directly from these kinds of advocacy activities, it must be pointed out that the majority of service-recruitment contacts across the state were made by program staffs alone and without any direct supportive advocacy efforts by Project staff. It was evident that the direction and encouragement provided by Project staff precipitated several of these contacts, but most were, in fact, carried out by program staff members themselves.

In conclusion, it can be stated with confidence that a great deal of resource mobilization occurred during the one year in which the staff demonstrated its statewide service delivery system in Minnesota. However, a cautionary note is necessary. Many special needs children, their parents, and their teachers did not receive the amount or types of services necessary to be considered truly comprehensive. The section on case management outcomes will illustrate this fact more specifically. Perhaps the most important results of the resource mobilization effort were 1) the realization that many more services could be obtained for Head Start/Home Start programs and 2) the demonstration of some methods of tapping potential resources. A process was begun which, it was hoped, would lead to even further expansion of service to Minnesota Head Start/Home Start children, their families, and their teachers. (Some data related to the maintainence and expansion of services in Minnesota after 1974-75 is presented in Section VII.)

SECTION IV
OUTCOMES--CASE MANAGEMENT IN MINNESOTA--YEAR 2

This section presents statewide outcomes of the case management objectives which had been established at the beginning of the 1974-75 program year. The findings related to the use of the "Mediator Team" as an organizational vehicle to enhance case management processes will be presented in the following section (Section V).

As mentioned previously, it was hoped that programs would perceive the value of a more structured, team approach to case management, but an unwillingness to engage in this kind of process did not preclude training, consultative, and advocacy services by Project staff. Even if programs chose not to develop a team and hold regular team meetings, the Project staff attempted to assist these programs in improving case management procedures, both quantitatively and qualitatively, in the following areas:

1) obtaining comprehensive screening of all children

2) obtaining comprehensive professional assessments of all suspected special needs children

3) obtaining comprehensive supportive services for teachers in planning and implementing educational/integrated experiences for special needs children

4) making arrangements to ensure continuity of services to special needs children when they go to their next educational setting

5) securing greater involvement of parents in decision-making, planning, and intervention processes

Obviously, there is overlap between some of these outcome objectives and the resource mobilization outcome objectives. The findings reported in the previous section on resource mobilization imply that, at least in a quantitative sense, the first three objectives stated above must have been realized to some degree by Minnesota programs taken as a whole. The purpose of this section is to present evidence relating more specifically to each of the case management objectives and also to give the reader some opportunity to judge the qualitative aspects of case management skills possessed by program personnel across the state.

Data collection. The evaluation data reported here were gathered primarily during the third on-site consulting visits to programs in the spring of 1975. However, in the area of screening, data were also obtained during the first and second consulting visits in the fall of 1974 and winter of 1975, respectively. Data collected from the third visit will be presented first, with the additional information on screening reported separately.

The overall purpose of the third round of visits was to 1)follow-up on previously made recommendations to program personnel (to Mediator Teams where they existed); 2) to make recommendations regarding the transition of

special needs children to their next educational setting; 3) to obtain some evaluation data on resource mobilization and case management; and 4) to make additional recommendations for future Mediator Team functioning (again, where Teams existed). As has been pointed out earlier, Project staff did not realize, at this point in time, the extent to which their activities would be curtailed in Minnesota during the up-coming third and final year of the Project. Thus, consultative activities continued to be emphasized during this last round of visits. It was assumed that more rigorous evaluation could take place the following year.

Because the Project staff wanted to accomplish several things on these visits, collection of specific case management data was limited to reviewing a sampling of cases of diagnosed special needs children who would be going on to public or private schools. See Appendix 11 for a copy of the form with the questions staff tried to answer as they reviewed children and talked with program personnel. It should be noted that coordinator level staff were the people usually present at these consulting sessions. Sometimes these people were organized into formal case management teams. In other instances, the nature of the teams was more informal. The structure of the teams will be further described in Section V, but the reader should realize with whom the Project staff members were holding discussions.

The folders and/or "cases" of 88 children, from 31 programs, were actually reviewed (average of 2.8 per agency). Of the 88 children sampled, there were folders for 78 children (89%) made available to Project staff. The centralized folders (written records) were not available in 10 instances (11% of the total cases). Records which were not available during the on-site visits were said to exist at another location in the program, usually at the center site.

The reviews of centralized written records usually revealed that all neccessary or desirable information was not filed in this central file, even though the information might exist and actually be on file elsewhere in the agency or in a file maintained by a community specialist (psychologist, speech pathologist, social worker, etc.) who was working with the child/teacher/family. Descriptively, then, the 78 central files reviewed by Project staff in the spring of 1975 contained the following kinds of records and information:

Type of Record contained in Central File	Number of Records Found	Percentage of Records Found-*
Screening Records	75	96
Diagnostic Records	41	53
Current Treatment Records	2	3
Current Overview	10	13
Individual Educational Plans and Progress Records	21	27

*To nearest full percentage point

Project staff were frequently told by program personnel that diagnostic records were still in the hands of clinical specialists. The current therapy/treatment records of children still being seen by clinical specialists were said to be in files maintained by those specialists. Any therapy/treatment records these specialists might send to Head Start/Home Start programs were not expected until May or June when the therapy/treatment ended. Individual educational plans and progress records were most often said to be in the hands of the child's classroom teacher/home visitor. In other words, the central files often contained incomplete information filed in one central location. Upon interviewing the program staffs, it appeared that most of the overall case management information about a child was known to the group. The lack of complete, written information in one central location did not mean that many case management functions were incomplete. Therefore, some of the following data regarding case management procedures for the children sampled were supplied verbally by progarm personnel.

Outcomes, screening. In order to obtain data regarding screening, Project staff asked the question: "Was the child screened in all areas." This included medical, dental, vision, hearing, social-emotional, motor, and speech/language (or cognitive) areas.

Was the child screened in all areas? (88 Children)	Number	Percentage*
YES	52	59
NO	35	40
Don't Know	1	1

*To nearest full percentage point

In only one case was screening information totally lacking from a child's folder and the screening information unknown to program staff. Over half of the children sampled were screened in all areas. For those not screened in all areas, the screenings which were lacking were usually in the developmental areas (language or cognitive, motor, and social-emotional). Nearly all of the children had received medical, dental, vision, and hearing screening. A few of the children not screened in these areas were relatively new to the programs and screening was often planned for completion in one month.

In most agencies it appeared to be the responsibility of the health coordinator to try to ensure that screening was completed. The major effort, it seemed, had been placed on screening in the medical, dental, vision, and hearing areas. Developmental screening did not appear to receive as much emphasis. No program staffs, as a group, had systematically reviewed the records of all children to attempt to ensure that the children were screened in all areas. The Project staff suggested that such a review would help in the attempt to ensure complete screening for all children. (Additional information on screening is contained later in this section.)

Outcomes, assessment. In order to obtain data regarding diagnostic assessment of suspected special needs children, the Project staff asked the question: "Did the child see all necessary specialists?" Depending on an individual child's behavior(s) and needs, a complete assessment might have been performed by one clinical specialist. Complete assessment of another child might necessitate the involvement of several clinical and/or educational and/or medical specialists. The Project staff, all being trained, clinical professionals, attempted to evaluate and judge the completeness of assessment by using information given in written records and given verbally by program personnel.

Did the child see all necessary specialists? (88 Children)	Number	Percentage*
ALL	43	49
MOST	15	17
SOME	23	26
NONE	5	6
DON'T KNOW	2	2

*To nearest full percentage point

Many reasons were given by program staff members to explain the incomplete diagnostic assessment of half of the children sampled. The most frequent response was that clinical specialists had promised to assess a child but had not completed the assessment. In some cases neither staff members nor an involved specialist had recognized the probable need for additional assessment by other specialists. Some children referred to an agency during mid-year had not received complete assessments by spring. For these children, some assessments had been done and others were pending with promised dates.

All assessments appeared to be completed for almost half of the sampled cases. About one-forth had completed "most" necessary assessment procedures; "some" assessments were complete on about one-fourth of the children sampled. Only 6% had not seen any appropriate specialist for diagnostic assessment.

It was obvious to Project staff that, under ideal conditions, more clinical assessments should have been completed on more of the children. The reasons why some children had not been completely assessed appeared to be known to most of the programs' staff members, but it also appeared to the Project staff that program personnel could have been, in some instances, more aggressive with clinical specialists. Some programs would have benefited from the regular guidance of a clinical specialist.

Outcomes, intervention. Project staff wanted to learn which persons were most involved in the therapy and/or treatment and/or teaching of the cases sampled, with the child's special need(s) as the target. In other words, how were specialists, teachers, and parents interacting to change target behaviors? What combinations of people were working most closely with the children? In order to obtain this data, the Project staff asked the question: "How were recommendations of specialists and program personnel acted upon?" More than one method of action was used with some children.

Program staffs did not know and central folders did not reveal the kinds of staff/specialist/parent involvement with 5 of the 88 children. Therefore, the data below represents information on 72 children.

Intervention recommendations acted upon primarily by:	Number of cases
Specialist therapy/treatment alone	19
Specialist/Teacher collaboration	46
Specialist/Parent collaboration	27
Teacher/Parent collaboration	28
Teacher acting alone	11

These data indicate that the most popular method of working on-line with these special needs children was for the appropriate clinical specialist and the teacher of the child to collaborate in some fashion to exchange information and, hopefully, skills. This kind of collaboration was of special interest to Project staff since this had been a special point emphasized to the agencies throughout the year. The involvement of parents with teachers and specialists in the actual teaching of their children was another emphasis. It should be noted that the agencies which most often reported the involvement of the parents in the actual teaching of their children were Home Start agencies. In 19 instances (26 percent), specialists alone acted to provide therapy/treatment/teaching toward some target behavior directly related to the special needs of children. And in 11 instances, (15 percent), teachers were placed in a position of having to effect changes without any specialist involvement. Most of these teachers did, however, have access to a Mediator Team, or informal team of coordinators, for direction and specific ideas.

In order to define more clearly the aspect of the involvement of parents with their special needs children, Project staff asked the question: "How were the parents involved?" Program staff members did not know, and records did not show, the extent of parent involvement for 12 children.

Nature of Involvement of Parents with their Special Needs Children (76 Children)	Number of Cases	Percentage of Cases*
Direct involvement in a therapy/ treatment plan under the guidance of a specialist	19	25
Direct involvement in educational plan under guidance of Head Start staff	40	53
Dialogue with Mediator Team and/ or Clinical Specialist	69	90

*To nearest full percentage point

The most frequent involvement of parents appeared to be information sharing contacts with clinical specialists, the child's teacher or other staff. It is significant that the parents of 53% of the children were involved to some extent with teaching staff working with their children on planned educational activities. Ideally, more parents should have been involved at this level. By the very nature of the type of program, proportionately more parents of Home Start children than Head Start children were involved with staff in the teaching of general skills and involved with specialists in therapeutic/treatment types of tasks.

Outcomes, transition. The kinds of information a Head Start/Home Start program passes along to a special needs child's next educational setting can be extremely important. Educators in those settings should know what Head Start/Home Start has done, what things worked, what things did not work, etc. In order to learn what types of personal contacts had been made or were planned, the Project staff asked the question: "Who have you contacted and who do you plan to contact regarding transition efforts?" More than one type of transition contact was being made or planned for most children sampled.

Persons Contacted: Transition Arrangements (81 Children)	Number of Cases	Percentage of Cases*
Clinical Specialists	67	83
Public School Administrators	39	48
Kindergarten Teachers	37	46
Parents	44	54

*To nearest full percentage point

No transition contacts or plans had been made for 7 of the children sampled at the time of the third round of consulting visits. The largest number of contacts that had been made or planned were with clinical specialists. This was viewed as a significant effort to provide continuity of service between Head Start/Home Start and the public school setting. Parents were next most frequently included in planning for transition. Ideally, all parents should have been contacted, or plans should have been made to involve the parents. Programs were usually informed of pending legislation which would mandate the involvement of parents at this kind of planning level. It is hoped that, by the end of the 1974-75 program year more parents were involved in transition planning. Public school administrators and kindergarten teachers were contacted, or contact plans were made, in an equal ratio.

Additional screening findings compiled by Project staff during several on-site visits to programs appear next in this section. These findings begin on the following page; they occupy a separate portion of this section because of the volume of information specific to screening.

Additional Screening Findings

During the first and second full-day, on-site visits to agencies made by the OCD-BEH Project staff, a great deal of attention was paid to the subject of screening. It appeared to Project staff that most Head Start/Home Start agencies had focused in the past on medical, dental, vision, and hearing screening. In line with Head Start Performance Standards, the goal was to screen one hundred percent (100%) of the children. The Mediator's Handbook developed by the Project proposed to agencies that additional attention should be paid to systematic screening for developmental lags or disorders: speech and language, motor, and social-emotional skills. By the very nature of screening, a teacher could not expect to plan a child's educational program based on screening information alone. However, screening information of all kinds could be used as indicators for the need to further investigate a child's physical status and a child's developmental skill levels. In other words, screening is one way to identify children who have special needs.

During the first on-site visit to agencies by Project staff (October-November 1974), it was often found that agencies had not completed screening of all children and, in some cases, had not previously made firm arrangements for agency staff or community resource people to do some type(s) of screening. As will be described, this picture changed significantly from the first on-site visit to the second on-site visit (January-February, 1975). Project staff began to make recommendations which, if implemented by an agency, could potentially speed-up the rate at which screening was accomplished. The earlier screening results were known, it was hypothesized, the earlier the teacher would have a better "total picture" of a child.

Project staff did not focus on counting the exact numbers of children who had been screened in each of the physical and developmental areas. Rather, an agency's specific arrangements for each type of screening and the methods used to screen were investigated. Project staff believed that the arrangements/methods approach would be more helpful to agencies to improve screening arrangements provided both by agency staff and community resources. Comprehensive, well managed screening arrangements should, in turn, result in the screening of all children early-on in the program year.

In order to describe the type of screening arrangements agencies had made, Project staff devised the following categories of description:

1. Direct specialist screening and systematic, supervised teacher observations;
2. Direct specialist screening and unsystematic, unsupervised teacher observations;
3. Systematic teacher observations with specialist supervision;
4. Unsystematic teacher observations with specialist supervision;
5. Systematic teacher observations without specialist supervision;
6. Unsystematic, unsupervised observations of teachers.

A direct specialist screening meant that a clinical specialist appropriate to the screening area (e.g., physician, speech pathologist, psychologist, etc.) directly observed or screened each child. Systematic, supervised teacher observations meant that the teachers used some type of standard tool or observation technique and their use of this tool or technique was monitored in some fashion by the specialist appropriate to the screening area. Systematic, unsupervised teacher observations simply meant that teachers used some standard tool to observe but they were not supervised by a specialist. Unsystematic, unsupervised teacher observations meant that the teachers were screening children by observing their behavior in the classroom/home without the aid of a standard tool and without any observation or help from a clinical specialist.

The findings presented here represent trends for a population size of one hundred forty-two (142) Head Start centers and sixty-nine (69) Home Start teacher caseloads (approximately fourteen children per teacher caseload). The two hundred eleven (211) centers or caseloads have a total enrollment of 4,284 children: 2512 children in Head Start centers and 1757 enrolled in Home Start. The data reported below were obtained from samplings of this total population.

Data are reported by screening area and in the following manner. Data from the first on-site visit encompasses only the intended screening arrangements as reported by agencies in October-November, 1974. Data from the second on-site visit encompasses the mid-year (January-February, 1975) report by agencies of the percentage of children screened, the type of arrangement used to screen these children, and the type of arrangements agencies intended to use to complete the screening of those children not yet screened.

MEDICAL/DENTAL SCREENING

Without exception, medical and dental screening arrangements had been made at the time of the first on-site visit (October-November, 1974). And, without exception, these arrangements were made with physicians and dentists. These practitioners were, for the most part, made aware of some exact screening information required by the Office of Child Development. Thus, under the described categories of screening arrangements, "Direct specialist screening and unsystematic, unsupervised teacher observations", was the arrangement for medical and dental screening at the time of first on-site visit.

During the second on-site visit (January-February, 1975), Project staff reviewed screening arrangements and asked for the percentage of children screened by this type of arrangement:

*From a sample size of forty-one (41) Head Start centers/Home Start teacher caseloads for medical screening, eighty-seven percent (87%) of the children had been screened by a physician and thirteen percent (13%) had not been screened.

*From a sample size of thirty-one (31) Head Start centers/Home Start teacher caseloads of dental screening, 84.8% of the children had been screened by a dentist and 15.2% had not been screened.

It was the intent of the agencies to continue efforts to screen those children not screened. In addition, the agencies intended to continue using the same type of arrangement for medical and dental screening, i.e., direct specialist screening without teacher involvement.

VISION/HEARING SCREENING

Arrangements for vision screening and hearing screening paralleled each other. Therefore, the findings are combined for this description. Screening arrangements intended at the time of the first on-site visit were heavily weighted toward the use of specialist screening (e.g., nurses, state operated screening clinics) for 79.2% of the 61 centers/caseloads in the sample. Other types of arrangements were planned for 20.8% of the centers/caseloads (see Table 4).

Table 4

Intended Arrangements for Vision and Hearing Screening

First On-Site Visit

Type of Screening Arrangement	Mean Percentage of Caseloads/Centers
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	79.2
#3 Systematic Teacher Observations with Specialist Supervision	5.2
#4 Unsystematic Teacher Observations with Specialist Supervision	0.0
#5 Systematic Teacher Observations Without Specialist Supervision	5.2
#6 Unsystematic, Unsupervised Observations of Teachers	10.4

N=61 Centers/Caseloads

Becaue of the technical nature of this screening, direct specialist screening (#2) was favored by OCD-BEH Project staff. The screening category with the next highest percentage (#6) described totally unsystematic screening. This prompted the OCD-BEH Project staff to make recommendations that the agencies attempt to arrange for direct specialist screening (e.g., nurses, special clinics).

The second on-site visit review of vision and hearing screening indicated that agencies may have been persuaded to use direct specialist screening as the desired arrangement. All of the children reported screened by the time of the second on-site visit (January-February, 1975) were screened by a specialist. The percentage reported screened was 82.0%. For the remaining 18.0% not screened, only direct specialist screening was being offered as the intended screening arrangement.

The most frequent recommendations made by the OCD-BEH Project staff were:

a. Try to arrange for a clinical specialist to screen hearing and vision;
b. Contact the following specific resources who may be able to help you.....;
c. Continue efforts to complete screening as soon as possible;
d. In the spring, make arrangements with specialists who you want to screen your children in the fall.

SPEECH AND LANGUAGE SCREENING

Intended arrangements for screening speech and language involved fewer specialists providing direct screening than was the case for medical/dental and vision/hearing screening. For speech and language screening the teachers/home visitors were relied upon much more heavily, often without in-service training, the use of a standard tool, or specialist supervision.

Direct screening of children by a speech pathologist and systematic teacher observations under the supervision of a speech pathologist (arrangement types 2 and 3) were considered best by the OCD-BEH Project staff. Many recommendations were made by Project staff during the first on-site visit regarding the recruitment of additional speech pathologists and about items that should be included in a speech/language screening.

Intended screening arrangements at the time of the first on-site visit favored the extremes. That is, the intended arrangements most frequently reported were for either direct specialist screening (type 2) or for totally unsystematic screening (type 6) (see Table 5). The types of screening arrangements favored by the OCD-BEH Project staff (types 2 and 3) were the arrangements intended for 50.8% of the 77 centers/caseloads in this sample. The intended arrangement was either direct specialist screening or for some type of systematic screening by teachers for 63.5% of the centers/caseloads (types 2, 3, and 5).

The review of screening during the second on-site visit revealed that the methods used for screening speech and language remained basically the same as the intended arrangements (see Table 6). The percentage of children actually screened by the preferred methods (types 2 and 3) was 49.75%. And agencies reported that they intended to screen another 10.5% of the children by these methods.

Table 5
Intended Arrangements for Speech and Language Screening
First On-Site Visit

Type of Screening Arrangement	Mean Percentage of Centers/Caseloads
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	47.6
#3 Systematic Teacher Observations with Specialist Supervision	3.2
#4 Unsystematic Teacher Observations with Specialist Supervision	0.0
#5 Systematic Teacher Observations Without Specialist Supervision	12.7
#6 Unsystematic, Unsupervised Observations of Teachers	36.5

N=77 Centers/Caseloads

The only significant difference between intended screening arrangements and the actual method used was the reduction in children screened by arrangement #5. The unsystematic, unsupervised observations of teachers (#6) as a screening method remained unfortuantely high.

The most frequent recommendations made by the OCD-BEH Project staff were:

a. Investigate the use of behavior checklists (language sections);
b. Ask speech clinicians to screen for language and voice disorders, as well as articulation;
c. Supplement teacher observations with the direct observations of a speech clinician;
d. Obtain training from a speech clinician.

Table 6
Mid-Year Speech and Language Screening
Second On-Site Visit

Type of Screening Arrangement	Percentage of Screenings Completed	Percentage of Screenings Incomplete/ Arranged
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	32.79	10.5
#3 Systematic Teacher Observations with Specialist Supervision	16.96	0.0
#4 Unsystematic Teacher Observations with Specialist Supervision	.96	0.0
#5 Systematic Teacher Observations Without Specialist Supervision	12.70	2.1
#6 Unsystematic, Unsupervised Observations of Teachers	35.7	0.0

N=77 Centers/Caseloads

MOTOR SCREENING

Intended arrangements for screening motor behavior also relied heavily upon teacher/home visitor observations without a consistent standard or specialist supervision.

At the time of the first on-site visit, the majority, 58.1% of intended arrangements for motor screening were totally unsystematic (see Table 7). In contrast, the Project staff favored direct specialist screening or systematic teacher/home visitor screening. The use of teachers to screen motor skills was viewed as a good arrangement if the teachers were provided with a standard tool for observation. This was the intended arrangement for 31.3% of the classrooms/caseloads.

Table 7

Intended Arrangements for Motor Screening

First On-Site Visit

Type of Screening Arrangement	Mean Percentage of Centers/Caseloads
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0
#2 Direct Specialist Screening and Unsytematic, Unsupervised Teacher Observations	10.6
#3 Systematic Teacher Observations with Specialist Supervision	2.5
#4 Unsytematic Teacher Observations with Specialist Supervision	0.0
#5 Systematic Teacher Observations Without Specialist Supervision	28.8
#6 Unsystematic, Unsupervised Observations of Teachers	58.1

N=77 Centers/Caseloads

During the second on-site visit, agencies reported that 57.1% of the children had been screened for motor skills in a manner favored by Project staff (direct specialist screening or systematic teacher observations). Thus, a greater percentage of children were actually screened via a favored method than was originally intended. Whereas the intent of agencies was to screen 58.1% of their centers in an unsystematic way, only 32.0% of the children were actually screened in this manner. For all children yet unscreened for motor skills, an arrangement involving systematic teacher observations or specialist screening was intended. Project staff viewed these changes as positive moves toward more complete and valid screening procedures.

Table 8

Mid-Year Motor Screening Completed and Arranged

Second On-Site Visit

Type of Screening Arrangement	Percentage of Screenings Completed	Percentage of Screenings Incomplete/ Arranged
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	14.9	3.1
#3 Systematic Teacher Observations with Specialist Supervision	30.2	1.2
#4 Unsystematic Teacher Observations with Specialist Supervision	2.3	4.3
#5 Systematic Teacher Observations Without Specialist Supervision	12.0	0.0
#6 Unsystematic, Unsupervised Observations of Teachers	32.0	0.0

N=77 Centers/Caseloads

The most frequent recommendations made by the OCD-BEH Project staff were:

a. Ask physicians to check specific neuro-motor functions when they are providing their medical (physical) screening;
b. Ask qualified specialists working with your program to observe all children for motor skill development;
c. Consider the use of a behavior checklist, by itself or as a supplement to what you are already using (e.g., Denver Developmental Screening Test).

SOCIAL/EMOTIONAL SCREENING

Of all screening areas, specialists were involved the least in the intended social/emotional skill screening. Again, at the time of the first on-site visit, the agencies intended to rely heavily on teachers to do the screening in an unsystematic and unsupervised manner (53.3%). Project staff favored the use of specialist screening or systematic teacher screening, but these arrangements were intended for little more than a third (38.4%) of the centers/caseloads.

The review of social/emotional screening at the time of the second on-site visit revealed that no children were screened by specialists. However, 40% of the children were screened systematically by teachers along with specialist supervision. Agencies had originally not intended to use that arrangement at all. Teachers/home visitors used behavior checklists and guidelines provided by specialists to accomplish this systematic observation. On the other hand, agencies had intended to screen 31.7% of their classrooms/caseloads by having teachers/home visitors use checklists but without specialist supervision. In actuality, only 3.0% of the children were screened via this arrangement. There was, from the Project staff viewpoint, insufficient reduction in the intended use of totally unsystematic screening. Initially 53.3% of the centers/caseloads were intended to be screened in this manner. Unsystematic and unsupervised screening actually occurred for 41.02% of the children and it was the intended arrangement for the remaining 1.8% of the children who remained unscreened for social/emotional skills.

Table 9

Intended Arrangements for Social/Emotional Screening
First On-Site Visit

Type of Screening Arrangement	Mean Percentage of Centers/Caseloads
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	6.7
#3 Systematic Teacher Observations with Specialist Supervision	0.0
#4 Unsystematic Teacher Observations with Specialist Supervision	8.3
#5 Systematic Teacher Observations Without Specialist Supervision	31.7
#6 Unsystematic, Unsupervised Observations of Teachers	53.3

N=77 Centers/Caseloads

The most frequent recommendations made by the OCD-BEH Project staff were:

a. Ask a psychologist who may already be observing in your classroom to specifically observe/screen for social/emotional skills;
b. Consider using a standard tool, such as a behavior checklist;
c. Try to establish firm screening arrangements in the spring for implementation in the fall.

Table 10

Mid-Year Social/Emotional Screening
Completed and Arranged
Second On-Site Visit

Type of Screening Arrangement	Percentage of Screenings Completed	Percentage of Screenings Incomplete/ Arranged
#1 Direct Specialist Screening and Systematic, Supervised Teacher Observations	0.0	0.0
#2 Direct Specialist Screening and Unsystematic, Unsupervised Teacher Observations	0.0	0.0
#3 Systematic Teacher Observations with Specialist Supervision	40.0	0.0
#4 Unsystematic Teacher Observations with Specialist Supervision	14.0	0.0
#5 Systematic Teacher Observations Without Specialist Supervision	3.0	0.0
#6 Unsystematic, Unsupervised Observations of Teachers	41.02	1.8

N=77 Centers/Caseloads

SUMMARY OF SCREENING ARRANGEMENTS/TRENDS:

To summarize the discussion of screening arrangements and trends noted, it may be helpful to view screening from a series of questions. These questions concern the time when screening arrangements were made, the time when screening was done, who did the screening, and the completeness of the screening.

1. When did the Head Start/Home Start agencies make arrangements for the various types of screening?

   It appeared that agencies had made arrangements for medical and dental screening either prior to or at the beginning of the year. Some agencies requested that medical screening be completed by a family's physician prior to the child's entry into the program. Dental screening was usually arranged to occur within the first two months of the program year. Vision and hearing screening arrangements were made by the majority of agencies after the program year began, but some agencies had not completed arrangements by the end of the second month.

   Arrangements for most developmental screening took place after the beginning of the program year. Speech/language screening arrangements were usually firmed-up earlier than arrangements for motor or social/emotional screening. As a result, agencies were able to make significantly fewer arrangements with clinical specialists to do the screening or provide much guidance to teaching staffs to do the screening.

   It appeared to the Project staff that, at the time of the first on-site-visit, the majority of agencies had not made a prior commitment to screen all children in the developmental areas of speech/language, motor, and social/emotional skills. At least these screening areas received much lower priority than medical, dental, and vision and hearing screening. Agencies which had not made prior arrangements for these types of developmental skill screening stated at the time of the first on-site visit that "Unsystematic, unsupervised observations of teachers," was their "intended" arrangement. On the other hand, it appeared that the continued emphasis of Project staff that these developmental skills should be screened led to more firm, complete, and appropriate arrangements as the year went on.

2. When was screening done?

   Medical and dental screening was completed prior to the

beginning of the program year for some children. Agencies placed most emphasis on medical screening and they attempted to get this screening completed by the end of the first month of the program year (partly to meet state day care licensing requirements). Nevertheless, at the time of the second on-site visit (January-February) medical screening was not complete (average 87% completed). Of the 13% of the children unscreened, most were either new to the program mid-year or their parents were balking (permission, transportation, or apparent lack of concern).

Dental screening also received a great deal of emphasis and most screening was completed by the end of the second month. By January-February, 15.2% of the children remained unscreened, largely due to the same reasons that some children had not received medical screening.

Vision and hearing screening was completed for approximately half of the children by October-November. This reflected the prior arrangements of several agencies to take their children to a State Department of Health vision and hearing screening clinic.

By January-February, 18% of the children remained unscreened. A few agencies still hoped to commit the state operated vision and hearing screening unit to screen the children, but arrangements were difficult to make because the work calendars of these screening units were usually filled well in advance.

Speech/language, motor, and social/emotional screening were nearly all completed for children in a few agencies which had acquired the commitment of clinical specialists (e.g., speech pathologists, psychologists, SLBP specialists) prior to the beginning of the program year. But most agencies relied on teaching staff to conduct these screenings. By January-February, approximately 88% of the speech/language screening, 91% of the motor screening, and 98% of the social/emotional screening was complete. But, of those children screened, more than one-third had been screened by the "Unsystematic, unsupervised observations of teachers." It was the impression of the Project staff that some agencies using this type of arrangement considered a child to be "screened" if the teacher did not request that a specialist evaluate the child.

3. Who did the screening?

The intended arrangements for medical and dental screening were carried through without any changes. All the children were screened by physicians and dentists or in supervised clinics (EPSDT). Likewise, all vision and hearing screening was conducted by specialists or volunteers who had been trained to conduct vision and hearing screening under the supervision of a specialist. Head Start/Home Start agencies which employed registered nurses or licensed practical nurses tended to ask these staff people to conduct vision and hearing screening.

Significantly fewer specialists conducted developmental screening than was the case for physical screening. Screening arrangements often changed significantly for developmental screening between October-November and January-February. Some of these changes were apparently due to workshops conducted by Project staff to sensitize teaching and administrative staffs to the availability and worth of criterion referenced assessment instruments (behavior checklists). In addition, a few agencies had requested and received in-depth training from the Portage Project, which encompasses a criterion referenced assessment/teaching approach.

Speech and language screening was not conducted by speech clinicians to any greater extent than was initially planned, but 20% more children were screened by teachers in a systematic way than was originally intended for the centers they attended. Intended arrangements for motor and social/emotional screening and the manner in which the screening was actually conducted changed little in terms of the people who would conduct the screening. That is, teachers were intended to do most of this screening and they did so, but in a much more systematic manner due to the use of behavior checklists.

4. How complete was the screening?

Medical, dental, vision and hearing screening was almost completed for all children by January-February (average 87% for medical, 84.8% for dental, and 82% for vision and hearing), as was stated under question two. Project staff made no attempt to determine the quality aspect of "completeness" as it related to individual

screenings performed by physicians and dentists. The only arrangement intended for screening those children who remained unscreened was direct specialist screening. Since all medical and dental screenings were performed by professionals, it was assumed that medical and dental screenings per se were of a reasonably high level of quality.

The quantitative completeness of speech/language screening was 88% by January-February. Qualitatively, however, more than one-third of the children were screened by teachers in an unsystematic and unsupervised manner. Project staff had reason to believe that this manner of screening resulted in too many false positive and false negative results. Several cases came to light where children should have been referred to a speech pathologist but were not referred, and many children were referred whose maturational speech articulation behavior was on target for age level. One positive qualitative note was that in several instances the intended screening arrangements for children not yet screened were to be direct specialist screening or systematic teacher screening (using behavior checklists). The quantitative completeness of motor screening by January-February was 91.4%. One-third of the children were screened in an unsystematic and unsupervised manner, which is a negative finding. However, the original intent was that 58.1% of the centers would be screened in this manner. Between the first and second on-site visits several agencies adopted the use of some form of systematic motor screening, usually behavior checklists filled-out by teachers. This was judged to be a qualitative improvement.

Social/emotional screening had been completed for 98.2% of the children by Januray-February. This was the highest percentage of completed screening reported for any screening area. However, more social/emotional screening was performed by teachers in an unsystematic and unsupervised manner than for any other area of screening. The quality of screening arrangements did improve between October-November and January-February with the adoption of behavior checklists as a screening tool for teachers. In addition, the recruitment of more school psychologists to come on-site to centers resulted in specialists observing all children in many classrooms. Agencies reported that 40% of the children were screened by specialists' general, on-site observations.

Project staff had hoped that all of the above screening data from FY75 could be used as a data base for the collection of similar kinds of data during FY76. With the directed changes in Project clientele for FY76, this was not possible. However, on the basis of one full year of consultation, data collection, and conversations with Mediator Team members, a few additional, general statements can be made.

Even though complete screening profiles were not available on all children early-on in the program year, agencies often reported that they were completing screening faster than in previous years. The implemented suggestions or recommendations of Project staff were often cited as the reasons for this. Agencies also reported that the percentage of children screened was often higher than in past years.

Overall, the quality of screening seemed to improve significantly over past years. Most agencies were arranging for more complete developmental screening. The type of instruments they used were often improved over the types they used in the past. It also appeared that children who failed screening were often followed-up more quickly than in the past (e.g., re-screening or referral for diagnostic assessment). Agencies were made more aware of the differences between screening for articulation, language, and voice. As a result, several agencies specifically asked specialists to expand their screening to include language and voice screening as well as articulation.

Finally, it appeared that Project staff emphasis on early screening (within the first 2-3 months of a program year) would result in more "prior" screening arrangements. In other words, agencies were asking specialists in the spring of the year to provide schedule time in the fall to screen their children.

It should be pointed out that the Project staff continually emphasized that screening tests/procedures were just that---- screening and not diagnostic. It was emphasized that results were to be used with caution. No diagnostic label was to be applied based on screening alone. Even when a diagnostic assessment was made by a specialist, Head Start/Home Start staff were encouraged to view diagnostic assessments as an on-going process which should result in better ways to provide education and other services to special needs children.

Summary of case management outcomes. Since the Project staff had not made contact with all Minnesota programs during the previous year (1973-74), no baseline data were available to compare with the above outcome results from 1974-75. However, based on observations of programs throughout 1974-75, and based on feedback from program staffs, it would seem reasonable to conclude that these staffs acquired new knowledge and skills which were applied to improve and expand delivery of services to special needs children. Although this conclusion is necessarily subjective to some degree, the following observations are offered to as substantiation:

1) As can be seen from the preceding description of screening, programs developed increasely sophisticated and coordinated screening systems, e.g., more clinical specialists were being recruited to do screening, greater numbers of teachers and other staff were trained to do some types of screening, more screening was being accomplished in motor, speech/language and social/emotional areas, etc.

2) Many more children were seen by clinical specialists for assessment as the year progressed and there appeared to be greater awareness of the need for multiple referrals with some children. This increase could be simply attributed to the passage of time, but the fact that so many more specialists provided service to programs in 1974-75 indicates that more children were being assessed, by some method, than had been the case the previous year. Feedback from many program staffs suggested that this was the case.

3) More teachers were receiving support from clinical specialists in the planning and implementation of intervention strategies as the year progressed. Again, the data from the resource mobilization section indicate that this was happening to a much greater extent in 1974-75 than in 1973-74. The resource mobilization data also suggest that teachers felt this type of support was important in bringing about successful interventions.

4) More efforts were taking place to provide continuity of services for children who were going to another educational setting. Prior to 1974-75, many programs did not even consider this to be a priority area and, thus, had not been engaging in transition efforts.

5) It appeared that more parents were being involved in decision-making, planning, and interventions with their children. One quantitative indicator of this is that more clinical specialists were providing parent counseling/education than previously.

Despite the apparent acquisition of case management skills and the resulting improvement and expansion of services, several findings and observations lend themselves to statements of need.

The sample review of case files pointed out the need for many programs to centralize information. Such centralization was often recommended as one

means of controlling the flow of data (for confidentiality purposes) and allowing easy access to those program personnel who should have the information.

Two types of records were glaringly absent from the files of several children: 1) copies of diagnostic reports; 2) progress reports from specialists. It appeared that programs tended to accept the verbal transfer of diagnostic information from some specialists. Programs were aware of the need for written documentation, but specailists were allowed some laxity in actually providing the written documents. The same appeared to be true for progress reports from specialists.

In only two instances had program staff written and compiled overviews of children based on diagnostic information from the various specialists a child may have seen. Although such overviews are not absolutely necessary documents, they could be useful to teachers, parents, and other program personnel when trying to gain a total perspective of a child's status.

In no instance did a program have a form indicating what kinds of information were included in an indivicual child's file. This type of form was suggested to most programs as a means to quickly identify what is in a file and to give an overview of services rendered to the child.

Programs did not routinely and periodically review central files to determine the presence or absence of screening information for all children. This type of routine and periodic review was recommended to all programs as a means of following-up the screening needs of children.

The data regarding diagnostic assessment pointed up several needs. It appeared that only half of the children in the sample had received all necessary diagnostic work-ups from specialists. Another 17% had received "most" assessments and an additional 26% "some" assessments. It is likely that more children would have received all necessary assessments had programs ensured that a clinical specialist was present at team meetings, or other types of staffings, for the purpose of helping to guide the case management process. The need for additional diagnostic assessments for some children might also have been realized if the programs Project staff had provided printed guidelines for programs to use when staffing special needs children. (Such a guide now appears in a revised edition of the Mediator's Handbook.)

In several instances a specialist had promised to evaluate a child "later" when his/her schedule was more free. Yet, in the spring several specialists still had not completed the evaluations. It might have been helpful for programs to attempt to establish definite dates with those specialists--or used some other means of reminder. Whatever the method, it appeared that programs allowed too long a time span between "reminders".

Although programs were continually encouraged to involve a child's teacher/home visitor in staffings, Mediator Team or other staffings, some opted to "inform" the teacher of staffing decisions. In these cases, the teacher may have attended some team meetings but not all. It is possible that the more frequent presence of teachers in staffings would have highlighted a child's needs even more and potentially would have resulted in the request for additional and timely diagnostic assessments.

According to the data regarding the interventions with children, it appeared that teachers/home visitors would have had no help with approximately 15% of the children had it not been for the efforts of other program staff and the Mediator Team. In spite of the statewide doubling of specialists working with programs during this one year, agencies were not successful recruiting the appropriate specialists for this 15% of the children in the sample.

Throughout the year, Project staff had encouraged programs to ask clinical specialists to come on-site to their classrooms, as opposed to transporting the special needs children to the specialists' offices for individual treatment/therapy. In fact, at least half of specialists serving Head Start/Home Start children during the year did come on-site for at least some time, and the kinds of services these specialists provided tended to expand. Never-the-less, 26% of the children in the sample received only one-to-one attention from specialists. Consultation with teachers and parents regarding the teaching of new behaviors/tasks was not provided by specialists for these children. Hopefully, this limited approach to intervention will be expanded as the movement to assume consultative roles increases in various professions.

When parent involvement is considered, it is obvious that more parents were simply informed of their child's status (27) as opposed to the direct involvement of parents (19) in the teaching of skills aimed at a particular special need. It appears that the additional involvement of parents in teaching particular skills needs to be a joint effort of teaching staff, coordinator staff, and clinical specialists.

During the Project staff's on-site consultation regarding transition of children from Head Start/Home Start to the next educational setting, several programs needed to be convinced that they should consider sending any information to the next setting, other than medical and/or attendance records. It appeared that these programs were overreacting to confidentiality and self-fulfilling prophecy issues. Programs were told that the schools needed to know about a child's strengths, gains, and the services provided to him in order to plan effectively and efficiently. This is especially true for children whose needs are complex. Most who were hesitant to consider sending anything but minimal information appeared to reconsider their stand.

The data that Project staff collected regarding transition was the least definitive of any case management area. Many programs had just begun to make specific arrangements for individual children. Therefore, questions to agencies were posed as an investigation of arrangements that were already made or arrangements that the programs planned to make. Multiple arrangements (two or more) were made or were planned for most special needs children sampled.

Clinical specialists and parents were the people most often involved in making transition arrangements. However, there was a significant percentage difference between specialists and parents (83% and 54% respectively). The percentage of public school administrators and kindergarten teachers involved was only slightly less than the percentage of parental involvement.

Under ideal conditions, the program staff, along with the parents, clinical specialists, school administrators, and kindergarten teachers who have had or who will have some direct responsibility for a special needs child should be involved in making such significant decisions as are involved in the transition of the child from one program to another. The implementation of new

federal legislation (P.L. 94-142) targeted at school districts (with Head Start as a probable "participating agency" under the law) should result in the involvement of all parents in transition planning, as defined under "due process". Likewise the involvement of a school administration representative is expected to increase, which should enhance decision making regarding special equipment, tutoring, etc. It appears very likely, therefore, that program staffs will be meeting with school based teams to mutually plan for the transition of special needs children.

The reader should note that Project staff did not concentrate on counting/confirming by diagnosis or diagnostic category all "handicapped" children in each agency. Project staff felt that their role was not one of enforcement or monitoring. Rather, the enforcement of the mandate to Head Start was the role of the regional Office of Child Development. It was believed that the Project staff should restrict itself to demonstrating methods by which programs could ensure that special needs children, regardless of the severity of handicapping condition, received appropriate and comprehensive services. Project staff did provide consultation to agencies regarding ways to recruit more special needs children. Suggestions were made regarding diagnostic confirmation of children suspected of having special needs. Agencies were informed of recruitment/diagnostic needs when it appeared that the ten percent minimum enrollment figure had not been reached. Across all Minnesota Head Start agencies, it appeared that approximately 400-plus children were (or were in the process of being) diagnosed as "handicapped" in 1974-75. Also, it appeared that few agencies had enrolled fewer than ten percent special needs children. Still, any "enforcement" aspects were considered the role of the Office of Child Development.

In conclusion, there was evidence to suggest that the case management objectives were met to some degree. There did appear to be improvement, both qualitative and quantitative, in the services delivered to Head Start/Home Start children, their families and the teachers who worked with them. Given the limited number of training and consultative contacts made by Project staff with each program, the outcome findings, such as they are, might be interpreted as reflecting a high degree of success for this aspect of the demonstration effort. (Counting workshops and consulting visits, the Project staff only had contact with any individual program approximately seven times throughout the year, and not all of these contacts involved training or consultation directly related to case management procedures.) On the other hand, it can be seen that there is room for greater improvement in programs' knowledge and application of case management techniques. Certainly, the availability of resources is a crucial variable contributing to successful case management outcomes. If there are limited resources available many of the service delivery objectives of case management cannot be met. However, it does appear that all approaches to obtaining various services were not explored nor exhausted. One contributing factor here is that individual programs obviously did not receive extensive training and/or consultation in this area during one year of statewide demonstration activities.

SECTION V
OUTCOMES--ESTABLISHMENT OF MEDIATOR TEAMS--YEAR 2

As stated previously, the Project staff did hope that the methods used to introduce and help implement the case management team concept, i.e., the "Mediator Team" concept, would result in programs perceiving this to be an effective way to organize their staffs for the purpose of carrying out the interrelated activities of resource mobilization and case management. It was definitely possible for programs to carry out some of these activities without the organizational vehicle of a formal team structure, but Project staff attempted to demonstrate to programs how such a vehicle could enhance efficiency and, in the long run, improve services for children, parents, and their own staff members. Thus, Project staff continued to provide training, consultative, and advocacy services related to case management and resource mobilization to the programs which did not establish teams immediately after the first workshop introducing the concept. However, most of these programs were also continuously encouraged to develop teams.

Data collection. As Project staff made on-site consulting visits to programs throughout the year, data pertaining to the following criteria were gathered: 1) members of a program's team or teams (some programs had more than one) were designated; 2) a team coordinator was assigned; 3) and the team was meeting with some degree of regularity (i.e., at lease once a month) for the specific purpose of case management of special needs children. These were the criteria by which the Project staff judged the existence of a team. Supportive data for these criteria were obtained from verbal reports of program personnel, examination of minutes from team meetings, and, with many programs, observation of at least one team meeting.

Unfortunately, it was not always possible to arrange visits at times when all team members could be present. Once Project staff had traveled to an area located a great distance from their home base (St. Paul), travel-cost and time factors made it necessary to attempt to visit all of the programs in that area before returning home. Thus, programs often had to adjust their schedules to meet those of Project staff. Although arrangements were usually made two or three weeks ahead of time, it sometimes was impossible for all program staff members to adjust their schedules and be present at the consulting visit. Of course, other factors undoubtedly caused the absence of some people. The greatest disadvantage resulting from the absence of some Mediator Team members was that a few meetings could not be held. Therefore, Project staff had no opportunity to observe and monitor the process of team meetings. Recommendations could only be made on the bases of what program personnel described about their meetings. In Project year three it was possible to avoid some of these problems, and Project staff developed improved training methods specifically related to conducting team meetings (see Sections VII and VIII).

Outcomes. It appears that the tools and methods used to introduce and help implement the Mediator Team model, e.g., the Mediator's Handbook, the summer "Mediator Workshop", the consulting visits, the "Mediator Media" newsletter, the four Team-related workshops, etc., resulted in the major-

ity of Minnesota programs perceiving this to be a relevant and potentially workable model. On evaluations of the initial summer "Mediator Workshop" presentation a majority of participants felt fairly strongly that the concepts could be applied, and that they had an interest in doing so. By the end of the 1974-75 program year, the Project staff judged that 17 programs (out of 35) had established a "formal" team and were carrying out case management/resource mobilization activities using this organizational vehicle. As stated above, these judgments were based on the criteria that: 1) members of the team had been designated; 2) a team coordinator was assigned; and 3) the team was meeting with some degree of regularity (at least once a month) for the specific purpose of case management of individual special needs children.

Another 10 programs had what the Project staff categorized as "informal" teams. These were programs which had no pre-arranged schedule for specific people to come together to discuss individual children but which did have staff who worked closely together to carry out the case management and resource mobilization functions outlined in the original Mediator's Handbook. All informal teams were located in smaller programs where staff sizes ranged from 3 to 12 and the number of centers (or Home Start "territories") ranged from 1 to 3. Although Project staff had encouraged even these small programs to set aside definite times for everyone to discuss the cases of individual children, it did appear that members of several of these staffs were able to carry out reasonably well-organized case management activities due to the on-going, close contacts inherent in their work situations. These assessments by Project staff were based on discussions with the program personnel and on reviews of children's files.

Two Minnesota programs eventually chose not to work with the Project at all (one of these was a program which operated in the summer only). Six other programs did not want consultation directly related to the Mediator Team approach but did attend workshops and received visits throughout the year.

For a variety of reasons several programs did not establish or have functioning teams until mid-way or later in the program year. Some of these programs had not attended the initial introductory workshop in the summer, and the Project staff had to introduce the team concept during the on-site consulting visits. (All of the programs which had not attended the summer workshop did work with the Project staff during the year.) Of those programs which had participated in the summer workshop, only 12 (50%) had made any attempts to establish a team prior to the first round of consulting visits made in the fall. It appeared that some of the programs which had not begun to organize a team were operating under the assumption that the first consulting visit was for the purpose of organization.

Disruptions within programs (e.g., administrative and other personnel turnover, funding problems, splitting up of agencies due to regionalization, etc.) were additional factors hindering some programs at different points in the year. In these cases, it simply took time before the program staffs felt they could direct, or redirect, attention to the team. This did not mean that the programs completely ignored their responsibility to

provide services to special needs children, nor did it mean that Project staff gave no assistance related to case management and resource mobilization. However, to these programs, organizing a team effort and holding team meetings were functions not seen as priorities when other problems were so pressing.

Still another factor that seemed significant, and one that played a part with many programs, was related to the role played by Project staff. Staff had to "prove" themselves by actually continuing to make on-site visits, to make follow-up phone and written contacts, to conduct workshops, and, generally, to provide services that were useful. It appeared that many programs had to be convinced that what was being offered would continue to be made available and would be relevant to their needs. Actual full implementation of the team approach did not come about in these programs until they had an opportunity to "test out" the utility of other ideas and recommendations of Project staff. It was obvious that personnel in several programs were initially rather skeptical about the value of training and consultation from professionals who they might seldom see and who might make suggestions which would be unrealistic or irrelevant for Head Start/Home Start people. Historically, the experiences of programs evidently tended to reinforce such notions about "consultants" and special projects. In some instances, these attitudes were just beginning to be disspelled toward the end of the year. It is quite possible that the initial skepticism of these people was reaffirmed when they discovered that the Project would no longer operate in Minnesota during the third year of its existence.

SUMMARY OF PROJECT YEAR 2

Was the demonstration of the broad-based service delivery model successful? Based on the outcome findings that were obtained, Project staff feel that the model has considerable merit. By providing training and consultation focusing on resource mobilization/case management techniques and simultaneously engaging in advocacy efforts, a small group of clinical specialists was able to set in motion a process which the data indicate resulted in a substantial increase in the number and quality of services provided to Head Start/Home Start children, families, and staffs throughout an entire state. There had been a facilitation of development of local community services to a level previously unattained in many areas. The vast majority of these services were provided at no charge to programs.

It would seem reasonable to suggest that the different components of the service delivery model could be applied by other service providers working with other programs and within other geographical parameters. That is, the model could probably be used by various types of clinical specialists, and possibly non-specialists, working with Head Start/Home Start or other kinds of programs. The model could also be applied by one service provider, or a group of service providers, working with one program or many programs scattered across a wide geographical area. It may be that adoption of this model by specialists, particularly those with a limited amount of time to serve programs, would be the most beneficial service that a specialist could provide.

The Project staff also feel that the Mediator Team model, or the individual resource mobilization and case management components of the model, could be applied successfully by many Head Start/Home Start programs. The extent to which training and consultation are necessary for any given program is not completely clear. When first introduced to the case management team approach via the original Mediator's Handbook and the intensive summer workshop, many Minnesota Head Start/Home Start personnel did not initially perceive the relevance or practicality of the various concepts for their own programs. It was not until the workshop was completed (or, in several cases, the on-site consultation visits were carried out) that these people began to realize that they could benefit from implementation of these concepts. (Issues related to amount and types of training/consultation will be discussed further in Sections VII and VIII.)

To this point in the report, the reader has had to rely on evaluations and interpretations of evaluation findings made only by Project staff. The next section (VI) presents findings of an evaluation study conducted by a team of independent investigators.

SECTION VI
OUTCOMES--INTEGRATION OF HANDICAPPED CHILDREN--YEAR 2

It was assumed that all of the outcome objectives established by Project staff at the beginning of the year-long demonstration effort in Minnesota would contribute to the overall goal of integrating handicapped, special needs children into Head Start classrooms. Because staff realized time would not permit a careful study of integration, and because an independent investigation would be preferrable anyway, a contract was awarded to an outside agency to examine the status of integration in Minnesota programs and, if possible, identify any Project activities contributing to integration.

The contract for this evaluation study was awarded to the Community-University Health Care Center in Minneapolis. The study was carried out in February and March of 1975. Although Project staff were necessarily involved in helping to plan some aspects of the evaluation design, the programs actually sampled and evaluated were unknown to the staff. The princiapl investigators were Richard Coder, Ph.D. and Joanna Coder, M.A. The following pages contain the verbatum report received from the Coders.

Independent evaluators were asked by a State Project staff to examine the following questions:

1) Is integration of handicapped children into the Head Start program happening?
2) If so, is integration happening as a result of the efforts of the State Project?

Some Federal guidelines had been offered as indicators of what integration meant: a) ten percent of the children in Head Start were to be handicapped children, b) the children were to be diagnosed as handicapped by a specialist, c) to be handicapped meant a child who needed more than the routine Head Start services typically provided (a child who needed eyeglasses was not considered handicapped, a child who needed a hearing aid was considered handicapped) d) the handicapped children were to be physically and psychologically integrated in the classroom (or home start, or field trip of whatever activity).

Excepting psychological integration, the quantified results presented below indicate that Head Start in Minnesota met or exceeded the Federal guidelines.

The question of psychological integration has been raised but not developed in evaluations of preschool programs in general and Head Start in particular.

Past studies, (Cicerelli, 1969, 1970; Smith and Bissell, 1970) have presented results centering on end products of Head Start. That is, their studies have been concerned with school achievement, number, letter, and color recognition, socialization, all quantified through test scores or some other variable in the form of mathematical reduction.

Further, such studies have raised much controversy. Part of the controversy has been rooted in the question of whether evaluators understood the original purposes of Head Start. While evaluators were on the industrial psychologists' track, (see Kohlberg, 1971) searching for signs of IQ gains and school achievement, the original planners of Head Start had stated as goals the improvement of the child's health and physical abilities first of all, then, secondly, "the encouragement of self-confidence and spontaneity, curiosity and self-discipline which will assist in the development of the child's social and emotional health" (OCD N-30-364-1, 1973). As a third goal they mentioned the enhancement of the child's mental processes and skills, but never intended IQ point gains or school achievement to be a goal of Head Start (Zigler, 1969).

In any case, psychology came in to examine Head Start with its traditional objective tests and tables, scientizing the original concerns resulting in end point objectifications.

The present study did not have as its charge to look at the achievement issue, educational success or progress of individual children, but, rather to find out about integration of special children - was that taking place? What did integration look like?

Such a charge meant the evaluators had to look at the ongoing process, the way the participants were experiencing the coming of special children into the Head Start program. If the evaluators in this study were to avoid the earlier problem of defining the area of concern from a privileged perspective, they wanted to approach integration from the perspectives of those who were really living it, the children, the parents, the aides, the teachers. Because this study was limited in scope it concentrated its efforts on the perspectives of the teachers.

Such an approach seemed to make good common sense. Moreover, it was consonant with the theoretical foundations of Psycholcgy as a specifically Human science (Giorgi, 1972; Merleau-Ponty, 1963; Graumann, 1970). Human-science psychology attempts to address the multiple perspectives out of which reality is constituted. The quantitative perspective of the traditional scientist is only one aspect of reality and not the most appropriate one from which to understand psychological processes in general and, in this study, integration in Head Start.

Collaborative Method

Approach. Part of the evaluators' task was to help the teacher reflect on and articulate her experience of being with special children in the classroom. Further, the evaluators wanted to be sure they were talking about a common referent from the teacher's world, and not an abstraction from their own academic backgrounds on the one hand, nor from the teacher's private world on the other.

If the evaluators had been satisfied to simply observe the children, teachers and classroom, they would have been recreating psychology as privileged vantage point. The information gathered would have come from the evaluators' perspectives only. They could not have contexualized what they saw, corrected notions and retested them. Posing as experts they would have come away with one side of a many-faceted event.

A teacher interview, on the other hand, would have gathered information from the teacher's perspective only, from her private world. Again, much information would have been missed.

Finally, observation plus an interview would not have provided common ground.

The evaluators sought a shared event, a juncture through which teacher and evaluators would labor together to allow their perspectives in inform each other toward a fuller sense of integration in the classroom. Through such a juncture, the evaluators and teachers could come to know the lived whatness of integration and be informed to promote how integration was happening in the classroom and intervene where it was not.

This general approach could utilize many tools. (See Fischer, 1973, for individual and systems collaborative assessment.)

Kagan (1972) has presented findings supporting the usefulness of an unstructured "recall" in which people view themselves immediately after a videotaped event. Kagan's use of his model was to teach clinical skills by having people view themselves reacting to their interaction with a client. Through the use of this model, the lived event was preserved. Yet, the subjects were able to gain distance, to see themselves interacting as a lived event and respond to it from new perspectives. Such a model readily suggested itself for use in this study: it preserved the lived event, gave participants distance from it and allowed examination from several perspectives.

Ivey (1971) has also presented studies in which videotape was used to teach counseling skills. Similar to Kagan, Ivey demonstrated the usefulness of having people view themselves. In his work, Ivey showed how the process could be used to develop behaviors useful to the client, provide immediate feedback and minimize the risk-feeling of the client. Results included increased client participation and feedback and sense of having his own perspectives taken into account.

The evaluators drew from both models then, emphasizing particularly the notion of videotape providing the shared event, with the teacher being at home with the data, thus motivated to participate and feeling no need to defend her position. It was hoped that the teacher would thus not view herself as the subject examined by experts but rather as co-evaluator of integration.

Videotape as the tool theoretically offered several practical advantages. First it allowed the gathering

of a maximum amount of data in a minimum amount of time. Second, it was fairly nondisruptive, and finally it provided a visual recording of the shared event.

Procedure. All of the Head Start agencies in the State were informed of the evaluation, told of the procedure and that they were free to cooperate or not with the evaluation as they wished. It was made clear that the State Project Staff and not the agencies or classrooms were the targets of the evaluation. They were told that the evaluators wished to come on convenient days but unannounced.

Ten Head Start classrooms were randomly selected for the on site evaluation. The sample was chosen so that an appropriate representation from large and small cities, well funded and under funded centers, large and small agencies, all various areas of the State, urban and rural, north and south, near the large cities or more than one hundred miles from them, and those connected with Public Schools and those not, was obtained.

Three centers were from large urban areas, one from a small city, six were rural; two centers were in large agencies, eight were in smaller agencies; four centers were well-funded, six were moderately to under-funded; the location of the centers visited stretched from the far north east corner of the state, to the far central west, to the southeast and south central. None of the centers were connected with Public Schools. In the original draw three centers were part of public schools. However, the evaluators were not allowed to carry out their work in those centers.

The same team of two evaluators visited all the centers. The third member of the team was a video technician. For half of the centers the video technician was an undergraduate psychology major who had received specific training in videotaping children prior to the site visits. For the other half, a graduate student in psychology who had had extensive experience both with preschool children and videotaping them, served as the technician.

One of the evaluators was a male psychologist who introduced the team to each Center staff, made arrangements for videotaping and the teacher's review of it and was responsible for all the concerns and questions the teacher or agencies had. He also served as an independent observer rating integration of the children while he observed the classroom during the taping. The second evaluator was a female psychologist who had extensive experience in working with preschool children.

Her role was to direct the cameraman. She also served as an independent observer and conducted the video recall.

Two days before the planned visit the evaluator called the agency director to tell her or him which center in the area had been selected for a site visit, reexplained the procedure and asked permission to call the teacher or teachers and ask their cooperation. The teacher was then called, the day and time set, procedures reexplained, assurances given that they were chosen by happenstance. The evaluator asked not to be told of any special children until after the videotaping.

On the day of the visit the evaluator introduced the evaluation team. The teachers in all ten centers introduced the team to the staff and children, and explained that the team was going to take television pictures of them. The teacher then went on to her regular routine and videotaping began. A Sony Portapack with half-inch videotape was used. For half the centers the camera was held waist high by the technician who directed the camera by using a mirror to view the children through the camera and follow the action. In the other half of the centers the camera was held at eye level by the technician while he knelt to be on the children's level. The former approach seemed to draw less attention from the children although only a few children followed the camera held at eye level to perform in front of it.

The attempt was made to tape the classroom as it regularly functioned with aides, volunteers, parents and observers going about the typical routine of their day. A minimum of fifteen minutes of activity was taped in each center.

Since each classroom had its own routine varying somewhat from the others, the evaluators could not use a precise plan of when to videotape which particular activities. However they had the following goals as guides:

1) To "pan" the room to get a complete picture of and orientation to the setting the children were in;
2) To videotape each child for at least a few seconds;
3) To videotape transition periods, for example from group to handwashing to snack;
4) To watch for any incidences of children being by themselves, apart from the group.

Thus, the fifteen minutes of tape included several cuts of activities that might have spanned as much as three

hours. The evaluators and technician followed the routine of the classroom, at one time into the kitchen for a bread-baking group time, at another into the bathroom for toothbrushing. The team maintained an observer relationship to the children during the entire duration of the taping, that is, none of the members of the team interacted with the children during the videotaping.

Immediately after the videotaping the teacher and evaluators left the classroom to view the tape. The teacher was instructed in operating the videotape recorder-playback machine and given control of playing the tape. She was asked to run the tape and tell the evaluators about the children - whichever children she chose, and in whatever order she chose.

Following Kagan's notion of an unstructured recall, instructions to the teacher were not made more explicit to allow her to describe those things she was attending to. In this way each teacher showed her own pattern of noticing and not noticing behaviors and children. The teacher was enabled to take the lead in describing the children and behaviors that were of most concern to her not only on the day of the evaluation, but also throughout the year. Finally, such a procedure allowed for Scriven's (1969) notion of being ready to collect data not originally sought.

The teacher, then, was able to stop any scene on the video monitor and hold it still for view while she described the child or the interaction which she had chosen to discuss. While the teacher commented on the videotape, a second videotape was being recorded of the original videotape adding the audio portion of the teacher's description. Prior to the beginning of this time, the teacher was reassured of the anonymity of the evaluation and the confidentiality of her descriptions and comments, as well as her freedom to interrupt, terminate or leave the sessions at any time. During the viewing of the tape, the evaluators made sure, through questions and comments that the following areas were included in the teachers' comments: The special needs children; how they got to be enrolled in the program, problems that accompanied integration, changes made to serve special needs children, resources from which help was available, the availability of resource people or team from their own agency, how helpful such resources were for integration, what things were helpful in integrating the children, preparation with Public Schools for the children's entrance and, finally, the teachers' and children's comfort with the handicapped child in the classroom.

When the teacher turned off the tape for the final time, all the machinery was turned off and the teacher asked if there was anything further she wished to add, and if so, did the collaborators have her permission to note it. She was then asked if she wished to review the new transcription for deletions or addenda. The videotape of the classroom together with the teachers' commentary thus served as the data for the collaborative evaluation. More specifically, the videotape served as the publicly perceivable shared phenomena to which evaluators and teachers could refer, the discussion between teacher and evaluators as the biographical presence. Through this data the evaluators were able to gain access to the phenomenon of integration of special needs children. Finally, teachers, aides, volunteers, and children were given the opportunity to view the original tape, not as part of the data collection so much as part of the evaluators relation to the classroom.

Results of Collaborative Assessment:

In every center, the evaluators found that the number of special needs children equalled or exceeded 10%.

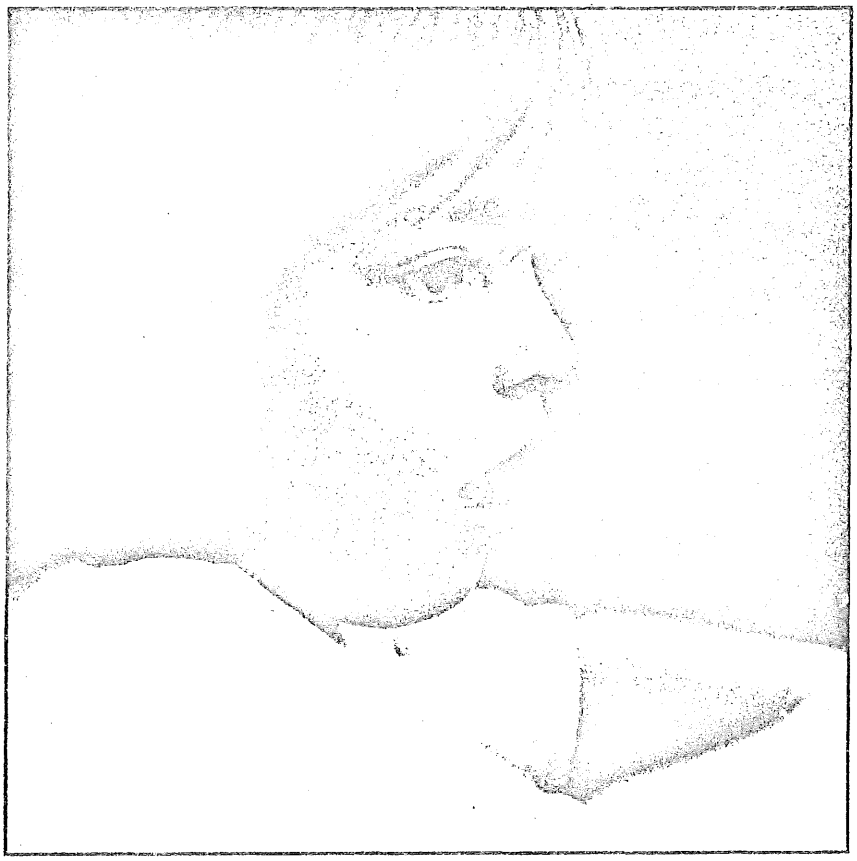
The evaluators, again in every case, observed a normally functioning classroom in which children were playing or working together, or comfortable with being alone.

The evaluators also saw teachers and adults in the classroom attending indescriminately to all the children with the same concern and attention.

Finally, observers found the children comfortable about being with a child who couldn't see, or a child with crutches, or a child acting strangely and omitting strange noises.

What did the teachers say brought about integration? Quite simply, the mandate. They were most willing to follow the mandate, yet had certain fears of the unknown about dealing with special needs children.

The teachers in every case mentioned, in one form or another, the State Project Office as the means by which their fears were allayed and they themselves were enabled



SPECIAL NEEDS PROJECT QUESTIONNAIRE

How is integration of special needs children working out at your Center? Has help been offered you to aid integration? A Special Project Staff concerned about these questions has asked for this information. One of the ways we are seeking this information is through the following questionaire.

Would you kindly answer the following questions? The questionaire is usually completed in twenty minutes. The information you give us will be confidential and anonymous. We will send you a summary of our findings as soon as possible.

1. Agency_____
2. Center_____
3. Sex of Respondent _____

	Last year	This year
4. Years at Center (Agency)_____		
5. How many classrooms in the Center?	____	____
(How many children in the Agency program?)	____	____
6. How many children in your class?	____	____
7. How many children have special needs?	____	____
Realizing that children may have more than one special need, how many of the following special needs do the children have:		
a. physically disabled	____	____
b. visually impaired	____	____
c. hearing impaired	____	____
d. delayed speech	____	____
e. learning disabled	____	____
f. serious emotional difficulty	____	____
g. difficult behavior	____	____
h. other	____	____

8. How were the special needs children identified?

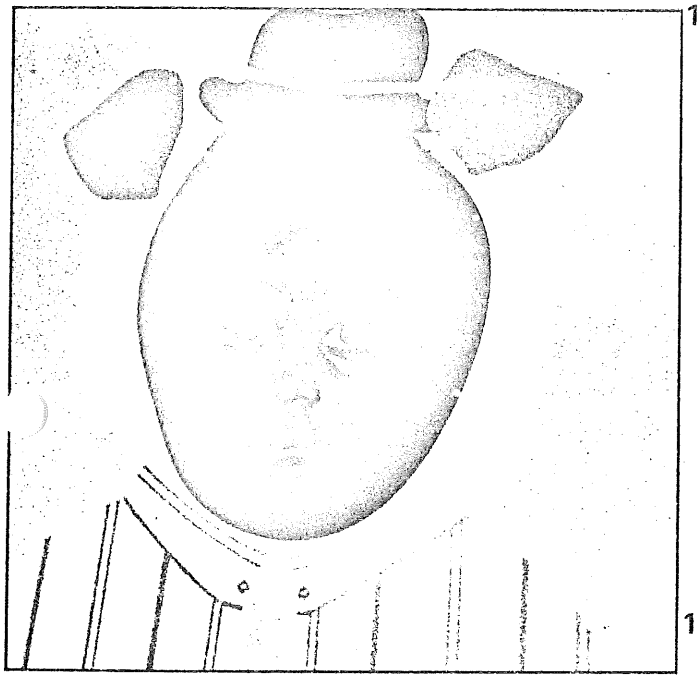
	Yes	No	How many
a. Recruited to enter the program	☐	☐	____
b. Children already at the Center, were identified by staff (with no subsequent assessment by specialist)	☐	☐	____
c. Were identified by staff and then assessed by specialist	☐	☐	____
d. Were identified and/or assessed by specialist	☐	☐	____

9. Describe briefly special problems that came with the added emphasis on integrating special needs children?

a. _____

b. _____

c. _____



10. With added emphasis on integrating special needs children did you use any of the following to solve the problem (did teachers make requests for any of the following):

	Last year		This year	
	Yes	No	Yes	No
a. Change the physical arrangement of the room	☐	☐	☐	☐
b. Add special equipment	☐	☐	☐	☐
c. Redo the daily schedule	☐	☐	☐	☐
d. Substantially alter curriculum	☐	☐	☐	☐
e. Simply vary planned curriculum	☐	☐	☐	☐
f. Add staff for classroom help	☐	☐	☐	☐
g. Call special parent conferences	☐	☐	☐	☐
h. Consult with a specialist for specific planning for a child	☐	☐	☐	☐
i. Consult specialist for total classroom planning	☐	☐	☐	☐
j. "Team" meeting to plan for a child	☐	☐	☐	☐

11. Either from the above or adding to the list, describe what you did that you consider most helpful toward integrating special needs children.

_____

_____

_____

12. What resources, agencies or specialists have you had contact with for help with special needs children?

	Agency/Specialist	Function	Last year	This year	Helpful Yes	Helpful No
a.			☐	☐	☐	☐
b.			☐	☐	☐	☐
c.			☐	☐	☐	☐
d.			☐	☐	☐	☐

13. Has your agency or Center formed a special team or program to aid integration of special needs children?

Yes ☐ No ☐

If yes: When? _____

Do you know how to contact the special team or program?

Yes ☐ No ☐

Briefly describe the special team or program:

_____

14. Have you talked with a member of the special team or program this year regarding special needs children?
Yes ☐ No ☐
If yes: What did you discuss? _____

_____

_____

_____

15. Now return to Question 12. If the special team/program assisted in making the contact or was the contact, mark an S in the space in front of the number.

16. Do you plan to encourage the continuation of the special team or program your Center formed to facilitate integration of special needs children?
Yes ☐ No ☐ Didn't form one ☐

17. What other resource agencies and specialists do you now know of that are available to you although you have not contacted them so far?

18. If you attended workshops intended to facilitate integration, do you think they were helpful?

	Yes	No	Didn't attend
a. for director	☐	☐	☐
b. for teacher	☐	☐	☐

19. At this point do you favor integrating special needs children with "regular" classrooms and programs for children?
Yes ☐ No ☐

20. Rate your comfort in working with special needs children:

	Very uncomfortable					Very comfortable
Physically disabled	1	2	3	4	5	6
Visually disabled	1	2	3	4	5	6
Hearing disabled	1	2	3	4	5	6
Speech disabled	1	2	3	4	5	6
Learning disabled	1	2	3	4	5	6
Severe emotional	1	2	3	4	5	6
Behavior	1	2	3	4	5	6
Other special needs	1	2	3	4	5	6

21. Have the following skills, discussed at workshops, learned from readings or the like, helped you with the special needs children:

	Yes	No
Task analysis	☐	☐
Observation skills	☐	☐
Language stimulation	☐	☐
Management of the individual child	☐	☐
Planning for the individual child	☐	☐

22. Is the process of referral to obtain help for special needs children easy to use?
Yes ☐ No ☐

23. Have contacts of any sort been made with the Public Schools regarding continued integration of special needs children into the classroom?
Yes ☐ No ☐

24. How enjoyable have you found your contacts with the staff from the State Office?

Not very enjoyable					Most enjoyable
1	2	3	4	5	6

Our sincere thanks for your cooperation.

Richard Coder

Richard Coder
For the evaluation team

Fold here

HEAD START
SPECIAL NEEDS PROJECT
2016 16th Avenue S.
Minneapolis, MN 55404

Staple here

to integrate the children. In some cases the teachers emphasized the workshops, in others, the mediator team, still others the links with local resources the State Project Team had helped them make.

The category of special needs most difficult for teachers to deal with was emotional-behavioral problems. Further, whereas teachers had been enabled to find effective resources for other special needs, and especially speech and language needs, the resources they found least helpful were the mental health ones.

A Special Needs Project Questionaire was sent out to 200 Minnesota Head Start Centers, and 100 centers in a State similar in geographic and demographic characteristics to serve as a comparison group. Seventy-five Minnesota Centers responded, and 48 comparison centers returned completed questionaires.

On the average, the comparison state teachers had been with Head Start Programs about a year longer than Minnesota Respondents (4.4 years for the comparison, 3.3 for Minnesota). There was a significant increase in the number of children with each disability in both Minnesota and the comparison State from 1974 to 1975. The increase in Minnesota for 1975 was significantly greater than that of the comparison for children with visual and hearing handicaps and delayed speech.

Increasing attempts to aid integration, 72% of the Minnesota respondents substantially altered the curriculum, with 77% of comparison respondents reporting the same. Almost 87% of the Minnesotans reported adding staff for classroom help. In the comparison State, 71% added staff. Again in Minnesota 73% had used a Team of specialists to make plans for special needs children. Of the comparison respondents, 64% reported a similar Team function. In Minnesota Head Start, the Respondents indicated a shift in consulting patterns from 1974 to 1975. In 1974 there was heavier reliance on individual specialists in assessing and planning for individual children; in 1975 there was a strong shift to the Team's assessment and planning function (15% greater emphasis on the Team). Changing curriculum substantially and introduction of the Team were the two actions Minnesota respondents considered most helpful toward integrating special needs children.

The formation of a Mediator Team to facilitate serving and integrating special needs children was a prime goal of the State Office Special Project. The success of meeting this goal is shown by the fact that almost 70% of the respondents had formed such a Team, and more than 70% both knew the procedure for contacting such a team and had in fact contacted and worked with such a team. Further, 100% of the respondents who had formed a Team were not only in favor of the concept of the team but planned to continue the notion in their centers.

Another effort of the State Office Special Project was conducting workshops to help directors and teachers in the process of integration. Of the directors attending, 27% said they found the workshops helpful, whereas 76% of the attending teachers reported they were helpful. Among skills discussed at the workshops, 76% of the respondents found Task Analysis helpful, 92% observation skills, 89% language stimulation, 83% management techniques and 90% planning for the individual child.

The Special Project team hoped to achieve other goals as well: increase in comfort level of teachers working with handicapped children, making the process of referral of special needs children easy to use, facilitating and encouraging contact with the Public School system for entry of special needs children from Head Start to the Public School classroom.

The results of this study show that 67% of the respondents found the referral process easy to use, and over 90% had been in contact with the Public Schools to provide smooth transition of the special needs children. The comfort level as reported by the respondents was above average in every disability area, with comfort level with severe emotional disturbance being lowest, and comfort with speech disability reaching the highest level.

The respondents were asked if they favored integration. Although data collected indicated a high percentage in Minnesota and the comparison state favored integration, the differences were still great with 96% in Minnesota favoring integration whereas in the comparison State 81% favored integration.

Finally, the Minnesota Special Project Team had hoped to enhance the chances of successful integration by good public relations -- hoping to represent the State Office in a positive light. To check on this the evaluation team asked the respondents how enjoyable their contacts with the State Office had been, on a scale from 1, not very enjoyable to 6, most enjoyable. The average response in Minnesota exceeded 4, in the comparison State, the mean response was less than 2, attesting to the success of this goal.

The collected, tabulated results have provided further evidence for what the evaluators learned during their personal observations and interviews: The Centers were serving handicapped children with a high degree of quality, the number of such children far exceeded 10%, and they were integrated.

The teachers were enthused about integration, felt confident about it in mid-school year 1975, and attributed the confidence and success to workshops provided by the State Office, local Teams of specialists, but especially to their contact with the Special Project Team from the State Office.

TABLE 1

(Mean Responses)	Minnesota 1974	1975
No. of classrooms per Center	2	2.7
No. of children in Center	85	111.0
No. of children per classroom	12	17.5
No. of physically disabled	.3	1.0
visually impaired	.5	.7
hearing impaired	.6	1.1
delayed speech	2.5	4.5 (significant increase)
learning disability	1.0	1.9
serious emotional difficulty	.5	1.1 (significant increase)
difficult behavior	.7	1.3 (significant increase)
Number of children (special needs) recruited into the program		89.3
Number identified by staff		78.5
Number identified by staff then assessed by specialist		88.5
Number identified by specialist		80.4

TABLE 2

Did you use any of the following to aid integration?

(In Percentages)	Minnesota 1974	Minnesota 1975	Comparison 1974	Comparison 1975
-Change physical arrangement of the room	6.7	12	21	15
-Add special equipment	22.7	36	40	23
-Redo the daily schedule	20	44	17	48
-Substantially alter curriculum	44	72	31	77
-Vary planned curriculum	16	48	10	48
-Add staff for classroom help	30.7	87	27	71
-call special parent conferences	12	19	8	21
-consult specialist for specific child planning	25.3	24	19	39
-consult specialist for total classroom planning	52	40	40	31
-Team meetings	69	73	54	65

TABLE 3

Have the following skills learned at workshops helped you with special needs children? (in percentages)

	Minnesota
Task analysis	76
Observations skills	92
Language stimulation	89
Management of the individual child	83
Planning for the individual child	89

TABLE 4

Comfort in working with special needs Mean Response, scale 1 (low) to 6 (High comfort)	
Physically disabled	3.8
Visually disabled	3.7
Hearing disabled	4.08
Speech disabled	4.40
Learning disabled	3.80
Severe emotional	3.36
Behavior	3.77

SECTION VII
DEMONSTRATION ACTIVITIES AND OUTCOMES IN MINNESOTA--YEAR 3

This section presents the on-going demonstration activities which were conducted with three Minnesota programs during the third Project year. Also, outcome findings from these three programs, as well as some findings from all Minnesota programs, are presented.

During the third year of the grant, Project staff had hoped to continue to work primarily with Minnesota programs. Although aware of the possibility that some dissemination or "replication" efforts would probably be required outside of Minnesota, it was assumed that further demonstration activities in Minnesota would be the major responsibility. This seemed appropriate in view of the fact that the statewide service delivery system had been in place for only one year and individual programs had received only a limited number of training/consultative contacts. Many programs appeared to have developed at least rudimentary case management teams and/or were carrying out improved case management/resource mobilization procedures. On the other hand, several programs were just beginning to implement teams. Also, the possibilities for the advocacy component of the system were far from fully explored or demonstrated. And, as stated previously in this report, the opportunities for extensive evaluation of demonstration outcomes had been limited during the second Project year.

Because the Minnesota programs were large in number and were a fairly diverse group in terms of size, geographic location, availability of local resources, etc., it seemed that the replicability of the team model and its components was to some extent already being demonstrated. However, in late spring of 1975 specific direction came from the Office of Child Development that all of the experimental projects were to spend the major portion of their time in the third year replicating or disseminating their models outside of their previous areas of operation.

At this juncture, the Minnesota Project staff began to question the wisdom of the decision to demonstrate a statewide service delivery system. Had the staff been privy to the knowledge that the third year was to be for out of state replication primarily, it might have been more appropriate to have worked with only a few target programs and to have devoted more time developing and evaluating training approaches and materials with just these programs. On the other hand, it seemed that by taking the approach it had, the Project already had provided some evidence of the replicability of the Mediator Team approach and at the same time had begun to demonstrate a system through which implementation of this approach and the supportive advocacy functions could be accomplished on a large scale.

On-going demonstration activities in Minnesota, 1975-1976. The Project was to work with three Minnesota programs. The purpose of working with these programs was twofold. First, it afforded some opportunity to assess the carry-over effects from Project training and consultation provided during the previous year. That is, it enabled Project staff to observe, first hand, to what extent the Mediator Team and related activities had been

continued and improved since the previous year. Of course, the sample of programs was very small and also biased due to the selection procedures (described below). The second reason for working with these programs was to attempt to develop stronger, more effective teams. The three programs were randomly selected from a larger group, all of which were judged to have the potential to develop exemplary teams with additional support and technical assistance. The agencies chosen by the Project staff and confirmed by Region V OCD were:

Inter-County Community Council Home Start
P.O. Box 187
Oklee, Minnesota 56742
Mr. Lowell Enerson, Director

Duluth Head Start
Board of Education Building
Lake Avenue and Second Street
Duluth, Minnesota 55802
Ms. Eldora Rechsiedler, Director

Goodhue-Rice-Wabasha Head Start
Zumbrota, Minnesota 55992
Ms. Kathy Swarthout, Director

When the Project staff began to explore future directions with the three Minnesota programs it was immediately apparent that each of the programs had remained committed to the case management team concept and had continued to use teams in the current program year as they had in 1974-1975. Despite the limited number of training and consulting contacts which the programs had been able to obtain from the Project staff in 1974-1975, it appeared that they had incorporated at least the most basic Mediator Team concepts into their individual teams.

On the other hand, each of the programs expressed the concern that their knowledge and skill was limited regarding how to conduct efficient team meetings and carry out effective overall case management. The staffs were uncertain of such things as how frequently to meet, how many children to discuss at each meeting, how to make the best use of their time at meetings, how to use specialists on the team, how to recruit more specialists, how to document the progress of case management for individual children, etc. Although most of these areas of concern had been dealt with by the Project staff the previous year, it was evident that the amount of training and consultation had been insufficient to enable the teams to feel secure and confident as they carried out the various team functions. Given the scope and complexity of the team concept, this was not surprising. Thus, the Project staff began to address these areas in its work with the Minnesota programs.

Unlike the situations that had sometimes existed in 1974-1975, Project staff were able to meet with most team members when visiting the three programs. Thus, staff were able to observe and provide feedback to the teams as they conducted meetings. Much of the consultation emphasized methods of conducting efficient and effective team meetings.

The Project staff developed a training approach which first involved presentation of a mock team meeting. This video taped meeting had been role-played by Project staff (and others) to illustrate those concepts and approaches which had been contained in the original Mediator's Handbook plus modifications and additions based on knowledge acquired by Project staff during the year long demonstration effort in Minnesota. These modifications and additions are reflected in the revised edition of the Mediator's Handbook.

After the video tape was shown, program team members were asked to conduct a meeting of their own which was video taped. This tape was replayed for the team members, and they were asked to evaluate various aspects of the meeting process. Project staff also offered feedback regarding the mechanics, dynamics, and content of the meeting process. This training approach was used whenever possible with the Minnesota programs and was also used with the out of state programs selected to work with the Project (see Section VIII). In those cases where video taping was not possible, the Project staff simply observed meetings and provided feedback about the meeting process and content. Further resource mobilization and enhancement of existing services were topics also continuously dealt with as staff consulted with the programs.

Additional activities were conducted as a part of a specific contract with the BEH/UNISTAPS Project. This contract was developed as part of the on-going collaborative efforts between the two Projects. (The contract was agreed upon relatively late in the third year and, therefore, was not specifically stipulated in the work plan submitted to Region V OCD.) Appendix 17 is a report which was submitted to the UNISTAPS Director at the conclusion of the contract. Because this report describes in some detail the manner in which the Minnesota programs operated teams, developed collaborations with service providers and carried out case management, the reader is referred to the report to assess the functioning of the three Mediator Teams during 1975-1976.

Outcome findings based on follow-up evaluation of all Minnesota programs, 1975-1976. In an attempt to obtain some information about the status of Minnesota programs one year after the statewide demonstration activities, the Project conducted a phone survey in May of 1976. Programs were asked a standard set of questions about services provided to their programs and about Mediator Team functioning. In programs where a team existed, the team coordinator was asked the questions. Where formal teams did not exist, program directors or coordinator level personnel were queried. Phone contacts were actually made with twenty-six of the twenty-nine programs from whom data related to specialist services had been obtained in the spring of 1975.

Outcomes, specialist services. In order to make some evaluation of resource mobilization carry-over from the previous year, the Project staff at least wanted to know if the number of specialists providing some type of service to programs had remained the same, increased, or decreased. Therefore, programs were asked the following question:

> "First, we would like to know about the specialist services you have been receiving this past program year compared to the previous year. We have the list of specialists that you gave us when we visited last spring. I will read through the list and you

> tell me if these specialists worked with you this year. If any of these people have not worked with you this year but someone of their profession from the same agency has, please indicate this to me. In other words, I'm just asking if the agency replaced one specialist with another one."

The list of specialists' names, professions, and employing agencies, which had been obtained from each program the previous spring, was then read. After the list was read and checked off, the question was asked, "Have additional specialists worked with you this year?" The number of new specialists, if any, was written down. The numbers were added and the program person was asked to confirm the number of "old" specialists, the number of "new" specialists, and the total number compared to the previous year, i.e., the same number, more, or fewer.

Data obtained from this survey indicate that, of the twenty-six programs contacted, twelve had more specialists providing some type of service to them than in 1974-1975, nine had fewer, and two had the same number. (Persons from three programs did not have the information at the time of the phone contact.)

Looking at the total number of specialists providing service to the twenty-three programs which supplied information, 333 provided services in 1974-1975; 353 provided service in 1975-1976. Thus, for these twenty-three programs taken together, the total number of specialists had been maintained from one year to the next, with a very small increase taking place. Of those nine programs which had fewer specialists, only three had more than two fewer specialists.

Outcomes, Mediator Teams. To acquire some information about the continued existence of teams, satisfaction with the team concept, and future prospects for team functioning, program persons were asked the following questions:

> "Has your agency had formal Mediator Team meetings this year? That is, have specific people on your staff (and possibly from outside your program) been designated to be on the team and do all of these people meet on a fairly regular schedule to plan for special needs children and their families?"

If the response was affirmative, the next question was, "How helpful are the Mediator Team meetings, and the various team functions, in your program's work with special needs children and their families? -- not too helpful? -- fairly helpful? -- very helpful? -- crucial?"

Then came the question, "Do you plan to continue using the Mediator Team approach next year (1976-1977)?"

Regardless of the type of response to the first question about whether a program had a team or not, all program persons were asked, "Do you think it

would have been useful to have received service from the OCD-BEH staff this year?"

Sixteen (16) of the twenty-six (26) programs contacted indicated that they had teams according to the criteria of having specific people designated to be on the team and meeting on a fairly regular schedule to plan for special needs children and their families. Five (5) programs said that they did not have teams and five (5) programs had an informal kind of team structure with infrequent total-team meetings.

Seventeen (17) of the twenty-six (26) programs responded that the Mediator Team meetings and the various team functions had been "very helpful" in their work with special needs children and their families. Seven (7) programs said "fairly helpful" and two (2) programs said "not too helpful". Three (3) of the programs which did not have teams gave the "fairly helpful" response and were referring to individual resource mobilization and case management aspects of the approach.

Twenty-two (22) of the twenty-six (26) programs indicated that they were going to use the Mediator Team approach the next year (1976-1977). These were sixteen (16) of the programs with structured teams and the five (5) programs with informal teams that did not meet frequently as an entire group. One (1) program tentatively planned to continue using this approach.

Fifteen (15) of the twenty-six (26) programs surveyed indicated that it would have been useful to have received service from the Project staff during 1975-1976. An additional three (3) programs where those with whom the staff had actually worked in 1975-1976. Two (2) programs commented that the staff's assistance had been necessary to get started but was probably no longer needed. One program person contacted was uncertain because she had not worked with the staff previously. Five (5) programs responded that further service would not have been useful.

Concluding remarks, Minnesota demonstration activities. Data and impressions obtained from on-going work with the three Minnesota programs and data gathered via the phone survey of twenty six Minnesota programs provide a basis for some tentative conclusions regarding the overall demonstration effort in Minnesota during 1974-75, and 1975-76.

Data obtained from the phone survey indicate that the number of specialists providing some type of service to Minnesota programs had been maintained at approximately the same level achieved in 1974-75. Thus, programs as a group were continuing to receive services from 75% more specialists than they were two years earlier, prior to initiation of statewide demonstration activities. This is definitely a positive finding, but it also raises the question whether programs might have tapped more resources with further training, consultative, and advocacy efforts from Project staff. At the end of year two, the staff felt that all avenues to resource mobilization had by no means been explored or exhausted.

The phone survey data also suggested that those programs which had implemented the Mediator Team approach were continuing to use this

organizational vehicle. And, although no data were obtained regarding case management outcomes, the majority of program staffs, themselves, appeared to feel that the Team approach was "very helpful" in their work with special needs children and the families of these children.

The above findings also can be interpreted positively. However, the case management outcome results obtained at the end of year two and the Project staff's experience with the three Minnesota programs revealed that there was definitely room for improvement in programs' ability to develop strong case management teams and carry out case management procedures. The reader is again reminded that individual programs received only seven training/consulting contacts during the year long demonstration effort, and not all of these contacts involved a direct focus on team development and resource mobilization/case management. Even with the three programs chosen for their apparent potential to have exemplary teams, this amount of training had appeared to be insufficient.

What, then, would be a minimal amount of training necessary for programs to develop independently functioning teams of a reasonably high quality? Also, what type of training would be most effective?

It is probably impossible to provide a definitive answer to the first question. Variables such as training and experience of program staff members, staff attitudes and personalities, administrative abilities of staff, current priorities of programs, skills of trainers, etc. all must be taken into account. Problems in any of these areas might tend to prolong the training process or rule out chances of success. However, the type of training/consultation provided undoubtedly has some bearing on the extent to which these problems become critical.

One major recommendation for training, which in retrospect seems obvious, is that as many program personnel as possible be included, particularly if the intent is to organize a fairly structured team that will conduct case management staffings. It seems crucial that the teachers be involved along with coordinator level staff. Because of logistic and expense considerations, and some lack of foresight, the Project staff did not specifically invite teachers to the first intensive workshop introducing the team approach and related concepts. The ramifications of this became obvious when teachers were present during initial on-site consulting visits. Teachers often were ill-informed or uninformed about the concept. Those who did know something about it were frequently skeptical about the value of holding "more meetings". However, as more teachers became familiar with the team concept and its various aspects, in many instances, they became the strongest advocates. Experiences of Project staff in year three, when teachers were always present at training sessions, reinforced this perception.

A second major recommendation would be that trainers adopt an approach similar to the one described in this section (also ses Section VIII). If the objective is to have people conduct team staffings as part of their case management activities, let them see how staffings could be conducted and then let them conduct a staffing themselves and be given feedback via video tape, if possible, and trainer observations. Seeing others conduct meetings may not be sufficient. Upon viewing a mock team meeting, participants in Project training often commented that this was the type of thing that they were already doing. It was not until they were engaged in staffing one of their own children and/or families that the complexities of conducting an efficient, effective meeting became obvious. Also, the gaps in the entire

group's knowledge about the children and families discussed, as well as the need for additional service and more coordination among staff members, became much more evident through this process. (See revised Mediator's Handbook for suggested team structures, methods of conducting meetings, content of meetings, etc.)

A final major recommendation would be that trainers spend as much time as possible suggesting methods of recruiting more services for programs and directly engaging in advocacy efforts to this end (see revised Mediator's Handbook). If program personnel do not perceive that their time spent in team meetings (and other case management activities preparatory to obtaining outside services) will result in expanded services, they may consider their attempts to be fruitless. By helping to recruit a specialist(s) to specifically attend team meetings, the continuation of the team effort may be better assured.

To end these remarks about the Minnesota demonstration activities on a positive note, the findings of the independent evaluation are re-called to the reader. Despite the fact that programs' case management skills may not have been optimal and truly comprehensive services were not provided, or not available, to all special needs children and their families, it appears that many Minnesota Head Start teachers were able to provide positive, integrated experiences for their special needs children. Certainly, the findings from the independent study reveal no evidence that these experiences were detrimental.

SECTION VIII
DISSEMINATION IN REGION V & REGION III--PROJECT YEAR 3

The work plan for year three was devised by Project staff and project officers at the Region V and National levels of the Office of Child Development. In addition to year three efforts already described with three agencies in Minnesota, this work plan called for specific arrangements in OCD Regions V and IV. The Project was to disseminate the Mediator Team portion of its model by: 1) attempting to establish a Mediator Team in two Head Start agencies in the states of Wisconsin, Michigan, Ohio, Indiana, and Illinois; 2) attempting to establish Mediator Teams at two agencies in Region IV. The latter was eventually changed to a planning and consultation role with the Head Start Regional Resource and Training Center in Region III.

Region V dissemination. The selection of Head Start agencies to be served was intended to be biased in favor of agencies which appeared to have a good chance of success. This meant that the agencies might have some qualities such as a good political climate, some coordinator level staff, and that they were not operating some other special grant which would be counter in time or effort to the implementation of a Mediator Team.

The reader should be aware that the entire dissemination plan (and continued work with three Minnesota agencies) did not begin until nearly half way through the third Project year. The late implementation date was caused by delays in approval of the final work plan for the year and by delays in the selection of recipient agencies from states in Region V (other than Minnesota). The reader should also be aware that, at the time Region V dissemination began, the Project staff size had reduced in size from four professional people and one office support person to two professional people and one office support person. However, due to the fact that Region V OCD staff did not assign the originally intended number of agencies (10) to the Project, the remaining staff were able to provide the full complement of services originally intended in the approved work plan to the full number of agencies (4) who were assigned to the Project and accepted the offer of service.

The initial selection of dissemination sites was completed at the offices of Region V OCD. Community representatives at OCD were asked to submit the names of two agencies in each of the five states (Minnesota excluded). The community representatives were to have been in direct contact with the agencies and printed information about the Project was to have been given. The names of the two consenting agencies in each of the states were to be given to the OCD-BEH Project officer in the Region V office and in turn given to Project staff.

In the actual seleIction process, only six agency names were transmitted to the Project. Initial telephone contacts with these agencies revealed that they had varying degrees of knowledge about the Project and the Mediator Team approach -- from no recalled knowledge to "some" knowledge and interest. At that point none of the agencies was willing to make a firm commitment to try the model. Project staff then sent a description of the

Mediator Team approach and copies of the Mediator's Handbook to each agency. Within two weeks of receipt of the materials, each agency was recontacted to solicit interest in proceeding further with a commitment. In all cases, the agencies expressed sufficient interest to agree to a one day on-site exploratory and consultation visit by Project staff. Only one agency did not receive an on-site visit. That agency contracted for similar services from a local consulting group. Only one of the agencies receiving the one day exploratory/consultation visit declined to commit its staff to try the Mediator Team approach.

Project staff attempted to inform and involve the regional staff who were assigned to each agency as community representatives. Prior notification of all on-site visits was sent to each agency's community representative, inviting participation/observation. However, their participation did not occur. Following each on-site visit, a summary report was sent to the community representative.

During the one day, on-site, exploratory/consultation visit, the primary focus was to explain the somewhat limited objectives of the dissemination effort: 1) establishing a Mediator Team for staffing of individual special needs children; 2) providing general information on the recruitment of local specialist resources for a broad range of services. This process resulted in agency staff explaining individual circumstances and asking for specific answers. Project staff related their answers to the two objectives above. The following Head Start agencies agreed to receive further training:

Cleveland Diocese Head Start
5103 Superior Avenue
Cleveland, Ohio 44103
Ms. Carol Pinkney, Director

Mansfield/Richland/Morrow Head Start
432 Annadale Avenue
Mansfield, Ohio 44905
Mr. Bob Boebel, Director

Five CAP Head Start
Box 132
Custer, Michigan 49405
Ms. Cheryl Dore, Director

Northwest Community Action Head Start
1106 Tower Avenue
Superior, Wisconsin
Mr. Dave Cochran, Director

In the process of developing the dissemination effort, the one day exploratory/consultation visits to Region V agencies accomplished purposes beyond exploring the team concept with these agencies. In effect, they were training visits for coordinator level staff. The exchange between Project staff and agency staffs led to discussions of how the concept could be adapted to fit the needs and structure of each agency. The logical extension of this was the commitment by four of the five agencies to try the Mediator Team concept as it was individually adapted. Each agency received a minimum of an

additional two days of staff training (maximum total of five days). An attempt was made to separate the two training days so that the second training day occured approximately one month following the first. This planned separation of training days allowed Mediator Teams to meet as often as possible during the interim. Any difficulties an agency might have with organizational structure of the Mediator Team or with the operational dynamics of the Team were, thereby, given a chance to occur. During the succeeding training day(s), Project staff could potentially help a given agency with plans to overcome possible difficulties.

The initial training day was attended by administrative/coordinator level staff and teaching staff in all cases. The four agencies had already established the basic structure of the Teams and the members of the Teams had been chosen. Therefore, after a brief introduction to the "team" process by Project staff (including a video tape presentation of a mock team meeting), the Mediator Teams were asked to conduct an actual staffing of a special needs child. As the Mediator Teams conducted this staffing, Project staff video taped the proceedings as a training tool for immediate feedback, critique, and general discussion. This was followed by the staffing of at least one more child so that the Teams could benefit from the immediate recall of any difficulties experienced in the first staffing experience. The tape was given to the agency to use as an in-house training tool. Each agency was given examples of forms to guide the meeting process, to record outcomes, and to record assignments to team members. Examples of these forms are found in Appendix 18.

Project staff made specific recommendations/suggestions to administrative level staff. Some of these recommendations/suggestions were related to administrative decisions which could be made to provide support to the continuing development and refinement of the Mediator Team's function in the agency. Other recommendations related more directly to compliance with new confidentiality regulations, recruitment of special needs children, recruitment of specialist resources, and other kinds of support for the teams, the teachers, and the special needs children and their families. These recommendations were always discussed and they were often presented in writing as well. Some examples are:

> Two contact people in special education services at the state level who may be able to help you are.....
>
> Agencies who refer children to you should be asked to give you some support services in order to integrate these children.
>
> You might assume that certain services will be needed for sure, e.g., psychological and speech/language. Therefore, you might try to link each center with a psychologist and a speech clinician. This is a different approach than waiting until you have identified a particular child with a specific problem.

Documentation of the team and its specific functions could satisfy many Performance Standards.

You may wish to present a resolution to the State Head Start Directors Association supporting House Bill ____ in your state legislature. Passage of this bill would mandate, for the first time, special education services in schools in your state. The mandate could extend down to some preschool age children.

Exploratory meetings with agencies serving handicapped children in a non-integrated setting might be helpful in two ways:

1. Sharing children who are handicapped (relates to recruitment);
2. Getting some on-site help from that agency to help you integrate the children.

Some of their children may be ready for limited integration into settings with non-handicapped children.

Schedule Mediator Team meetings on a regular basis.

Provide forms to record team activities and designate a recorder.

Communicate necessary information about your Mediator Team to parents so that they are fully informed and involved at appropriate planning stages.

Address all confidentiality and due process issues through an agency-wide system which is known to all staff and parents.

The first half of the second training day(s) was again organized to work with full Mediator Teams. Whether or not the Project's time schedule allowed separation of the first and second training day(s), the staffing emphasis for the second day meeting of the Teams was on the transition of special needs children from Head Start to their next educational setting. A packet of information regarding transition concerns and possible transition arrangements was given to each person in attendance (see Appendix 19). The information served as a guide to the actual planning (staffing) of transition arrangements for special needs children.

The last half of these days was spent in consultation with coordinator/administrative level staff. At this time the Mediator Team concept and the agency's specific team arrangements were reviewed. Any concerns regarding

team structure or dynamics were reviewed. The topics of support from community-based specialist resources and the most desirable roles these specialists could play with Head Start had been interwoven throughout the exploratory and training visits. Thus, during this last half day, the possibilities of additional specialist recruitment was also reviewed.

The following are descriptions of the specific Mediator Team arrangements made by each Region V agency:

Cleveland Head Start
Catholic Diocese
Cleveland, Ohio

Team Members:

- Head Start Director
- Parent Involvement Coordinator
- Education Coordinator
- Social Service and Handicap Coordinator
- Health Coordinator
- Home Development Coordinator
- Volunteer Coordinator
- Supervising Teacher
- Parent Counselor

Team Coordinator:

At the time of the training, the Head Start Director assumed the role of Mediator Team Coordinator for the staffing of most children. The Handicap Coordinator assumed the coordinator role at one point. It is not known who will be assigned as permanent Mediator Team Coordinator.

The team members listed above will act as a core group who will meet with individual teachers to staff the special needs children. Mediator Team meetings will be held at the central office site, which is only a few minutes by car from any center.

A couple of specialists have been working with the agency fairly closely. The agency will consider asking them to attend Mediator Team meetings to help guide the case management process.

The team hopes to meet with each teacher once a month.

Five CAP Head Start
Custer, Michigan

Team Members:
Five-CAP Head Start Director
Five-CAP Parent Involvement Coordinator
All teaching staff from three delegate agencies, thereby creating three Mediator Teams with support and coordination coming from Five-CAP personnel.

Team Coordinators:
The head teacher at each delegate site was chosen as Mediator Team Coordinator.

Staff from all four delegate agencies attended the first day of training. Staff from three of the delegate agencies were in attendance during the second day. Thus, three Mediator Teams were formed. One or both of the Five-CAP staff persons will attempt to attend each Mediator Team meeting. Teams will attempt to meet every two-to-four weeks.

It appears that the one delegate agency which did not form a team will require some additional convincing and support, if in fact it is expected that the agency forms a team in the future.

The teams requested that schedule time be allowed specifically for team meetings. There appeared to be no question that administrative support would be given for schedueling regular meeting times.

Northwest Wisconsin Head Start
Superior, Wisconsin

Team Members:
Head Start Director
Assistant Director
Special Needs Staff (2)
Health Coordinator

Team Coordinator:
Team coordinator duties were largely assumed by the Assistant Director.

Mediator Team members intended to meet with individual teachers every two-to-four weeks. Most meetings would probably be at the agency office in Superior. Meetings would occasionally be held in Ashland or a center site in the eastern portion of the agency. It was understood that the Director would not always be able to attend. The Assistant Director would attempt to attend all meetings.

Mansfield/Richland/Morrow Head Start
Mansfield, Ohio

Team Members:
Head Start Director
Education Coordinator
Health Coordinator
Parent Involvement Coordinator
Nutrition Coordinator (upon request)
Social Services Coordinator
Handicap Coordinator (part time)

Team Coordinator:
At the time of the training, the duties of the Mediator Team coordinator were shared by the Health Coordinator and the Handicap Coordinator.

At the time of the training, no particular specialist from the community was being considered as a member of the Mediator Team, although a couple of people were discussed as specialists who might be able to consult with the Mediator Team on a fairly regular basis.

The team members listed above will act as a core group who will meet with individual teachers to staff the special needs children. The agency director was hopeful that the team could meet with each teacher every two weeks, with the teacher coming to the agency office site for the Mediator Team meetings. Still under consideration was a plan whereby the core team would occasionally travel to a southern center site for meetings.

Region V dissemination outcome. The initial reactions of the four agencies to the implementation of Mediator Teams was very positive. The administrative and/or coordinator level staffs of three of the four agencies had been considering some type of "team" organization prior to being contacted by Region V OCD or Project staff. The offer of Project training and consultation at no cost to the agencies was accepted as an appropriate vehicle to begin a team effort.

The training process also appeared to be well received. In contrast to the Project's initial Mediator Team training efforts in Minnesota, teachers from all Region V agencies were included in all team training efforts. The time involved in the consultation and training was realistic in terms of teachers' obligations away from their classrooms. The training process accounted for local situations and needs. The reactions of teaching staff at all locations was significant as well. Some teachers at all agencies voiced their satisfaction with the process. Characteristic of comments were: "I really feel like I've been given a lot of help"; "The group

discussion and planning is so helpful"; "So many new ideas came up". For similar reasons, administrative staff voiced pleasure with the concept and the training.

Positive reactions spoke to the point that the Mediator Team approach was a basic "systems" approach which was easily adapted to local agency circumstances (geographic, political, staffing). The kind of close working relationship that effective team activity requires did highlight a few personal priority or personality issues. Where this did occur, most administrators were aware of the personal situations. They thought it possible that the team approach might help to resolve some personal issues.

Project staff were not able to play the same training and advocacy roles in Michigan, Wisconsin, and Ohio as they played in Minnesota to help stimulate recruitment of specialists. The suggested process for obtaining new specialist resources and enhancing current specialist involvement was relayed to administrative/coordinator staff via the Mediator's Handbook and some verbal exchange. The agencies appeared to be receptive to the idea of trying some new tactics with local specialists. To the knowledge of Project staff, the agencies did not begin a specialist recruitment effort concurrent with their efforts to establish Mediator Teams.

Finally, it was the stated intention of the administrators of all four agencies to support the continued development of the Mediator Team(s). A stated incentive was the use of Mediator Teams as a structure for coming into compliance with Head Start Performance Standards.

Region III dissemination. Project officers from the National and Region V Offices of Child Development requested that the Project staff also disseminate parts of the Project model outside of Region V boundaries. It was originally intended that the Project disseminate the Mediator Team aspect of the model in Region IV of OCD by training two Head Start agencies in that region to use Mediator Teams. However, Project communications with several people in Region IV did not produce any definitive plan (e.g., site selection). Meanwhile, Project staff had maintained contact with a special project coordinator at the Head Start Regional Resource and Training Center in College Park, Maryland. That office was under contract to Region III OCD to supply various types of training to Head Start/Home Start agencies throughout the region. The special project coordinator was designing training to implement case management teams at selected sites in Region III. The teams in that design were called Comprehensive Developmental Teams. The conceptualization of their design was a parallel to the Project's Mediator Team design. The project director at the Region III RRTC and OCD-BEH Project staff made a joint request to National and Region V project officers that the Project be allowed to substitute a training/consulting role with Region III RRTC for the originally proposed Region IV dissemination. This change was approved.

This dissemination effort was very different from the effort with the four Head Start agencies in Region V. The training of ten (10) Head Start agency representatives would be performed by RRTC staff. Likewise, periodic on-site follow-up would be performed by RRTC staff. The training/consultation/facilitation efforts of the OCD-BEH Project staff would hopefully make good use of past experiences with the team approach as it was applied with Head

Start programs in Minnesota. The Region III effort to establish Comprehensive Developmental Teams had to be conducted in a shorter period of time (four months from the beginning of of agency training to an evaluation of implementation results).

The initial training/consultation effort with the RRTC staff was conducted on November 17-18, covering an eight hour period. The two major topics of concern were the contents of the Comprehensive Developmental Team Handbook and the organization/contents of the RRTC training workshop. A detailed account of the items covered, printed information exchanged, and additional products the Project would provide is contained in Appendix 20.

Between the time of the November consultation visit and the February training workshop in Region III, numerous telephone and written contacts were conducted. Project staff were still somewhat unclear what their roles would be during the Region III workshop. Ten possible roles had been proposed at the time of the November consultation visit. The primary intent was that Project staff would act as facilitators of training activities and as on-site consultants to the RRTC staff. Project staff could be presenters of small portions of the training. It was clear that the major organizers and presenters should be the RRTC staff.

The workshop was conducted February 2-5 at Airlie House, Airlie, Virginia. At the request of RRTC staff, the Project staff did act as facilitators of training and they performed some general support functions for the RRTC staff. Project staff were not involved at the level of making presentations. However, some support and clarification was given to topics when it seemed appropriate during general discussion sessions.

As follow-up to the workshop, RRTC staff planned to make two on-site visits to each of the ten participating agencies. The Region III community representatives to these agencies were asked to support the training effort by making two on-site visits to their respective agencies. One Minnesota Project staff person made two on-site visits to observe Comprehensive Developmental Teams in operation and offer some general suggestions and support (Early Learning Center--Philadelphia, Pennsylvania; Model School Preschool--Washington, D.C.).

The outcomes of the Project's dissemination efforts with OCD Region III were, it appears, successful. In addition, several things were gratifying to the Project. The RRTC saw fit to use a large portion of the Mediator's Handbook verbatum when the Comprehensive Developmental Team Handbook was written. Some very helpful additions were made in the areas of parent involvement (including due process concerns), detailed procedures and forms for training all agency staff regarding the team concept, and detailed procedures and forms to be followed during actual team meetings. In the judgement of RRTC staff who made on-site visits, about two-thirds of the agencies had formed operating teams within the four months following the formal training. Approximately the same ratio of Minnesota Head Start/Home Start agencies formed operating teams during a nine month period. One difference was that the Region III agencies were chosen by OCD community representatives as being good and willing candidates for training. In Minnesota, all agencies were included in Project efforts.

The effort described above suggests that the Mediator Team approach can be effectively used by other trainers--at least by others with specialist training and background. Descriptive data were collected by RRTC staff. At this time that report is in process. The reader may be able to obtain a copy by writing:

Head Start Regional Resource and Training Center
4321 Hartwick Road, Room L-220
College Park, Maryland 20740

The data focuses largely on the development of the teams, as opposed to case management outcomes for special needs children.

SECTION IX
REVISION OF THE MEDIATOR'S HANDBOOK

Following the first year of training using the original Handbook, a decision was made to develop a new, revised version. It was hoped that the revision could be completed in time to complement some Project efforts during year three. However, due to the reduction in Project staff size this objective was not met. Although this was unfortunate in some respects, the delay in writing enabled the staff to acquire additional insights and new perspectives through training experiences with the three Minnesota programs and the other programs in Region V. The collaborative effort with the staff from the Region III Resource and Training Center was also extremely valuable in this regard.

The contents of the revised Handbook reflect the modified and new ideas gained by Project staff through work with Head Start/Home Start personnel and others. Also, there are format changes which the staff hope will make the applicability of the contents more readily apparent. In attempt to provide a clearer picture of the Mediator Team concept, an illustration has been interwoven throughout the Handbook. This illustration traces the efforts of a hypothetical Head Start program, and its Mediator Team, to provide comprehensive services to a 4½ year old girl with a hearing disability. The chapters are arranged so that there is always a chapter illustrating particular aspects of the Team concept followed by a chapter which further discusses those same features of the concept.

Copies of the revised Handbook have been sent to the programs (Region V and Minnesota) with whom Project staff worked during 1975-1976, to the Region III Head Start Regional Resource and Training Center, to the Minnesota Department of Education (Special Education Section/UNISTAPS), to Minnesota Department of Education Special Education Regional Consultants, and to all Minnesota Head Start/Home Start programs with whom Project staff worked during 1974-1975. Copies have also been sent to the Minnesota Developmental Disabilities Planning Council, Region V Office of Child Development, and the National Office of Child Development.

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APPENDICES

APPENDIX 1

EVALUATION OF MEDIATOR WORKSHOP

OCD-BEH COLLABORATIVE PROJECT

EVALUATION OF MEDIATOR WORKSHOP
Quadna Mountain Resort
Hill City, Minnesota
July 8-11, 1974

INTRODUCTION

Due to the short-term, experimental nature of the OCD-BEH Project, a case management team or "mediator team" approach has been given special emphasis by the Project staff. The notion behind this approach is that, since the Project will be of short duration, it follows that some system must be established within programs whereby they can become relatively self-sufficient in dealing with special needs children. In addition, the fact that the Project has state-wide responsibilities also suggests this kind of approach. It is impossible for the Project staff to work extensively with Head Start children, families, and teachers on an individual basis. Therefore, programs must be assisted in mobilizing local specialist services and in developing their own abilities to integrate special needs children into their programs. With this as a frame of reference the Project prepared a Mediator's Handbook and presented the concepts therein at a workshop for potential mediators.

The overall goals of the mediator workshop were to provide information and develop skills which would enable Head Start staffs to (1) obtain as many special services from their own communities as possible and (2) develop a team approach within their programs so that all efforts for a particular child are coordinated and maximized.

Based on its experiences during the first year of the Project, the OCD-BEH Project staff believes that integration of handicapped children into a Head Start program will be most successful if cer-

tain people are designated to assume certain responsibilities for this integration process. These are the people the Project refers to as "mediators" and these are the people to whom the workshop was directed. The term "mediator" is not a new or substitute title for titles that already exist in Head Start programs. People who are referred to as mediators by the Project will still be Education Coordinators, Social Service Coordinators, etc. within their own programs. It is intended that these people, by virtue of the jobs they already have in Head Start (e.g. Education Coordinator, Social Services Coordinator, Health Coordinator, etc.) will have the ability to travel regularly and frequently among centers, observe children, talk with teacher and parents, and have frequent contacts with resource specialists (e.g., social workers, speech pathologists, psychologists, public health nurses, etc.). An attempt was made to invite to the workshop only those people who are in a position to carry out the above mentioned activities.

General format of the workshop

This workshop to promote the mediator team concept covered a three day period from the evening of July 8, 1974, through noon on July 11. The workshop was held at Quadna Mountain Resort, Hill City, Minnesota.

The "Introduction" to the workshop consisted of remarks by regional and national Office of Child Development representatives and a section by the OCD-BEH staff to explain the procedures for the three days, an introduction to the mediator team concept, and the rationale for the concept.

The remaining two and one-half days followed a consistent format as follows:

a.m.	Session I
	Session II
	LUNCH
p.m.	Session III
	Free time for recreation & Relaxation
7:00-9:00	Session IV
	Rap sessions and whatever

The morning sessions lasted about 1 1/4 hours, with a brief coffee break in between; the afternoon session usually ran for a full 2 1/4 hours, with a break, scheduled where convenient. The evening session ran for approximately two hours, followed by rap sessions, informal meetings between Project staff and other presenters, and participants. (see agenda in the appendices).

Half of the Tuesday and Wednesday evening sessions were devoted to presentation by the Project staff. The remainder of these sessions was turned over to representatives of state or private organizations who work in behalf of special needs children (see agenda in the appendices). The intent of these sessions was to promote dialogue between participants and these representatives, and hopefully foster a closer working relationship between the organizations these guests represented and Head Start.

Each presentation by the Project staff and other presenters allowed time for participant reaction, questions, etc. A portion of several Project staff presentations included role playing the concept involved, or meeting in small groups for discussion.

Presentations were given in a sequential order designed to approximate the ordering which Head Start programs should use to create a mediator team. The Mediator's Handbook was written with this same sequencing in mind. It was intended that this written explanation of the concept be

capable of standing alone. Thereby, the Head Start programs which did not send representatives to the workshop would be able to understand the concept by reading the Handbook, and might find it feasible to implement the mediator team model.

Workshop evaluation

The ultimate success of the mediator concept will be measured in terms of practical application/results. The more modest goal of the workshop itself was simply that the participants receive the information illustrating the concept. Practical application during the workshop was attempted to ensure better comprehension of information, informal evaluation of student progress, and to increase the probability of future on-the-job application. However, the workshop was never presumed to ensure future, consistent, on-the-job application of the information. (Subsequent on-site visits to each program will be the vehicle for ensuring on-the-job practice of the mediator team concept.)

Did the participants receive the information? Prior to the workshop, "instructional objectives" were developed, both to guide the content presentation and to determine if, in fact, the participants received the material. The instructional objectives were stated in terms of what the students would do to indicate their comprehension of the content. In other words, each instructional objective stated that to demonstrate comprehension of the material, a certain percentage of participants would have to correctly answer a certain percentage of pre-determined questions. An instructional objective was developed for each of the subject areas which was considered most significant to the understanding of the mediator team concept, and which was most amenable to objective evaluation.

In most subject areas, the test questions for a particular instructional objective were administered both prior (pre-) and subsequent (post-) to the material presentation. After some pre-tests the student answers were evaluated within fifteen minutes and the presenters were informed of the results. In this way, the discussion could be altered both to meet unexpected group needs (such as levels of sophistication, misperceptions, etc.) and to more accurately approach the subject from the point of view of the audience.

Even though the participants may meet an instructional objective, a valid question is whether the performance is due to the workshop experience or some other external learning experience? Can it be said that the participants had the information prior to this experience? By comparing pre- and post-test results, the least that can be said is that the participants performed "better" after the workshop than was true before the workshop. And, under most circumstances, one might hazard a guarded conclusion that the workshop was more than coincidently related to the students' improved performance.

All pre-tests were administered "closed book" so that each student's "starting point" (baseline, operant level, etc.) could be determined prior to presenting workshop/Handbook material. All post-tests were administered "open book" for the following reasons: (1) the overall goal of the workshop was that the participants receive particular information -- not record it (as in long-term memory); (2) if the students were expected to memorize the information, then why record the same information in the Handbook? The assumption is that in most cases, if an individual can produce a specific piece of information on command, then it can be said that in that instance the person did receive that information; hence the objective was

completed.

Non-"academic" evaluations were also employed, such as in the observation of student role-playing, group discussions, etc. But such evaluations were informal and subjective efforts primarily used for guiding moment-to-moment curriculum activities.

EVALUATION RESULTS

Abstract: The workshop was attended by seventy student participants from twenty-six agencies (all six Indian agencies and three other agencies did not attend). Of seven pre-determined instructional objectives, four were accomplished. In all instructional areas student performance greatly improved from pre- to post testing. Student subjective opinions were generally favorable regarding subject presentation, material, and their intentions for later application.

The workshop was designed for presentation primarily to Head Start agency staff, such as directors(17), and various coordinators (26). Other participants included small numbers of Head Start parents (8), teachers (9), teachers' aides (7), and allied community agency staff (5). Special guests included professional representatives from various local, state, and national government and agency organizations. Approximately seventy student participants and twenty guests attended the workshop. Of twenty-nine

non-Indian agencies, twenty-six sent representatives (those not participating included Mahube, South Central, and Arrowhead). All six Indian agencies did not attend.

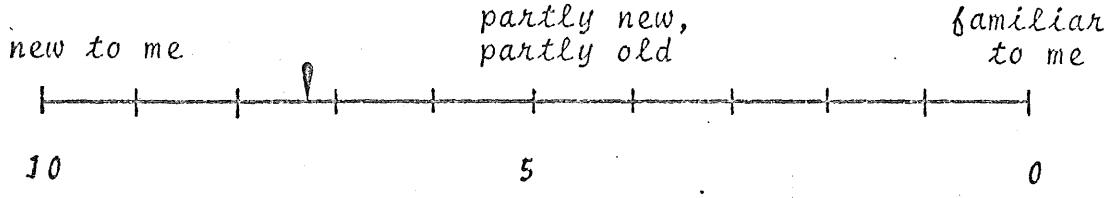
The workshop began Monday night and ended Thursday noon. Regular attendance was requested at all workshop activity which averaged eight real hours of instruction per full day. Actual instruction consumed twenty-nine hours during the workshop.

Board, room, and mileage expenses for all student participants were paid by the Project.

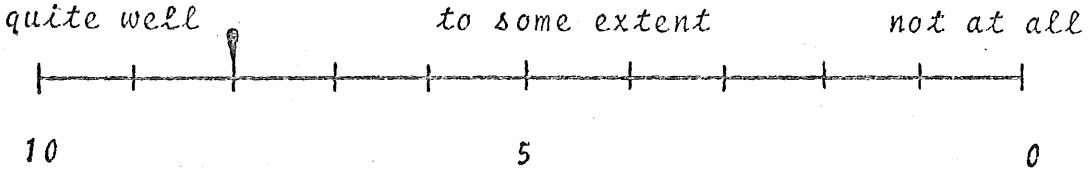
On the morning of the last day of the workshop, the attending participants were asked their subjective, anonymous opinions of the workshop. Forty-three people were present to answer the questions. Each of ten open-ended statements was to be completed by choosing a number most closely representing the person's opinion on a semantic scale. The results are graphically illustrated below to indicate the group mean (average) response to each question. Caution: the number indicating the group average is not typical of the opinions of most individuals on any question. On any given question, there was always at least two number values around which student opinions clustered (the clusters were often quite similar in size, and the values were often quite spread apart) - so, it was usually impossible to select one number as representing the most frequent student opinion. And, when on a particular question

one number value was technically selected by more students, that number was usually not the same as the value of the group mean (thus, mode ≠ mean).

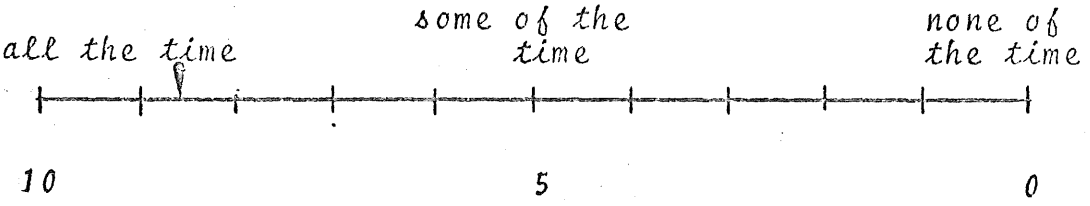
Statement #1: The information which was presented was...



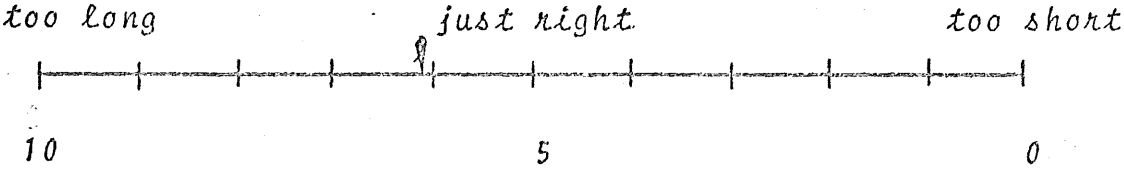
Statement #2: I think that the workshop information can be practically applied...



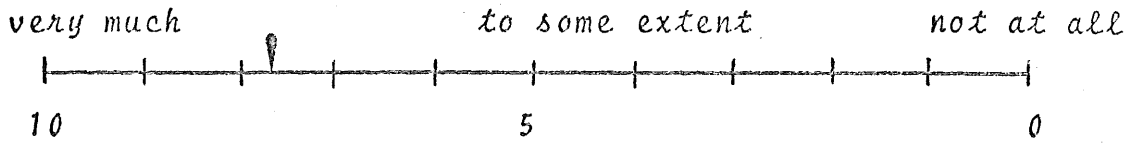
Statement #3: The presentations were clear to me...



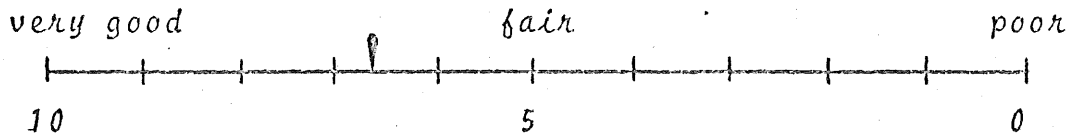
Statement #4: The length of each lecture presentation was...



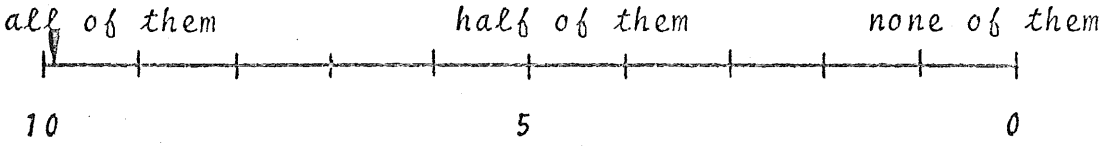
Statement #5: I would like to try organizing some sort of Mediator Team...



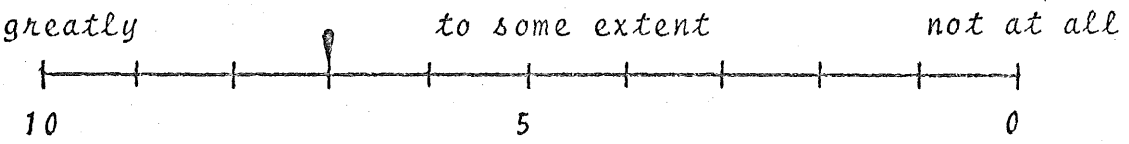
Statement #6: Practically speaking, the chances that a Mediator Team will work in my agency are...



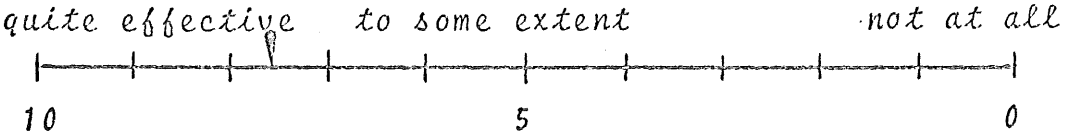
Statement #7: How many sessions did you attend?



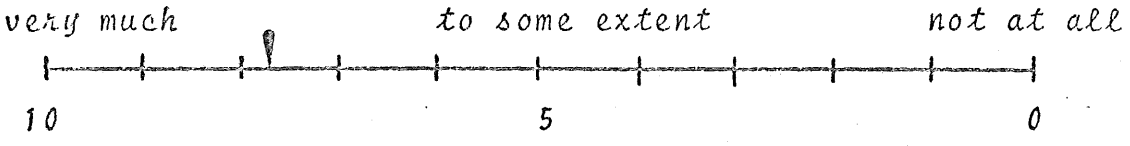
Statement #8: The workshop will help me better mobilize specialist help....



Statement #9: I feel that I can help teachers promote a handicapped childs integration...



Statement #10: I would be interested in using a prescriptive teaching instrument... *



The evaluation of instructional objectives follows such that one objective is evaluated per page.

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* *This question was asked prior to the subject presentation of prescriptive teaching concepts. The students had only been exposed to a five minute description of the prescriptive teaching concept.*

SUBJECT GOAL #1: Participants will demonstrate familiarity with and be able to recognize definitions of professional specialty for nine specialists in the human services.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will answer correctly by matching professional duties with the titles of nine professional specialists in the human services.

ACTIVITY: Presenters will describe, define, and provide examples of professional functions of nine specialists in the human services.

RESULTS:

Pre-test: No fewer than 87% of the participants correctly matched seven of nine specialists/definitions. 66% of the people correctly answered each of the other two items, whereas the other participants directly confused the functions of the "optometrist" and opthamologist."

Immediate evaluation of the pre-test indicated the above results and an immediate group discussion followed. In the ensueing discussion the staff concluded that the two confused test items were poorly worded, thus invalidating the test objectivity of those two items.

Further instruction and post-testing on this subject were not conducted because the participants attained the objective in the pre-test.

SUBJECT GOAL #2: Participants will demonstrate knowledge of at least four specialist "service roles-" functions which the specialist may assume (other than test administration or one-to-one therapy) when assisting Head Start programs.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will correctly list six descriptions of roles (other than test administration or one-to-one therapy) the specialist may assume when assisting Head Start programs.

ACTIVITIES: Presenters will describes twelve specialist "service roles" via lecture, visual aides, handbook, group interaction and role playing.

RESULTS:

Pre-test: In the pre-test the group, as a whole, listed each of the twelve specialist roles yet to be discussed. Those specialist roles most often listed by the participants included (in descending order) observation of children at centers, guiding referrals to other specialists, and conducting in-service training. Only 38% of the people listed six items and only 19% of the participants met the instructional objective.

Post-test: In the open-book post-test, 94% of the participants met the instructional objective. The majority of students rote-copied the first six or seven functions listed in the Handbook, indicating their ability to use the Handbook. The majority of students who rote-copied the functions consistantly excluded the fourth item from the Handbook - ("the specialist could consult teachers regarding program planning"). Whereas each possible function greatly increased in the number of people listing it as a specialist role (from pre- to post-test), the "program consultant" item did not increase. The specialist role which showed the greatest increase in popularity was "parent education" which, however, still remained a less favored selection. The specialists' role in screening showed the second greatest improvement in popularity, and this role (in comparison to the others) assumed a favored status.

SUBJECT GOAL #3: Participants will demonstrate knowledge of at least four functions they (the mediator) should accomplish prior to requesting the services of a consulting specialist.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will correctly list four activities they must engage in prior to requesting the services of a specialist/agency.

ACTIVITY: Presenters will describe the functions the mediator should accomplish prior to requesting the services of a specialist/agency. Instruction will be conducted via lecture, visual aides, handbook, group interaction, and role playing.

RESULTS:

Pre-test: On the closed-book pre-test, the vast majority of participants listed activities they would perform just before they "called the doctor" to see a particular child. (The portent of the question/subject related to activities engaged in prior to organizing a regular system of specialist services to an entire program).

Post-test: On the open-book post-test only 65% of the participants attained the desired accuracy. There was extensive replacement of the correct answers with entire sets (outlines) of answers from other blocks (subjects) of instruction, some of which had not yet been addressed in the workshop!

SUBJECT GOAL #4: With respect to the Minnesota Special Education Law, Section 120, participants will demonstrate knowledge of at what ages and with what disabilities Head Start children are eligible for public school services.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will correctly identify (match) which of the following handicaps make a child eligible for public school services at what ages: speech-language disorders, crippling condition, mental retardation, hearing impairment, visual impairment, emotional disturbance, behavior problem with learning disability.

ACTIVITY: Presenters will describe the law (Minn. Statute 120) using lecture, handbook material, and a "reaction panel" composed of members from State Department of Education, local school district administrators and specialists, and state legislators.

RESULTS:

Pre-test: On the closed-book pre-test, no item was correctly matched by less than 25% and no more than 57% ($\bar{X}$=39%) of the participants. 0% of the people correctly answered all items.

Post-test: On the open-book post-test, no item was correctly answered by less than 90% of the participants ($\bar{X}$=95%) and 66% of the people correctly answered all items.

SUBJECT GOAL #4A: Same as Subject Goal #4.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will correctly answer "true" or "false" to the following question: "The public school system does not have to screen four year old children for developmental skills," (answer= "false").

ACTIVITY: Same as #4.

RESULTS:

Pre-test: Of sixty-four people taking the closed-book pre-test, 21% of the participants attained the desired accuracy.

Post-test: Of fifty people taking the open-book post-test, 100% of the participants attained the desired accuracy.

SUBJECT GOAL #5: Participants will demonstrate knowledge of at least four primary functions of the "staffing team" following their discovery of a particular child with special needs.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will list four actions of the mediator team after a teacher has brought to the team the name of a child having "special needs."

ACTIVITY: The presenters will describe the mediator team's on-going functions. Instruction will be via lecture, handbook materials, role playing, and group interaction.

RESULTS:

Pre-test: The closed-book pre-test responses eluded objective evaluation for the following reasons. The responses typically did not fit the pre-determined categories of the test answers - technically speaking. However, the responses did consistantly reflect a logical and effective pattern of action which restated the material content in different words. The participants' responses typically stressed the function of a mediator team, close observation of the child, referral, and parent involvement.

Post-test: During the open-book post-test the participants' answers did consistantly conform to pre-determined test answer categories. 89% of the people attained the desired accuracy.

SUBJECT GOAL #6: The participants will demonstrate knowledge of ways the mediator can help the teacher integrate into the classroom children with special needs.

INSTRUCTIONAL OBJECTIVE: 75% of the participants will list four ways that the mediator might assist the teacher in promoting a healthy self-concept in children.

ACTIVITY: Presenters will describe several methods by which the mediator can help the classroom teacher integrate into the classroom children with special needs. Instruction will be via lecture, handbook material, visual aides, role playing and group interaction.

RESULTS:

Both in the pre- and post-test virtually every student answer can conceivably be construed as eventually aiding a child's self-concept and integration. However, discrete suggestions which were emphasized in the instruction presentation will be the criteria for test evaluation.

Pre-test: During the closed-book pre-test most participants were responding as though the mediator would be working directly with the child, as a kind of "therapist." Of those who talked in terms of working with the teacher, many suggestions were in terms of convincing teachers about proper" attitudes toward children. Several suggestions included formal in-service training (which illustrated the sequential concepts of presentation, demonstration, and follow-up). Family involvement and reinforcement (of both child and teacher) were also stressed.

Post-test: Of forty-six people taking the open-book post-test, 68% met the desired performance. A much reduced variety of suggestions among student answers was evident as most people adhered to the same outline of responses. It is still not clear whether or not many of the mediators see themselves working directly with the child. Some suggestions now appearing which did not appear in the pre-test answers include: helping interpret specialists' recommendations; not overprotecting children with special needs; and, answering questions raised by children regarding special needs.

Discussion

Several aspects of the evaluation are of particular concern to the Project staff.

Perhaps the most significant concern is the lack of representatives of several agencies at the workshop. The fact that no Indian agency sent participants was puzzeling because, as a group, these agencies have in the past participated in other Project workshop activities. Also, this group of agencies has experienced particular difficulty recruiting specialist consultant services. On the other hand, Mahube agency, which sent no representatives, has had a history of poor participation in OCD-BEH efforts. Arrowhead agency and South Central agency also sent no representatives. Because technical assistance from the Project during the coming year will pivot on the mediator team concept, special and expensive efforts may be needed to deliver assistance to those agencies not acquainted with the concept.

Of the participants who attended, a group of about fifteen people, at various times, missed entire sessions, entered sessions late and left sessions early. It is highly possible that the behavior of this group was the cause of the unaccomplished instructional objectives. The objectives missed were always due to the fact that instead of 75% of the people attaining the desired accuracy, only 65% to 69% attained the accuracy. In several cases the correct test answers were replaced

by outlines of subject matter printed in the Handbook which were not yet discussed in the workshop! It appeared that people may not have attended a block of instruction only to return the next morning for the post-test, producing poor results. (Also, twenty-five people left the workshop - usually to get home earlier - on the morning of the last day, prior to the last half-day's instruction). Because the presented material was necessary information, the staff is concerned that a small but significant group of people are unaware of information which is necessary for effective service to handicapped children. In the future, these attendance problems can be anticipated and alternative strategies used to discourage these problems (e.g., not ending the workshop on a morning, clearer, more assertive, early and repeated statements that attendance is required, direct and/or indirect confrontation of individuals, etc.).

The fact that three instructional objectives were not accomplished is of interest to the staff. The missed objectives are not interpreted as a lack of success in the workshop. Stated differently, the results of each objective indicate that 65% to 69% of all people received the information which was considered important. In every case, there was a remarkable improvement in student performance during the course of instruction. Yet, fewer than the desired number of participants attained sufficient accuracy in three subject areas. The staff has considered several

possible reasons for this, the most probable being the sporadic attendance of some people. The more serious problem is the fact that post-tests were evaluated after the workshop - and, therefore, the staff did not have an opportunity to bolster weaker areas of instruction. In the future, an attempt will be made to evaluate post-tests on-site.

On one of the post-tests it appeared that participants actually went out of their way to exclude "program consultant" as a possible role of the specialist. At first, this observation sounded a warning to the staff - who's primary role is program consultation. Paradoxically, the staff has never encountered anything other than willing cooperation from nearly all the agencies. Several interpretations of the test results have been offered, the most plausible being that what the participants perceive as program consultation is not the same as that perceived by the Project staff. Agency personnel may balk at an "outsider" telling them what to teach - curriculum. However, the Project staff view a program consultant as someone who suggests alternative ways of administration and instruction. The discrepancy of perceptions is not surprising since an earlier survey and pre-test results indicate that Head Start has not used specialists in too many different roles. And, few people (Head Start or specialists) have had experience using program consultants. Perhaps the consultation success of the

Project staff lies more in the area of gradual personal familiarity with agency people; Head Start staffs know the Project people well, and consequently do not view their instruction as being so threatening as an "outside" specialist.

The role of the parent was an interesting aspect of the evaluation results. Of all the possible specialist roles, "parent education" showed the greatest increase in popularity during the workshop. Yet, this role still remained one of the least mentioned. Despite encouragement of agencies by the Project staff, parent attendance has been very poor at previous workshops. Therefore, the results of this Mediator Workshop add support to an increasing effort on the part of the Project staff to facilitate parent involvement.

When taking each test, the participants were asked to write the name of their agency at the top of the page. In this way, the Project staff can create an "agency profile" - a description of the performances and opinions throughout the workshop of each agency's group of participants. These profiles can help guide the Project staff during on-site agency visits in that the staff can have a little better appreciation for the "point of view" (perspective) of each agency regarding the mediator team concept. In compiling these profiles, for instance, it is apparent that some agencies were represented by people whose performance and opinions were quite consistently similar. Other

agencies had participants who were diametrically opposed. Where an agency had similar participants, it will be easier to anticipate abilities and attitudes awaiting the Project staff visit. However, the Project staff is cautious to interpret these profiles as tentative, very sketchy, and potentially inaccurate indices of an agency's true status.

APPENDIX 2

ON-SITE VISIT ONE
FORM SENT TO MINNESOTA HEAD START/HOME START PROGRAMS

OCD-BEH COLLABO[illegible]IVE PROJECT

Agency Checklist for Seven Initial Functions of the Mediator Team

		Completed	Soon to be completed	Experiencing difficulty
Function #1	Establish mediator team (pp. 12-14, Mediator's Handbook)	_____	_____ (Please check one)	_____
1a	Designate team coordinator (pp. 39-42)	_____	_____	_____
Function #2	Decide on types of resource specialists needed (pp. 14-15)	_____	_____	_____
2a	Complete a needs assessment of children past and present (p. 14)	_____	_____	_____
2b	Decide on specialists needed (p. 14)	_____	_____	_____
2c	Identify two specialists who can guide you in finding other resources (p. 15)	_____	_____	_____
Function #3	Consider the desirable roles for specialists (pp. 16-20)	_____	_____	_____
Function #4	Consider number of centers to be covered by a specialist (pp. 20-21)	_____	_____	_____
Function #5	Consider frequency of a specialist's visits to centers (pp. 21-22)	_____	_____	_____
Function #6	Meet with specialists to request services (pp. 23-26)	_____	_____	_____
		How many specialists have you met with? _____		
6f	Explore possible roles that specialists could assume (p. 24)	_____	_____	_____
6g	Agree upon roles which specialists could assume (p. 24)	_____	_____	_____

Agency Checklist for Seven Initial Functions of the Mediator Team

		Completed	Soon to be completed	Experiencing difficulty
Function #6h	Make a written or gentleman's agreement or contract for services with the specialists (pp. 24-26)	_____	_____ (Please check one)	_____

How many agreements or contracts do you have?____

The OCD-BEH Project staff will discuss Function #6 in greater detail when we visit you.

Function #7	Make arrangements for screening procedures (pp. 27-29)	_____	_____	_____

Please check the areas for which you have arranged screening:

____Medical

____Dental

____Language

____Speech

____Vision and Hearing

____Motor

____Social/Emotional

APPENDIX 2

ON-SITE VISIT ONE
FORM SENT TO MINNESOTA HEAD START/HOME START PROGRAMS

OCD-BEH COLLABO IVE PROJECT

Agency Checklist for Seven Initial Functions of the Mediator Team

		Completed	Soon to be completed	Experiencing difficulty
Function #1	Establish mediator team (pp. 12-14, Mediator's Handbook)	_____	_____ (Please check one)	_____
1a	Designate team coordinator (pp. 39-42)	_____	_____	_____
Function #2	Decide on types of resource specialists needed (pp. 14-15)	_____	_____	_____
2a	Complete a needs assessment of children past and present (p. 14)	_____	_____	_____
2b	Decide on specialists needed (p. 14)	_____	_____	_____
2c	Identify two specialists who can guide you in finding other resources (p. 15)	_____	_____	_____
Function #3	Consider the desirable roles for specialists (pp. 16-20)	_____	_____	_____
Function #4	Consider number of centers to be covered by a specialist (pp. 20-21)	_____	_____	_____
Function #5	Consider frequency of a specialist's visits to centers (pp. 21-22)	_____	_____	_____
Function #6	Meet with specialists to request services (pp. 23-26)	_____	_____	_____
		How many specialists have you met with?_____		
6f	Explore possible roles that specialists could assume (p. 24)	_____	_____	_____
6g	Agree upon roles which specialists could assume (p. 24)	_____	_____	_____

Agency Checklist for Seven Initial Functions of the Mediator Team

		Completed	Soon to be completed	Experiencing difficulty
Function #6h	Make a written or gentleman's agreement or contract for services with the specialists (pp. 24-26)	_____	_____ (Please check one)	_____

How many agreements or contracts do you have?____

The OCD-BEH Project staff will discuss Function #6 in greater detail when we visit you.

Function #7	Make arrangements for screening procedures (pp. 27-29)	_____	_____	_____

Please check the areas for which you have arranged screening:

____Medical

____Dental

____Language

____Speech

____Vision and Hearing

____Motor

____Social/Emotional

APPENDIX 3

ON-SITE VISIT ONE
FORMS USED BY PROJECT STAFF TO MONITOR VISIT ONE PROCEEDINGS

OCD-BEH PROJECT STAFF'S EVALUATION FORM FOR SEVEN INITIAL MEDIATOR FUNCTIONS

Name of Agency _____ Date of Visit _____

Individuals Present:

OCD-BEH COLLABORATIVE PROJECT FOR HEAD START CHILDREN WITH SPECIAL NEEDS

Name of Agency (and Director) _____

Centers & Location:	Q	W1	W2	N of Children in Class	N of Spec. Needs Children in Class
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Attendance at Workshop No. 1_____ at Workshop No. 2_____ Other presentations_____

How are records maintained_____ By whom_____

Mediator team:

When was it organized_____

Names of members_____ Position_____

_____ _____

_____ _____

_____ _____

_____ _____

Is team meeting_____

Regularly_____

When does it meet_____

Name of mediator team coordinator/leader_____

Address of mediator team leader_____

_____

What is each center's method of communication with parents?

Letter_____

Regularly meeting parent board_____

Parent newsletter_____

Telephone_____

Home visits_____ By whom_____

No formal structure_____

Is the parent communication structure determined with the parent board of the agency _____

How_____

KODER VISIT

_____ 1. Researcher's names: Joanna Koder & Judy Zinc
_____ 2. Purpose: to find out if integration happening;
_____ also, does Projrct really help? (focus on us)
_____ 3. Not to draw conclusions about any one person/agency.

Function #1: Establish Mediator Team and designate Team Coordinator
Evidence: Written list of members, their positions, mailing addresses, when and where the team meets
Emphasize: Broad spectrum of interests on team; regular and frequent meetings; possible school person (e.g., teacher) on.

DATA	Name (Q?)	Position	Address	When meet	Where meet

SUGGESTIONS TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #2.A.1.: Review needs of children identified during previous year
Evidence: Written list indicating children's names, sex, diagnosed by whom, type of problem, what center.
Emphasize: Involve all team members; gather information from files, memory; all areas of disabilities.

DATA	Initials	Sex	Diagnosed?	By whom?	Problem	What center

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #2.A.2.: Assess current problems of special needs children (at this point)
Evidence: Written list indicating children's names, sex, diagnosed by whom, type of problem, and what center.
Emphasize: Involve all team members; screening arrangements from Function #7; all areas of disability.

DATA	Initials	Sex	Diagnosed?	By whom?	Problem	What Center

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #2.B.: Decide on appropriate and necessary specialists
Evidence: Written list of possible specialists to account for major disabilties of each child on previous page.
Emphasize: Specialist for major disability of <u>each</u> child on previous page;

DATA	Type of specialist	Possible resources	Applies to which child?

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #2.C.: Indentify two specialist advisors to Mediator Team
Evidence: Written list of, and previous dialogue with, two such specialists
Emphasize: Specialists with broad background of child development; frequent visit with team

DATA	Names of specialists	Profession	Employment address	previous dialogue?	freq. of visit

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #3: Consider desireable roles for specialists
Evidence: Present discussion considering all possible roles for each specialist identified in #2.
Emphasize: Consideration of all roles for every specialist.

DATA	Specialist	Roles by letter	Comments

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP BY AGENCY STAFF

Completed	Soon to be	Difficulty

Function #4: Consider number of centers to be potentially covered by a specialist
Evidence: Present discussion considering number of centers to be covered by each specialist in #2.
Emphasize: This consideration for <u>each</u> specialist;

DATA	Specialist	Number of centers	Comments

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP BY PROJECT STAFF

Completed	Soon to be	Difficulty

Function #5: Consider frequency of visits for each specialist.
Evidence: Present discussion considering frequency of visits for each specialist in #2.
Emphasize: Frequent and regular visits; consider each specialist.

DATA	Specialist	Frequency of visits	Comments

SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

Function #7: Make arrangements for screening procedures.
Evidence: Completed screening records in all developmental areas for every child.
Emphasize: All developmental areas; each child; prior to November; valid screening procedures; have specialist roles provided for on-going screening?

DATA	Developmental area	Resource agency	Specialist/Instrument	Date	Child Capacity	Completed
	Medical Health					
	Dental					
	Vision					
	Hearing					
	Speech/Language					
	Social/Emotional					
	Motor					

COMMENTS:

Function #7, continued

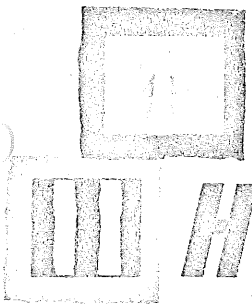
SUGGESTIONS MADE TO AGENCY

PROPOSED FOLLOW-UP FOR PROJECT STAFF

Completed	Soon to be	Difficulty

APPENDIX 4

LETTER TO MINNESOTA PROGRAMS ANNOUNCING WORKSHOP 1 (1974-1975)



STATE OF MINNESOTA
GOVERNOR'S
OFFICE OF ECONOMIC OPPORTUNITY
404 Metro Square – 7th & Robert
ST. PAUL, MINNESOTA 55101

612/296-2367

November 15, 1974

Dear Mediator:

We have talked with most of you about our first workshop. Now we wish to give you more details.

The purpose of this workshop is to acquaint parents of special needs children and the Head Start teaching staff with a concrete, on-going system for observing children. We hope to help improve the teachers' and parents' skills to screen children and work with them. We will be talking about behavior checklists, which we have already discussed with many of you. These checklists are comprised of specific skills or behaviors that you would expect children to be displaying in several areas (such as language development, motor development, social/emotional development, etc.) at different ages. These checklists can be used to help people better understand what to look for that suggests normal development or developmental lags. They can also be used to determine more specifically what the child is doing and is not doing (strengths and weaknesses), which may help teachers and parents figure out where to start working with children.

The workshop will begin at 9:00 a.m. and conclude at 3:30 p.m. The workshop dates and sites are:

November 22 (Friday) St. Cloud (final arrangements being made)
December 5 (Thursday) Bemidji State College Ballroom, Bemidji
December 6 (Friday) Thief River Golf Course (North on Hwy. 32 out of Thief River Falls 1 mile)
December 10 (Tuesday Village Inn, 1215 East Superior St., Duluth
December 12 (Thursday) Twin Cities (place to be designated)
December 6 (Friday) Holiday Inn, Mankato
December 9 (Monday) Holiday Inn, Fergus Falls
December 13 (Friday) Donovan's Inn, Redwood Falls
December 20 (Friday) Owatonna Inn, Owatonna

You may attend whichever workshop is closest to you.

Please encourage the parents of special needs children in your program to attend with your staff. If these parents cannot attend, use your judgement in asking other parents. Also, please consider inviting one or two public school people. For example, kindergarten teachers, principals, special education directors, specialists, etc., might be your guests. Please make a real effort to communicate this information to your teaching staff, parents, and school people. That is, tell them what the workshop is about as specifically as possible, and be sure to tell teachers that parents will be at the workshop. Teachers should expect to work with parents at the workshop.

We are hopeful that one CDA credit can be given to qualified staff who attend both this workshop and the next workshop to be held in February. However, we have yet to get final word from the CDA programs.

We will be calling your agency soon to get an idea how many parents, staff, and guests will be attending. It is necessary for us to have some idea of how many people you anticipate sending.

We hope to see you there also. If you have any questions, please do not hesitate to contact us.

Sincerely yours,

Jon Boller
Jon Boller, Ph.D.
Project Director

Don Henry
Donald Henry, Ph.D.
School Psychologist

Fred Aden
Fred Aden, M.A.
Speech Pathologist

Dave R. Garwick
Dave Garwick, M.A.
Speech Pathologist

OCD-BEH COLLABORATIVE PROJECT

APPENDIX 5

WORKSHOP 1 (1974-1975)
GUIDES FOR LOOKING AT CHILDREN IN THE HOME & CLASSROOM
BEHAVIOR CHECKLISTS

HEAD START children with special needs

ocd/beh project

1974-75 WORKSHOP NO.1

GUIDES

FOR LOOKING AT CHILDREN IN THE HOME & CLASSROOM:

behavior checklists

1974-75 WORKSHOP NO. 1

GUIDES FOR LOOKING AT CHILDREN IN THE HOME & CLASSROOM: BEHAVIOR CHECKLISTS

INTRODUCTION

People often want to know what kinds of things they should expect a child to be doing during the time he or she is in Head Start. One way of answering this question is to say that you might expect a Head Start child to do the things that most other children of the same age are doing. (For example, most four year olds can correctly point to their eyes, nose, mouth, ears and many other parts of their body, so you might expect that most Head Start children would do this if asked.) Another way of answering the question is to say that you should expect the child to keep on doing the things he or she is already doing (regardless of what most other kids of the same age can do) but also expect that new things will gradually appear. (Even if most other four year olds can point to many parts of their body, the four year old who can only point to his nose and mouth will probably need some time to learn to point to other body parts.) Both of these answers are accurate. It is important to know what to expect in the normal course of development. However, it is also important to know that just because a child is not doing some, or many, things that other children of the same age are doing you cannot expect that he or she should automatically be able to do those things. The progress may come about slowly.

The use of written guides when looking at children is one way of helping to understand what is expected in the normal course of child development. Also, written guides can help parents, teachers, specialists, and others figure out specific things that a child seems to be able to do at any particular time.

What Are These Written Guides?

The guides are lists of things that most children can be expected to do at different ages. They are often called behavior checklists. These checklists have been put together by people who have observed many different things about children as they develop during the early years of their lives. Some of these things include: 1) the way children talk, how they use words and make sentences; 2) the way children take care of themselves, how they put on clothes, eat, wash themselves, etc.; 3) the way children get along with other people, how they play with other children and

respond to adults; 4) the way children coordinate their movements, how they walk, run, hold spoons, etc..

So now you have an inkling of what the behavior checklist is all about. It is a tool for you to use, to help you figure out what kinds of things you see children doing, and to help you chart or record these things in a meaningful way.

Continue reading. The following is some information we have put together, telling about some of the developmental areas that the checklist can help you look at, some of the reasons for using a behavior checklist, some ways to use a behavior checklist, and some cautions you might want to be aware of when using a behavior checklist.

SKILL AREAS

The following are the usual areas covered by currently available checklists:

1. COGNITION

Cognition relates to the ability to remember, to tell the difference between important and unimportant activities, to pay attention (attending) to important experiences, to recognize patterns like shapes and melodies, to recognize things in their correct order, to tell the difference between two things, to keep up with the speed of information being communicated, to not be distracted by background activity like noise, etc.

Examples:

a. Can compare three pictures (which one is prettier).
b. Reassembles a circle which has been cut in four pie shaped pieces.
c. Imitates folding a six inch square of paper twice to form a triangle.

2. MOTOR

This area relates primarily to the movement and use of the large and small muscle groups of the body. Large muscles are those we use for walking (large leg muscles), throwing (the bisceps, triceps, and back muscles), lifting (usually back and shoulder muscles), etc. These movements are called gross motor because they relate to muscle activity which doesn't necessarily call for precision. Small muscle movement (called fine motor) examples are: working with fingers (tying shoes, writing, picking up marbles), or perhaps using the toes to make a letter in the sand.

Examples:

a. Catches an eight inch ball bounced to him from four to six feet
b. Prints simple words
c. Climbs to playground slide and slides down

3. SELF-HELP

Self-help skills relate to those activities we do which imply caring for ourselves, like eating and knowing which utensils to use (peas don't stay on a knife very well), being able to dress and get all the buttons buttoned (overlaps of course with fine motor above), brushing teeth, knowing how to use the toilet, or bathing oneself (and knowing how to use a washcloth or towel).

Examples:

a. Dresses self except tying
b. Cleans up spills without help
c. Uses toilet by himself without supervision

4. LANGUAGE

This area deals with symbols like words, and pictures, and the use of writing tools to express ideas symbolically; with reading skills; knowing how these symbols/pictures/words are used and what they mean; and being able to organize them in a way that is meaningful and which communicates your idea to someone else. Speech is included in as much as it relates to the use of words to communicate. All of this comes out of experience, which is basic to language development. It is difficult to find a situation where language is not a part of the activity.

Examples:

a. Carries out three directions on request
b. Listens to and tells long stories, sometimes confusing fact and fantasy
c. Uses the prepositions in, on, beside, under, above, and below appropriately when asked to describe his own body position (four positions).

5. SOCIALIZATION

This area refers to appropriate and effective behaviors that involve living with other people. Almost all of preschool behavior occurs with other people (parents, other kids, teachers, the family doctor, etc.). Learning how to get along with others, what is right and wrong (you learn this from parents, teachers, your minister, etc.), what to do when company comes, how to play with other children without getting into too many fights--these are all examples of becoming socialized. Socialization is learned through imitating other people who are important to you, participating in activities where you want to learn how to do something, and by communicating with other people (hearing what they have to say and trying to make them understand what you want to say). And, of course, whether or not you get spanked, put in the corner, or are given a candy bar determines to a fair degree how much of this "social" behavior you will do again.

Examples:

a. When playing group games, waits and takes turn with minimum of external control
b. Answers telephone efficiently
c. Enjoys dressing up in adult clothes

USES FOR BEHAVIOR CHECKLISTS

1. AS A GUIDE TO THE NORMAL PROCESS OF CHILDHOOD DEVELOPMENT IN SUCH SKILL AREAS AS:

   Cognition
   Self-Help
   Language
   Social/Emotional
   Gross Motor
   Fine Motor

   A teacher's and parent's awareness of the normal sequence of skill development in each of these areas is important. It is even more important when the parent and teacher have responsibility for working with a child who has special needs which affect his/her ability to learn these sequence of skills.

2. AS AN OBSERVATION-SCREENING TOOL.

   Behavior checklists can help guide and direct teacher and parent observations of behavior. This means going beyond a simple awareness of the behavior, to the actual use of a checklist by a teacher and/or parent to record the observed behavior. Behavior checklists can help you identify children who are having problems in one or several areas of development. This identification may then lead to referral of children to specialists. In this way a great deal of specific behavioral information can already be available to the specialist at the time the child is seen.

3. AS A BETTER WAY TO DESCRIBE THE BEHAVIOR OF ANY CHILD.

   A completed checklist describes the level of skill development a child has reached in each of the skill areas observed. No label is placed on a child when you use a behavior checklist.

4. AS AN EDUCATIONAL ASSESSMENT TOOL FOR CHILDREN WITH OBVIOUS SPECIAL NEEDS.

   Behavior checklists help teachers and parents to make on-going educational assessments of a special needs child's strengths and weaknesses across many areas of development. Checklists are an equally good tool for the educational assessment of all children.

5. AS A GUIDE TO THE EDUCATIONAL PLANNING/PROGRAMMING FOR ANY CHILD.

   Checklist systems also provide educational guides. These can guide the teacher and parent in planning activities and learning experiences which are appropriate to each child's rate of growth and development.

6. AS A TOOL FOR EVALUATION OF THE PROGRESS OF ALL CHILDREN IN A PROGRAM.

   As a straight-forward evaluation approach, all children might be assessed at the beginning and end of the program year (perhaps in the middle of the year also) by using behavior checklists. This assessment might provide information about the strengths and weaknesses of the children as a group, and could suggest where the curriculum is strong, where the curriculum may need modification, etc.

7. AS A TOOL TO ENHANCE COMMUNICATION BETWEEN ADMINISTRATIVE OR COORDINATOR LEVEL STAFF (MEDIATORS) AND TEACHING STAFF; BETWEEN ALL HEAD START STAFF MEMBERS AND SPECIALISTS: BETWEEN HEAD START STAFF, SPECIALISTS, AND PARENTS.

   Behavior checklists can help to direct everyone's attention to specific, identifiable behaviors when you are observing and/or talking about children. Checklists might help reduce some of the confusion that often results when different people, with differing points of view, try to describe problem areas and strength areas of children.

HOW TO USE A BEHAVIOR CHECKLIST

Before you or your staff use this approach an in-service practice session and a follow-up in-service review (perhaps one month later) is recommended.

---

1. Use one set of checklists (cognitive, motor, self-help, language, and socialization) for each child to be observed.

2. Thoroughly review a checklist prior to using it so you know what behaviors you will be looking for. It is not necessary, however, to memorize the sequences of tasks on a checklist.

3. Start by looking at one child and at one skill area at a time. Practice this kind of observation with the idea that you are developing your own observation skills and understanding of developmental skills that are important.

4. Select those children who are having special learning needs as the children you will observe at the outset. A parent with more than one child might want to select the child who may be showing some special learning need.

5. Observe the child during normal activities in the home or classroom. Usually it is not necessary to set up a special activity which is different from the home routine or classroom curriculum.

6. Observe the child at different times, over several days, and during different activities.

7. Observation periods can be short -- 5 to 15 minutes at a time, or less.

8. Your prior knowledge of how well the child performs should help you to immediately narrow-down the possible choices on a behavior checklist. In other words, it will usually not be necessary to start with item #1 and go through every item.

9. Score a plus (+) or check (✓) if a behavior given on a checklist occurs fifty percent (50%) of the time in a normal situation calling for that performance.

10. A plus (+) or check (✓) can be placed by a behavior on the exact date it is achieved or when observed during periodic skill reassessment. Recording the date that the observation was made is important.

11. Move on to the next developmental area checklist, or observe other children using the same checklist.

12. Begin thinking how you might use the information you have gained through this careful observation. How might this information apply to what you want to teach the child next? How might it apply to your expectations for the child? How might it affect the way you teach a skill?

HOW TO USE A CHECKLIST TO SCREEN AN ENTIRE CLASS:

1. Before you or your staff use this approach, an in-service practice session and a follow-up in-service review (perhaps one month later) is recommended.

2. Select one subject area to be observed (for example, language).

3. Assign five youngsters to each parent/teacher/aide to be casually observed for two or three days.

4. At the end of the observation period, have each observer complete the checklist for her/his five children.

5. Review each child's checklist with an appropriate consulting specialist (for example, speech clinician, child psychologist, special education teacher, etc.).

6. Repeat #1--#5 for the next subject area to be observed.

CAUTIONS ABOUT THE USE OF BEHAVIOR CHECKLISTS

Just like all other tools or methods, a behavior checklist can be misused. Therefore, it is advisable to look at some cautions.

1. DO NOT USE A BEHAVIOR CHECKLIST AS A TEST TO COMPARE ONE CHILD WITH ANOTHER.

   A checklist should be used to determine the level at which the teacher and parent should begin working with each individual child.

2. DO NOT BECOME OVERLY CONCERNED WHEN YOU SEE THAT A CHILD IS NOT PERFORMING CERTAIN TASKS OR BEHAVIORS.

   Too much concern, without additional observations and possibly specialist evaluations, can lead to "over-teaching". Trying to force a child to learn will only result in more frustration for the child.

3. DO NOT TRY TO TEACH A SKILL AS IT IS GIVEN ON A CHECKLIST.

   Each skill can be broken-down into many smaller tasks. The process of breaking-down a skill into smaller tasks is called "task analysis".

4. DO NOT TRY TO OBSERVE ALL OF THE SKILL AREAS AT ONE TIME, OR IN ONE SITTING.

   This would be too confusing. And children do not display all skills at any one time. Try several observations of a child's behavior, during different activities and at different times of the day. This should make the observation process easier and more accurate.

5. DO NOT TRY TO SECOND GUESS THE CHILD.

   If you do not actually observe a child performing a skill, do not give him/her the benefit of the doubt when marking the checklist. Remember, checklists give a description of a child's behavior. A checklist is not a test, so a child cannot fail. "If you don't see it, don't mark it."

6. DO NOT EXPECT ALL CHILDREN TO FOLLOW THE WRITTEN ORDER OF THE CHECKLIST EXACTLY.

   For example, children may skip some behaviors completely or they may learn behaviors out of sequence.

7. DO NOT BE CONCERNED ABOUT THE AGE OF THE CHILD.

   If a child's behavior can be described by items on the checklists, then it is appropriate to use the checklists with that child, no matter what age. In other words, each

7. (continued):

child's educational program should be guided by an understanding of that child's skills and difficulties. You observe what he/she is doing and what he/she is not doing --- and then you plan what you will do based on those observations.

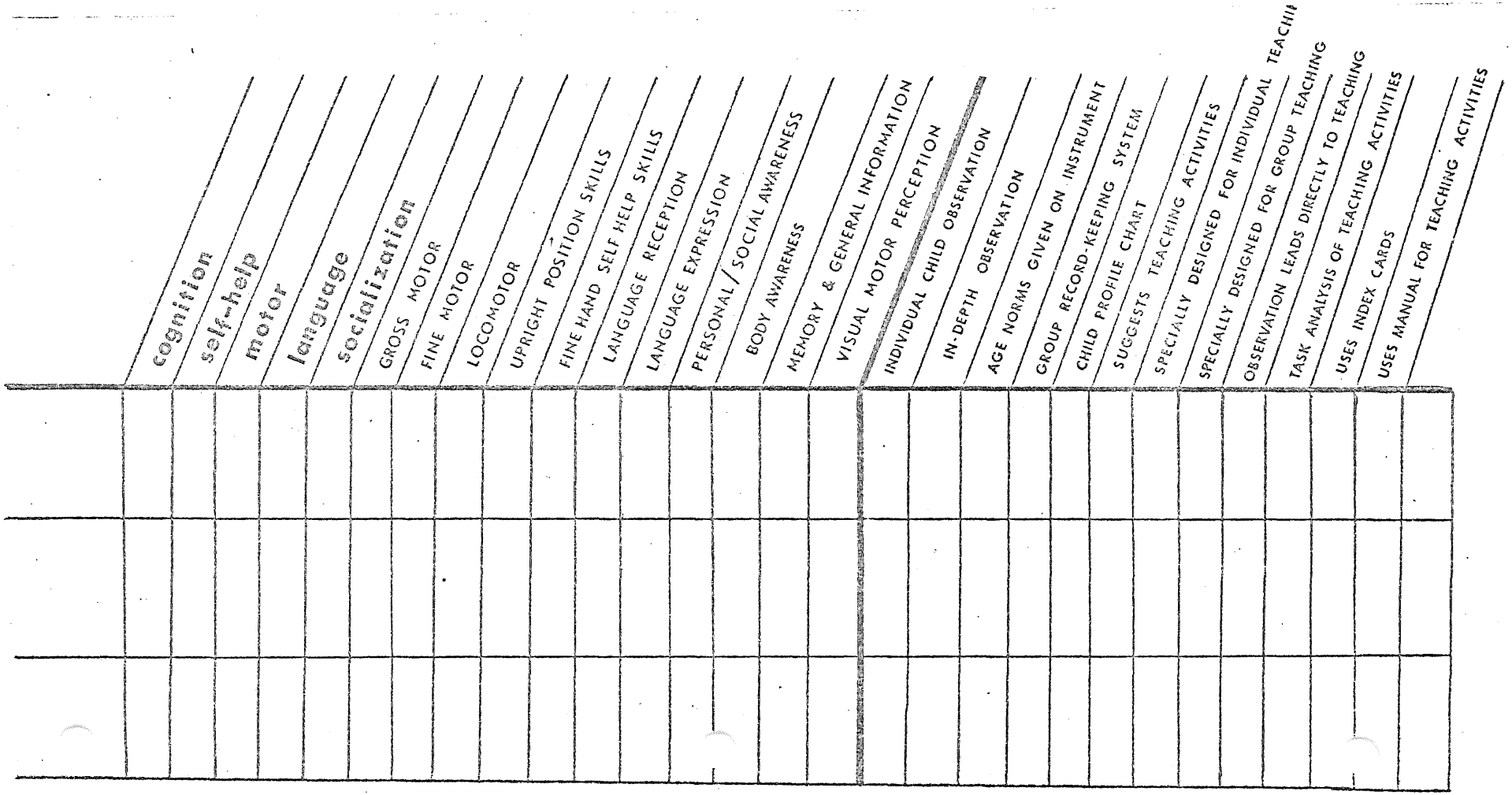
"CONSUMER OPINION"

r..."Which Prescriptive Teaching Program should I use?"

While The OCD-BEH Project is not in the business of recommending one commercial instrument over another, several of these do exist, and they are significantly different from each other to warrant some comment.

The Project Staff can show you some of the differences among these programs, but you will have to be the judge as to what is "good" and "bad" - depending upon your particular needs.

Incidentally, with a little ingenuity and effort on your part, each program can be modified in most respects to be like the other programs.



"A List of Some Behavior/Prescription Checklists"

1. Chapel Hill Training-Outreach Project Products:

   A. Learning Accomplishment Profile (LAP) (1 per child @ $1.50 ea.)
   Order from: Student Stores, Daniels Building
   University of North Carolina at Chapel Hill
   Chapel Hill, North Carolina 27514

   B. LAP Smithfield Revision for Group Recording (no listed cost)

   C. A Planning Guide - The Preschool Curriculum ($4.00 per copy)

   D. Slide-Tape Training Programs

   The above, order from: The Chapel Hill Training-Outreach Project
   Lincoln Center, Merritt Mill Road
   Chapel Hill, North Carolina 27514
   (check payable to: Chapel Hill-Carrboro City Schools)

2. The Meyer Children's Rehabilitation Institute Prescriptive Teaching Program for Multiply Handicapped Nursery School Children

   A. For an in-depth description of this program:

   Handicapped Children in Head Start Series:
   Meyer's Children's Rehabilitation Institute
   Teaching Program for Young Children $3.50

   Order from: Head Start Information Project
   The Council for Exceptional Children
   1920 Association Drive
   Reston, Virginia 22091

   B. For the actual program, inquire from:

   Edward LaCrosse, Ed. D.
   Meyer Children Rehabilitation Institute
   444 S. 44th Street
   Omaha, Nebraska 68131

3. The Portage Guide to Early Education (Checklist and prescription cards) $21.00

   Mail check to: Portage Project
   Cooperative Educational Service
   Agency 12
   412 East Slifer Street
   Portage, Wisconsin 53901

APPENDIX 6

ON-SITE VISIT TWO
LETTER SENT TO MINNESOTA PROGRAMS ANNOUNCING ON-SITE VISIT TWO

STATE OF MINNESOTA
GOVERNOR'S
OFFICE OF ECONOMIC OPPORTUNITY
404 Metro Square — 7th & Robert
ST. PAUL, MINNESOTA 55101

612/296-2367

12/30/74

TO: Mediator Team members

FROM: OCD/BEH Project Staff

That time is here again, and we are preparing to make our second round of visits to the Mediator Teams. It is at this meeting we hope to continue discussing with you any problems you may be encountering as you, in turn, attend to the problems of the special needs children in your programs.

We would like for you to schedule (if possible) a regular "team meeting" for this visit. It'll give your team an opportunity to meet while we are there to work with you, and hopefully for us to interpret any confusion you may have regarding the functions in the Handbook. This is one way we can work with you on the "on-going" functions. (For this meeting, your team might have prepared to discuss two or three special needs children.

It would be helpful if you would bring with you the files of special needs children in your program (both screened/suspected, and diagnosed). Also, if you can assemble lists of specialists you have worked with during program year 1973-74, and 1974-75 this would be helpful. We will be trying to identify specialists and the roles they played, and do now perform for you. One point--we won't be recording names of children or taking names with us; the initials we collect (and collected from our first visit) were only for purposes of our discussions of these children with you.

We will meet you at _____am., on January ____, at _____ _____. Our meeting should last no longer than from about 9:00 to perhaps 2:30. We look forward to this meeting, to sharing with you experiences from other programs, and to hearing from you how things are going.

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LETTER SENT TO MINNESOTA PROGRAMS ANNOUNCING ON-SITE VISIT TWO

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APPENDIX 7

ON-SITE VISIT TWO
FORMS USED BY PROJECT STAFF TO MONITOR VISIT TWO PROCEEDINGS AND COLLECT DATA

OCD-BEH PROJECT STAFF'S EVALUATION FORM FOR SEVEN INITIAL AND ON-GOING MEDIATOR FUNCTIONS

Name of Agency_____ Date of Visit_____

Individuals Present:

VISION	HEARING	SPEECH/LANGUAGE	SOCIAL/EMOTIONAL

A= Assisted (by specialist &/or instrument)
U= Unassisted

S= verified by oral statement
R= verified by written record

#2= direct specialist observation and unsupervised, unsystematic teacher observations

#3= systematic teacher observations with specialist supervision
(i.e., appropriate specialist trains/instructs teacher &/or reviews at least 50% of records, &/or observessome of the teachers" administration)

#4= unsystematic teacher observation with specialist supervision

#5= systematic teacher observations without specialist supervision

	vis.	hrng.	sp/lang	soc/emot
classroom #1	100% R (2)	100% R (2)	100% S (5)	100% R (4)
classroom #2	100% R (2)	100% R (4)	0%	0%

example

P.S. Agency _____

Type of Specialist	His/Her Agency	Number of Centers Served	Frequency of Visit	Length of Each Visit	Non On-site Services	On-site Services

H.S. Agency _____

Type of Specialist	His/Her Agency	Number of Centers Served	Frequency of Visit	Length of Each Visit	Non On-site Services	On-site Services

Types of Facilitating Roles by OCD-BEH Staff

A. Resource agency and/or specialist's name suggested to Head Start

B. Phone contact made with resource agency or specialist

C. Written " " " " " " "

D. Visit made to " " " "

E. " " " " " " " and Head Start staff in a joint meeting.

*= H.S. and/or resource agency have known of each other, but have not been in direct contact

Types of Service Provided by Specialist or Resource Agency

1. Arrangements for service in progress

On-site Services

2. Observation of children at centers
3. Consulting with the mediator team
4. Consulting with teachers regarding individual children
5. Consulting with teachers regarding overall programming
6. Consulting with parents
7. Conducting in-service trainging with staff
8. Conducting parent education groups
9. Screening testing
10. Full diagnostic testing
11. Teaching or counseling individual children

Non On-site Services

12. Consulting with mediator team at resourc agency site.
13. Counseling with parents " " " "
14. Conducting training for staff " " " "
15. Screening testing " " " "
16. Full diagnostic assessment " " " "
17. Teaching or counseling individual children at resource agency site
18. Guiding referrals to other specialists

Frequency of On-site Services

a. once a week
b. once every two weeks
c. " " three weeks
d. " a month
e. less than once a month

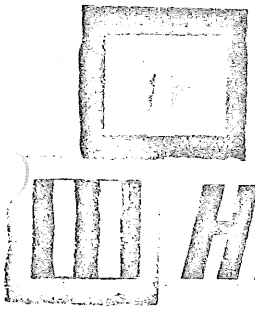
PROGRESS ON PAST RECOMMENDATIONS

Initials/Sex	Our guess of high-potential problems to be checked out	S/R: Has child been seen by appropriate specialists since initially identified?	+/-: Has child been discussed by entire team at a meeting?	+/-: Was the teacher present at the meeti	+/-: Parent working with teacher/team?	NOTES	RECOMMENDATIONS

Initials/Sex	Our guess of high-potential problems to be checked out	S/R: Has child been seen by appropriate specialists since initially identified?	+/-: Has child been discussed by entire team at a meeting?	+/-: Was the teacher present at the meeti	+/-: Parent working with teacher/team?	NOTES	RECOMMENDATIONS

APPENDIX 8

LETTER TO MINNESOTA PROGRAMS ANNOUNCING WORKSHOP 2 (1974-1975)



HEAD START

STATE OF MINNESOTA
GOVERNOR'S
OFFICE OF ECONOMIC OPPORTUNITY
404 Metro Square — 7th & Robert
ST. PAUL, MINNESOTA 55101

612/296-2367

TO: Head Start Mediator Team Members and Other Staff
Parents
OCD-BEH Advisory Council
Friends of Head Start

Second OCD-BEH Workshop Series

We will soon begin our second round of workshops for Head Start staffs and parents. Hopefully, many of you have already been informed of the workshop sites and dates. We attempted to set up these sites and dates while we visited your agencies. The schedule for the workshops is as follows:

March 6	9:00 - 3:30	Bald Eagle Outdoor Learning Center
March 10	9:00 - 3:30	Education Bldg., St. Cloud State
March 11	9:00 - 3:30	Duluth - Village Inn
March 12	9:00 - 3:30	Marshall - Ramada Inn
March 13	10:00 - 4:00	Mankato - Holiday Inn
March 14	9:00 - 3:30	Owatonna - Inn Towne Motel
March 17	9:00 - 3:30	Thief River Falls - Country Club
March 21	9:30 - 4:00	St Paul - St. Stephanus Church, 739 Lafond Avenue

Fergus Falls not arranged yet

This workshop series will deal with two areas; the hearing impaired child and the "hyperactive" child. These subject areas were proposed to many of you during our visits to your agencies. Based on the responses given, we have the impression that these are areas of interest to a majority of people.

Hearing loss happens to almost every Head Start child at one time or another. Serious hearing loss over a long period of time almost always hinders a child's ability to speak, understand and express many concepts and, of course, hear. What causes hearing loss? Why will a child usually have language problems after a long history of head colds as a child? The workshop will answer these and other questions. Participants will practice ways of using the home as a "therapy" program to help a youngster develop language; each person in the workshop will wear a hearing aid and try to hear through its electronic static; each person will practice "trouble-shooting" and fixing minor problems with hearing aids; everyone will observe hearing impaired youngsters with teachers and parents on videotape; trouble signs of hearing loss will be reviewed; ample opportunity will exist for "question-answer" and small group discussion about individual children.

Hyperactivity is a commonly used, but often misunderstood, term. We will be attempting to; 1) clarify what hyperactivity means, 2) describe how it relates to terms like behavior problem, minimal brain damage, hyperkinesis, etc, and 3) discuss some approaches to working with children who are highly active. We will also talk about the use of medication to help manage "hyperactive" children.

As has been the case in our previous workshops, a significant portion of the day will be devoted to small group sessions where participants will be encouraged to bring up specific problems that they are experiencing with kids in the classroom or at home.

Some of you will receive extra copies of this letter to distribute to your entire Head Start staff. We want everyone to know the workshop topics prior to the workshop. We also remind everyone that parents of special needs Head Start children are invited to the workshops. We hope that each of you will actively encourage parents to attend and help us make the workshop a success for parents as well as for you.

See you soon.

OCD-BEH Staff
Jon, Fred, Dave & Don

P.S. Those people who are CDA candidates, and wish to obtain one credit for our workshops, must attend both workshops. That is, they need to have attended the first workshop in the Fall and will have to attend this second one in March. Also, it is necessary that attendance be for the entire workshop each time. We would appreciate receiving a list of the CDA candidates who will have attended both workshops. Perhaps Directors or other staff persons could give us this list at the end of each of the second round of workshops.

APPENDIX 9

WORKSHOP 2 (1974-1975)
HYPERACTIVITY-HEARING IMPAIRED-LANGUAGE

ACKNOWLEDGEMENTS

Our thanks to the following who have contributed suggestions, equipment, and other educational material to this workshop presentation:

Terry Griffing, Ph.D. (Audiologist) and staff of Qualitone Hearing Aid and Audiometer Manufacturers;

Wayne Staab, Ph.D. (Audiologist) and staff of Telex Communications of Mpls., MN;

Lowell Rife, of Rife Hearing Instruments of Mpls., MN;

Gene Bowman of Bowman's Hearing Aid Center of St. Paul, MN;

Miller's Hearing Aid Center of St. Paul, MN;

Bud Raas of Earmold Design of Mpls, MN;

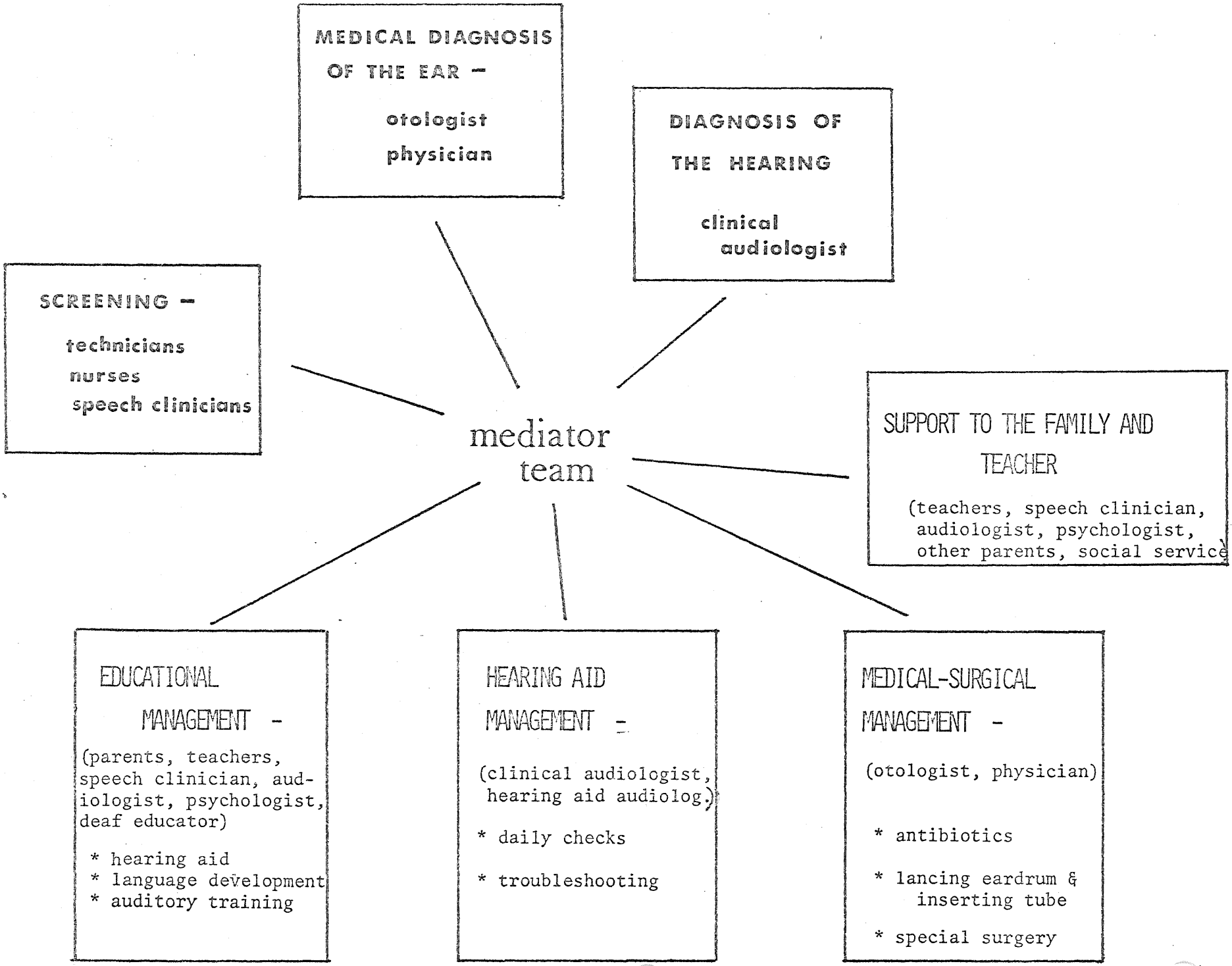
Helen Beirne Ph.D., and staff of the Alaska Head Start Experimental Handicap Project;

Winnifred Northcott, Ph.D., of UNISTAPS Project, Early Childhood Education Consultant, Special Education Section, MN. State Dep't. of Education;

Alexander Graham Bell Association for the Deaf;

Better Business Bureau, Consumer Information Series;

Hearing Aid Industry Conference, Inc.


MEDICAL DIAGNOSIS OF THE EAR –
otologist
physician
DIAGNOSIS OF THE HEARING
clinical audiologist
SCREENING –
technicians
nurses
speech clinicians
mediator team
SUPPORT TO THE FAMILY AND TEACHER
(teachers, speech clinician, audiologist, psychologist, other parents, social service
EDUCATIONAL MANAGEMENT –
(parents, teachers, speech clinician, audiologist, psychologist, deaf educator)
* hearing aid
* language development
* auditory training
HEARING AID MANAGEMENT –
(clinical audiologist, hearing aid audiolog.)
* daily checks
* troubleshooting
MEDICAL-SURGICAL MANAGEMENT –
(otologist, physician)
* antibiotics
* lancing eardrum & inserting tube
* special surgery

MOST COMMON TYPES OF HEARING LOSS

CONDUCTIVE
(Reduced Loudness)
(Outer Ear -- Middle Ear)

- --Plugged ear wax
- --Ear infections
- --Hole in eardrum
- --Diseases that cause hardening of the bones
- --Brittling of the bones

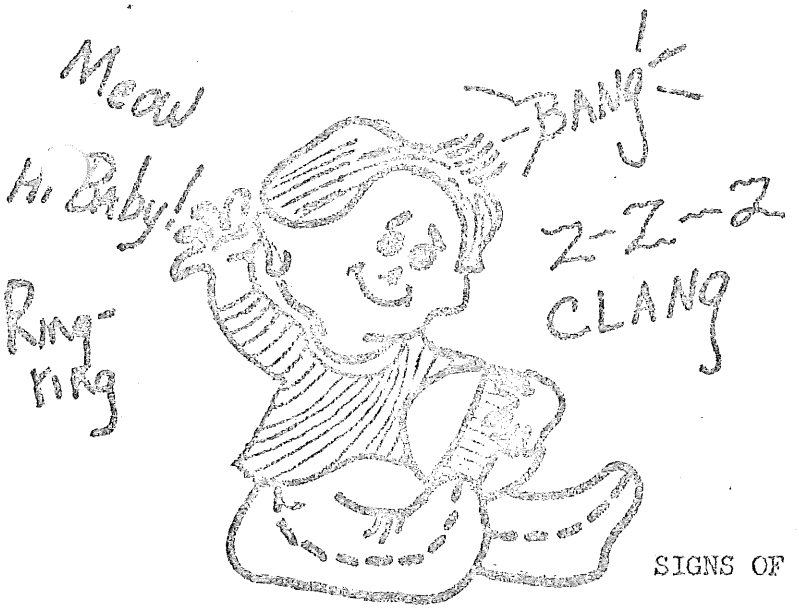
SENSORI-NEURAL
(Reduced Loudness)
(Reduced Discrimination Ability)
(Inner Ear)

Pre-Birth (prenatal):
- --Genetic
- --Diseases

External influences
- --Trauma
- --Health
- --Drugs

Birth:
- --Anoxia

Post-Birth (postnatal):
- --Noise damage
- --Disease
- --High fever
- --Drugs



CAN YOUR BABY HEAR?

SIGNS OF HEARING LOSS

Before the age of one year:

Is it difficult to awaken the child from sleep without touching or shaking him?

Does the baby respond to comforting only when you hold him?

Does the sound of speech or footsteps fail to get a response (turning to look, startle, fright) from the child?

Does he show little interest in musical toys or noisemakers unless he can touch or hold them?

Does he ignore his own name unless you motion to him or look at him when you call?

Does he show little interest in babbling or imitating sounds other people make?

Between one and two years of age:

Is the child not talking by the age of two?

Does he ignore the ring of the telephone or doorbell?

Does he seem startled to look up and see you in the room?

Does he use gestures (pointing, pulling, touching, etc.) to express his needs?

Although he attends to very loud, sudden sounds, does he fail to respond to ordinary speech sounds or to music or listening on the telephone?

What to do if concerned:

1) Don't wait.

2) Seek medical advice. See your family physician first. He may wish to refer you to an otologist (ear specialist) for a more complete examination.

3) You may wish to have your doctor request a hearing evaluation by an audiologist who is certified by the American Speech and Hearing Association. This professional has skills to assess your child's hearing even though your child is very young.

- - MEDIATOR TEAM - -
- - SUPPORT TO THE FAMILY - -

1. Does the family understand the immediate and long-term consequences of not correcting the hearing problem?

2. Does the family need help in finding a doctor, in making an appointment, or with transportation?

3. What are the family's concerns about cost? Who has helped them and how?

4. Does the family have realistic access to a specialist they can talk to about the facts of hearing loss?

5. Then, how many times in the recent past have they talked to this person?

6. Has this problem caused additional "friction" within the family?

7. Is the family having difficulty coping with the emotional aspects of learning that their child is hearing impaired?

8. Do the parents have questions or misunderstandings about the cause of this problem? Are there questions about the chances of future offspring having the same problem?

9. Do the parents know exactly what the doctor will do and why?

10. Do the parents have some idea of what to expect with this child in the near future?

11. Do the parents need assistance in helping the child or siblings understand the situation?

12. Does the family understand the public school's legal responsibilities?

13. Do the parents know how to check the child's hearing aid daily?

14. Do the parents know how to "trouble-shoot" a hearing aid?

15. Are the parents assisted in learning how to provide their child with maximum opportunity to learn language in the home?

16. Are the parents assited in learning how to provide their child with special listening training (i.e., sound awareness, direction of sound, sound discrimination).

- - MEDIATOR TEAM - -
- - SUPPORT TO THE TEACHER - -

1. Is the teacher aware of the problem?

2. Is the teacher involved in the referral arrangements/plans?

3. What are the classroom concerns related to the child's hearing problem?

4. Is the child usually interacting with the other youngsters?

5. If not, is the teacher being helped in ways to include the child in the activities of other youngsters?

6. Is the teacher or aide spending an excessive amount of time alone with the child?

7. Is the teacher directly receiving classroom suggestions from a speech clinician?

8. Is the teacher directly meeting with the speech clinician at least twice a month?

9. Has the speech clinician helped the teacher conduct classroom activities that address: language development; sound awareness; sound localization; sound discrimination?

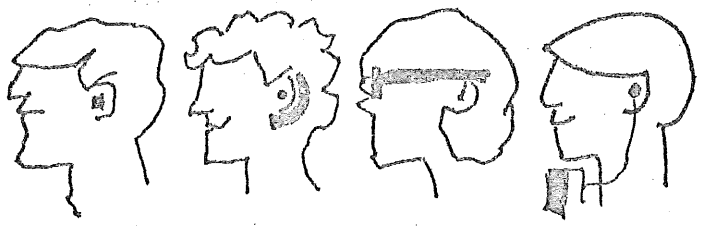
10. Does the teacher know how to check the child's hearing aid daily?

11. Does the teacher know how to "trouble-shoot" a hearing aid?

12. Is the teacher supplied with an extra packet of hearing aid batteries?

13. Does the teacher know not to stand in front of a window, cover her face with her hand, etc.?

14. Does the teacher provide visual clues (mouth and gesture) when speaking to the child?



CHECK THAT HEARING AID!

The first thing in the morning ...

1. Make sure the child is wearing the hearing aid (it must be worn all the time);

2. If it is a "body borne" aid, make sure that the box unit (on the front of the child) is being carried so that the microphone is facing away from the child (so it can pick up the sounds);

3. Make sure it is turned "on;"

4. Make sure the hearing aid is working-

   hold the receiver (ear piece) to the microphone (where the sound is picked up) - it should squeel when you do this.

* keep an extra packet of batteries at home and at school;

* store batteries in the open - not in the refrigerator;

* with head level aids, after a while, the batteries may show a white film; just wipe it off (it won't hurt clothing, but it will corrode the batteries).

TROUBLESHOOTING THE HEARING AID

PROBLEM	CHECK
1. When you hold the ear piece to the microphone, it does not squeal.	1. a. Is it turned on? b. Is it mistakenly turned to the "telephone" switch? c. Is the ear piece plugged with ear wax? d. Check the battery to make sure: - the battery is present; - the battery is right side up; - the battery and terminals are clean (if not, the battery can be cleaned by rubbing it on paper, and the terminals can be cleaned with a pencil eraser - then the eraser shavings have to be blown out- if you do this with your own breath be careful about leaving moisture on the terminals); - the batteries are not dead (try new batteries and see if there is a difference); e. If it is a body borne aid, is the wire that connects the ear piece to the box frayed or have loose connections? f. If it is an ear level aid, is the plastic tube broken, bent, or kincked?
2. There is no sound coming out of the ear piece.	2. Same as #1.
3. When the child is wearing the hearing aid, it squeals (it shouldn't do a lot of this)	3. With the hearing aid out of the ear, turn the aid all the way up and place your thumb over the opening in the earmold. If the whistling stops, then the problem is an earmold that is too loose in the ear (try re-inserting the mold for a better fit; the youngster will probably have to be refitted for a new earmold - sometimes 2-3 times a year); If the whistling does <u>not</u> stop, try inserting a special gasket between the receiver and the ear mold; If the whistling still does not stop, then there may be a problem with the aid, itself and it should be seen by a hearing aid dealer

PROBLEM	CHECK
4. There are a lot of scratchy noises or the aid works some times but not others.	4. a. If it's a body borne aid, try a new cord; b. If it's a body borne aid plug and unplug the wire connections a couple times; c. Move all switches back and forth a couple times to clear connections of dust, etc.; d. Make sure batteries and terminals are clean.

GUIDES FOR HELPING THE HEARING IMPAIRED CHILD

1. The child must see your lips. Do not stand in front of windows while talking. Allow the light to shine on your face and not in the child's eyes. Keep your hands and books down from your face while speaking.

2. Sit the child fairly close to you, or place yourself fairly close to the child when talking. A distance of about three (3) to five (5) feet should allow the child to hear you fairly well plus see your lips and gestures.

3. Do not turn your back while talking or explaining something. Do not walk about the room while talking about important instructions, but select the spot that is most advantageous for the child.

4. Allow the child to move freely about the room in order to hear what is going on.

5. When calling the child, mention his/her name and get visual attention before proceeding with your question, instruction, or statement.

6. Talk in whole sentences about what is going on at the moment. The sentences should be fairly short -- not complex.

7. Do not proceed too far in your instructions or statements without asking or making sure that the child understands what you are saying. If he/she does not understand, re-state what you said in a different way.

8. Expect the child to speak, using as complex a language structure as he is able to at the time.

9. Help the child be more at ease in a new situation by giving a brief explanation of an event before it occurs.

10. Tell the child to let you know when he/she does not understand something. Hearing impaired children may nod and smile instead of questioning for fear that they will be scolded.

11. If the child wears a hearing aid, check the aid at the beginning of each day to make sure it is operating correctly.

12. Teach the child to tell you when his/her hearing aid is not operating properly.

13. Your rate of speech should not be too fast -- and the loudness of your voice should be the same you use when talking to normal hearing children.

SPECIFIC LANGUAGE STIMULATION TECHNIQUES

1. Get down to the child's physical level. The child can miss so much visual contact when you stand so high above him. And it is more personal when you are on his level.

2. Get the child's attention before proceeding with instructions or conversation. Attention precedes understanding.

3. Use model language: full sentences; short sentences; non-complex sentences. "Baby talk" is definitely out. The child must hear a good language model several times before he can be expected to use it.

4. Speak at a moderate rate. Adult-level language is very complex. More slow speech gives the child more chances to interpret what you are saying.

5. Use a normally loud speaking voice. The child is more likely to respond favorably to normal loudness than to shouted commands.

6. Expand the child's receptive language, not always expecting a reply from him. Keep the complexity of your language at a level where you believe the child can just absorb it. Keep introducing new concepts and new language.

7. Use good questioning techniques. Use content questions as opposed to "yes" or "no" type questions. Use open-end questions.
   Example: "What do you want?"---as opposed to "Do you want the car?"
   "This is a _____."

8. Use choices when questioning. Ask the child to choose between two items or alternatives.
   Example: "Do you want to play with the car or paint a picture?"

9. Use self-talking. Talk your way through an activity in the child's presence. Talk out loud about what you are hearing, seeing, doing, or feeling whenever the child is nearby. The child needs to hear about daily events -- the usual, not the unusual.

10. Use repetition-expansion. Repeat what the child has said, making corrections in language in a very matter-of-fact way.
    Example: Child---"Go downtown?"
    Adult---"Yes, we are going downtown."

11. Use expansion. Expand on a language concept.
    Example: Child---"That's hot."
    Adult---"Yes, the stove is hot. And you know that fire is hot. And Mommy's coffee is hot."

12. Stimulate the child's own self-expansion. Stimulate the child to attempt to expand his own language by using such directives as, "Say the whole thing." This techniques can be useful when you are sure the child is capable of producing the full sentence.

(OVER)

13. Use reinforcement when the child says more complex language, e.g., "I like to hear you say more words."

14. Use repetition of your own words, phrases, and sentences. Repetition is one of the more useful techniques for developing new vocabulary and language.

15. Use a pleasant speaking voice. A pleasant voice has a calming, soothing effect. A pleasant voice is easier to listen to -- not distracting.

16. Give your immediate response to the child whenever possible. Immediate attention is usually expected of the child when you speak. Giving your attention says that you are interested in what the child is saying.

17. When you are angry with a child, it may be more instructive to that child to delay your response (as opposed to reacting impulsively with short, angry answers). A moment's pause may help you to think of a way to use your anger as a teaching tool, not just an emotion.
Example: "What you did made me angry. Do you know why I am angry?"

18. Spaced group seating is sometimes better than closely group seating. A child is less distracted by his neighbor when there is some space.

19. Allow time for an individual conversation with each child daily. This is his personal time with you, even if the amount of time must sometimes be short.

20. Keep manipulative objects in the room at all times. A bare room inspires little interest. Something that can be handled is more interesting than a poster on the wall.

----------SOME RESOURCE MATERIAL----------

Helpful Hearing Aid Hints
Alexander Graham Bell Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
$0.25

Book Catalog
Pamphlet Catalog
Alexander Graham Bell Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
Free

Facts About Hearing Aids
Publication #03-250-73
Council of Better Business Bureaus, Inc.
1150 17th Street, N.W.
Washington, D.C. 20036
Free

The Hearing Impaired Child in a Regular Classroom: Preschool, Elementary, and Secondary Years. Edited by Winifred Northcott.
Alexander Graham Bell Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
$7.95

Watch My Words: An Open Letter to Parents of Young Deaf Children
Alexander Graham Bell Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
$1.75

Hearing Impaired Preschool Children by Jean E. Semple
Alexander Graham Bell Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
$7.75

Helping the Child Who Cannot Hear
Public Affiars Pamphlets
381 Park Avenue South
New York, New York 10016
$0.25

TOPICS FOR THOUGHT

PROBLEMS AS WRITTEN BY PARENTS OF HEARING IMPAIRED CHILDREN

COUNSELING OF PARENTS:

1. Over-use of technical language;
2. Lack of attention by professionals to the problems of family adjustment;
3. Lack of instruction to parents in teaching techniques;
4. Confusion arising from professional differences of opinion.

EQUIPMENT AND AIDS:

1. Lack of appropriate guidelines in the selection of aids and devices;
2. Lack of instructions in the use and maintenance of devices;
3. Having no hearing aid while the child's is being repaired;
4. Lack of information to parents about the availability of other devices than aids;
5. Lack of evaluation of equipment immediately after purchase.

EDUCATION:

1. Lack of school programs;
2. Poor programs in schools.

FINANCES:

1. Lack of information regarding funds;
2. Excessive bureaucratic procedures;
3. Unrealistic eligibility requirements;
4. Lack of adequate insurance;
5. Poor guarantees on equipment;
6. Rising costs.

COORDINATION OF SERVICES:

1. Lack of proper diagnosis;
2. Lack of information regarding services;
3. Fragmentation of services;
4. Professionals do not talk to each other;
5. Lack of alternatives;
6. Lack of services outside metropolitan area.

HYPERACTIVITY

WHAT IS IT?

This term, hyperactivity, is used in a variety of ways by different people. However, it refers generally to certain groups of behaviors which include many, or all, of the following: restlessness, irritability, distractability, aggressiveness, constant talking, poor motor coordination, short attention span, difficulty in sharing with other children, etc. The list could go on but these are common groups of behaviors that are usually referred to when a child is called "hyperactive".

BUT WAIT! Before you decide that most of your children are hyperactive, by this definition, it is important to realize that almost all young children will display many of the above behaviors at one time or another in various circumstances. And, this is to be expected in the normal course of any child's development. However, the term hyperactivity has become very well known and popular with the general public. Unfortunately, the meaning of this term is much less well understood. As a result, the term is often used indiscriminately, and many children are being called hyperactive when, in fact, their behavior is not that atypical for their age, or some other, more complete, diagnostic description would be more appropriate and useful.

BEWARE OF LABELS! Indiscriminate use of the label, hyperactivity, might be fairly harmless except that the label often suggests many negative things to people. For instance, a teacher who hears that a "hyperactive" child is coming into her class may think that this child will be completely unmanagable, that the child cannot learn to control his behavior, and that she can do little to help the child. These things are seldom completely true, even when a child is extremely active, but it is not uncommon to find people who hold this belief. Therefore, a good deal of caution is recommended when referring to a child's "active" behaviors. (For this reason, the phrase "highly, or extremely, active behavior" will be frequently employed throughout this handout. It is suggested that this be considered as an alternative to the phrase "hyperactive behavior".) The issue of labeling and self-fulfilling prophesy will be discussed in greater detail elsewhere in this handout.

WHAT DO THE EXPERTS SAY? Even within professions and among different professions (that is, medical, mental health, and educational) there is a great deal of confusion and disagreement as to; 1) what kind of behaviors should really be given the diagnosis of hyperactivity, 2) what the underlying causes of extremely active behavior might be, and 3) what kind of management or treatment should be used with children who are extremely active.

It is probably accurate to say that the majority of professionals would restrict the diagnosis of hyperactivity to only those children who seem to be almost constantly highly active; children who are constantly restless, wiggling, running around without any apparent purpose, bothering or fighting with children (or adults), not paying attention to instructions or tasks or T.V., talking all of the time, etc. Not each of these behaviors would have to be occurring. The important key to this diagnosis is the constancy of the behaviors and the fact that the behavior has been going on over a long period of time. This is why the professional who is attempting to diagnose a child should be careful to determine just how constant and pervasive the behavior is (not only by asking parents but teachers and other adults as well), and how long it has been this way. A detailed developmental history of the child should be obtained. Of course, the age of the

child at the time of the examination has to always be taken into account. Two and three year old children will more frequently engage in several of the above mentioned behaviors than four or five year olds, but this is to be expected. The active behavior of a two or three year old would have to be very excessive indeed to be diagnosed as hyperactivity.

NOTE: Hyperkinesis is another label that is also used by professionals to describe constant, highly active behavior. It is sometimes used almost interchangeably with hyperactivity, although it is not used so widely. Medical professionals are probably more likely to use this term than others and restrict its use to fewer cases. The important thing to remember is that a child who is called hyperkinetic will often be displaying behavior very similar to the child who is called hyperactive.

Another important factor that professionals often look for (or should) when considering an actual diagnosis of hyperactivity or hyperkinesis is whether or not there are signs or concrete evidence of underlying physical problems like a neurological, or brain, impairment of some type. Definite evidence has been found with some extremely active children that brain damage does exist. However, it is more frequently the case that only signs or symptoms of possible brain damage are present, and concrete evidence is not found. These children are often thought to have minimal brain damage or dysfunction and it is theorized that it is this condition which causes or partially causes the "hyperactive" behaviors.

LABELS, LABELS, LABELS! To this point, three different labels have been mentioned, hyperactivity, hyperkinesis, and minimal brain damage, all of which are often used interchangeably to describe similar types of behaviors. And, there are even more labels! Special learning disability and behavior problem are two additional ones that sometimes are applied to children who are extremely active, distractible, aggressive, restless, etc. So, various people might label these behaviors as hyperactivity or hyperkinesis or minimal brain damage or a special learning disability or a behavior problem. Perhaps it will help to clarify matters somewhat if each label is dealt with separately and the similarities and differences among the different labels are presented.

Hyperactivity - Probably the label most commonly used by people in general for describing extremely active children. Also, it is probably used inappropriately more often than the others. That is, it is often casually applied to children's behavior that is not terribly extreme or abnormal.

Hyperkinesis - Frequently used interchangeably with hyperactivity, but is not as common a label. Medical professionals probably use this more than other professionals and certainly more than the general public. There is usually more evidence of an underlying physical problem when this label is employed.

Minimal Brain Damage or Dysfunction - Although not definitely proven, there is a good deal of theorizing that minimal brain damage does exist in many children and that one of the things that this condition may lead to is the type of behavior which is called hyperactive or hyperkinetic.

Special Learning Disability - This term is applied to children who have at least average intelligence but have difficulty learning because of perceptual problems and/or poor hand-eye coordination and/or auditory discrimination problems and/or language problems and/or emotional problems, etc. Many of these children are also highly active, distractible, restless, etc., and are often thought to have minimal brain damage. Whether the "hyperactive" behavior causes the learning problems or is a result of the learning problems is not well understood. It is also seldom clear whether the "hyperactive" behaviors stem from some physical problem like brain damage or some emotional problem or both.

Behavior Problem - This is also a commonly used term and, like hyperactivity, is often used indiscriminately when children are displaying behavior that is not completely acceptable to some adults. Many professionals would use this term when the active, disruptive behavior is not so constant or pervasive and when the cause appears to be related strictly to social/emotional problems rather than physical ones. However, again this label is frequently applied somewhat freely, and possible physical causes of the problem have not always been checked out.

The intent of presenting these different diagnostic labels is not so much for the purpose of having people try to frequently use them as it is to give a clearer picture of how these labels are used by various specialists.

Also, a discussion of the different labels gives some clues as to the causes of extremely active behavior in children. But, there is more to be said about causes.

WHAT ARE POSSIBLE CAUSES OF EXTREMELY ACTIVE BEHAVIOR?

The main reason that there is confusion and disagreement as to what diagnostic label to apply to extremely active children is that there is also confusion and disagreement among the professionals as to what causes this behavior. Undoubtedly, this has come about, in large measure, because of different training and points of view among the professions. Thus, some medical people have tended to emphasize physical or organic causes while some mental health and educational specialists have looked more to environmental factors (things like the child-rearing practices of parents, family stability, teachers' approaches to behavior management, etc.). Unfortunately, this situation has often resulted in a one-sided and probably simplistic view of the problem. (For example, "Johnny has something wrong with his brain - the doctors don't know quite what it is, but if there is brain damage we can't do anything to help change his awful behavior - it's not our fault". Or, "The psychologist says we haven't done the right things with Freddie and that's why he acts this way - it must be our fault - I feel so guilty".) So, on the one extreme, you have people who feel that the problem is strictly physical and, therefore, there is little or nothing that they, or the child, can do about it - responsibility is abdicated. On the other extreme, physical problems are not considered and the full responsibility, or blame, is directed at the parents.

Assigning all of the "blame" to either physical or environmental factors will, in most cases, be counterproductive. If there is some type of physical cause for a child's extremely active behavior there is more than likely some role played by parents, other family members, and other adults as well. That is to say, it is quite possible that parents and others have not dealt with the behavior in the most effective manner. In fact, they may have unknowingly encouraged or reinforced the negative behavior. This is not implying that they are to "blame", simply that they may have a role in perpetuating the behavior without realizing it. Let's look at a hypothetical example.

The Case of Sam. Sam is a four year old boy who is attending Head Start. At the center he seems to be constantly on the go. He very seldom stays in one place for more than a few seconds at a time, and he is often wiggling and squirming when he is sitting down. Nor does he concentrate on any center activities for more than a few moments. He runs around the room much of the time and is constantly pushing, shoving, and hitting other children. Teachers find themselves scolding him frequently and sometimes shouting at him. On occasion, they grab him, hold him, and try to talk to him but usually both Sam and the teacher are so upset that nothing much seems to be accomplished - and Sam is soon back to his disruptive activities.

Sam is the youngest of three children. His birth was very difficult and the doctors were fairly certain that some brain damage occurred due to anoxia (lack of oxygen). Sam was very active, fussy, and restless as an infant. He cried a great deal, had difficulty with sleeping and feeding, and even was difficult to cuddle. Sam's mother and father were confused, somewhat frightened and often irritated by his behavior. They had not experienced these difficulties in such an extreme form with their other children. There was more tension in the family generally, and Sam's mother was often tense and irritated when she interacted with him. She was seemingly running to him constantly because he was crying or, as he grew older, creeping around and getting into

things. She became increasingly less patient with him and was scolding and saying "no" very frequently. This was true of other family members as well. When Sam was less active everyone would 'breathe a sigh of relief' and tend to leave him alone, thinking that this might help him stay calm and fairly happy.

This pattern continued and became worse as Sam began to walk (at an early age) and the possibilities of things to get into were increased. He seemed to continually be in motion, always touching things, breaking things, distracting other family members from activities that they were doing. Sam's older brother and sister now were even more annoyed with him and there was a great deal of bickering, teasing, and fighting among them. All of this, of course, added to the parents' frustration, with the result being that they found themselves shouting at Sam much of the time and spanking him very frequently. It seemed that Sam was doing "good things" so seldom that almost all of their interactions with him were negative. And, although Sam's mother and father felt guilty about it, they actually had to admit that they had such generally negative feelings about Sam. They had a difficult time seeing "good things" even when Sam might have been behaving reasonably well.

By the time Sam came to Head Start a persistent and negative pattern had been established. Through most all of his young life the majority of his interactions with other people involved being told "no", scolded, shouted at, and hit or spanked by people who were irritated or very angry. In a very real sense he learned that the only way to get attention from other people was to keep on doing the things that he did most of the time, even though the attention came in what most children would consider an unwanted form. He never learned what positive attention was like. His extremely active and annoying behavior made it very difficult for his particular parents and brother and sister to give him positive attention for doing more acceptable things. They got to a point where they did not think anything he did was acceptable. Because this pattern of learning has been so firmly established, Sam continues to behave this way in Head Start. (Possible ways of working with "Sams" will be presented elsewhere in this handout.)

But, What About Causes? The purpose of this example is to illustrate the oversimplication of saying that a child is "hyperactive" because there is either a physical cause (for example, brain damage) or a failure on the part of parents. In the case of Sam, there was extremely active and other difficult behavior right from birth on. Whether this was a result of the brain damage that was strongly suspected cannot be known for sure, but what is certain is that it was not poor childrearing techniques on the part of the parents which caused this behavior immediately after Sam's birth. Thus, it appears that there was something physically (physiologically or neurologically) different about Sam at the outset. The resulting behaviors set up a whole different pattern of interactions between Sam and his parents which had not existed between the parents and Sam's brother and sister.

On the other hand, the inability of Sam's parents to deal with his "hyperactive" behavior as he developed was also a contributing factor. They unknowingly reinforced much of the behavior that was so unacceptable to them. This is not said to blame these parents. Many extremely active children are very difficult for anyone to deal with, professionals and nonprofessionals alike. The point is simply that the particular approach that these parents used (or fell into, because they didn't know what else to do) did play a part in the on-going

development of Sam's "hyperactive" behaviors. Both underlying physical factors and the parents' way of dealing with the behavior were involved.

It should be pointed out that with some modifications in the above example Sam might have looked different when he got to Head Start. If, for instance, Sam's behavior had not been quite so extreme and difficult when he was an infant it is possible that his parents would have been better able to cope with him and would have established more positive patterns of interaction with him. Or, given the same set of difficult behaviors, if Sam's parents had been the type of people who could tolerate and accept this kind of behavior without becoming so confused, tense, and irritable, it is conceivable that they could have found some positive behaviors to attend to while ignoring or downplaying the negative ones. Again, this would have resulted in more positive interactions from which Sam might have learned more acceptable behaviors. He probably would still have been highly energetic but perhaps in a more constructive way.

Other Causes? This example, and its modifications, suggest only a few of the many factors which can contribute to development of extremely active behavior. Following are several other possible causal factors. It must be kept in mind that it is often the case that more than one of these factors are involved at the same time!

Sensory Deficits (For example, hearing and visual impairments) - Children with significant problems in these areas will frequently appear highly active, distractable, restless, etc. Often these children experience a great deal of frustration due to their inability to understand many of the things that are going on around them. Other people's responses to this frustration will play a role in the kind of behavior that results.

This same kind of process can occur when children have other physical or mental handicaps. Some mentally retarded children display extremely active behavior. It should not necessarily be inferred that these children behave this way simply because they are retarded; the majority of retarded children do not display this kind of behavior. However, the retarded youngster, like any other child, can experience frustrations which sometimes may be more pronounced due to a lower ability to understand things. Again, the way in which other people cope with the child's frustration will be a crucial factor in determining how the child will learn to deal with frustrating situations.

It must be pointed out that some children with physical or mental handicapping conditions could also have brain damage which could contribute to the total picture of causes.

Nutritional Deficits - There is evidence that poor nutrition may be involved in some cases of overactive behavior. It is likely that lack of good nutrition leads to chemical or neurological problems which, in turn, can lead to the active behavior. Hypoglycemia (deficiency of sugar in the blood) is an example of a condition that can be caused by poor dietary habits and which, in turn, may be one cause of highly active, restless behavior. Recently, evidence has also been found that food additives may be a possible causal factor.

Child abuse or other types of maltreatment of children - Although some abused children are completely withdrawn and very inactive, the opposite kind of behavior (overactive) is also seen. It is possible that sometimes children are abused because they are initially so active and completely frustrating to some parents. Also, the type of family circumstances that lead to child abuse may, in many instances, involve other problems (like poor nutrition, lack of sleep, etc.) all of which may underlie the "hyperactive" behavior.

Overprotection or "spoiling" on the part of parents and others - Just as physical abuse or harsh treatment can be a cause, or partial cause, so can unusually permissive treatment. If a child has few restrictions placed on his activities he will probably fail to learn to control his behavior. He will have difficulty learning the kinds of things that will be expected of him as he grows older. This type of child may show the same kind of purposeless running around, shoving, hitting, short attention span, irritability, etc., that other types of overactive children display. Note: The term behavior problem is usually employed in a situation like this when there is no apparent physical cause for the highly active, negative behavior.

Inappropriate expectations and poor educational planning by teachers. Sometimes children do not display extremely active behavior until they are in a school situation. It is likely that in some of these cases the child has, in fact, been active at home but the parents are not particularly bothered by this behavior, so they do not see it as being unusual or some kind of problem for them. However, when this type of child comes to school (or Head Start) some teachers will find this kind of behavior very annoying and difficult to deal with satisfactorily. If the teacher expects the child to be very calm and quiet and tries to force the child to behave this way, there may be problems. Also, if a teacher has unrealistically high expectations of the kinds of learning tasks a child can accomplish, this may produce frustration in the child when he/she fails to perform well, or at all, on those tasks. This could cause or increase extremely active, disruptive behavior on the part of the child. Finally, a teacher may fall into the trap of unknowingly reinforcing the child's active behavior by constantly saying "no", scolding, and doing other things which seem to be punishing. Unfortunately, what appears to be punishment to adults may not be so punishing to some children - it may be the main kind of attention that some children receive and, therefore, they behave in ways that will insure that they do get that kind of attention.

This list of possible causes, or contributing factors could be extended. However, the most important thing to understand is that the causes can be multiple, and it is often difficult to discover which causes are involved.

What does all of this mean for Head Start staffs and parents? One obvious conclusion is that the various terms, or labels discussed thus far should not be used casually or indiscriminately to describe overactive children. There is enough confusion already! The OCD-BEH staff has continued to emphasize that specific descriptions of a child's behavior, and the behavior of other people interacting with the child, will help present a clearer picture than a diagnostic label (like hyperactivity) alone. This might not be true if everyone knew exactly what the labels mean, used them in exactly the same way, and knew exactly what the underlying causes are. Unfortunately, this is not the case with the general public, nor specialists. Thus, the use of labels is likely to only add to the confusion.

Another conclusion is that it is very critical to thoroughly investigate the possible causes of a child's highly active behavior. One of the main reasons this is seldom done satisfactorily is because of poor communication and coordination.

among the various people who are involved (or should be involved) with a given child; for example, doctors, parents, and teachers. Head Start is in a unique position to alter this typical "state of affairs". Especially in those Head Start programs where good communication and coordination exist among members of The Mediator Team, there is an excellent opportunity to do a more thorough job of exploring, with the help of parents, the possible causal factors. Let's look at how this coordinated effort might work.

The Mediator Team's Role in Working with the Extremely Active Child.

At a Mediator Team meeting, one of the teachers on the staff describes a child who is causing a great deal of concern to her and her aide. The child's behavior is very disruptive because he "----always runs around the center, bothers other children, doesn't pay attention, and doesn't stay at any task for longer than a few moments". In other words, the child is acting very much like Sam did in the earlier example. At this point, no one on the Team has visited the boy's family, so they do not know if the parents are experiencing the same kind of difficulty at home. The boy has just had his medical examination for Head Start, and vision and hearing screening have recently been done. There has been no observation at the center by a psychologist or any other specialist.

The first question confronting this Team is, "What do we really know about this child right now? To attempt to answer this question a first step might be to have the health coordinator present the results of screening to the rest of the Team members. Some clues could be found in this information. The Team might also explore more carefully with the teacher and the aide just what is happening in the center. Is the child's active, disruptive behavior happening all of the time? Is it much more frequent on some days? Is there something happening in the center that could be frustrating him a lot? What does his developmental level seem to be? Does he seem to be tired or hungry when he comes to the center? Are there any apparent hearing or visual problems or other health problems?

After trying to answer these kinds of questions, the next main question is, "What further information do we need to find out about this child?" Does the doctor's report imply that someone on the Team should talk with him/her to get more information? Did the doctor recommend a referral to another specialist for further diagnosis, and will Head Start have to help insure that the child is seen by the other specialist? In either case, the child's parents will have to be visited by a Team member so that parental permission can be obtained. Also, the parent's feelings about the child will have to be explored. Do they see any problems with his bevavior at home? If so, what specifically are those problems? How long have they been occurring? Do the parents seem to be dealing with those problems in a reasonable way? Do they report problems with eating, sleeping, etc.? In some cases, it will be possible for the person visiting the home to make some observations of the child in the home.

The Team may also want to obtain more information about the child's behavior in the center. The teacher and/or aide could be asked to observe exactly how often the active and disruptive behavior occurs, when it occurs most often, what others are doing just before it occurs, and what others do immediately after it occurs, etc. Someone else from the Team should probably go to the center to help observe for these things. A behavior checklist could be used to guide further observations which would provide information about the child's overall developmental level in motor, speech/language, social/emotional, self-help and cognitive areas. Finally it might be decided that a psychologist or some other specialist should also be called in to do additional observing. (This should probably be postponed until after the teacher, teacher aide, and another Team member have done

their observations and after a Team member has made a home visit. Using this approach the Team would have much more information to present to the specialist, which would be very valuable to that person.)

Next comes the question, "Who is going to gather all of this information?" Obviously, no one person will be able to do all of the things outlined above. This is one of the main reasons that Mediator Teams have been developed in many Minnesota Head Start programs. Several people, meeting regularly and working together as a team, can share in these various responsibilities. Different people will do different things, but each person knows what everyone else is supposed to be doing, and each person will find out what others have done because of the regular communciation at Team meetings. As far as which responsibilities are carried out by whom is concerned, this will be determined by the particular circumstances of each Mediator Team. The type of experience and training represented on the Team, the number of people on the Team, and the willingness of people to assume responsibilities are some of the elements that have to be considered.

Finally, there is the question of "What is to be done with the information once it is obtained?" The answer to this question is most critical. It is very important that each person concerned with the overactive child in this example be able to share with one another their observations and other information regarding the child. Ideally, this would be accomplished by having everyone (doctor, parents, teacher, teacher aide, other Mediator Team members, psychologist, etc.) meet together for this purpose. However, this is not always possible and, in some instances, might not be the wisest approach, at least initially. Yet, some kind of coordinated communication must take place among all of these individuals even if they do not all meet at one time. If the Head Start Mediator Team is well-coordinated itself, then there is a good chance that the members of the Team will be able to "mediate" and bring about good communication among all of the other people involved. This is a very crucial step in the effort to get as clear a picture as possible of what factors are contributing to the child's behavior. And, obtaining a reasonably clear picture of these contributing factors is an important step in developing a successful plan for "treating" or "managing" the child. Of course, the coordination and communication among all people involved will have to be continuous in order for the plan to have the best chance of success. Hopefully, the reasons for this will become clearer in the following section.

WHAT ARE SOME POSSIBLE APPROACHES TO TREATMENT AND MANAGEMENT OF CHILDREN WHO ARE EXTREMELY ACTIVE.

One of the most controversial means of treating extremely active children is the use of drug therapy. Just as there is confusion and disagreement among professionals regarding the use of diagnostic labels and the causes of overactive behavior, there is also much confusion and disagreement over the use of drugs to treat children who display this type of behavior. The arguments range from "we are making drug addicts out of our children" on one extreme to "doctors are irresponsible if they don't prescribe drugs for 'hyperactive' children" on the other extreme.

There is probably less disagreement over the issue of whether drugs are effective in reducing the highly active behavior of some children and in helping them to become more attentive to some tasks, concentrate better, become less irritable, etc. Although medical and pharmocological professionals are not completely sure how this happens, or with exactly which children it will happen, it is true that stimulant drugs will often lower the activity level of highly active children. Obviously, this change in behavior can potentially be very beneficial to a child in terms of how he gets along with other people, how he learns, how he feels about himself, etc. It is important to point out that this process of change probably occurs not only as a result of the drug's effect alone but also as a result of how people react to the child. If the drug helps the child to "slow down" then it is highly probable that he is going to be more "likable" in the eyes of his parents, brothers and sisters, and other people with whom he comes in contact. If this attitudinal change on the part of others occurs, then the child will receive more positive attention for the "good" or more appropriate things he is now doing, and because his active, negative behaviors are reduced, he will receive less attention for those things. The response of others undoubtedly plays a role in the "cures", just as it does in the causes.

The real cries of protest come from those people, professionals and lay persons alike, who are concerned about the possible harmful physical and psychological side-effects of drug treatment with children and are concerned about the increasingly widespread, and sometimes routine, use of stimulant drugs to treat "hyperactive" or "behavior problem" children.

There is apparently no evidence at this time which indicates that stimulant drugs do cause harmful long term physical side effects. Also, many medical practitioners report that they have not seen any cases of harmful long term side-effects (like drug addiction) over many years of treating children with stimulant drugs. This is important and worthwhile information, but it is also the case that no sound, long term research has been conducted in this area.

Perhaps of greater concern is the possibility of harmful psychological side-effects. It is well-documented that many children, even young children, who are taking medication for their behavior and/or learning problem report things like "I am nervous today because I didn't take my pill", or "I forgot to take my pill this morning and I can't do my school work without it", or "I have something wrong with my brain and I need to take pills to help me be good and do my work better".

Obviously, this type of attitude is rather frightening. It suggests that some children feel the only way to deal with their "problem" is to "take a pill". In the case of young children, this attitude is probably conveyed to them most often by their parents, who must have also been given the impression, or want to believe, that the child's problem can only be "fixed" by drug treatment. As mentioned earlier in this handout, this idea often results when parents are told that their child probably has something physically wrong, like minimal brain damage, and this suspected condition is the cause of the problem. Unfortunately, this oversimplified (and sometimes inaccurate) explanation made by professionals, or oversimplified interpretation of the explanation made by parents and others (like teachers) fails to shed light on how the reaction of parents and other people to the child's behavior is also likely to be contributing to the problem. More importantly, this explanation fails to shed light on how parents can react differently toward the child to help bring about changes in behavior, even when

drugs are also being given to the child.

The fact must be faced that some parents are just plain having a difficult time figuring out how to raise their children, or are neglecting or abusing their children. These parents need assistance in learning how to be better parents and often first need help in dealing with their own personal problems. In many of these families it is simply inaccurate, or at least misleading, to say that the child's extremely active, negative behavior is caused only by some type of physical problem. On the other hand, it is undoubtedly true that many people have unjustly been given the impression that they are poor parents when, in fact, the initial underlying cause of their child's problem would make it extremely difficult for anyone to work effectively with that child.

The foregoing has not been presented as an indictment of all drug therapy for children who display overactive behavior. Rather, it is an attempt to put matters into perspective and is a call for responsibility in the prescription of stimulant drugs and in the exploration and explanation of the contributing factors underlying overactive and/or other types of negative behavior. Many children have been inappropriately labeled as hyperactive and/or minimally brain damaged. This labeling, along with the administration of drugs, can potentially lead to a kind of negative self fulfilling prophecy. That is, "there is something physically wrong with me (my child, my student) over which I (child, parent, teacher) have little or no control, and I (child, parent, teacher) can't do much about it except take (or give) a pill". Even where there is clear evidence of an underlying physical problem it is unlikely that there is nothing that can be done by parents, teachers, and others to help the child learn to alter his behavior. Stimulant drug treatment is one approach; a change in diet may also be indicated, surgical correction of a sensory impairment (e.g., hearing or visual problem) or other handicapping conditions may be necessary, parents and teachers may have to change the way they interact with the child, etc. Some, or all, of these things may have to take place, but usually there has to be some change in the way adults interact with the child. Of course, this change may come about more easily if drug therapy, surgical correction, or a change in diet helps to "slow the child down", but it is not always easy!

How can parents and teachers change the way they interact with the extremely active child? Because this is a very large topic in itself and because the OCD-BEH staff has dealt with this topic in previous workshops, we are going to refer you to the book that we have handed out before, Teaching Your Child. We should be able to give one copy of this book to every parent who attends this workshop and has not attended others. If for some reason you do not receive this book, contact your Head Start agency. They should have extra copies. Teachers and other staff will have to use the agency's copies.

Basically, Teaching Your Child discusses ways to increase the kind of behaviors that you want your child to be doing and decreasing those that you do not want. If parents have any questions about what the book says, they should feel free to ask for help from their child's teacher or other Head Start staff. If parents and staff have questions about the book, they should contact the psychologists, or other specialists, who work with their program. It may not always be easy to understand or put into practice some of the ideas, and it could be very helpful to get assistance from the specialists who work with your program.

Teaching Your Child can be very useful to teachers as well as parents. We have also included (at the end of this handout) for teachers some material on classroom management as it relates to the "hyperactive" child. This material is taken from HEW Publication No. (OHD) 75-1075 entitled, Responding to Individual Needs in Head Start.

What role should the Mediator Team play in the overall treatment or management of the extremely active child? The role of the Mediator Team in exploring the possible causes of extremely active behavior has already been discussed. In addition, it was pointed out that obtaining as clear and complete a picture of the causes as possible is a crucial step in determining how to treat or manage the child. It was also stated that on-going observation and coordinated communication will be important.

The following are some suggested questions which the Mediator Team might ask of itself while attempting to coordinate the treatment or management of the extremely active child.

Once several observations have been made and other information has been obtained, does everyone involved have a chance to communicate with one another? Is there some kind of on-going system set up for this communication? If the medical doctor cannot attend meetings is there someone on the Mediator Team who will convey the information obtained from classroom observations and home visits? Can the same arrangement be made if a psychologist cannot make center visits? Do the parents know about, and agree to, all of these activities? Have they met with the medical doctor and the psychologist or have arrangements been made for them to do so? Will the medical doctor, the psychologist, and Head Start people say similar things to the parents? If not, how can this be handled?

Given the situation where the medical doctor feels that an actual diagnosis of hyperkinesis (or hyperactivity) seems appropriate and he prescribes stimulant drugs, does everyone else involved with the child feel comfortable with that diagnosis? Do they know why it was made? Did others have a chance to give their input to the doctor? Has the medical doctor asked for help from Head Start teachers to "monitor" the child's behavior so that he can determine the correct drug dosage to prescribe? How can this information be conveyed to the doctor? (Whether or not it was asked for, it may be very important to pass on to the doctor!) Do parents and Head Start staff know what kind of side effects to expect the child to display when he first takes the drug (possibly sleepiness, lack of appetite - possibly increased activity for a period of time)? Did the medical doctor give any suggestions to the parents and Head Start as to how they might alter the way they interact with the child? If not, can someone on the Mediator Team and/or another specialist (psychologist, social worker) help parents and teachers to do this? Do the parents feel that the problem is strictly physical (for example brain damage) and that there is little they can do other than give the pills? If so, can the medical doctor be asked to deal with this attitude or does he feel the same way? Perhaps everyone has agreed that drug therapy should be tried, but the parents are reluctant; who can best deal with this situation?

In those situations where the medical doctor does not prescribe drugs but feels the parents may need some counseling, how can the Mediator Team be of assistance?

Can the Team help make a successful referral to a mental health center, for instance? Who is going to help the teachers deal with the child in the center? Can a Mediator Team member or members offer on-going advice and support to the teachers. Can a specialist visit the center for this purpose? Will there be communication established between the person working with the parents and the Head Start staff working with the child? Is there something a Mediator Team member can do to help the parents and family?

Concluding Remarks. The whole issue of "hyperactivity", its labels, its causes, and its "cures" can be confusing. Hopefully, some guidelines have been presented here that will be useful. It is important to be careful about using labels; it is important to recognize that there can be several contributing factors underlying highly active behavior; and it is important to have good communication and coordination among those people who are involved in exploring the causes of highly active behavior and in treating or managing this behavior. The solutions are often not simple, but success can be achieved!

Prepared by Don Henry, Ph.D.
School Psychologist
OCD-BEH Project for Head Start Children
with Special Needs

Classroom Management

Some classrooms adapt themselves very easily to the hyperactive child. These are usually classrooms which are fairly large, well-organized, do not contain a lot of clutter, and which have some sort of permanent indoor climbing equipment, or separate noisy/active room.

What happens if your classroom doesn't fit the above description? Can you handle a hyperactive child in your class and make it a positive experience for him and for the other children? In most instances reasonable adaptations can be made which allow you to accommodate an overactive child without too much disruption.

Space

One of the primary needs for a child who is extremely active is space to move about. The space you have may not seem large at all, but could you use it better? Here are some ideas that have been found useful for teachers in small classrooms:

1. Use wall space for storage and tempera painting. This eliminates the need for easels and some book shelves. Wall storage may often be made cheaply by stacking and glueing large cardboard tubing or quart bottle soda cases on their sides.

2. If table space which accommodates everyone simultaneously is only needed at lunch time, collapse folding tables, or stack non-folding ones top surfaces together, legs up. Chairs, too, can be stacked when not in use. Most children can learn to do this easily.

3. Movable low partitions help delineate small areas when they are needed, but allow you to open up a large space quickly. Book shelves are best for this. They are not tippy and not too easily moved by children.

Interest Span

4. Always have some toys out available to everyone and other things put away. This reduces clutter which confuses hyperactive children. Varying the toys available creates interest and is one way to extend few materials.

Inability to Sit Still

5. At the very beginning of school make it clear to all children which exits they may use to go to the playground or to other parts of the building and when they may leave the room. Repeating this carefully and firmly until all children understand it may help you keep track of wanderers, and cut down on the amount of chasing you need to do.

6. If possible, provide for some sort of indoor climbing equipment. Climbing apparatus may seem bulky and distracting to you if you haven't been fortunate enough to have had any in your classroom. However, some are bulkier than others. Some take up relatively little floor space but use lots of vertical space. Some kinds of jungle gyms have attachable slides or side pieces which you can use when you do have the space, but they do not need to be available everyday. One piece of equipment that is collaspsible, takes up relatively little space, and costs little is a balance beam with a low sawhorse or two. This makes a seesaw, a small slide for sliding down or struggling up, a ramp for cars and tracks, and walking board. The versatility of this material makes it appealing to children.

7. Make better use of your outside play yard. You may find that two short outdoor times work better for your class than one. While outside vary the activities. Add some simple running games and exercises to your repertoire. Bring a large ball one day. Another day get out the tricycles. Still another day go for a short walk. In the springtime or early fall, digging and water activities are fine.

Impulsiveness

8. Provide other soothing and absorbing materials. Equipment that provides a tactile experience usually works best. Sand boxes, water tables, salt trays, shaving soap dispensed by the teacher for finger painting on table tops, bubble blowing, or sink water play are some that most children like best. Vary these kinds of activities every few days, so that they keep their appeal.

9. Have some place like a quiet corner where a child can go to calm down or see what others are doing. Teaching hyperactive children to take time out to look around and decide what to do next is a valuable way for them to learn to handle their problem. You will need to suggest and accompany them the first few weeks but if it is a useful place, eventually they can learn to use it if you remind them.

10. On rainy days see if you can use an auditorium or gymnasium. If neither of these is available, you could use a hall for some running games. Be sure to have a teacher at each end as a "stop sign." Halls also accommodate tricycles and wagons well in a pinch. Jumping games, follow the leader, and Simon Says will help you utilize this space in a quieter way should you find that noise is a problem. Halls lend themselves well to parades, either musical or dress-up.

Fostering Concentration and Sustaining Attention

Just having the proper space is only one hurdle. Teaching active children when and how to use it to control their behavior is another.

Hyperactive children can and do sit down and concentrate on some quiet activities. Of course this should be encouraged. Their attention spans are shorter than average. Because of this they cannot sit still as long as the average child. They need the chance to get up and move about in a socially acceptable way when they have done all they can.

How do you know when a child has been inactive for as long as he can manage it? You won't know what the child's limits of concentration are the first day or even the first week. First you must establish how long he can work without leaving the situation or disrupting the activity. After a certain amount of clocking, you will begin to anticipate the hyperactive child's need for change. Just before you think he needs a break, it is a good idea to move over to him quietly and suggest that he run off some steam in some way that is permissible. That way you are telling him that you understand his problem, that there is an acceptable solution, and that you care about him and will try to prevent his getting into trouble.

Hyperactive children can be encouraged to work longer at quiet activities. Once you have some idea of their capacities, you can often help them to extend the time and interest in a favorite toy or activity, by stepping in just before the child would ordinarily make a transition to doing something else and helping him stay with the original item. How do you do this? One's first impulse is to have the child keep going as he is. But usually it works better to change the activity just a little bit, by adding something new to what he is already doing. For instance if the child were making a collage you might help him continue his project longer by stepping in just before he was about to get up and leave, and offering him a bit of tin foil for his picture. If he takes it and glues it, and you admire what he has done, he has probably stayed with his work a minute or two longer than he would have without your help. If you consistently encourage his staying with something just one or two minutes longer over three or four weeks, he may be able to manage that extra time soon by himself. Another way to keep a child going is by verbal interaction around what he is doing. You might praise it, ask a question about it, show it to another child or sing a song mentioning it. We are talking about one or two minutes here. That may seem like a lot of work for the teacher to do for very little improvement, but those small bits of extra learning time add up over the year. Usually it pays off.

When you first begin making these observation you may feel that the child gives no warning before he leaves an activity or disrupts. Actually for most hyperactive children this is not so, it just seems that way. Usually there are signs of impending movement. They are subtle, and vary from child to child, but the most frequently noticed ones are a fleeting impish grin, a distant hazy look, a slight crossing of the eyes, or a glance to a distant part of the room.

Once you have been able to pick up some of these warnings you can move in and help the child make a transition before it is too late. Once you have discovered the warning signs don't keep the information to yourself. Share it with the child. Often if this is repeated to him he will begin to understand these inner physiological tensions which precede his dashing off. Once he can grasp these feelings and recognize them as warnings, sometime he will be able to make an appropriate transition to a more active kind of play himself.

Although such observation and management is not easy to do and certainly is time consuming, if you are able to do it at the beginning of the year, it will cut down substantially on the amount of policing you need to do. Helping the child manage his problem in the healthiest way he can is one of your goals. It is time consuming and takes a certain amount of both dedication and consistency. It is easier for some teachers than others, just because it fits in with their natural styles of teaching. It helps if the teacher has a fairly high activity level. Teachers who have an ability to tolerate a fair amount of noise and motion often find that hyperactive children do well and cause little disruption in their classes. Teachers whose chief interest is in outdoor or active play, or teachers who find it possible to run a program which allows for several choices of activities, may like having an overly active child in their classes. Other teachers may find hyperactive children a difficult drain on their energy supply. In order to avoid getting tired, and hence cranky, classroom personnel need to work out consistent ways of managing the child so that they can help each other. As one begins to get tired, another one steps in to take over. If one teacher begins to find herself not tired but angry at the child it is a good idea for someone to step in as releif for a little while.

Praise has been mentioned frequently throughout this section because it is one of the most useful tools in the management of hyperactive children. We know that all human beings like to be praised, but approval and praise mean more to hyperactive children because usually they don't feel as good about themselves as others. Why? Most of these children have been constantly reprimanded for their disruptive behavior. They begin to feel that there is nothing that they do that is right. If you as a teacher can begin to help them learn to conform to school expectations in a small way, and allow for the times when they cannot behave like others, and give them chances to run off steam in acceptable ways, eventually they will feel better about themselves.

When you praise a child give small amounts frequently. Be sure to let the child know that he has done something well, or managed his behavior well at the time he is doing it. That way he will know exactly what it is he has done right. Vast amounts of empty praise do very little.

Almost everyone who has tought hyperactive children has found it discouraging in the beginning, then a challenge, and finally very rewarding. Hyperactive children do benefit enormously from inclusion in a good nursery shcool program. It is possible with good management to see a significant improvement in their behavior.

WORKSHOP #2 Evaluation

1. Since the last workshop (where we discussed observation skills), have you spent any time intentionally observing any particular child?

   _____yes

   _____no

2. If you did make it a point to observe a child, how frequently do you think you did so?

   ONCE_____/_____/_____/_____/_____/_____/_____MANY TIMES

3. Were these observations random, or did you pick a specific time and did you observe on a regular schedule?

   ___Observed randomly
   ___Observed (same times everyday day)
   ___Observed (on a regular schedule over several times)

4. What kinds of things did you observe _____

   _____

5. Did you find the observation process useful--did it help to clarify for you what behaviors to help the child with?

   _____

6. Problem children often act the way they do because they are:

   (a) born to be problems
   (b) taught to behave that way
   (c) not concerned with their parents feelings
   (d) children who were not breast fed

7. Many otherwise pleasant people find themselves "yelling and nagging" when they deal with children because:

   (a) they expect but do not comment on good behavior
   (b) they do not truly love or care for these children
   (c) they focus too much on negative behavior

8. Based on your experiences, and on what we've been discussing in this workshop, what would you say are some of the common, observable behaviors seen in most 4 year olds?

_____

_____

9. During the workshop we specifically talked about five (5) behaviors which could be clues to speech communication problems. Put an "X" next to each of the 5 most important behaviors which could be clues to speech communication problems:

___the youngster bit another kid
___the child cannot say his/her "R's"
___the child's speech cannot be understood by other kids
___the child pouted and said "I'm never going to talk again"
___anybody thinks that this child stutters
___the child has a harsh or hoarse voice for more than five days
___the child has a lisp--cannot say "S's"
___the child said a swear word yesterday and today
___when the child isn't looking at you, often you must repeat things
___the child has bad teeth and cold sores
___the child does not use speech to get what he/she wants or needs
___the child only talks with other kids

10. A child says "There's a bird!" You should:

(a) look at something else and say "What's this?"
(b) tell the child he is right
(c) repeat what the child said, name the kind of bird, tell something a bird does, etc.

11. You want a child to tell you about the field trip to the airport that morning. You could start off by saying:

(a) "Did you go to the airport?"
(b) "Where did you go this morning?"
(c) "You went to the airport, didn't you?"

12. A child looks at you in a puzzled manner and asks you "My hanky?" You should say:

(a) "You shouldn't leave your hanky laying around; find it and put it in your pocket."
(b) "Where is your hanky? Where did you leave it? We'll find it and put it in your pocket so that it won't get lost."
(c) "Well, go find it then, honey"

13. You want the children to wash their hands for lunch. You should:

(a) announce "Let's go wash our hands."
(b) before you make the announcement (as above), first say "Children, look at me..."
(c) say "It's time for lunch."

14. You want to cut out a more tricky part of a drawing before giving it to a cerebral palsied child to finish; you should:

(a) show, and slowly describe what you are doing before giving the paper to the child.
(b) do your cutting at your speed and talk about what you are doing.
(c) do your cutting and then tell the child what it is you want him to do.

APPENDIX 10

ON-SITE VISIT THREE
LETTER SENT TO MINNESOTA PROGRAMS ANNOUNCING ON-SITE VISIT THREE

HEAD START

STATE OF MINNESOTA
GOVERNOR'S
OFFICE OF ECONOMIC OPPORTUNITY
404 Metro Square – 7th & Robert
ST. PAUL, MINNESOTA 55101

612/296-2367

TO: Mediator Team Members

FROM: Fred Aden and Don Henry
OCD-BEH Project for Head Start
Children with Special Needs

As many of you probably know, we are about to begin our third round of visits to your programs. We would like to give you a brief outline of the types of things we hope to discuss with you during our visit.

1) Management of Special Needs Children - we would like to review the overall management of special needs kids that has taken place since our last visit, especially the management of those kids who will be going to public school next year. It will be important for us to look at the individual files of these kids (confidentiality will be insured by only using children's initials).

2) Transition of Special Needs Children to the Public Schools- we will be interested in finding out about your efforts to communicate with special education personnel (or other public school people) regarding the special needs Head Start kids who will be going to public school next year.

3) Specialist Services - It is necessary for us to know the types of specialist services that you received throughout the year. Although you have given us some of this information previously, we would like to have a complete listing of services now at year's end. We are particularly interested in the services provided by nurses, speech clinicians, psychologists, social workers and SLBP teachers or consultants. If you could have specialist's names and addresses ready for us it would expedite matters. We would also like to know if a specialist's services are new this year, and whether service was provided at centers (or in children's homes). Finally, we would like to hear about your arrangements, or plans, for obtaining services next year. These are the areas we would like to deal with during our visit.

This may take up most of our time, but we will certainly try to help with any other questions or concerns that you might want to bring up.

See you soon.

APPENDIX 11

FORMS USED BY PROJECT STAFF TO MONITOR VISIT THREE PROCEEDINGS AND COLLECT DATA

Head Start Agency_____

Type of Specialist	Name	His/Her Agency	New	Old	On-Site	Non-on Site	Arrangements for Next Year

	1. Was the child screened in all developmental areas?	2. Did the child see the necessary specialists?	3. How thoroughly were clinical recommendations acted upon?	4. How will the child experience a smoother transition into P.S.	5. How complete and descriptive are the records for this child?	6. How have the parents been involved?

APPENDIX 12

PROTOTYPE OF JOURNAL ARTICLES FOR
MINNESOTA SCHOOL PSYCHOLOGISTS ASSOCIATION
AND
MINNESOTA SPEECH AND HEARING ASSOCIATION

SCHOOL PSYCHOLOGY SERVICES FOR HEAD START?

In 1972 Congress ordered Head Start to successfully integrate children with all types of handicapping conditions into its classrooms. At least 10% of the total Head Start enrollment is to be comprised of children with handicapping conditions. This Congressional order is commonly referred to as "the mandate".

The OCD-BEH Collaborative Project for Head Start Children With Special Needs is one of Minnesota's efforts to meet the mandate. This Project is a three year demonstration effort which is federally funded by the Office of Child Development, the funds being administered by the Governor's Office of Economic Opportunity. The Project staff consists of two psychologists and two speech pathologists. The purpose of the Project is to develop a statewide system for helping Head Start programs successfully integrate handicapped children into their classrooms. "Handicapped" is defined in the 1972 Amendments to the Economic Opportunity Act to mean: "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education and related services". The Project effort is to assist Head Start programs in becoming relatively self-capable of doing those things necessary to 1) provide successful, integrated experiences for youngsters with special needs and 2) obtain special services for these youngsters when services are needed. As such, the Project's activities are in four areas: 1) workshop presentation of information; 2) on-site, in-service training/application of workshop materials; 3) development of local and statewide referral systems that actually do work; and 4) development of a core of "case managers" or mediators at the Head Start agency level. The function of the case managers will be to guide their agencies through those agency level functions necessary to provide special services to a particular child, e.g., observation, possible limited screening, identifying appropriate referral resources, etc.. The Project staff does not provide direct services, per se. If a child is seen by a staff member this activity will be for purposes of training the Head Start staff. Since January, in an experimental effort to determine the most effective approaches, the Project has delivered twenty-eight one day workshops, numerous on-site visits, and has helped guide several collaborations between Head Start programs and specialist resources.

Although the wisdom and intent of the Congressional mandate has been questioned in some quarters, both within Head Start and elsewhere, the fact remains that children with special needs have always been enrolled in many Head Start programs and increasing numbers of these children will probably be enrolled in the future, particularly in those areas of the State where Head Start may be the only preschool program available. In response to this demonstrated need, some Minnesota school psychologists have been providing services to Head Start children, parents, and teachers. The range of services provided include: on-site observations of children and programming, screen-

ing, individual assessments, in-service training, parent education and counseling, membership on educational and health advisory committees, etc.

Unfortunately, in many instances, Head Start programs have had difficulty obtaining specialist services from psychologists as well as other professionals working in schools. By directing official attention to handicapped children, "the mandate" may help bring Head Start people one step closer to services available in school systems and other resource agencies. In its facilitating role, the OCD-BEH Project is a special effort to connect Head Start with professional services. But, this closure can only occur with the willing cooperation of professional individuals. With direction and encouragement from the Project staff, Head Start people will be approaching school psychologists with requests for various kinds of service. We hope that many of you will find ways in which you can offer those services. Undoubtedly, you are confronted by time and/or administrative constraints, but be assured that even a few hours spent in an advisory or consulting capacity would be an important and necessary service to many programs.

Those of you who wish to initiate or expand services may wish to contact a local Head Start center, a Head Start agency, or our Project staff. If we can be of any assistance in establishing collaborative relationships with Head Start, please feel free to contact us. Also, we would be interested in hearing from people who have been offering services in the past.

Jon Boller, Ph.D.
Counseling Psychologist

David Garwick, M.A.
Speech Pathologist

Don Henry, Ph.D.
School Psychologist

Fred Aden, M.A.
Speech Pathologist

OCD-BEH Project Address:

404 Metro Square
7th & Robert
St. Paul, Minnesota 55101

Phone: 296-5740

APPENDIX 13

SPECIAL WORKSHOP PROCESS REPORT
DULUTH HEAD START TEACHERS -- DULUTH SPEECH CLINICIANS
PRIORITIES & ROLES

"Collaboration Between the School Speech Pathologist and the Preschool Teacher"

On June 3, 1975 twelve Duluth Head Start Teachers met with seven public school speech clinicians. The Head Start Director and Educational Coordinator were present. The training session was conducted by Fred Aden and Dave Garwick who are speech pathologists from the Minnesota Head Start Experimental Handicap Project.

The purpose of the meeting was to explore specific ways in which the speech clinicans and teachers could most effectively meet with each other. For the past school year, there had been disagreement as to what should be the role of the speech clinicians (e.g., should the clinician primarily function with individual children outside the classroom or with clients inside the classroom)?

The meeting progressed in the following manner. All participants remained in one large group during the entire meeting.

Step 1. Open discussion: "What does each person expect to get out of this experience?"
Result: The consensus was in line with the above stated purpose of the meeting.

Step 2. Open discussion and vote: "If a child in the program had a communication disorder, what individual should usually be the direct client (with whom the speech clinician has the most direct personal contact) of the speech clinician?"
Result: 100% of the speech clinicians chose the child.
100% of the teachers chose the parent.
No one chose the teacher.

Step 3. Open discussion and vote: "Which individual is most often the most influential-to effect change-with the child?"
Result: Both the speech clinicans and the teachers chose the parent most often and the teacher next most often.

Step 4. Individual work and large group discussion: Each teacher was asked to independently list all problems and needs in the preschool that might involve a speech clinician. Then, the individuals volunteered their responses to the large group, and the collective responses were listed on newsprint. Later, each participant was asked to review all items on the newsprint, and to cast votes for the two most significant needs on the list. (See Figure 1)
Result: The need most frequently cited by the teachers was the same one which tied for highest priority among the speech clinicians: "Routine, on-going communication among speech clinicians, parents and teachers." Overall, there was close correlation between the needs perceived by speech clincians and teachers.

Step 5. Individual work and large group discussion: Each speech clinician was asked to independently list all possible roles which a speech clinician could assume in the preschool. Then, individuals volunteered their responses to the large group, and the collective responses were listed on newsprint. Later, each participant was asked to review all items on the newsprint, and to cast votes for the two most significant roles on the list. (See Figure 2)
Results: Two clinician roles figured in the higher priorities of both speech clinicians and teachers:

1) screening and diagnosis;
2) helping teachers become aware of on-going classroom activities that aid communication development (paraphrased).

Two other clinician roles also figured in the opposite extremes of priority for the speech clinicians as opposed to the teachers. The teachers emphasized parent support and the clinicians emphasized out-of-the-room therapy for individuals/ small groups.

Step 6. Open discussion: "Accentuate the Positive"
Since both the speech clinicians and the teachers strongly agreed on the priority of two speech clinician roles, it appeared that these two roles would best serve the needs of the collective group. The balance of this meeting was devoted to discussing ways in which both teachers and speech clinicians could develop these two roles.
Results: (See Figure 3 & 4). A significant discovery was that both teachers and clinicians had parts to play in developing these two clinical roles.

Another major finding was that, in developing the two high-priority roles, both the parent support role and the outside-classroom-therapy role (upon which the clinicians and teachers disagreed) were concurrently reinforced.

Step 7. Printed materials were distributed to all participants. Both the article by Jane Rieke and the writing by Joseph Wepman illustrate how a speech clinician and a teacher can cooperatively function as a close team within the classroom-this reinforces the two high priority clinician roles agreed upon by both clinicians and teachers.

Figure 1.

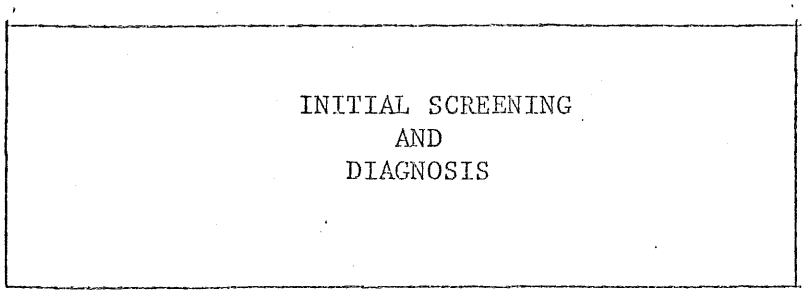
Speech Clinician's Priority Votes	Teacher's Priority Votes	Teacher Needs Involving Speech Clinicians (as suggested by the Teachers)
4	12	-routine, on-going communication among speech clinician, parent, and teacher (e.g., SST);
4	3	-specific educational coordination between the speech clinician and teacher (e.g., games and other classroom activities, materials for parents, observing teacher activities, exchanging observations and notes, etc.).
1	5	-Formal Teacher Education (e.g., pre-service; in-service; college training; subjects such as observation techniques; actually being observed).
1	2	-Formal Parent Education (e.g., Conferences and in-service; subjects such as observation techniques, "How to" Handouts, etc.).
0	0	-Ensuring transition from this year to next year such things as information about child's level of language skill development and previous educational activities;
0	0	-ensuring that each child receives consistent attention from clinicians.
0	0	-scheduling enough time for clinicians to deliver effective service to kids.
1	0	-occasional problems of inter-relationship between the child and speech clinician (e.g., the child who won't go to therapy).
0	0	-year-to-year consistency among Head Start teaching staff within a given center.

Figure 2.

Speech Clinician's Priority Votes	Teacher's Priority Votes	Possible Speech Clinician Roles (as suggested by the clinicians)
0	6	-helping parents stimulate child's communication development and changing child's behavior;
0	1	-conducting formal in-service for teachers;
4	6	-helping teachers understand and become consciously aware of communication development activities that are on-going in the classroom, as well as how to enrich this;
5	5	-screening and diagnosis;
0	0	-assisting in referrals to other agencies;
4	0	-individual/small group activities in the classroom;
0	2	-individual, small/large group activities in the classroom;
0	0	-consulting with teachers regarding the indirect programming of individual youngsters with whom the clinician is not in direct contact;
0	0	-consulting with teachers regarding the direct programming of individual youngsters with whom the clinician is in direct contact;
0	0	-public relations for Head Start;
0	1	-observing youngsters and consulting teachers regarding overall general child behavior.

One of Two High Priority Speech Clinician Roles (as perceived by Teachers & Clinicians)

Figure 3.



Teacher's Involvement
Screening phase:

- Classroom observation
- Language checklists
- Communication with clinicians
- SST's
- Home visits of center staff
- Home visits of Nurse-Community Aide

especially for language and fluency clinicians depend to large extent on teachers' input - teachers didn't know this

Speech Clinician's Involvement
Screening activities:

- Articulation
- Language
- Voice
- Motor Fluency

Diagnostic phase:

- Parent observations
- Teacher observations

Diagnostic activities:

- articulation evaluation
- receptive language
- expressive language
- Hearing
- Medical Information
- Psychological Information

One of Two High Priority Speech Clinician Roles (as perceived by Teachers & Clinicians)

Figure 4.

To Help Teachers understand and Become Consciously Aware of Communication Development Activities that are On-Going, as well as How to Enrich This

Teacher's Involvement	Clinician's Involvement
-reserve time for meetings with speech clinicians;	-help design/implement classroom games for teachers;
-"tune-in" on specific children who need particular help in developing certain language concepts;	-exchange notes with teachers;
-be willing to accept demonstration (e.g., by Sp.Clin.) of "communicative interaction" (ala' Rieke);	-have teachers observe therapy;
-be willing to accept one of their primary roles as "interaction facillitators" (ala' Rieke)	-observe teachers' activities;
	-set specific time for teacher-clinician communications;
	-help teachers apply materials used by speech clinicians;
	-clinicians should be aware of concepts in curriculum in the classroom

APPENDIX 14

"MEDIATOR MEDIA"
NEWSLETTER

the MEDIATOR MEDIA

published monthly by: OCD-BEH project staff

DECEMBER, 1974

- - - - - - OUR FIRST ISSUE - - - - - -

HAPPY NEW YEAR - 1975!! This is the first issue of the Mediator Media. We on the OCD-BEH staff have felt a need for some means of regularly communicating with all Mediator Team members and others in all Head Start agencies in Minnesota. The result will be the monthly printing of this newsletter, the Mediator Media. In this newsletter we want to include some general and some specific bits of information we come across from various sources.

We would like much of this information to come from the Head Start agencies in Minnesota -- so that there are already thirty-six sources of information! We think this newsletter could be one way for coordinators and teachers to share their knowledge and successes with their counterparts in all the other agencies in Minnesota. Many Head Start people are doing fantastic things they may wish to share.

It is our hope that the newsletter will further enhance the integration of special-needs children into Head Start in Minnesota. Certainly parents and teachers may find some of the information to be as valuable to them as it may be to coordinator level people. So please share our news with everyone. If you have information you would like to have printed in the Mediator Media, please send it to the new, fifth member of our team -- Sue DeCorsey -- at the address below. Or call her at 612/296-5760.

Here is a list of some interest areas. You may want to send your ideas about:

- Recruitment
- Parent Involvement
- Unique Programs at Your Agency
- Arrangements with Public Schools
- Managing Space in a Head Start Center
- Career Development

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(continued from column 1)

- New Materials
- New Publications
- Notes About Preschool Philosophy
- Mailing Lists to Get On

ANOTHER SLEIGH RIDE

As you are reading this article, you may already be aware that we are starting our second round of visits with the Mediator Team members of each Head Start agency. We are focusing on the "On-Going Functions" of the Mediator Team, as they are given in the Mediator's Handbook. We hope to give some assistance to your agency's team regarding the actual special-needs children identified since our first visit in September and October. How is your team managing these children? Another way of saying this is, "How are the Mediator Team, the teacher, the parents, and the specialists working as a team for the benefit of each special-needs child?" We hope that mid-winter weather conditions do not hamper our schedule too much. Maybe we really will need to take sleighs!!

"THE TURTLE"
by
Ogden Nash

The Turtle lives 'twixt plated decks
that practically conceal its sex;
I think it clever of the Turtle,
in such a fix, to be so fertile!

OCD
Office of Child Development

GOVERNOR'S OEO | 404 METRO SQUARE BLDG. ST. PAUL MN. 55101 /612/ 296-5740

OCD-BEH WORKSHOP #2

Thank you for your work at our first workshop of the year! And congratulations on the fine job many of you did when learning about behavior checklists and teaching tasks. A few dates have been set for our second workshop; the remainder of the dates will be set shortly. The workshops will come during a period from the last of February through the first week of March, 1975. We still seek your ideas about the kind of training you want, so please give us a call or write a note soon!

BEH
Bureau of Education for the Handicapped

LANGUAGE IS A MOUTHFUL

On December 17th and 18th, Dave Garwick and Fred Aden of the OCD-BEH staff met with seven speech clinicians and one SLBP specialist to discuss a philosophy for providing developmental and clinical speech/language services to children in Head Start, as well as some practical ways of implementing that philosophy.

All of the people invited have been providing services to Head Start children in one way or another. Four are actually employed by Head Start agencies or work with Head Start full-time: Sue Dosen, Arrowhead; Jean Martin, Arrowhead; Cheryl Strachan, RAP (St. Paul); Faye Zimmerman, West Central.

With the input from all of these people, Dave and Fred intend to write a handbook which can be used by speech clinicians who work with preschool children. The handbook will probably contain sections on a philosophy of service, some practical alternative ways of providing services, some ways of helping with the language development of all children in a preschool program, and some lists of clinical materials.

During the past year we have been suggesting that there may be some better and more effic-

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ient ways a speech clinician can operate -- other than giving one-to-one clinical services. We have suggested that the speech clinicians could work as a team with teachers for the benefit of all children in a classroom as well as the speech/language handicapped child. Hopefully the handbook will make another dent in the old philosophy of one-to-one service given outside of the classroom.

****A WORKSHOP FOR MEDIATOR TEAM MEMBERS****

The OCD-BEH staff is looking at a date somewhere between the middle and end of March, 1975 to hold a state-wide, one-day workshop for all Mediator Team members or other Head Start agency representatives. Some emphasis will be placed on the recruitment of special-needs children into your agency's program. The main focus will be on the transition of special-needs children from Head Start to their next educational setting -- most likely the public school.

Written material on "transition" was purposely not included in the original printing of the Mediator's Handbook. The "transition" section will be supplied at the workshop for insertion into the Handbook. We will be informing you of the exact date and place very shortly.

HEALTH

Head Start is providing for all necessary vaccinations and immunizations appropriate to the age group it serves. But there are several articles being printed in newspapers and magazines which say that a large number of preschool children are not receiving these vaccinations and immunizations. Therefore, the incidence of some diseases is again rising.

This would be a good opportunity for Head Start to brag a little -- or reeducate the public.

NIFTY ARRANGEMENTS

Increase in Specialist Services To Head Start

Many Mediator Teams are finding new and innovative ways of obtaining services from various specialists in their local areas. These efforts have resulted in more and better services to special-needs children and to the programs in general. Following are brief descriptions of collaborations that some Mediator Teams have established with specialists. We have included the name and telephone number of each team coordinator. You may wish to contact these people for more information.

At Arrowhead, the Mediator Team is comprised of several specialists who have been hired full-time by the Head Start program itself. Speech pathology, SLBP, public health nursing, early childhood education and special education are the areas of training represented on this team. In addition to providing service to children, teacher, and parents, these people are actively recruiting the services of other specialists from public schools and other resource agencies. Mediator Team Coordinator -- John Vukelich 218/749-2912.

At PICA (Minneapolis), the Mediator Team has recruited the services of a graduate student in school psychology who visits one center for one-and-a-half days a week. This person works closely with the teachers in planning classroom management, designing the use of space and equipment in the classroom, developing curricula, and planning for individual children. The Minneapolis Mediator Team has also obtained similar types of service for other centers by developing collaborations with other resource agencies. Mediator Team Coordinator -- Betty Farrow 612/377-1493.

At Duluth, there are several Mediator Teams, each of which has specialists from the public school serving as members. The Duluth Head Start centers are all located in public school buildings. At each school there is a team of specialists (speech pathologist, social worker, nurse, and psychologist), which is expected to provide service to Head Start as well as to the rest of the school. The teachers from a

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Head Start center and the specialists who provide services to that school make up a Special Services Team (SST). The individual teams from the centers are coordinated by Head Start administrative personnel and some other public school personnel. Mediator Team Coordinator -- Gene Sauter 218/727-8006.

At Anoka, the Team has contracted for psychological services from a psychologist in private practice. Instead of asking this person to do mainly diagnostic testing, they have requested that he visit centers to observe children and consult with teachers and parents. It is felt that this type of service is much more helpful and cost-efficient than just diagnostic testing. This type of service has been obtained at a relatively small cost to the program. Team Coordinator -- Bernice Huston 612/755-5080.

At Northwest, the Mediator Team is meeting bi-weekly with the staff of the special education cooperative for that area. These meetings are conducted at the office of the special education director. The purpose of the meetings is to discuss special-needs children, make plans for the management of these children, determine which children may need to be seen by the various specialists on the special education staff, etc.. In addition to these case conference meetings, the special education staff also provides screening services, some diagnostic testing, and some consultation with teachers and parents. Mediator Team Coordinator -- Doris Miller 218/528-3258.

At Southwestern, the Mediator Team has retained the voluntary services of four ophthalmologists. These medical eye specialists occasionally visit individual classrooms, answering teachers' questions about youngsters with visual problems, providing suggestions to teacher in identification and classroom activity/management of youngsters with visual difficulties. Every two weeks, over a cup of coffee, teachers meet with a local psychologist to discuss questions about individual youngsters. Mediator Team Coordinator -- Chuck Anderson 507/376-4195.

NIFTY ARRANGEMENTS
(continued)

At Western and Southwestern, the services of speech pathologists have been purchased from the Educational Resource Development Center in Pipestone. These clinicians meet directly with the Home Start visitors, the Head Start teacher, and the parents to discuss the development/management of specific youngsters with communication disorders. Mediator Team Coordinators: Western -- Jackie Lovald 507/532-2504; Southwestern -- Chuck Anderson 507/376-4195.

MR&S has been fortunate in receiving the voluntary services of a dental hygienist. She visits each classroom, screens each child for dental health, and teaches the youngsters (through the use of puppets!) how to care for their teeth -- as each child provides himself with flouride treatment! The dental hygienist at the same time talks with each individual parent and teacher as she provides each with special training in dental care. Mediator Team Coordinator -- Marvin Rothfusz 507/647-2222.

Ottertail-Wadena, there is developing a system similar to Northwest. The Mediator Team is establishing a routine policy of holding Mediator Team meetings with the case management team of the public school special education cooperative. Mediator Team Coordinator -- Jeanne Tonsfeldt 218/385-2900.

Goodhue-Rice-Wabasha uses the 204th Medical Battalion of the Minnesota National Guard to provide each child with medical check-ups and immunization (the medical doctors in that Battalion come from the Mayo Clinic). Team Coordinator -- Barb Mayer 507/732-5249.

"LET YOUR FINGERS DO THE WALKING"

...Through the "Green Pages?" Each issue of Early Years magazine includes a section called the "Green Pages," filled with more than 100 classroom activity ideas for preschool teachers (and children).

Also, there is now a pamphlet which combines 1,051 of the better ideas which readers have used in the past! And, they will ship it to
(continued, next column)

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you on the day they receive your order. To order: Pay $3.95 for "Your Green Pages" to Early Years, Book Services, Box 1223, Darien, Connecticut 06820.

This does not imply the Project's endorsement or commercial/profit advertisement.

IN THE NEXT ISSUE

A special article on "body painting" for preschoolers!! The fold-out is great!!!

***
The work presented herein was compiled and written pursuant to DHEW/OHD/OCD Grant No. 5118. The material does not necessarily reflect OCD position or policy. Official OCD endorsement should not be inferred.
***

the MEDIATOR MEDIA

published monthly by: OCD-BEH project staff

February, 1975

* * * * * * * HELLO AGAIN * * * * * * *

As you are probably aware, the past month has been the time for the OCD-BEH Project to visit each Head Start agency. As of this writing, most of the visits have been completed. Needless to say, Jon, Dave, Don and Fred have been on-the-move and out of the office. One result is that this issue of the Mediator Media is a week or two late. Another result is a good feeling by all Project members that Minnesota Head Start is operating with its head up!!! Some excellent arrangements have been made by Head Start agencies to serve the needs of individual "special-needs" children. And many by-products have come about, such that all the children are reaping some benefits from general arrangements an agency has been able to make with local resource specialists. Therefore, a large portion of this issue is devoted to telling about Mediator Team arrangements and accomplishments. Maybe you will read about an arrangement you would find useful!

- -

Some people are so nice they wouldn't hurt a flea. Other exceptionally nice people wouldn't even hang a "No-Pest" strip.

- -

* CHECK MATE *

The OCD-BEH Project is very pleased with the response of teaching and agency personnel to our first workshop this year! A primary aim of our workshops is to attempt to stimulate interest in new ideas and concepts. The use of behavior checklists, as described in our workshop, has generated a lot of interest! Some agencies, such as Indian-CAPs, Minnesota Valley, Northwest, Inter-County, and others

(continued from Column 1)

are using some type of behavior checklist extensively. The checklists are being used to describe a child's current skill level, to help plan a teaching approach, and to describe a child's progress at learning new skills.

By simply describing behavior, the problems associated with "labeling" a child and making subjective judgements are avoided. This relates to the new law allowing every parent to inspect their child's school records, including achievement, intelligence, psychological and aptitude test scores, as well as evaluations by educational personnel. When a person becomes 18, she/he also has the same rights to inspect. The law also provides a way to challenge the records.

If a behavior checklist system is used, the parent is often involved in observing and checking. It seems, then, that these types of observations could go into a child's individual folder without administrative concern or parental concern that "damaging" statements are being made about a child.

The law, the Family Educational Rights and Privacy Act, went into effect November 19, 1974. Copies of PL 93-380 can be obtained from: Senate Documents Room
U. S. Capitol
Washington, D. C. 20510

- -

BRING AND BRAG

TEACHERS! COORDINATORS! ALL! Tell it all. about the good things you are doing. Send your articles to us c/o Sue DeCorsey -- at the address below or call her at 612/296-576

GOVERNOR'S OFFICE | 404 METRO SQUARE BLDG. ST. PAUL MN. 55101 /612/ 296-5740

THE TEAM SCHEME

It is exciting to see Mediator Teams operating at so many Head Start agencies throughout the state. More than two-thirds of all the agencies in the state have teams which have begun to function in ways similar to those outlined in the Mediator's Handbook. These teams meet regularly, usually more than once a month, to discuss and plan for individual special-needs children. These meetings are attended by teachers, coordinators (i.e., health, education, parent, social service) and, in many instances, specialists from within or outside the Head Start program (e.g., speech clinicians, special education directors, psychologists, nurses, social workers, SLBP specialists, etc.).

The coordinator level staffs in several agencies are traveling out to centers for meetings held in one center one week, another center the next week, etc. Sometimes staff are visiting more than one center per week so that the time lag between meetings is minimal.

Other agencies are asking teachers to come to the central office for team meetings. Usually this is accomplished by asking teachers to come at different times during a day. In this way, the teacher is away from the children very little and the meeting time is devoted to her special-needs children only.

A third approach employed by a few agencies is to meet in the office of the special education director for the local school district(s). This approach insures that other specialists are immediately and continuously aware of special-needs Head Start children and can contribute to the planning for those children on an on-going basis.

Still another approach is being tried in those agencies that have centers close together or all in one building. The various staff members are in constant contact with one another and formal meetings are held infrequently. It is important to point out that even in these circumstances it is a good idea to occasionally set aside a definite block of time to discuss the children with no outside interruptions.

(continued from column 1)
Some examples of agencies using these various arrangements are given below so that you can contact them for additional information. (Note most of the agencies named are from the northern part of the state only because this article was written by Don and Fred.).

Examples of agencies where coordinatros travel out to centers:

Bi-County
Ruth Wahnschaffe
218/751-4632
and
Duluth
Gene Sauter
218/727-8006

Examples of agencies where teachers come to the central office for meetings

Inter-County
Kathy Simonson
218/796-2325
and
White Earth I-CAP
Blanche Niemi
218/983-3285

Examples of agencies meeting with special education personnel regularly:

Northwest
Doris Miller
218/528-3258
and
Southwestern
Chuck Anderson
507/376-4195
and
Ottertail-Wadena
Jeanne Tonsfeldt
218/385-2900

Examples of agencies whose centers are close or in one building:

Mille Lacs I-CAP
Norma Thompson
612/532-3358

(continued from page 2)

Koochiching-Itasca
Delores Bretti
218/326-2760

- -

BLEEP

No one can be fooled into thinking that one kind of Mediator Team arrangement or one kind of arrangements with specialists will work for every Head Start agency. One reason for writing this newsletter is to highlight the different kinds of arrangements we find across the state. If your agency has tried some things that have not worked very well, write an article for the Mediator Media telling about that. We learn from our mistakes and we should feel none-the-less successful by being willing to share them.

Who said that true confessions are good for the soul???

- -

FREEBIE

We have in our hands a thirteen (13) page listing of "National Sources of Free or Inexpensive Health Education Materials". Only a few examples of topics are:

Cooking and diets
Handicapping conditions
Urban renewal
Health conditions
Safety
Classroom arrangement

If you want this listing, send your request to Sue DeCorsey (address on bottom of first page).

- -

SPECIAL QUESTIONS - FOR SPECIAL NEEDS - FOR SPECIALISTS

Who spends the most time with a special-needs child in an intentional educational setting? Answer -- the teacher is probably the person who has the most time to influence the development of these children. With this great opportunity, are the teachers securing direct assistance from clinical specialists? Does the teacher know exactly why a particular child is in speech therapy and exactly what is

(continued from column 1)

being done in therapy? Has the speech clinician or the psychologist given the teacher specific things to try in the classroom with the special-needs child (to help "carryover" new speech/language behavior or to change other behaviors). Have the teacher and the specialist(s) reviewed the success or failure of the suggested ideas? If suggestions have been given, have these been recently updated?

To address these aspects of their programs, several Head Start agencies have developed new policies and activities. These agencies have involved the teachers, themselves, in doing the initial developmental screening --- via the Denver Developmental Screening Test or a more expanded behavior checklist system. In the past some of these agencies have had difficulty getting specialists to visit the classroom, home or the teacher. Some of the agencies directly involving teachers in all parts of developmental screening are:

West Central
Chris Spaulding
612/246-3248
and
Tri-Valley
Mary Riske
218/281-5832
and
Ottertail-Wadena
Jeanne Tonsfeldt
218/385-2900
and
Northwest
Doris Miller
218/528-3258
and
Minnesota Valley
Phil Lederman
507/387-4135
and
Inter-County
Kathy Simonson
218/796-2325

In these agencies the Mediator Teams are maintaining or plan to maintain frequent, direct contact with the teachers. The team members may communicate teacher concerns to a specialis convey specialist recommendations to teachers, and help the teacher implement suggestions.

In Meeker-Wright the Health Coordinator and Education Coordinator interpret to every teache the screening results of every child in her car Classroom implications are also discussed at this time. The nomadic Home Start visitors

(continued from page 3)

will begin a policy of meeting over a cup of coffee for a half-day each month with a school speech clinician and psychologist to informally "rap" about individual children.

Meeker-Wright
Jackie Marketon
612/658-4415

At Western, the home visitors will also try the "coffee klatsch" idea once a month with two Mental Health Center psychologists. The staff already has direct contact with a speech clinician. Southwestern has similar arrangements.

Western
Jackie Lovald
507/532-2504
and
Southwestern
Chuck Anderson
507/376-4195

In Scott-Carver a new policy will be initiated. Before the Mediator Team refers a child to a specialist, the teacher will write a brief letter of observations and concerns to the specialist. When the child is seen by the specialist, an accompanying team member will specifically ask for classroom suggestions regarding this child. In unusual circumstances the Mediator Team will try to facilitate the teacher directly accompanying the child to the specialist.

Scott-Carver
Judy Nustad
612/448-2302

The Mediator Team at Ottertail-Wadena is creating an "Educational Advisory Board" of educational/clinical specialists who will meet monthly with the Team. They intend to discuss individual children and general program management. In addition, the Team also meets twice each month with each home visitor to discuss programming for each child and to convey the recommendations coming from the Educational Advisory Board - Mediator Team meetings.

Ottertail-Wadena
Jeanne Tonsfeldt
218/385-2900

At West Central, Mediator Team meetings include a brief up-date of each special-needs child's situation. Team members directly visit each concerned teacher to observe individual children, offer classroom management or parent involvement suggestions, and convey Mediator Team/specialist recommendations.

(continued from column 1)

West Central
Chris Spaulding
612/246-3248

In Clay-Wilkin one of the Home Start visitors has two youngsters who also attend special education classes part time. This visitor plans into her schedule occasional visits to the special education class to exchange ideas with the teachers.

Clay-Wilkin
Dennis Heitkamp
218/233-7514

In summary, there are at least two characteristics of agencies whose teachers/Teams are getting the direct support of specialists:

1. The agencies and teachers actively search for specialist services and meet face-to-face with the teachers/Team to provide "teacher-pertinent" suggestions;
2. The agencies actively encourage teachers to take time to meet with clinical specialists.

- -

INTERIOR DESECRATORS

It seems that the former occupants of some CAP offices do not leave the quarters in very good condition. Bi-County CAP in Bemidji recently moved into quarters previously occupied by a hotel-rooming house. To solve the redecorating problem, each staff person was given the opportunity to paint and furnish his/her office. The result is fantastic!! Take a look at the black-and-white room; the bi-centennial room; the fireside room. Certainly the Bi-County staff has talent beyond what is written in job descriptions.

- -

SCRSCRUMPDILEICIOUS

The OCD-BEH staff is very excited and encouraged to find such a positive response to the Mediator Team concept. Based on the reports of many Head Start people, we have the distinct impression that the teams are not only helping to provide better services to special-needs children and their families but are also helping to enhance communication, generally, within agencies. We certainly hope that this is the case and we strongly commend your efforts!!

(continued from page 4)
We do know that there are a couple of agencies that have expressed a definite interest in developing a Mediator Team but have been unable to do so for a variety of reasons. These same agencies have indicated a desire to initiate that team concept next year. We are very willing to help develop plans with these agencies during the remainder of this program year.

- -

POTPOURRI

Agencies are designating different staff persons as coordinators of their Mediator Teams. Directors, health coordinators, education coordinators, etc., are usually the Team coordinators. However, in Duluth, the Head Teacher at each center is the coordinator and in one of the PICA centers a teacher aide is the coordinator.

Duluth
Gene Sauter
218/727-8006
and
PICA
Betty Farrow
612/377-1493

Tri-County has a parent from their policy council on the Mediator Team. This person volunteered for the Team and was approved by other policy council members. The agency feels strongly that parent input at team meetings is important, and they do not think that the issue of confidentiality has to necessarily be a problem.

Tri-County
Sylvia Ray
612/632-3617

At Arrowhead, some staff specialists are planning to meet with all special education directors and the Special Education Regional Consultant in their area to present massive screening results. And they expect to talk about the availability of resources in schools to meet the needs they have uncovered.

Arrowhead
John Vukelich
218/749-2912

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WISH

FOR

SPRING

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AS PROMISED

In the last issue we promised you an articl on "body painting" for preschoolers -- and fold-out. Unfortunately, the article becam smeared and is totally illegible. Freddie messed it up! BUT -- turn the page for February's fold-out!!!!!!!!

- -

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The work presented herein was compiled and written pursuant to DHEW/OHD/OCD Grant No. 5118. The material does not necessarily re flect OCD position or policy. Official OCD endorsement should not be inferred.

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the MEDIATOR MEDIA

published monthly by: OCD-BEH project staff

March, 1975

SQUEALS AND SQUAWKS

By the time you receive this newsletter we hope your ears have recovered from the squeals and squawks of the hearing aids Dave and Fred used for demonstration during the recent workshop. And Don and Jon hope you haven't run out of medication for your "hyperactivity" (ha, ha). Rest assured that time will take care of that ringing in your ears --- and that we are confident in your ability to manage behavior "cold turkey".

Seriously, we have really enjoyed being with you on another round of workshops throughout Minnesota. You might be interested to know that this workshop was presented at:

St. Cloud
Duluth
Bald Eagle (near Cass Lk. and Bemidji)
Fergus Falls
Owatonna
Mankato
Thief River Falls
Twin Cities
Marshall

Of course, we appreciate your positive responses, of which there were many. One regret we have is that we usually have to work with fairly large groups and the time factor is also somewhat limiting. If groups were smaller and time longer, we could get to know each of you better. Nevertheless, we hope you enjoyed being with us as much as we are enjoying being with you!!!

PARENT EDUCATION GROUPS

With the near completion of the OCD-BEH Project's second (and last) teacher-parent oriented workshops for this year, a few comments can be made about parent involvement. First, the number and percentage of parents attending has increased greatly over last year. We are very pleased that Head Start/Home Start programs have invited so many parents, helped them to arrange babysitting, provide transportation, etc.

Second, whether because of increased numbers or other factors, active parent participation in the small group discussion sections of the workshops has been very valuable and enlightening. Something special seems to happen when a parent reinforces a teacher and/or another parent.

Finally, based on these results, the OCD-BEH Project would like to suggest that Head Start Home Start programs consider organizing ongoing parent education groups. The regular meetings of such groups should deal with specific child centered concerns -- not program operation concerns. There already exist parent groups to deal with those concerns. Parent education groups could be facilitated by Head Start/Home Start staff, could be controlled by parents and could be supervised at appropriate times by a psychologist. Of course, other resource people, from within or outside of the agency, could be participants. THINK ABOUT IT.

WELCOME TO SPRING

Spring has sprung,
The grass is riz.
I wonder where
The flowers is?

THE COUNCIL FOR EXCEPTIONAL CHILDREN REPORTS

"Parents suspecting their child may suffer from learning disabilities are able to receive immediate assistance from the American Foundation on Learning Disabilities. In less than an hour information will be gathered by a computer-based retrieval system developed at the Massachusetts Institute of Technology. Information will include where to locate evaluation centers, professionals specializing in the treatment of the handicap, and so on. The retrieval system is currently in operation for New York, New Jersey, Connecticut, and Pennsylvania. Does it sound like a good idea for your state? Write to the American Foundation on Learning Disabilities, Box 249, Convent Station, New Jersey 07961."

(From Teaching Exceptional Children, Fall, 1974.)

DID YOU KNOW

The Minnesota Commission for the Handicapped is collaborating with other state agencies and officials to develop a state-wide information and referral system. It is anticipated that Minnesota's system will yield information on all types of handicapping conditions. Address any questions or comments to:

Minnesota Commission for the Handicapped
492 Metro Square Building
St. Paul, Minnesota 55101

Even when the time comes that this system is in full operation, the individual, personal touch will probably be needed to design a complete referral program for a special-needs child. This is where the Head Start/Home Start agency's mediator team comes in. The OCD-BEH Project is pleased that so many agencies are already "ahead of the game". Use your mediator team effectively!

HEAD START LEADS

On October 21, 1974, the Scott-Carver Head Start Program sponsored a workshop on the social, medical, and legal aspects of child abuse and neglect. In attendance were representatives of all child care components in Scott and Carver Counties, including group and family day care personnel.

Shirley Pierce, Coordinator, Ramsey County Child Abuse Team, gave a comprehensive presentation on recognizing and identifying the abused child. She also provided basic information

(continued from column 1)
regarding the legal aspects of child abuse.

Personnel from Scott and Carver countys' Family Services agencies gave presentations on the case management processes used to provide protection services in each of the counties. A guide for determining possible abuse or neglect was also distributed.

Carver and Scott countys' Public Health Nursing Service representatives explained their role and how they contribute best to the protection of children.

It was stressed that it is not enough to discover an abused or neglected child. Parents who attack their children may have poor concepts of themselves as persons and parents. They need understanding and guidance. Their children need them, as every child needs an identification with family. A parent substitute for an abused child is demanded only when all efforts fail to correct the problems that cause a mother or father to assault a child.

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YOUR SCHOOL DISTRICT HELPS

Throughout the state of Minnesota, public school systems have -- as a rule -- been tremendously supportive to Head Start in serving special-needs youngsters!! In fact, the OCD-BEH Project has written to all special education directors in Minnesota thanking them for their part in supplying special services. All this, in addition to the fact that some school districts have supplied classroom space for Head Start. Head Start Directors, Mediator Team Members: In addition to thanking special education directors and the specialists face-to-face, you should write formal letters of "thank you". And it certainly would not be out of place for parents whose children have received special services to do the same. If it were not for public school special resources, we would be left out in the wilderness!

- -

THINK TWICE -- THINK THRICE

Is your Head Start/Home Start program really the best placement for a special-needs child referred to you? In most cases the answer is "YES" -- you have proven it time and time again this year and in the past! But, there have been some isolated cases where placement in another early education program has seemed to be a better approach. An example is the placement of a child in a Day Activity Center after his/her parents first applied to Head Start. Decisions like this are not easy to make. And they should be decisions made jointly by the child's parents, Head Start, local school district, and appropriate professionals who have seen the child.

In Minnesota there are instances just like this example. But there is an additional component for several of these children. It has been determined that they are ready for part-time integration into Head Start. Some attend Head Start for only a few hours a week. Others may spend a half day in a Day Activity Center program and the other half-day in Head Start. The possible time combinations are endless.

*

Thanks in part to some special grants, some Head Start programs are hiring their own clinical specialists -- like speech clinicians, special education teachers, SLBP specialists, etc. It would be nice to think of these special positions as on-going slots for a staff. However, year-to-year financing may make it uncertain that these specialists can be with your program forever. The OCD-BEH Project staff has suggested to some programs that they approach their local school districts about the possibilities of total or partial financial collaboration. A school district may be willing to hire your specialist but allow the specialist to continue spending all or most of his/her time with Head Start. In this way the school district could meet at least part of its mandated obligation to serve pre-kindergarten children.

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In another light, it could be easy for a Head Start program to become too dependent on the services of its own special clinician or teacher. Even if Head Start has its own specialist, are the local school districts aware of the special services needed by some Head Start children? If, for some reason, the specialist has to leave Head Start, will the public schools be geared-up to provide the same amount of service? With these questions in mind, the OCD-BEH Project has suggested that specialists in Head Start have as one of their primary objectives the identification and development of services from community resources which are possibly more permanent -- like services from public schools, mental health centers, child development centers, etc.

*

The OCD-BEH staff has been strongly recommending that Head Start programs contact special education personnel in those public school systems where special-needs Head Start children will enroll next year. It is crucial that these people, along with sprincipals and kindergarten teachers, be made aware of special-needs children who will be attending their schools. The Head Start staffs will have had an entire year of experience learning about these children. The knowledge and insight gained over a year's time definitely should be shared with the public school people in order that they might begin now to develop plans for good programming during the school year. Of course, parental permission must be obtained for this transfer of information (whether written or oral). If most cases, parents should be involved in the actual discussion about their children and the plans that are considered.

It is schedule time!!! Public school specialists will soon be devising tentative work schedules for next year. Begin this month to ask school speech clinicians, psychologists, and other specialists to commit a regular amount of time in next year's schedule for your Head Start program. Several clinicians in different areas of the state told us that they will reserve a place for Head Start on next year's schedule if you contact them NOW!

SOLICITED

We asked some people who are using the mediator team approach -- and like it very much -- to write an article for the Mediator Media. Here are two of these articles.

*

THE SLEEPING BEAUTY WHO WOKE UP
Contributed By
Beverly Schmunk, R.N.
Health Coordinator
Bi-County Head Start

She's a healthy, active, normal four year old at first glance. If you know where to look though, there are the healed-over scars and strange lumps from the accident and surgery.

Her entry into the program coincided with the regularly scheduled mediator team meeting. Our mediator team consists basically of three people: the center supervisor, family coordinator, and the health coordinator. Because we have several centers in different areas and because the immunizations schedule is on a four week basis, I, the nurse, lead most of the team discussions. I am the most comfortable with a Kardex File System, so we have a Kardex card made up for each child with color coding for special-needs children and a separate Kardex for each center.

The meetings tend to resemble hospital shift reports -- flipping through the Kardex with each component contributing anything of special interest on each child with special attention to the color coded special-needs cards.

For Sleeping Beauty, the team was worked out with the program director and all the classroom staff who would work with her. She sees a specialist from another town so an in-person meeting with the staff was impossible for him. Instead, we sorted out our questions about her limitations and how we could help her. We wrote to the specialist and have included his recommendations in the plan for her care.

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In addition, a mediator team meeting with the speech clinician helped toward a smoother coordination with the classroom and special help. Our team is still planning on calling for help from more specialists for special help for a special little girl.

*

TESTIMONIAL
Contributed By
Phyllis Bohaty
Health Services Director
Lakes and Pines Head Start

We have been utilizing the team approach for several months, and, though we were slow in getting started, now that it has been implemented, we find it most beneficial. The sharing of ideas and suggestions for working with different families has been extremely helpful for individual staff people, as well as the families involved. We are learning a great deal from each other and about each other during our team conferences.

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DID YOU KNOW?

In the United States, "More than 10 million children are now living with only one parent, and 2 out of 3 of these are the product of divorce or separation."
(From U.S. News and World Report, January 13, 1975)

Certainly parent involvement in Head Start should address this issue by giving support to single parents.

- -

ANOTHER TWIST ON THE
SELF-FULFILLING PROPHECY

So, a child has a handicap. But is the youngster a boy or a girl? What does that matter?

(continued, page 5)

(continued from page 4)
Well, most people would agree that how we treat any child depends on how we view that youngster. It may be that what we see in a child largely depends on whether that child is a boy or a girl.

The January, 1975 issue of Psychology Today reported some research done by three psychologists at Tufts University. A number of babies were chosen so that the group of 15 boys was similar to a group of 15 girls in terms of height, weight, skin color, muscle hardness, nerve irritability, heart beat rates, and breathing rates. So, actually there was no real physical difference that was obvious between the groups -- except for their sex.

But, "Parents of daughters thought their babies were significantly softer, finer featured, littler, and more inattentive than did parents of boys," even though there were no obvious physical differences.

It may also be that some of the ways we treat a child depend largely on the child's sex, often regardless of other things that might be important about the child. The Psychology Today article reported on other research at West Virginia University. Eleven different mothers got a chance to play with the same six month old boy. But, six of the mothers were led to believe that this baby was a girl because it was clothed in a pink dress and named "Beth." The other five mothers met "Adam" who was clothed in blue pants.

> "Three toys -- a fish, a doll, and a train, were available in the nursery. The women who thought the baby was a girl handed him the doll more frequently; those who thought he was a boy gave him the train more often. They did not differ in handing out the fish, a sex-neutral toy.
>
> Mothers also smiled more at 'Beth' than at 'Adam,' although there were no significant differences in talking to the baby, touching or handling. Two mothers said they could tell 'Beth' was a girl because he was sweeter and cried more softly; one said she could tell he was a boy because he had a little boy's face. The others later admitted they wouldn't have known, except for the name and the outfit."

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So, are we observing a child's special needs that are really present or are we seeing what we expect of a child? Is the fact that the child is a boy or a girl affecting what we see? Do we treat a child in certain ways because of that child's special needs or is our treatment confused because of the child's sex? SOME FOOD FOR THOUGHT!

- -

GOING UP!

In the last year:

> Listening training equipment and hearing aids have increased in cost 20-30 percent;
>
> Children's wheel chairs have increased from $130 to $160;
>
> Canes from $2.75 to $4.25;
>
> Costs of educational personnel have increased by 5%.
>
> (From a letter by Raphael Semches, President of the Council for Exceptional Children, to President Ford) (Printed in Exceptional Children, January, 1975)

- -

BEWARE

If the same medicine is made by two different companies, why not buy the cheapest brand since both products are the same? Right?

WRONG!

"The 'same' medicines made by different companies aren't always comparable," according to the Pharmaceutical Manufacturers Association. Their statement is based on a report by the U.S. Congress Office of Technology Assessment. If you want to know more, write for:

> The OTA Report Summary
> Pharmaceutical Manufacturers Assoc.
> Dept. PT-411
> 1155 Fifteenth Street N.W.
> Washington, D.C. 20005
>
> (Reported in Psychology Today, November, 1974)

IT'S THE PARENTS

In a child's life his/her parents are usually his/her strongest advocate! This seems to be especially true for children who have special needs!! Fortunately, special education services are graciously given by school specialists and others. Under these circumstances it is usual to find the parent also becoming a strong advocate for the specialists providing those services and for the schools from which they come.

However, in some circumstances it has been necessary for Head Start and parents to reacquaint some school personnel with their responsibility to serve young special-needs children. One such example occured at West Central. When a multiply disabled school-age child did not receive special education service by the public school, all of the parents within the particular Head Start center organized to challenge this lack of service. Using the Mediator's Handbook as a guide, this group followed the "parent appeal process" all the way up to the Special Education Regional Consultant (SERC). To make a long story short, the child is now receiving attention from the public school.

West Central
Chris Spaulding
612/246-3248

The Goodhue-Rice-Wabasha Health Coordinator teamed up with a school speech clinician to petition the school system to provide speech therapy to several Head Start youngsters.

Goodhue-Rice-Wabasha
Barb Mayer
507/732-5249

Again, the moral of the story is that, when the whole system works as it should, the parents will be a strong advocate for their child, for Head Start, and for the school district and its specialists.

CHEAP

That is not us! We charge for our services! But there is another publication similar to the one listed in the last Mediator Media, which lists free and inexpensive materials. It is:

"Free and Inexpensive Learning Materials" -- 17th Edition

There are 224 pages of listings -- all that can be yours for $3.50. This is an offer you can't refuse!

Write for it at:
Division of Surveys and Field Services
George Peabody College for Teachers
Nashville, Tennessee 37203

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FOOD FOR THOUGHT

The social service workers at Inter-County Community Council, headquartered in Oklee, wanted to provide information re. nutrition to people in their 3 and 1/2 county area. We all know how nutrition effects our general health and even the readiness of young children to learn.

So, the social service workers collaborated with four nutritionists in their area to devise a questionaire. The questionaire was sent to all low-income families in the area because the purchasing and preparing of low-cost, nutritious meals can be a real trick when one is living on a limited income. So many people responded that ten training sessions were given on low-cost meals and menues. Follow-up is planned for this summer when additional training sessions will focus on the canning and freezing of fresh and home-grown produce.

Inter-County
Lowell Enerson
218/796-2325

DID YOU KNOW?

In Minnesota approximately 390,000 children are under the age of 6.

In Minnesota perhaps as many as 40,000 children under the age of 6 have significant handicaps, but only 2,500 are receiving special services.
(From the Minnesota Child Development Planning Project, 1974)

POTPOURRI

In addition to a new, large mobile home for the Head Start center, Grand Portage is getting some new services from a speech clinician. Nancy Deans has not been able to visit the Head Start center as regularly or as often as she would like to. But when there she has observed, "...beautiful interactions between the teachers and the children." In addition to what Nancy thinks is an already good language development program, she has demonstrated language stimulation and development techniques. We are flattered that she used a focus and some material suggested by our Project!

Grand Portage
Mary Deschampe
218/475-2234

Speech Pathologist
Nancy Deans
218/387-2273

*

Anoka has some new people on board to whom we extend a warm welcome!! Mr. Terry Kreegin has been appointed CAP Director. And Margaret Douglas has been appointed Head Start Director.

Anoka CAP
Terry Kreegin
612/421-4760

Anoka Head Start
Margaret Douglas
612/755-5080

*

The Northwest Regional Interdistrict Cooperative (special education), which meets regularly with the Northwest Home Start mediator team, is already trying to arrange for programs within public schools to accomodate Home Start special-needs children when they start classes in the fall, 1975.

Northwest
Doris Miller
218/528-3258

*

One member of the Koochiching-Itasca mediator team is also a member of a regional child abuse committee. The whole issue of child abuse and neglect is receiving a lot of attention in that part of the state.

Koochiching-Itasca
Delores Bretti
218/326-2760

*

The Red Lake Head Start program is having an "Open House" and a kindergarten teacher from the public school has asked to attend so she can also meet some parents. Head Start intends to invite this kindergarten teacher to a meeting they will have with the Bemidji Regional Interdistrict Cooperative (special education) to discuss special-needs children.

And Red Lake has been able to offer a part-time job to a speech clinician who recently completed a student-teaching assignment at the reservation school.

Red Lake
Judy Roy
George Jurgenson
218/679-3396

*

At PICA (Minneapolis) some students in school psychology from the University of Minnesota will be doing individual assessments (not I.Q.) on many children.

PICA
Gary Offenberg
612/377-1493

POTPOURRI
(continued)

Tri-County has a new mediator team member and staff person. She is Karen Muehlhausen -- the social service and career development coordinator. As is this editor, Karen is a Nebraska transplant.

Tri-County
Karen Muehlhausen
612/632-3617

- -

WE NEED YOU

There has been some response to our request for articles for the Mediator Media. Articles can come from anyone -- parents, administrators, specialists, aides, parent groups, teachers, etc.

WE NEED MORE!!!

COPY - COPY - COPY

PLEASE FEEL FREE TO COPY THE MEDIATOR MEDIA TO DISTRIBUTE THROUGHOUT YOUR HEAD START/ HOME START AGENCY. THE NEWS IS FOR ALL!!

the MEDIATOR MEDIA

published monthly by: OCD-BEH project staff

APRIL - MAY, 1975

IT HAS BEEN

YES! It has been a fun and rewarding year for the OCD-BEH Project. And we hope it has been equally fun and rewarding for all Head Start/Home Start aides, teachers, parents, coordinators, directors, advisory council members, etc. There are usually trials and tribulations to organizing any event or completing any objective. That is just part of living and accomplishing something. Of primary importance is the eventual outcome --- and the OCD-BEH Project has seen many exciting changes and new efforts take place in Minnesota Head Start/Home Start programs during the year. Of course, progress and innovations are largely the efforts of individual agency programs, so CONGRATULATIONS TO YOU ALL!!!

The Project members have just returned to the office after several weeks on the road. During this time we have nearly completed our third round of one-day visits to each Head Start/Home Start agency. And we have attended other events such as a regional meeting of the Alexander Graham Bell Association for the Deaf and a regional meeting of the American Speech and Hearing Association.

Project members also attended a conference which included representatives of the other twelve Head Start demonstration projects for special-needs children. We learned that our activities will have to be a bit different during the coming year. Of course we will keep you informed of the specifics as we formulate our plan of action. And we will continue to work for the establishment of Mediator Teams (case management teams). Because of all these

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different activities, this issue of the Mediator Media covers the months of April and May (even a bit of June). We hope you enjoy this issue.

A SPECIAL NOTE

"During the years 1971, 1972, and 1973, Crippled Children Services provided speech, language services to 26 separate Head Start centers. The services consisted of screening, diagnosis, limited follow-up, and staff in-service education. We met with limited success to transfer these tasks to the local school systems. At the present time, as well as I can determine, all these programs are now receiving local "speech" services, and from the news items in the "Mediator Media," it appears this is a state-wide trend. The switch to local service is a result of the efforts of the OCD-BEH staff and agency mediator teams. As a result, I'm sure Head Start children in Minnesota are now receiving speech and language services as never before, both in terms of quantity of children served, and the speech pathologist's contact with the children's parents and Head Start personnel."

Tom Sweet
Speech Consultant
Crippled Children Services
Minnesota Department of Health

--NOTE--

This year Minnesota Head Start/Home Start agencies have recruited sixty-seven (67) new speech clinicians to help meet the needs of speech/language handicapped children. This is nearly a 200% increase.

Down in the bottom
Of an itty, bitty pool
Swam three little fishies,
Until they got caught
In the smelt run.

- - - - - - - - - - - - - - - - - - - -

--TRANSITION--TRANSITION--

During the OCD-BEH Project's third round of visits to each Head Start/Home Start agency in Minnesota, one of the primary functions has been to determine what agencies are actually doing to provide for transition of their children to public school. Of course, by the nature of our Project, we have looked primarily at the transition efforts being made for special-needs children.

The Project did some brain-storming prior to beginning the visits and therefore we were able to offer a few ideas to some agencies re. some transition activities they might want to try. As is usually the case, we learned alot just by listening to the things agencies already had in place -- or were already considering doing. We would like to share some of those things with you.

When we visited agencies, we asked to see some folders containing the records of some special-needs children. We did not wish to take any information from folders ---that would be a breech of confidentiality. We did want to get some idea of the overall case-management provided these children throughout the year, and some of idea of what arrangements were in-place for transition of the children to public school. This process seemed to be easier for us when there was some overall descriptive synopsis of the child's skill development included in the folder. Nett Lake was one good example of this. One staff person is responsible for writing these descriptive statements and for up-dating them periodically.

Nett Lake
Judy Kampa
218/757-3179

Similar synopses were written for some children at Inter-County.

Inter-County
Kathy Simonson
218/796-2325

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An example of transition efforts comes from the Lakes and Pines agency. After a year of contact with a severely handicapped child and his family and after several mediator team meetings, one team member arranged a conference to deal with the transition of the child to public school. The list of people involved is quite impressive: Head Start teacher; Head Start social service worker; kindergarten teacher; director of the special education cooperative; school psychologist; both parents; Indian community coordinator; county social service personnel; and the elementary principal of the school the child would attend. Even then, this writer may have made the mistake of leaving someone out. In total, everyone seems to be pulling for this child.

Lakes and Pines
Roger Corbin
612/679-1800

***

Several Head Start/Home Start agencies are finding it possible to actually visit with kindergarten teachers -- about <u>all</u> children. Sometimes this occurs because the Head Start center is located in the school where the children will go for kindergarten. It may not be a policy of a Head Start/Home Start agency to require that all teachers talk with all kindergarten teachers about all the children. But this kind of contact does occur often enough to be a significant step in arranging for successful transition. Several Head Start/Home Start programs are located in small communities where Head Start and kindergarten or first grade teachers have frequent contact with each other throughout the year. This facilitates the helpful exchange of teaching information.

At Grand Portage all children remain in the Head Start program through the "kindergarten" year. All children are discussed with the first grade teacher at Grand Portage prior to a one-day visit of the first grade class by all children who will be entering the class. Any children going to Grand Marais for first grade are followed by the Grand Marais elementary principal. In addition, the Grand Portage first grade teacher will attend a Head Start "Open House" for all parents.

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Grand Portage
Mary Deschampe
218/475-2238

At Red Lake there is a good deal of contact between two kindergarten teachers and Head Start teachers. The kindergarten teacher at Ponemah works with the Head Start teachers throughout the year to develop curricula that will be complementary. The kindergarten teacher at Red Lake has attended a Head Start "Open House" for parents and has visited classrooms at other times.

Red Lake
Judy Roy
George Jurgenson
218/679-3396

***

In some places we saw mediator teams meeting more often than they usually did during their mid-year schedule. The successful transition of special-needs children to public school has been the biggest factor in increasing meeting frequency.

***

At Mille Lacs the public health nurse working with the Head Start program has a chance to follow-up on a child's medical needs when the child enters school. This is accomplished primarily through regular meetings during the school year between the Head Start nurse and the public school nurse.

Mille Lacs
Kay Mickus
612/532-3358

At Northwest, Doris Miller and Colleen Lorenson have revised the "Progress Report" suggested by the Portage Project to better serve their own (Northwest's) needs. The "Progress Report" is a summary of each child's developmental skill accomplishments (cognitive, motor, language, socialization, self-help). It is intended as descriptive information to be passed on to a child's next educational setting, providing parental approval is given. You might want to take a look at Northwest's version.

Northwest
Doris Miller
Colleen Lorenson
218/528-3258

THE CONGRESSIONAL MANDATE

When Congress mandated in 1972 that Head Start make available at least ten percent (10%) of its enrollment slots to handicapped children, the interpretation was that each Office of Child Development region had to meet that figure. During the 1974-75 year the interpretation was changed to read that each state had to meet the figure. For 1975-76 the interpretation is that each Head Start/Home Start agency must meet the ten percent figure.

Certainly this will be an on-going requirement for each agency. Your agency's current recruitment processes may be adequate to meet the requirement. Never the less, your Policy Council should be made aware of this interpretation change.

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FROM ANOTHER PROJECT

You can obtain this publication: "To Give an Edge: A Guide for New Parents of Downs Syndrome (Mongoloid) Children."

We are not sure of the cost -- but make inquiry to:

Mr. Roger Hegeman
Research, Development and
Demonstration Center in
Education of Handicapped
Children
Pattee Hall
University of Minnesota
Minneapolis, Minnesota 55455

- -

---NOTE---
Have you written, or has someone in your agency written, to all the specialists who have worked with your program and/or teachers this year? GOOD WORK DESERVES RECOGNITION!!

- -

"HEALTH CONTEST"

How can a Health Coordinator encourage parents to get their youngsters in for medical and dental check-ups? Jackie Lovald, Western Home Start Health Coordinator uses a "Health Contest" to boost parent cooperation. On a wall chart each home visitor's group is represented by a tall tree. As a visitor has more families complete check-ups, that visitor's tree grows taller. Side-by-side these "trees" compete in growth. The children and parents of each visitor are told that all the children in that group will receive a prize if their tree is the first to reach the top.

Results? The percentage of completed check-ups quickly accelerated in the first month. Both parents and children constantly "bugged" the staff to find out how their tree was coming along. Some parents even became concerned that their doctors had not mailed in the completed forms soon enough.

Western Home Start Health Coordinator
Jackie Lovald, R.N.
P.O. Box 246
Marshall, Minnesota 56258
507/532-2504

- -

EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), a joint effort between the departments of Welfare and Health, is supposed to be available free to any child in Minnesota whose family qualifies for medical assistance. Arrangements to establish screening clinics are in various stages of development throughout the state. One place where there has been alot of movement is at Red Lake. About twenty-six (26) children who will be in Head Start next year have already been screened!!

Red Lake
Judy Roy
218/679-3396

- -

SOON

Head Start/Home Start will be, for most agencies, over for the year.

AND

School will be out.
DRIVE CAREFULLY!!!

- -

THE BEH IN OUR NAME

Some of you know that the full name of our Project is the OCD-BEH Collaborative Project. OCD = the Office of Child Development. BEH = the Bureau of Education for the Handicapped. So, how is our Project "Collaborative" between OCD and BEH? It goes like this.

OCD has graciously supplied the funds for the Project itself. From these funds come salaries for the five of us, our travel expenses when we conduct workshops or visit Head Start/Home Start agencies, books, films, equipment, printing costs, etc.

BEH has funded another project in Minnesota for several years now. This is the UNISTAPS Project. Part of that project is a laboratory school (within the Minneapolis Public Schools) for low-incidence handicapped children ages 0-6, primarily hearing impaired, visually impaired, and severely language impaired. Another part of the UNISTAPS Project concerns the state-wide systems of service to young handicapped children. This is headed by Dr. Winifred Northcott, State Consultant, Early Childhood Education for the Handicapped. Dr. Northcott is also the UNISTAPS Project director.

Now -- the COLLABORATION! Dr. Northcott participates on the OCD-BEH Project Advisory Council. And one OCD-BEH Project person attends the UNISTAPS Advisory Council meetings. Information is exchanged about state service systems. One collaborative effort is in the form of money given to the OCD-BEH Project (by the UNISTAPS Project) to pay for some services to hearing impaired, visually impaired, and low-incidence handicapped Head Start/Home Start children. Some children the OCD-BEH Project has identified during visits to agencies will travel to the UNISTAPS laboratory program for a day. A child's parents and teacher may go along. For some

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other children, consultants are being identified to see the children and consult with parents and teachers on-site (Head Start classroom; home).

The state level UNISTAPS operation has another person on-board ---Kathleen McNellis. Her title is Coordinator/Liaison, Major Provider/Consumer Agencies. Kathleen has been meeting and exchanging information with the OCD-BEH Project members. She has a rich background: Education Director for the Ramsey Action Program (RAP Head Start, St. Paul) and more recently the Career Development Office at the University of Minnesota Family Day Care Training Program. Ultimately it is hoped that she can develop an information-exchange system relating to screening, detection, referral, and community resources out of the major state departments, and consumer agencies.

The UNISTAPS Project has also engaged in other efforts which have, or will have, direct relevance for Head Start/Home Start programs throughout Minnesota. UNISTAPS has provided some funding to Mankato State College and the University of Minnesota which they are to use for training pre-school educators, including Head Start/ Home Start personnel. A recent extensive workshop co-sponsored and co-conducted by Mankato State College and Minnesota Valley Head Start is one of the activities which was made possible by these funds. The Minnesota Round Table in Early Childhood Education III, which takes place June 6th and 7th, and the U. of M. course, "Integrating Children with Special Needs," July 7-18, are additional activities made possible by UNISTAPS funding and their collaboration with the Center for Early Education and Development at the University of Minnesota. Both the Round Table and the University course will have Head Start/ Home Start personnel as participants. The UNISTAPS Project has also conducted several state-wide workshops in the past which have focused on various aspects of working with special-needs children and their families. Head Start/Home Start personnel have always been welcome to attend these workshops and should definitely consider doing so in the future.

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The most recent UNISTAPS, Minnesota Department of Education co-sponsored event was a two-day workshop focusing on inter-agency collaborations in Minnesota for dealing with the needs of handicapped preschool children. It is significant that several Head Start/Home Start people did attend.

Winifred Northcott
Kathleen McNellis
612/296-2547

- -

PIONEERING

Clay-Wilkin Home Start is helping pioneer two new programs. The Southeast Mental Health and Retardation Center (Fargo, N.D.) has developed, and is helping Clay-Wilkin implement, the "Land of OZ" Screening Program and the PACT parent education program. The "Land of OZ" is a comprehensive developmental screening program in which each child proceeds through a carnival cake-walk of forty-two stations, winning prizes for completing screening tasks at each station. The cake-walk is actually "The Yellow Brick Road" surrounded by castles in the Wizard of OZ motif. As many as fifty children can be screened in one day at a cost of $1.00 per child. Trained parent volunteers can do much of the observing.

The PACT (Parents and Children Together) program is a parent-run, consultant-guided parent education program of child development. By attending the bi-weekly meetings and completing assignments, the parents earn "PACT dollars" (token money) which are later exchanged for merchandise in a trading-stamp fashion. Having been tested on hundreds of Head Start parents in several states, the parent attendance is 84% on an average.

Dr. Bill Gingold
700 1st Avenue South
Fargo, North Dakota 58102

Clay-Wilkin
Dennis Heitkamp
218/233-7514

DIVORCE: SOME IMPLICATIONS FOR THE CHILDREN

According to Dr. Salvador Minuchin, Director of the Philadelphia Child Guidance Center:

"Divorce need not be a hardship on children. In some cases it alleviates the stresses caused by constant conflict between parents.

"Nonetheless, the rise in divorces means we are creating a new social network of children with multiple parents, and in that situation children may find themselves the sufferers.

"Divorce and remarriage are within the realm of normal crises. In these moments of normal crises, people go through strain. But children, who have fewer defenses and depend more upon the adults for security, may feel more strain.

"Sometimes in the conflict between divorcing parents, children are used as Ping Pong balls, flying back and forth between the parents. Or children can play the parents against each other in the transition created by divorce.

"Furthermore, adults who divorce and remarry are searching consciously for a better way of growing and being happy. But the children are carried along in these processes without choice. A child does not say to the parent: 'Marry' or 'Divorce'. Children are carried along without being participants in the decisions, so they are confused and mystified -- and this is the real source of their danger.

"Then, when one or both parents remarry, there is another transition and another crisis. Suppose a divorced man meets a woman he wants to marry. He needs not only to establish emotional contact and intimacy with her, but he also needs to become a father to the children of her previous marriage, who he doesn't know. At the same time he has to maintain a good parental relationship with his own children by

(continued, next column)

(continued from column one)

a previous marriage.

"This is a very complex network with many built-in problems, and we have not created systems of support to help remarrying persons."

Dr. Minuchin recommends that as parents enter counseling to help their own personal adjustment, they should also be helped to provide for the emotional support of their children (not just legal support).

(From an interview with the staff of U.S. News and World Report, January 13, 1975)

- -

VIDEOTAPING

The mediator team at RAP (St. Paul) has used videotape for observation purposes. As the team was discussing one child, everyone apparently thought that the child showed disturbing social/emotional behavior. Yet, no one could come up with an objective description of the behavior. The team coordinator then videotaped the child so that all team members could simultaneously observe and discuss the same events.

RAP
Jim Nickolei
612/227-8954

The OCD-BEH Project owns a portable videotape camera, recording deck, and monitor. Depending on the availability of the equipment and a means to transport it, this videotape system can be loaned to your Head Start/Home Start agency.

Sue DeCorsey
OCD-BEH Project
612/296-5760

Another experimental project for Head Start/Home Start special-needs children in Cooperstown, New York has developed a manual on how to use videotape observation of special-needs children. It is quite in impressive (and well-proven) program. For more information write:

Esther Fink, Project Director
Head Start Opportunities for Otsego, Inc.
Cooperstown, New York 13326

(continued from page 6)
If you are seriously considering routine videotape observation of children in your centers/homes, you might also contact Dr. Richard Coder. Dr. Coder recently directed a research effort involving videotaping of Head Start children in Minnesota Head Start classrooms. The researchers developed videotaping techniques over several months of practical trial-and-error practice.

Richard Coder
612/376-4774
Community-University Health Care Center
2016 - 16th Avenue South
Minneapolis, Minnesota

- -

POTPOURRI

At Arrowhead the mediator team is meeting regularly -- the 1st and 3rd Fridays of each month. At a recent team meeting they met with Sue Stubblebine, Social Worker for Crippled Children Services and Mary Lou Crotty, Social Services Supervisor for Welfare, to discuss their interaction with the Head Start program. From this meeting the mediator team believes there has developed a better understanding of how and when to utilize services.

*

Bi-County is getting very good attendance at their Health Advisory Board meetings. They were able to increase attendance by holding meetings at a Head Start center at lunch time.

Bi-County
Ruth Wahnschaffe
Bev Schmunk
218/751-4632

*

Inter-County will be hiring a public health nurse to coordinate health services for its Home Start children during the 1975-76 year.

Inter-County
Lowell Enerson
218/796-2325

*

Tri-CAP, headquartered in St. Cloud, is gearing up to expand services to more children next year. Arrangements for new Home Start services are already under way, following intensive training of new staff by Portage Project personnel.

Tri-CAP is also planning a week long pre-service training session next fall for all home-based and center-based teachers. Training efforts aimed at special-needs children will include familiarizing teachers with agencies and individual specialists who can provide services to teachers and/or children. Some specialists may be presenting overviews of the kinds of services they provide.

Tri-CAP
Kathleen McCormick
David Miller
612/251-1612

*

Anoka is thinking ahead to next year. They are planning a pre-service training program which will include training for parents as well as teachers. There is some thought that this may be the beginning of an on-going parent education program.

Anoka may also be looking into some special training for their outreach worker and parent coordinator. The thinking behind this idea is that most training in Head Start is aimed at classroom personnel.

Anoka
Michaeline (Mike) Lind
612/755-5080

*

Fred Aden and Dave Garwick will be meeting with all teaching staff and all speech clinicians working with Head Start children in Duluth. The teachers and clinicians will be examining how they perceive each others' roles and how they can work together in a unified effort for speech/language impaired children. This working session may produce some models which can enable both teachers and clinicians to do the most effective job of building speech/language skills.

Next year Arrowhead will have a new dental consultant who will do dental screening and who wants to provide in-service training to parents regarding dental health care.

Arrowhead
Fran Williams
218/749-2912

Arrowhead has held an appreciation dinner to thank all non-CAP or Head Start employees who have worked with the agency this year. Head Start invited all specialists who have worked with their special-needs children this year.

Arrowhead
John Vukelich
218/749-2912

*

NOTE

PLEASE FEEL FREE TO COPY THE MEDIATOR MEDIA TO DISTRIBUTE THROUGHOUT YOUR HEAD START/HOME START AGENCY - Parents - Aides - Teachers - Councils. THE NEWS IS FOR ALL!

*

At South Central Home Start, one of the public school speech clinicians conducted a one-day workshop for the staff and parents. "Teach Your Child to Talk" was a theme of this in-service which left all home visitors with materials and suggestions for day-to-day work with all children in the program. The moral of this story: You do not have to go to the Twin Cities for a good workshop. There are experts in your own back yard -- use them!

South Central
Shirley Fosness
507/235-3236

*

When Gillette Children's Hospital (in St. Paul) was closing down its preschool, it occurred to West Central that there must be some available surplus toys. The OCD-BEH Project helped negotiate a free exchange of toys and materials from Gillette to West Central -- would you believe an 8 foot tall stuffed dog? Thanks to Gillette

(continued, next column)

(continued from column one)
Hospital for their good will! And congratulations to West Central for their industriousness.

West Central
Chris Spaulding
218/685-4486

*

For some new ideas on record-keeping, contact Ottertail-Wadena. Returning from St. Louis, Missouri, the staff modified several record-keeping ideas discussed at the National Home Start Conference. Their new, revised forms, which include on-going logs and referral, follow-up checklists, have all been printed and are ready for use now.

Ottertail-Wadena
Roxanne Hartung
218/385-2900

*

How about a new twist with EPSDT? At Scott-Carver there are plans for some school clinicians to coordinate their speech/language screening with EPSDT clinics in late summer. That will make for a high-powered EPSDT clinic. And, four school speech clinicians met with Scott-Carver to plan next year's services.

Scott-Carver
Judy Nustad
612/448-2302

- -

FOR ADULTS ONLY

Because of the OCD-BEH Project's work and efforts for special-needs children in Minnesota Head Start/Home Start agencies, Dave Garwick and Fred Aden have been participating on one of the councils of the Minnesota Commission for the Handicapped. As a result, the following page is a questionaire regarding housing for handicapped people, as it came to the Project office.

Do you know of handicapped people who do not have adequate housing because of high cost, poor accessibility, or poor condition? If you do, please make a copy of the questionaire; have the handicapped people complete it and return it to the address given on the

(continued, next page)

(continued from page 8
questionaire. This is one effective way your Head Start/Home Start or Community Action Agency can outreach to the community. (Oops, the questionaire is not on this page. Try the next!)

- -

EXTRA

Congratulations to M&R ! A local health care provider began a meeting by saying she did not think people on welfare needed more free medical services -- that poor children get better medical care than the "rich" kids. By the end of the meeting, the Head Start director talked her into conducting two different and free, comprehensive screening clinics for two Head Start classrooms!

M&R
Marvin Rothfusz
507/647-2222

- -

HEAD START RIDES AGAIN

One year ago no one seemed aware of any EPSDT activity in Meeker and Wright counties. The health coordinator of Meeker-Wright inquired throughout the community and she became a member of a new EPSDT Advisory Board. After she attended the Head Start Health Roundtable, she returned to the Advisory Board with technical information received at the Roundtable. Result? EPSDT in Wright County will begin its first clinic operations in September, 1975.

Meeker-Wright
Jackie Marketon
612/658-4415

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The work presented herein was compiled and written pursuant to DHEW/OHD/OCD Grant No. 5118. The material does not necessarily reflect OCD position or policy. Official OCD endorsement should not be inferred.

APPENDIX 15

QUESTIONAIRE TO PROFESSIONALS PROVIDING SERVICES
TO MINNESOTA HEAD START/HOME START PROGRAMS

June 11, 1975

TO: Professionals providing services to Minnesota Head Start and/or Home Start Programs

FROM: The OCD-BEH Collaborative Project for Head Start/Home Start Children with Special Needs
Jon Boller, PH.D. Counseling Psychologist - Director
Fred Aden, M.A., Speech Pathologist
Dave Garwick, M.A., Speech Pathologist
Don Henry, PH.D., School Psychologist

We are sending you this questionaire to obtain information about the kinds of services that you have been providing this year to Head Start and/or Home Start children, staff, and parents. We obtained your name as a result of a random sampling of all health, mental health, social service and clinical speech professionals whom Minnesota Head Start and/or Home Start staffs have indicated as having provided some service to them this past year.

Our OCD-BEH Project is a federally funded demonstration project, the purpose of which is to assist Head Start and Home Start programs throughout Minnesota in their efforts to successfully integrate handicapped (or special needs) children into their programs. These programs have been mandated by the U.S. Congress to accomplish this goal.

One of our Project's main objectives has been to encourage and assist Head Start and Home Start programs to obtain direct services for children, staff, and parents from various specialists in their own communities or surrounding areas. Our intent in sending the enclosed questionaire is to obtain information which can be used to evaluate the above-mentioned objective and to guide our general efforts to facilitate collaborations between Head Start/Home Start programs and local service providers during the next program year. However, we hasten to add that individual responses to the questionaires will be kept completely confidential. Any sharing of information which might take place, or reports which might be written, will be done in terms of the entire state, and no individual names (i.e., specific Head Start/Home Start programs, specific resource agencies, or individual people) will be used.

Each Head Start or Home Start Director is aware that we are sending out this questionaire. Their staffs have also filled out a similar questionaire dealing with the types of services which they have received from you as well as other specialists. Again, this information will be kept confidential.

Please return your questionaire in the enclosed self-addressed envelope. Feel free to call us if you have any questions, concerns, etc. We estimate that it will take approximately 15-20 minutes to complete the questionaire.

Thank you for your time and cooperation.

Your Name _____

Your Profession _____

Agency that you work for _____

Address _____

Phone _____

1. For which Head Start or Home Start program did you provide service this year (1974-75)?

_____

Did you (or someone of your profession from your agency) provide service to this program last year (1973-74)? Yes_____ No_____ Don't know_____

2. If you provided service on-site in a Head Start Center (i.e., classroom) where was that center located? _____
Did you(or someone of your profession from your agency) provide on-site service in this center last year (1973-74)? Yes_____ No_____ Don't Know____

3. If you worked in the homes of children in a Home Start or Head Start program in what general area were these homes located? _____
Did you(or someone of your profession from your agency) provide on-site service in children's homes last year (1973-74)? Yes_____ No_____ Don't Know___

4. Who made the initial arrangements with you, or your supervisor, for your services this year (1974-75) (e.g., Head Start Teacher? Director? Health Coordinator? Professional Colleague?) _____
At what point in the school year were these arrangements made? _____

5. Which of the following services have you provided this year (1974-75):

a. observed children: ____yes ____no
(if "yes", where?)
____in the center
____in the children's homes
____in your office
____other _____

b. met with teachers to discuss ways of working with individual children:
____yes ____no
(if "yes", where?)
____in the center
____in the children's homes
____in your office
____other _____

c. met with teachers to help plan things like curriculum activities, uses of space and equipment, scheduling of activities for all the children, etc.: ____yes ____no

d. provided the kind of service to teachers in b. and c. above, but mainly by phone or other written communications:
____yes ____no

e. provided in-service training to groups:
____yes ____no
(if "yes", to whom?)
____staff
____parents
____both

f. provided screening services for children:

____yes ____no

(if "yes", where?) ____in the center

____in the children's homes

____at your office

____other _____

g. provided more complete diagnostic testing of children:

____yes ____no

(if "yes", where?) ____in the center

____in the children's homes

____at your office

____other _____

h. provided direct service (teaching, speech therapy, counseling, health service) to individual children:

____yes ____no

(if "yes", where?) ____in the center

____in the children's homes

____at your office

____other _____

were teachers ever present? ____yes ____no

were parents ever present? ____yes ____no

i. provided counseling to parents regarding how they might work with their children, or other matters: ____yes ____no

(if "yes", were teachers ever present?) ____yes ____no

j. provided consultation at Head Start or Home Start "Mediator" (Case Management) Team meetings: ____yes ____no

k. provided assistance in identifying and recruiting other specialists to work with Head Start or Home Start children, staff, and/or families:

____yes ____no

If "yes", could you give an example: _____

_____

_____

6. If you (or someone of your profession from your agency) provided services to Head Start or Home Start last year, did you do any new things this year? That is, were any of the above services (a. - k.) different from last year?

____yes ____no ____don't know

(If "yes", please check the letter of the new services offered).

a.___ b.___ c.___ d.___ e.___ f.___ g.___ h.___ i.___ j.___ k.___

Comment if you can recall any other new or different services offered this year:

_____

_____

APPENDIX 16

QUESTIONAIRE TO MINNESOTA HEAD START/HOME START PERSONNEL REGARDING PROFESSIONAL SERVICES PROVIDED TO THEIR PROGRAMS 1974-1975

SPECIALIST INFORMATION

Name of specialist_____

Type of specialist_____

Agency specialist works for_____

Address_____

Phone_____

1. Did someone outside of your program recommend this specialist to you? (yes___) (no___) (don't know___)
If "yes," who

2. In which Head Start center or centers did the specialist work? _____

_____

3. Home address of head teacher: (name, address, zip code)

_____

_____

Other teachers:

_____

_____

4. Did a teacher or other staff person (director, coordinator) make the initial arrangements for service from this specialist? _____

5. Was service provided to you or your children last year either by this specialist, or another specialist of the same profession from the same resource agency?
(yes___) (no___) (don't know___)

6. This year (1974-75) has this specialist done the following:

a/ observed children: ___yes ___no
(if "yes," where?)

___in the center
___in the home
___at specialist's office
___not sure

b/ met with teachers to discuss ways of working with individual children: ___yes ___no
(if "yes," where?)

___in the center
___in the home
___at specialist's office
___not sure

c/ met with teachers to help plan things like curriculum activities, uses of space and equipment, scheduling of activities for all the children, etc.:

___yes
___no
___don't know

d/ provided the kind of service to teachers in b/ and c/ above, but mainly by phone or other written communications:

___yes
___no
___don't know

e/ provided in-service training to groups:

(if "yes," to whom?)
___agency staff
___parents
___both
___not sure

___yes
___no
___don't know

f/ provided screening services for children:

(if "yes," where?)
___in the center
___in the home
___at specialist's office
___not sure

___yes
___no
___not sure

g/ provided more <u>complete</u> diagnostic testing of children:

(if "yes," where?)
___in the center
___in the home
___at specialist's office
___not sure

___yes
___no
___don't know

h/ provided direct service (teaching, speech therapy, counseling) to individual children:

(if "yes," where?)
___in the center
___in the home
___at specialist's office
___not sure

___yes
___no
___don't know

were teachers ever present? ___yes ___no ___don't know

were parents ever present? ___yes ___no ___don't know

i/ provided counseling to parents regarding how they might work with their children, or other matters:

(if "yes," were teachers ever present?)
___yes
___no
___don't know

___yes
___no
___don't know

j/ provided consultation at Head Start Mediator Team meetings:

___yes
___no
___don't know

(a.-k.), which of these services would you prefer to spend the most time providing?

(Order from 1 through 11 according to your preferences)

___a) observation
___b) teacher consultation re: individual children
___c) teacher consultation re: overall classroom management
___d) b. and c. mainly by phone or written communication
___e) in-service training
___f) screening
___g) diagnostic testing
___h) individual therapy, teaching, health services, etc., to children
___i) counseling parents
___j) consultation to the case management team
___k) recruiting other specialists

8. If you provided on-site services in centers or children's homes this year, approximately how often did you make visits:

____less than once every two months

____once every two months

____once a month

____once every other week

____once a week

____more than once a week

9. According to your impressions, what kinds of services did you provide this year that the children, staff, and/or parents had the most need for and received the most assistance from?

_____

_____

_____

_____

_____

10. Again, according to your impressions, could you have done other things that would have been helpful:

_____

_____

_____

_____

_____

THANK YOU FOR YOUR COMMENTS AND TIME!

k/ provided assistance in identifying and recruiting other specialists to work with your children and/or families:

___yes ___no ___don't know

If "yes," could you give an example: _____

_____

_____

11. If this specialist (or someone of the same profession) provided services to your children or to you last year, did he/she do any new things this year? That is, were any of the above services (a/ - k/) different from last year?

(If "yes," please check the letter of the new services offerred).

___yes
___no
___don't know

a/___ b/___ c/___ d/___ e/___ f/___ g/___ h/___ i/___ j/___ k/___

Comment if you can recall any other new or different services offerred this year: _____

_____

12. If this specialist visited your center this year, approximately how often did he/she make visits:

___less than once every two months
___once every two months
___once a month
___once every other week
___once a week
___more than once a week

13. In your own words, what kinds of things did this specialist do that you found most helpful:

_____

_____

_____

_____

_____

14. Again, in your own words, could the specialist have done other things that would have been helpful to you:

_____

_____

_____

_____

_____

THANK YOU FOR YOUR COMMENTS AND TIME; THIS INFORMATION WILL HELP US TO BETTER ASSIST YOU IN THE FUTURE.

the OCD-BEH project
st.paul, mn.

the OCD-BEH project
the governor's office of economic opportunity . . 104 metro square bldg.
st. paul, mn. 55101

TO: Minnesota Head Start Personnel

FROM: The OCD-BEH Collaborative Project
for Head Start Children with Special Needs
Jon Boller, Fred Aden, Dave Garwick, Don Henry

We are sending you this questionnaire to obtain information about the kinds of services that you have been receiving this year from non-Head Start specialists (for example; nurses, psychologists, speech clinicians, social workers, etc.). We want to find out how many specialist services have been provided to Head Start programs throughout Minnesota. One of our Project's main objectives is to help Head Start programs obtain more of these kinds of service. We hope to use your information to help meet that objective.

You will find the name of a specialist who has provided service to you on the first line of the questionnaire. The remaining lines and questions are to be filled in or answered by you.

Your responses to the questionnaire will be kept completely confidential. Any reports that might be made will be done in terms of the entire state, and no names (Head Start agencies, resource agencies or individual people) will be used.

Please return your questionnaire in the enclosed self-addressed envelope.

Thank you for your time and cooperation.

jon boller 612-296-5753
don henry 5751
fred aden 5751
dave garwick 5752

APPENDIX 17

FY76 COLLABORATION
MINNESOTA OCD-BEH PROJECT/
MINNESOTA DEPARTMENT OF EDUCATION-
UNISTAPS PROJECT

FY76 COLLABORATION

Minnesota OCD-BEH Project/
Minnesota Department of Education-
UNISTAPS Project

JUNE 17, 1976

This report is written persuant to the obligations assumed by the Minnesota OCD-BEH Collaborative Project, Minnesota Office of Economic Opportunity (Division of Economic Opportunity, Governor's Manpower Office), in an intergovernmental agreement:

Account ID, 498410
Revenue, 134446
Activity, 380

HISTORY OF COLLABORATION
Minnesota OCD-BEH Project and the UNISTAPS Project

In July, 1974 the Minnesota OCD-BEH Collaborative Project undertook a demonstration effort to expose selected people in thirty-five Minnesota Head Start/Home Start agencies to a system to integrate special needs (handicapped) children. (The OCD-BEH Project is one of fourteen demonstration projects funded by the Office of Child Development following a 1972 Congressional mandate that Head Start make available at least ten percent of its enrollment slots to handicapped children.) The system suggested by the OCD-BEH Project had at its core the development of a case management team in each Head Start/Home Start agency in Minnesota. The name given to the team in this case management approach was "Mediator Team". In fact, most Head Start/Home Start agencies in the state did choose to try the Mediator Team approach.

Case management was interpreted to mean that an agency's Mediator Team had the responsibility to ensure (1) that all children were screened (physical and developmental), (2) that those who failed screening were comprehensively assessed, (3) that the treatment plan attempted to ensure integration into the classroom/home learning setting, and (4) that there was specific planning to enhance the child's transition from the Head Start/Home Start program to the public school (or next educational setting).

An essential part of the Mediator Team concept was that an agency Team needed to coordinate resources within the agency and to recruit specialist resources in the community to accomplish the case management goals. More specifically, the Team needed to recruit specialists such as psychologists, speech pathologists, nurses, social workers, SLBP personnel, and other special educators. In Minnesota, the principle employer of such specialists is the public school district.

The "collaborative" aspect of the OCD-BEH Collaborative Project name was to materialize as a direct collaboration between the OCD-BEH Project and the Minnesota UNISTAPS Project, with the enhancement of the integration of special needs Head Start children as the goal. During FY75 the UNISTAPS Project offered training slots at workshops, on-site teacher and parent training, and observation/assessment of some special needs children at the UNISTAPS laboratory site in the Minneapolis Public Schools. These collaborative efforts were well received by Head Start and they greatly enhanced the group and on-site training that the OCD-BEH Project staff provided to the agencies.

This history of collaboration led to the additional collaboration in FY76 that is described in this report.

OVERVIEW OF COLLABORATION FY76

The goal of FY76 collaboration between the OCD-BEH Project and the UNISTAPS Project is outlined in the "Inter-Governmental Agency Agreement" to which this report is addressed. The stated goal was:

> "To enhance and build upon previous collaborative efforts at three Minnesota Head Start sites which have demonstrated the potential and capacity for using the Mediator Team concept effectively."

As has been stated, the effectiveness of a Mediator Team within a Head Start agency is determined in part on the community-level collaborations the agency and Team develop with resource specialists. The primary agency housing these specialists in most communities is the public school. Therefore, an extension of the goal statement is:

> "The goal is to demonstrate viable linkages between Head Start and the Minnesota public education system for delivery of educational services to preschool handicapped children."

The OCD-BEH Project and the UNISTAPS Project agreed upon six collaborative activity statements. For the agreed-upon sum [three thousand dollars($3,000)], the OCD-BEH Project staff would complete the following activities:

1. Planning meetings with Mediator Team staff, public school special education administrators, and support specialists;

2. Monitoring and reporting case histories of six children as managed and acted upon by the Mediator Teams at selected Head Start programs, with the assistance of local specialists;

3. Training activities relating to further improving the connections between Mediator Team staff and public school special education staff, support specialists, state agencies, etc.;

4. Training guide relating to practical inter-agency collaboration for effective case management of preschool special needs children;

5. Shall submit to the Department of Education a detailed account of all expenditures for each of the above activities;

6. Shall submit a written report summarizing the results of the activities performed and an evaluation of each of the four major activities.

This entire report is written to satisfy activity #6.

COLLABORATIVE ACTIVITY 1

Planning meetings were conducted with the three agencies which continued to receive the help of the OCD-BEH Project during FY76. These agencies were assigned to the Project by the Region V Office of Child Development. In the previous year, each of the three Head Start or Home Start agencies had made some efforts to acquire more services for their special needs children, and in each case the primary resource was the public school. Nevertheless, these relationships between the Head Start/Home Start programs and the public schools needed to be strengthened.

Two of the agencies, Goodhue-Rice-Wabasha and Inter-County, are the grantees of the local Community Action Agency and, therefore, they have no direct relationship with the local public school districts. One agency, Duluth, is located entirely within the public school system and the public school district is the delegate agency for the local Community Action Agency.

Travel and staff time were encumbered by the OCD-BEH Project to provide information and consultation specific to strengthening Head Start/Home Start and public school joint efforts for special needs children. The descriptions of these joint efforts and the descriptive case studies which follow may be the best evaluations of the outcomes of the effort. The descriptions are not designated by the name of the agency or the children, in order to provide additional protection of confidentiality. The intricate and strong relationships that have been developed in three locations in Minnesota are definitely reflected. It should be pointed out that other Head Start/Home Start agencies and independent school districts in Minnesota have developed relationships which are equally exemplary.

DESCRIPTIONS OF PRACTICAL COLLABORATIONS:

Agency A:
The developmental screening of all children is accomplished by the joint efforts of the teaching staff of the agency and the direct screening testing of special education cooperative personnel. Information is shared at a Mediator Team meeting and plans for the further assessment of some

children are made. Even at this point the teachers are given some prescriptive information on a few children. The special education cooperative personnel conduct most evaluations and offer more prescriptions. The special educators include speech clinicians, psychologists, and SLBP specialists. The teaching and administrative staff of the Head Start agency continue to meet as a Mediator Team once a month. During these meetings the special needs children are periodically staffed and necessary assignments are made to staff members. Special education cooperative staff, meanwhile, provide some individual or small group services and maintain periodic contact with the teacher. Another large Mediator Team meeting is held during the year with all teaching and special education cooperative staff in order to provide more follow-up and to plan for unmet needs. Formal arrangements are being made with the future kindergarten teachers of most of the special needs children to discuss their entry into public school. Special education cooperative staff are aware of all of these children and, when possible, they will sit in on the meeting between the Head Start staff and the kindergarten teacher.

Agency B:
This agency has several Mediator Teams, each comprised of teaching personnel from one classroom and the special education personnel assigned to that location (nurse, psychologist, social worker, and speech clinician). Most developmental screening is done by these special educators, supplemented by the observations of the classroom teacher. Attendance of all special education personnel at the monthly Mediator Team meetings is not complete, but assignments may be made during a staffing which continue to involve an absent specialist. Staffings in this agency produce fewer prescriptions for the teachers. The clinical specialists tend to see many special needs children individually or in small groups outside of the classroom. Efforts are underway to formalize meetings between Head Start teaching staff and kindergarten teachers who will have the children next school year. Previously this kind of formal exchange of information has been left to the initiative of the Head Start teacher or the kindergarten teacher.

Agency C:
This agency has strong working relationships with individual special education personnel. These individuals include school speech clinicians, psychologists, SLBP specialists, and a special education director. Other special education personnel who do not work for school districts are also working with this Head Start agency. The Mediator Team at this agency has undergone recent reorganization and more specialists are likely to be directly involved in these meetings in the future. Teaching staff conduct most of the developmental screening of all children. However, clinical speech and language people do see most of the children for a screening procedure in the fall. Prescriptions for classroom activities go directly from the clinical specialists to the classroom teacher, in most cases. Some children are seen for individual or small group procedures, with reports going to the classroom teacher. The exchange of information between the Head Start teacher and next year's kindergarten teacher is not formalized as yet. This kind of exchange does occur for approximately half of the special needs children; a more formal approach is planned for next year.

COLLABORATIVE ACTIVITY 2

In order to further reflect the intricate and strong relationships these three Head Start/Home Start agencies have with school special education personnel, the following case studies are given. The case studies should help to broaden the reader's view of the local collaborations. They were written by Head Start/Home Start personnel (with parent permission); only minor editing was performed by OCD-BEH Project staff, in most cases.

CASE STUDIES:

Case Study A:

This last year was the second year this four year old child was enrolled in our program. He has physical handicaps of oral structure, hands and feet. The child was initially referred to our program by the county nursing service. When he was enrolled in the program it was quite obvious that his speech and language were delayed. Not only was his speech difficult to understand, but the act of speaking was extremely difficult for him. As he had previously had some serious choking problems, he was not yet eating solid foods. At this time he was fitted with adaptive shoes and an ankle brace, and he was visiting an orthopedic surgeon regularly.

During the first year he was enrolled in our program, he was referred to a Crippled Children Services Field Clinic for a speech and language evaluation. This resulted in several other referrals ending with a thorough diagnostic evaluation at a rehabilitation hospital. This evaluation occurred in the summer between our program years. Also, during this first year the local speech clinician from the child's school district saw the child a few times and gave the home visitor recommendations for activities.

In September of this program year the home visitor again began making visits. The parents discussed the rehabilitation hospital visit with her and informed her of the suggested home programs for speech, feeding and use of hands. As the child had only received home visits the first year in the program, arrangements had to be set up at this time for the child to attend center based activities. (The center

based activities are offered to the children the year before kindergarten and are held twice a month at a local kindergarten room.) Because of the child's susceptibility to choking, the parents were quite concerned as to how the center based activities would be conducted.

Also, early in September, the rehabilitation hospital requested that the Instructional Services Specialist from the special education cooperative attend a team staffing regarding the hospital's recommendations for the child. After this staffing a meeting was arranged by both the Instructional Services Specialist and the Home Start education coordinator. The parents, Home Start home visitor, Home Start health coordinator, school speech clinician, school nurse, elementary principal and the Instructional Services Specialist were present. The details for a cooperative effort between the Home Start program and the school for serving the child were worked out then. The home visitor would transport the child to the school where he would have a session with the speech clinician before participating in the center based activites. He would ride the school bus home with his older siblings. The parents were assured that the school nurse would be readily available if she were needed during the center based activities. The home visitor and speech clinician also planned to meet after each center base to discuss activities for a carry-over speech program. It was decided to have a similar meeting in December to follow up the progress.

The December follow up meeting was held with the parents, Home Start home visitor, Home Start health coordinator, school nurse, speech clinician, principal, Instructional Services Specialist and Rehabilitation Specialist from the special education cooperative present. The primary purpose of the meeting was to evaluate how well the arrangements were working. The parents reported how the home activities were progressing, that they were well satisfied with the arrangements and that their child was making a great deal of progress. The Rehabilitation Specialist made a few suggestions for activities which would develop more hand strength and better fine motor skills.

After this meeting the home visitor and speech coordinator continued their bi-weekly conferences and the child's progress was followed at Home Start Mediator Team meetings.

A May meeting is planned at which time the child's transition to the school will be discussed and the child's health and education records will be transferred to the school. The parents, Home Start visitor, Home Start education coordinator, Home Start health coordinator, kindergarten teacher, school nurse, principal and Instructional Services Specialist will attend.

Case Study B:
This child was born with a bilateral cleft palate, strabismus, a hernia and a cardiac lesion. The child's cleft palate was repaired and he was referred to another section of the clinic for evaluation of speech difficulties.

According to the clinic, the child's speech was judged to be generally unintelligible. Resonance characteristics were difficult to assess due to lack of consonant production. However, it was felt that some degree of hypernasality was present. Articulation was characterized primarily by vowels and the substitution of the nasal consonant "m" for a variety of sounds. Fricative and plosive consonants generally were not attempted, and tongue placement for these sounds was poor. Tongue constriction was not made anteriorly but more of a posterior pattern was observed. A speech pathologist from another clinic found hypernasality to be present in the voice.

The child has been seen for speech therapy in the public schools by a speech pathologist for two years. This year the child was enrolled in a four day week Head Start program. The child has been re-enrolled for next year and will continue with the speech therapy program in the schools.

The child was seen by a plastic surgeon who recommended a cineradiographic study of the palate and oropharynx. Through the Head Start program the child was checked by a dentist and given a flouride treatment. No cavities were found. Also through the Head Start program the child received a vision and hearing screening done by the county nurse. It was recommended that the child be rescreened. The parents are following-up in May.

A school psychologist did an overall evaluation of the child. The follow-up is being done by Head Start's SLBP technician. This technician

developed prescriptive techniques and materials to be utilized in the classroom and home and assists the parents to carry out the plan.

The parents felt that their child had become a behavior problem and requested help. Upon Head Start's referral, the school psychologist observed the child in the Head Start center and then conferred with the parents. The psychologist recommended that the Head Start teacher and the parents chart his activities and how he deals with them. Further conferences were set up with the psychologist, parents and the Head Start staff.

This child is seen on a regular basis at a clinic by a panel comprised of a surgeon, two speech pathologists, a pedologist, an orthodontist and a prosthodontist. The child is also seen at a university clinic. The family doctor is in consultation with the family and other specialists.

Case Study C:
This case study is of twin sisters. G. and J. were admitted to Head Start in February of 1975. They were screened at the preschool speech and hearing clinic conducted by school speech clinicians and they were marked as top priority for admission to the program because of a total lack of understanding of verbal language. The girls had developed a "language" between themselves. After being admitted to Head Start they received speech help until the end of May. The school speech clinician advised that the girls be admitted to the public school summer speech program.

In October they joined Head Start again as they were still four. They had progressed to naming objects and answering questions in one or two word sentences. By December, both girls were talking in complete sentences. An aid to their speech development was the fact that the girls now knew the rules and they were called on by the other classmates to help with games and rules. The girls also gained a better individual identity because the classmates called them by name which promoted language. This gave the girls confidence to participate in large group discussions. Without the help of the Mediator Team, including school specialists, to keep track of the girls and to ensure that all of the people on the team knew what progress was being made, the girls would have had an even later

start on their progress in preparation for kindergarten. Now in the spring of 1976 the girls have gained to the point of other five year olds ready for kindergarten.

Case Study D:
This girl entered the Head Start program in October, 1975 at age four. It was immediately apparent that she had special needs, probably stemming from a combination of factors. Her behaviors were brought to the attention of the Mediator Team, composed of Head Start staff (teacher, aide, and community aide) and public school specialists (nurse, social worker, and speech clinician).

It was hoped that the parents would take their daughter to a local Early and Periodic Screening, Diagnosis and Treatment (EPSDT) clinic, but they refused to do so. They chose to take her to their family doctor and his evaluation revealed no special needs or directions for working with her. Therefore, the Mediator Team decided to document her various behaviors and set up a consistent pattern for modification. Her most troublesome behavior was targeted as the first behavior to try to change. The parents did cooperate on this matter by trying to handle the behavior in the same way the Head Start staff did.

Several Mediator Team resources helped set-up the behavior modification and skill teaching program for her. These people included the school nurse, psychologist, speech clinician, social worker, and principal. Another psychologist from a community mental health center also observed her and offered suggestions. The Mediator Team also decided to assign a special resource aide for the handicapped to the case. This one-to-one assignment was made in an attempt to have one person with the girl during any activity for a large portion of each morning. Still a lot of her behavior persisted (frequent masturbation, talking and singing to herself, and rocking back-and-forth).

The involvement of Mediator Team members with the parents had been consistent throughout, with several visits made to the home by the teacher, community aide, school social worker, and school nurse. Throughout most of the year the parents refused to consent to the suggestions of having a complete assessment performed at a clinic or the idea of retaining her in Head Start for one year. At this time the parents have consented only to take their daughter back to their family doctor (kindergarten

physical examination) and to a rehabilitation center for a "gross motor" evaluation. She will enter kindergarten next fall. Obviously, what the teaching staff and the Mediator Team has been able to accomplish is not complete. But a lot has been done to manage this girl's behavior and teach her some new skills. Hopefully the parents will change their attitudes about schools and specialists so that their daughter can be even more successfully integrated into her kindergarten class.

Case Study E:
This boy turned five years of age early in November. He had originally been referred to Head Start by the social worker employed by the county welfare agency. It seems that the welfare agency had been trying to work with the family over a period of five years with little success. During this five year period the target had been to involve the parents in counseling provided by a local mental health center. The referral of the boy to Head Start now indicated a new concern.

During the first few days of the program year the teacher met with the social worker. She learned, in addition to the above, that it was becoming increasingly difficult to get into the home for any reason. Since the Head Start's program was largely home-based, the family's reluctance to let anyone in the home could seriously affect any program efforts.

The first Mediator Team meeting to discuss this boy's case involved the teacher, a school psychologist and speech clinician from the special education cooperative, a clinical psychologist from the mental health center, the director, health coordinator, and education coordinator from the Head Start program, and the social worker from the welfare unit. Various descriptions included the facts that the child was still being dressed in diapers (often nothing else), he seemed to have almost no speech, and he generally exhibited "strange" behavior. The mother appeared to be a fairly withdrawn person -- and withdrawn from her child and the living environment. The teacher's attempt to conduct an initial skills inventory through parent interview was not successful. And it seemed that hot meals were a rare thing in the home.

The mother allowed her son to enter Head Start, but she participated little when the teacher came to the home, in spite of various types of encouragement.

She would not allow her son to participate in center-based activities unless she was in the room with him. Nevertheless, there seemed to be some "breakthrough" in the sense that the teacher was the first person who had been allowed in the home for two years.

In November the Head Start Mediator Team decided that another meeting was necessary with the welfare department and other specialists. The meeting was attended by the welfare social worker, the school psychologist, the clinical psychologist, and the director, teacher, health coordinator, and education coordinator from the Head Start program. The group attempted to arrange priorities: (1) the grossly substandard housing problem had to be solved; (2) the family was in need of financial management help; (3) the mother was in need of the help of a homemaker to learn housekeeping and meal preparation skills. As it turned out, the only item the welfare department was willing to address was the housing issue.

Some positive factors developed. The family was moved to a better house. The mother was finally persuaded to let her son attend center-based activities without her direct supervision. In fact, she consented to let him ride the bus to center-base. He began to learn new skills and to increase his rate of learning. He began to act more independently with his peers and adults.

The team meeting to plan for his transition from Head Start was attended by the afore mentioned Head Start staff and the school social worker and psychologist. Although the boy would go to parochial kindergarten in the fall, the team discussed his completed program and recommended regular kindergarten placement (mornings) and day care (afternoons) for the coming year. In addition, the parochial school kindergarten teacher volunteered to begin working with the boy during the last few weeks of the summer --- before school began for all children.

Case Study F:
This is a case study of a boy who was four when he entered the Home Start program. His case turned out to be fairly uncomplicated --- but initially it appeared to the Home Start staff and to the mother that something had to be done before the boy's

uncooperative behavior did become more difficult and in-grained.

The home visitor had gone to the home for her first visits and she had found the boy very uncooperative. That is, he would not talk to her, he refused to perform any simple tasks, he occasionally lashed out at her physically --- generally refusing to cooperate. The mother seemed exasperated with his behavior, indicating that he did such things often with her and she did not know how to handle the situations.

The first Mediator Team meeting occurred after the teacher had made four home visits and had been unsuccessful at changing the boy's behavior. She asked for help. The meeting was attended by the teacher, the Home Start director, health coordinator, and education coordinator, and by the school speech clinician and psychologist. It was decided that the school psychologist would make home visits with the teacher. The mother agreed enthusiastically with this arrangement.

The school psychologist made three visits to the home. He worked with the mother and the boy, using a very basic written guide which concentrated on one negative behavior and one technique at a time to change the behavior. The mother read and applied the material (with the benefit of demonstrations from the psychologist). The teacher and mother continued to work with the boy, and the teacher consulted frequently with the psychologist.

By the time of the next Mediator Team meeting (one month later), dramatic changes were seen in the boy's behavior. He was fairly cooperative and he was learning new skills. Additional follow-up was requested at the next two Mediator Team meetings. But there were no problems to report. In addition, the school psychologist made two more home visits to follow-up with the mother. It was obvious that the mother had learned a great deal about managing the behavior of her own son.

The team meeting to plan transition to public school involved the kindergarten teacher, school social worker, the Home Start teacher, and Home Start health coordinator. The team reviewed the boy's initial behaviors and the changes that were made. However, now the primary focus (for the benefit of the kindergarten teacher) was on the very adequate skill levels he had attained.

COLLABORATIVE ACTIVITY 3

Training activities for Collaborative Activity 3 took the form more of area-wide planning by Head Start personnel and others for the physical and developmental screening of children than the form of traditional in-service training. In a sense, it might be called "systems" training for coordination.

The focal point of this activity was the development of an exemplary collaboration of agencies at three levels for implementation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The first level, from which the collaboration eminated, was the Advisory Council to the Minnesota EPSDT program. At this level are involved representatives from State Departments of Welfare, Health, and Education as well as representatives from Head Start (an OCD-BEH Project staff member), day care, parent advocacy groups, state councils (Handicapped, Developmental Disabilities), providers of EPSDT screening, and others. The collaboration of similar groups, however, did not appear to be taking place at the local (regional or county) levels. The EPSDT Advisory Council determined that local collaboration might take place if some Advisory Council members acted together as a catalyst to develop demonstration/exemplary collaboration at three or four local sites. The UNISTAPS financial collaboration with the OCD-BEH Project allowed the OCD-BEH staff member to participate in this effort.

The second level of collaboration took place at a meeting called by an Advisory Council member (State Department of Education-UNISTAPS). At this meeting there were representatives of school districts, special educators, Head Start (OCD-BEH staff person), county nursing services, and welfare.

At this point it should be noted that several agencies have some responsibility to screen children. The Welfare and Health Departments have collaborated to develop EPSDT screening in Minnesota in order to meet the federal mandate to implement the EPSDT system. Public school systems have a responsibility according to state and national laws to provide some type of screening system to identify handicapped children. Head Start must screen children as part of the national Head Start Performance Standards. In other words, combining financial and staff resources, the agencies and programs mandated to screen children might be able to screen all targeted children at minimal cost to each and with minimal

(or no) duplication of efforts.

One of the demonstration/exemplary collaboration sites chosen was Cass County. Those chosen to guide this collaboration included representatives from the State Departments of Welfare, Health, Education (UNISTAPS), and Head Start (OCD-BEH). The local organizer was a social worker for the Cass County Social Services Department who was also the child care coordinator for the county.

The third level of collaboration, then was the county level; those mentioned in the previous paragraph acted as facilitators at a meeting in Walker, Minnesota on March 2, 1976. Attending the meeting were the facilitators and representatives from the administrations of six school districts, two special education cooperatives, two Head Start agencies, Cass County Public Health Nursing Services, and Cass County Social Services Department. Most representatives were receptive to the idea of coordinating their efforts to provide EPSDT screening. However, several were unclear as to how this practical level of coordination/collaboration would take place and how financial responsibility/payments would be assigned. The group was sufficiently cohesive to vote to continue meeting at the local level.

Most follow-up regarding the local developments since March has been provided by the OCD-BEH Project staff person; the information has been transmitted to the state EPSDT Advisory Council. The status report is this. Head Start, county public health nursing, and school district representatives have met with the county social services worker as chairman. School district personnel reportedly began to "back-off", questioning space and personnel costs/allotments. However, at the suggestion of one nurse, the group decided to begin planning two demonstration/training sites. One site would be located in a school district in the northern part of the county and one site would be in a school district in the southern part. As yet the sites have not become operating EPSDT screening clinics. This limited operating plan met with more favor than a proposal to begin county-wide. Those who initially expressed some reservations began to offer suggestions for different screening methods and for increasing the screening population. The group may stay together as an on-going committee.

According to the social services worker, the programmatic responsibilities of the different agencies has not surfaced within the group as a prime reason for collaborating, even though this was pointed out by the original

facilitators of the Cass County demonstration. This was reviewed again for the social services worker.

This social services worker expressed an additional need which was reported to the EPSDT Advisory Council. The need is for some person(s) at the state level to work out examples of how the agencies' collaboration can be a mutually beneficial financial collaboration as well as an efficient way to meet programmatic responsibilities. In other words, state reimbursement for EPSDT screening could pay most costs. School districts could provide space and some special educators or other personnel to perform some of the developmental screening. Head Start could provide space and personnel. These "in-kind" contributions would be a minimum cost for the provider compared to attempts to operate individual, complete screening operations. The state EPSDT coordinators and two Advisory Council members will provide the required information and they will be available for a planning meeting in Walker. This meeting will probably occur in August, 1976.

COLLABORATIVE ACTIVITY 4

The training guide which is designed to help Head Start/Home Start agencies provide for better case management and practical interagency collaboration is the revised edition of the Mediator's Handbook. The Handbook, now being printed, will be distributed to all Minnesota Head Start/Home Start programs, Special Education Regional Consultants, and to UNISTAPS staff in the Minnesota Department of Education, Special and Compensatory Education Section.

It is believed by the authors that this revision is more comprehensive and readable than the original Handbook. The entire Handbook speaks to the scope of case management for special needs children. Included in this is the stated need to recruit and use local specialist resources in the most effective and efficient manner. It is important that the collaboration between the OCD-BEH Project and the UNISTAPS Project is allowing for wider distribution of the Handbook than would have otherwise been possible.

COLLABORATIVE ACTIVITY 5

As per the Inter-Governmental Agency Agreement and the specific request of the UNISTAPS Project Director, the following is a general itemization of expenditures:

	Travel	Staff Time	Equipment/ Supplies
Collaborative Activity 1	$350	$700	----
Collaborative Activity 2	----	$200	$25
Collaborative Activity 3	$200	$400	$50
Collaborative Activity 4	----	$550	$300
Collaborative Activity 6	----	$200	$25
TOTALS	$550	$2050	$400

APPENDIX 18

PROTOTYPES OF MEDIATOR TEAM RECORDING FORMS

MEDIATOR TEAM MEETING PROCESS

I.
STATEMENT OF THE PROBLEM

II.
GATHERING INFORMATION FROM ALL TEAM MEMBERS

III.
CHOOSING ALTERNATIVE SOLUTION(S)

IV.
ASSIGNING RESPONSIBILITIES TO TEAM MEMBERS

MEDIATOR TEAM STAFFING

DATE _____

Plan for _____ :
(Child's Name)

Responsibilities of---

Teacher:

Education Director:

Parent Coordinator:

Social Service Director:

Health Coordinator:

Parent:

Specialist:

FORM FOR MEDIATOR TEAM

DATE _____

Center I ☐	Center IV ☐	Center VII ☐	Center X ☐
Center II ☐	Center V ☐	Center VIII ☐	Center XI ☐
Center III ☐	Center VI ☐	Center IX ☐	Center XII ☐

Persons Attending:

Children Discussed:

Other items of concern:

APPENDIX 19

TRANSITION TRAINING PACKET
1975-1976

TRANSITION ACTIVITIES TO BE CONSIDERED
WITH SPECIAL EMPHASIS ON THE TRANSITION OF SPECIAL-NEEDS
CHILDREN FROM HEAD START/HOME START TO THEIR
NEXT EDUCATIONAL SETTING

1. Introduce the kindergarten teachers to the parents.

2. Introduce the kindergarten teachers to all the children.

3. Give an outline of this year's curriculum activities for all children to the next education agency.

4. Get the fully informed, written consent of all parents or guardians to release information to anyone in the child's next educational setting. This must be done prior to talking to kindergarten teachers, specialists, etc. about children and prior to exchanging written information, if the information is personally identifiable. A "Release of Information" form must be specific about "who" is releasing "what" information "to whom" for "what purpose." This must be done for each piece of specialist information released and each set of Head Start/Home Start produced information.

   EXAMPLE OF A RELEASE OF INFORMATION FORM THAT PROBABLY MEETS ALL FEDERAL GUIDELINES:

   I give permission for the (agency name)

   to release:

   (name or names of reports or information)

   _____

   _____

   about my child (child's name) to

   (name of person and that person's agency) at

   (full address of that agency).

   This permission is given only for the following dates: _____ to _____.

   I understand that I have the right to view all of these records and to obtain copies of them if I so desire.

   Signed (parent or guardian)

   Witness (name of witness)

   Date (date signed)

5. Once parents have given their fully informed, written consent to release information, it may be important to talk with the kindergarten teachers and/or special education personnel and/or school administrators about these kinds of things:

   a. History of the child's association with Head Start/Home Start;

   b. Screening and diagnostic information collected;

   c. Any diagnostic/therapy referrals which were not followed through;

   d. What the special-needs child's specific educational program has been, with integration as a special focus;

   e. Any special problems or successes the child may have had learning;

   f. Any special problems or successes the teacher had integrating the child into the classroom or home activities;

   g. The child's entry levels of skill development as compared to current skill levels;

   h. Any special services provided the child, the teacher, or the parents which were directly related to the child's educational program;

   i. Any special activities or techniques the Head Start/Home Start teacher has used that have been especially helpful.

TRANSITION ARRANGEMENTS

SPRING -- With Fully Informed, Written Parental Consent

1. Parents must at least be informed of the Mediator Team meetings dealing with the transition efforts for their child. Parents should be invited to participate in the portion of the Mediator Team meeting(s) devoted to discussing transition arrangements for their child.

2. Invite the kindergarten teacher to a spring open-house to meet parents.

3. Mediator Team members and teachers could visit the kindergarten teachers at each school (e.g., once a week the last couple of months).

4. Head Start/Home Start could invite the kindergarten teacher to meet with the Mediator Team and Head Start/Home Start teachers.

5. Meet with kindergarten teachers on a cluster basis.

6. Meet together with the kindergarten teachers and special education personnel who have served the child while he/she was in Head Start/Home Start.

7. Meet with special education personnel --- such as members of a special education department or cooperative (e.g., psychologist, speech clinician, SLD specialist, specialist in retardation, etc.).

8. Parents could meet with kindergarten teachers -- accompanied by the Head Start/Home Start teacher, the Mediator Team, etc.

9.

FALL -- With Fully Informed, Written Parental Consent

1. Follow-up call by Mediator Team and/or teacher to the kindergarten teacher within 2-3 weeks of the beginning of the next school year

2. Follow-up visit by Mediator Team and/or teacher to the kindergarten teacher within 1-2 months of the beginning of the next school year

THE DEVELOPMENT AND USE OF ANECDOTAL RECORDS

GUIDELINES

Purpose of Anecdotal Records

Anecdotal records shall be developed by school personnel for the sole purpose of objectively describing an individual student's academic, social, and physical behavior, where such records will be considered as part of the total evaluation of the child in relation to providing the child with a more appropriate education.

Development of Anecdotal Records

All anecdotal records shall describe only observable behavior.

All anecdotal records shall be written, dated, and signed by the observer.

All anecdotal records shall be written as soon as possible after the observed behavior, preferably within 24 hours.

All descriptions must specify:

- the time and date of the observation
- the circumstances surrounding the behavior including the setting
- other participants, if any
- prior observable stimuli, if any
- resulting behavior
- the relationship of the behavior to the individual child's present educational program

All descriptions must specify whether the recorded behavior had been previously observed and recorded and, if so, with what frequency.

Maintenance and Use of Anecdotal Records

All recorded descriptions must be placed in the child's "education records" (cumulative, permanent) within 5 school days after completion.

All anecdotal records in the child's education records will be evaluated in relation to the child's present individual educational plan each time that the plan is reviewed. The review must occur no less than annually.

If, after a determination has been made that an individual anecdotal record has no relation to the child's individual educational plan and program, it shall be removed from the record and destroyed.

Anecdotal records shall remain within the child's official records for as long as they remain directly related to the child's educational plan and program.

In all instances the collection, maintenance, and use of anecdotal records shall conform to all other requirements relating to the collection, maintenance, and use of school records.

*Courtesy of the Council for Exceptional Children

INSURING CONFIDENTIALITY

OF RECORDS

Title 45 of the Code of Federal Regulations now contains regulations to protect the confidentiality of data collection in efforts to identify, locate, and evaluate all handicapped children. These are specifically defined as obligations of States and public education agencies. But, the rules and regulations go on to define "participating agencies":

> Any agency or institution which collects, maintains, or uses data, or from which data is obtained to meet P.L. 94-142, the "Education for All Handicapped Children Act". This is all part of "due process" legislation.

Head Start/Home Start programs characteristically have kept data on all children, including special needs (handicapped)children integrated into the programs. Also, Head Start/Home Start programs have characteristically transferred data to officials who work in a child's next educational setting, usually the public schools. Head Start/Home Start programs are agencies from which data is obtained for the education of the handicapped. Therefore, Head Start/Home Start programs would be "participating agencies" under the law.

According to the law, each participating agency shall protect the confidentiality of data at all stages: collection, storage, disclosure and destruction. Also, each agency shall assign one official as the responsible agent for assuring the confidentiality of any personally identifiable data.

WHAT SHOULD BE KEPT IN A CHILD'S FOLDER?

Head Start/Home Start programs are required by a set of performance standards to produce certain kinds of screening records (medical, dental and developmental) on all children and some very specific diagnostic records and educational plans for special needs children. In addition, information such

as a child's name, address, birthdate, etc., is kept on all children. Teachers may keep some records that specifically identify a child. In general, IF A PIECE OF INFORMATION IS USEFUL FOR PLANNING AND COMPLETING A CHILD'S EDUCATIONAL EXPERIENCE, IT SHOULD BE KEPT BY THE EDUCATION PROGRAM. If a piece of information will not contribute to planning, it should not be included at all.

WHAT IS "PERSONALLY IDENTIFIABLE" INFORMATION?

Personally identifiable information is any data that includes:

1. Name of the child, the child's parents, or other family member;
2. The address of the child;
3. A personal identifier, such as a social security or student number;
4. A list of personal characteristics or other information which would make it possible to identify the child with reasonable certainty.

WHO HAS TO KNOW ALL THIS INFORMATION ABOUT CONFIDENTIALITY?

According to the law, a participating agency must ensure that employees are trained in the policies and procedures regarding confidentiality. This implies training about the law itself and about the agency's specific guidelines for maintaining records and the confidentiality of them.

HOW IS ACCESS TO RECORDS CONTROLLED?

Each Head Start/Home Start program must develop a listing of the types and locations of personally identifiable data (records) collected, maintained or used by the agency. This listing must be provided to any parent who requests it.

A parent can request to see his/her child's records. The program must provide access to the records without unnecessary delay (no more than 45 days) and prior to any hearing related to the identification, evaluation or

placement of the child. The parent, by law, has the right to a response to a reasonable request for explanation and interpretation of regulations and the data, and to obtain copies of records.

The Head Start/Home Start program must maintain a record of any "third" parties (from outside the agency) obtaining access to a child's records. This includes:

1. Name of party;
2. Date access was given;
3. Purpose of authorization to use the data.

This record of access does not cover access by parents and authorized employees of the Head Start/Home Start agency. The prior, written consent of the parent(s) for viewing confidential information is not necessary for:

1. Officials in the same agency with a "legitimate educational interest";
2. Various state and national education agencies, when enforcing federal laws;
3. Accreditation and research organizations helping the agency.

The Head Start/Home Start agency must maintain, for public inspection, a current listing of the names of those employees within the agency who may have access to the personally identifiable data. These employees will probably include the agency administrative staff, component coordinators, head/classroom teachers, any special education staff hired by the agency, and special education consultants with whom the agency has a formal, written agreement for service.

4. Those with court orders.

The agency may charge a fee for copies of records which are made for parents, providing that the fee does not effectively prevent the parents from exercising their right to inspect and review those records. The agency may not charge a fee to search for or to retrieve data.

WHAT HAPPENS IF A PARENT DOES NOT LIKE SOMETHING THAT IS INCLUDED IN A CHILD's FILE:

A parent who believes that data is inaccurate or misleading or violates the privacy or other rights of the child may request the agency to make appropriate amendments to the data. Within a reasonable period of time following the request, the agency must decide whether or not to amend the data in accordance with the parents' request. If the agency decides to refuse the request, it must inform the parent of the refusal and advise the parent of his/her right to a hearing. If the parent requests a hearing, the agency shall provide for one. Just how Head Start/Home Start agencies will fit into the "hearing" system is as yet unclear. But it is likely that hearings, if requested, would be conducted under the systems being written by each state. If, as a result of the hearing, the agency decides that the data is in fact inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, it shall amend the data accordingly and so inform the parent in writing. If the agency, as a result of the hearing, decides that the data is not inaccurate, etc., it shall inform the parent of the right to place in the records a statement commenting on the data and stating any reasons for disagreeing with the decision of the agency not to amend it.

These parent-initiated hearings must:

1. Be held within a reasonable period of time after the agency has received the request, and the parent shall be given notice of the date, place and time, reasonably in advance of the hearing;

2. Be conducted by a party who does not have a direct interest in the outcome of the hearing;

3. Afford the parent full and fair opportunity to present evidence relevant to the issues raised and may be assisted or represented by individuals of his or her choice at his or her own expense, including an attorney;

4. Provide that the agency shall make its decision in writing within a reasonable period of time after the conclusion of the hearing;

5. Provide that the decision of the agency shall be based solely upon the evidence presented at the hearing and shall include a summary of the evidence and the reasons for the decision.

If a parent wishes to continue his/her appeal, this can be done under guidelines to be developed by each state.

WHEN MUST PARENTAL CONSENT TO VIEW OR RELEASE BE MADE IN WRITING?

Head Start/Home Start parents need not be asked for written consent before the program conducts certain procedures such as:

1. Outreach to locate or identify special needs (handicapped) children;

2. Screening all children (medical, dental, developmental);

3. Observation to complete skill-behavior checklists.

However, parents must provide fully informed, written consent for any selective individual testing to identify children in need of special education services.

WHAT IS "FULLY INFORMED CONSENT"?

Fully informed parental consent must include the following items:

1. Consent must be in writing. Verbal or other notice qualifies only if written notice is inadequate, such as in the case of a parent who is blind or whose language is not in written form (as some American Indian languages). State due process plans must be written to specify these other means of notification;

2. Information to parents must be in his/her native language unless it clearly is not feasible to do so;

3. Parents must be informed in writing of identification and evaluation efforts (does not include basic tests administered to or procedures used with all children);

4. Consent must specify the activity for which consent is given and which records, if any, are to be released and to whom the records are to be released;

5. The parent should understand that the granting of consent is voluntary (if a parent refuses to consent and if evaluation is deemed necessary, the agency's remedy would be to seek court intervention under state law).

6. "Parent" is defined as a 'parent or guardian (or individual acting as a parent in the absence of a parent or guardian) of any child on whom data is collected, maintained, or used for purposes of providing education.

CAN I JUST TALK TO A SPECIAL EDUCATOR ABOUT A CHILD?

No - if the child is personally identified in any way. Disclosure of information means permitting access or the release, transfer, or other communication of the education records. Without fully informed written consent of the parents such disclosure cannot take place orally, in writing, by electronic means, or any other means to any party.

WHAT ABOUT DISCLOSING INFORMATION FOR HEALTH OR SAFETY EMERGENCIES:

Personally identifiable information may be disclosed without the prior written consent of the parent under certain conditions:

1. Appropriate parties in connection with the emergency must need the information to protect the health or safety of the child;

2. The seriousness of the threat to health and safety must be considered;

3. The need for the information to meet the emergency must be considered;

4. Consider whether the parties to whom the information is disclosed are in a position to deal with the emergency;

5. Consider the extent to which time is of essence in dealing with the emergency.

WHAT ARE THE REGULATIONS FOR DESTRUCTION OF DATA?

First, records must be maintained until five years after they are no longer needed to provide educational services. Prior to destruction of data, reasonable efforts must be made to notify parents that they have the right

to be providee with a copy of any data which has been obtained or used for the child's education.

The definition of destruction is: the physical destruction or removal of personal identifiers from data so that the data is no longer personally identifiable.

APPENDIX 20

REPORT OF FIRST CONSULTING VISIT
WITH REGION III HEAD START REGIONAL RESOURCE AND TRAINING CENTER

November 21, 1975

FIRST CONSULTING EFFORT WITH REGION III HEAD START TRAINING OFFICE RE: MEDIATOR TEAM MODEL

DESIGNATED BY REGION III TRAINING OFFICE AS COMPREHENSIVE DEVELOPMENTAL TEAMS

DATE OF CONSULTATION: November 17-18, 1975

ITEMS COVERED DURING THE 8 HOURS OF CONSULTATION:

1. Review of the Region III training outline (Handbook or printed document)
2. Rationale for team approach
3. Review of the OCD-BEH Project evaluation of its initial outline re. the team process to Minnesota Head Start Programs
4. Region III cluster workshop concerns:
   - Time planned
   - Recreation
   - Possible reduction in planned time
   - Inclusion of state special education policy makers
4. Team organization options
5. General contacts with state departments of welfare, education, and health
6. Enhancement of communication between pilot programs via some form of newsletter
7. Factors for choosing team coordinators (appended)
8. Possible activities for the OCD-BEH Project staff at the February cluster training workshop (appended)
9. Consideration of the broader functions (program-wide concerns) of the teams
10. OCD-BEH Project proposal for continued funding (submitted to BEH Research and Development Section
11. Three copies of the original version of the Mediator's Handbook
12. One copy of the OCD-BEH Project handout used during training with Minnesota Head Start programs re. criterion referenced assessment instruments
13. One copy of OCD-BEH Project handout re.language stimulation techniques
14. Items the OCD-BEH Project will attempt to provide to the Region III Head Start trainers (appended)

PERSONS ATTENDING CONSULTATION SESSIONS:

Joni Cohan: Region III Head Start Training Office
Brenda Riley: " " " " " "
Pat Henney: " " " " " "
Jon Boller: OCD-BEH Collaborative Project
Fred Aden: " " "

GENERAL IMPRESSIONS:

It was the impression of the OCD-BEH Project consultants that the Region III Head Start Training personnel have a good, general grasp of the case management team process and the specific concepts from this model that apply particularly to preschool programs and Head Start specifically. The consultation sessions were characterized by an open exchange of information, opinions,

and alternatives. Some specific decisions were made. The OCD-BEH Project personnel were pleased with the efforts made to date by the Region III training staff; the Region III staff seemed quite pleased with the material and discussion help provided by the OCD-BEH Project.

FUTURE:

The Region III training staff will contact the OCD-BEH Project staff by telephone/letter about information/concerns re. the February cluster session workshop.

The Region III staff will decide what they wish the OCD-BEH staff to do or present at the cluster session workshop in February.

The OCD-BEH Project staff will continue to maintain telephone/letter contact with the Region III training staff in an effort to provide any additional TA needed prior to the February cluster workshop.

OCD-BEH PROJECT
WILL ATTEMPT TO PROVIDE

1. Questionnaire to be used initially with selected program

2. Suggested prototypes for team records

3. Video tape of mock meeting
   5024 Allan Road
   Bethesda, Maryland 20016

4. Team organization alternatives

5. Copy of each mediator media