



**UNITED STATES DEPARTMENT OF EDUCATION  
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES**

August 25, 2000

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Dear Mr. Simon and Dr. Knickrehm:

The U.S. Department of Education's Office of Special Education Programs (OSEP) conducted a review in Arkansas during the weeks of November 29, 1999 and January 10, 2000 for the purpose of assessing compliance in the implementation of the Individuals with Disabilities Education Act (IDEA) and assisting your State in developing strategies to improve results for children with disabilities. The IDEA Amendments of 1997 focus on "access to services" as well as "improving results" for infants, toddlers, children and youth with disabilities. In the same way, OSEP's Continuous Improvement Monitoring Process is designed to focus Federal, State and local resources on improved results for children with disabilities and their families through a working partnership among OSEP, the Arkansas Department of Education (ADE), the Arkansas Department of Human Services (ADHS), and parents and advocates in Arkansas.

A critical aspect of the Continuous Improvement Monitoring Process is collaboration between Steering Committees of broad-based constituencies, including representatives from ADE, ADHS and OSEP. The Steering Committees assessed the effectiveness of State systems in ensuring improved results for children with disabilities and protection of individual rights. In addition, the Steering Committees will be designing and coordinating implementation of concrete steps for improvement. Please see the Introduction to the report for a more detailed description of this process in your State, including representation on the Steering Committees.

OSEP's review placed a strong emphasis on those areas that are most closely associated with positive results for children with disabilities. In this review, OSEP clustered the Part B (services for children aged 3 through 21) requirements into four major areas: Parent Involvement, Free Appropriate Public Education in the Least Restrictive Environment, Secondary Transition and General Supervision. Part C (services for children aged birth through 2) requirements were clustered into five major areas: Child Find and Public Awareness, Family-Centered Systems of Services, Early Intervention Services in Natural Environments, Early Childhood Transition, and General Supervision. Components were identified by OSEP for each major area as a basis to review the State's performance through examination of State and local indicators.

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The enclosed Report addresses strengths noted in the State, areas needing corrective action because they represent noncompliance with the requirements of IDEA, areas of concern that may need further investigation by the State, and technical assistance on improvement for best practice. Enclosed you will find an Executive Summary of the Report, an Introduction including background information, and a description of issues and findings.

ADE and ADHS have indicated that this Report will be shared with members of the Steering Committees, the State Interagency Coordinating Council and the State Advisory Panel. OSEP will work with your Steering Committees to develop corrective actions and improvement strategies to ensure improved results for children with disabilities.

Thank you for the assistance and cooperation provided by your staffs during our review. Throughout the course of the review, Dr. Diane Sydoriak and Ms. Sherrill Archer were responsive to OSEP's requests for information, and provided access to necessary documentation that enabled OSEP staff to work in partnership with the Steering Committees to better understand the State's systems for implementing the IDEA. We appreciate the effort made by State staff to arrange the public input process during the Validation Planning week and, as a result of their efforts, OSEP obtained information from a large number of parents (including underrepresented groups), advocates, service providers, school and agency personnel, school and agency administrators, and special education unit administrators.

Thank you for your continued efforts toward the goal of achieving better results for infants, toddlers, children and youth with disabilities in Arkansas. Since the enactment of the IDEA and its predecessor, the Education of All Handicapped Children Act, one of the basic goals of the law, ensuring that children with disabilities are not excluded from school, has largely been achieved. Today, families can have a positive vision for their child's future.

While schools and agencies have made great progress, significant challenges remain. Now that children with disabilities are receiving services, the critical issue is to place greater emphasis on attaining better results. To that end, we look forward to working with you in partnership to continue to improve the lives of individuals with disabilities.

Sincerely,

Kenneth R. Warlick  
Director  
Office of Special Education Programs

Enclosures

cc: Dr. Diane Sydoriak  
Ms. Sherrill Archer

## **EXECUTIVE SUMMARY** **ARKANSAS MONITORING 2000**

The attached Report contains the results of the first two steps (Validation Planning and Validation Data Collection) in the Office of Special Education Program's (OSEP) Continuous Improvement Monitoring of the Individuals with Disabilities Education Act (IDEA), Parts B and C, in the State of Arkansas during the weeks of November 29, 1999 and January 10, 2000. The process is designed to focus resources on improving results for infants, toddlers and children with disabilities and their families through enhanced partnerships between the State agencies, OSEP, parents and advocates. The Validation Planning phase of the monitoring process included the completion of a Self-Assessment by Part B and analysis of both the Self-Assessment and the Part C Self-Study, a series of public input meetings with guided discussions around core areas of IDEA, and the organization of two Steering Committees, one for Part B and another for Part C, that provided further comments on the status of implementation of IDEA. As part of the public input process, OSEP and the State made particular efforts to include a wide geographical area that included both multi-cultural and underrepresented populations. The Validation Data Collection phase included interviews with parents, students, agency administrators, local program and school administrators, service providers, teachers and service coordinators and reviews of children's records. Information obtained from these data sources was shared in two meetings, one conducted with the Arkansas Department of Education (Part B) and the other conducted with the Department of Human Services (Part C).

The report contains a detailed description of the process utilized to collect data, and to determine strengths, areas of noncompliance with IDEA, and suggestions for improvement in each of the core IDEA areas.

### **Early Intervention Service for Infants and Toddlers With Disabilities:** **Part C of IDEA**

#### **Strengths**

OSEP observed the following strengths:

- Paraprofessionals are trained through a joint effort of the ADE and the ADHS. These paraprofessionals are trained for a variety of professions to serve children in both the Part C early intervention program and in special education.
- Most of the local agencies providing services to children aged birth to three are in a collaborative, cooperative partnership in the provision of these services. Agency representatives are knowledgeable and actively participate in interagency activities to serve this population.
- ADHS and the State Medicaid Staff collaborated to improve identification of eligible children which resulted in the requirement for physicians serving Medicaid eligible children to refer those children who may be developmentally delayed to the First Connections Program.

- ADHS and ADE collaborate to produce Part C First Connections public awareness materials at the State and local levels. This collaborative effort is part of Arkansas' interagency agreement for the early intervention program. OSEP also was told by local Part C Interagency Coordinating Council staff that local school systems assisted with printing local materials, as well as coordinating child find efforts.
- Collaboration of ADHS state staff and State Medicaid staff helps to ensure that all children in Arkansas who receive Medicaid are referred to First Connections if their Medicaid primary care physician suspect a developmental delay. Doctors who provide services to Medicaid eligible children are required by Medicaid to refer those children who may be developmentally delayed to the First Connections program.
- There is interagency collaboration at the local level for finding children who may be eligible. The local Developmental Disabilities Services Center, the special education cooperative for children 3-5, and the local health department collaborate on organizing and conducting child find events. The ADE prints public awareness materials for ADHS at the local and State levels as part of their collaborative agreement.
- Concerned about the lack of referrals from primary referrals sources in its area, one local area implemented a public awareness campaign that included visits by local Interagency Coordinating Council members to physicians and pediatricians in their area to explain the early intervention program and provide them with posters that have "tear-off" tabs containing a telephone number for referrals. This local area noted a significant increase in referrals from these referral sources as a result of this activity
- Arkansas analyzed a wide variety of data information such as at-risk, demographic, economic, and prevalence information to provide the State with a more sophisticated analysis of factors contributing to identification of potentially eligible children. Arkansas already serves 1.9% of this population which is greater than the national average and is committed to increasing the percentage.
- Arkansas requires its Developmental Day Treatment Clinic Services centers to accept normally-developing children, aged birth to five, into these centers to ensure an integrated environment.

### **Areas of Noncompliance**

- Complete and effective monitoring system not implemented; monitoring materials and activities do not ensure compliance with all Part C requirements.
- Child find efforts among public agencies are not coordinated.
- Procedures are not in place to determine the extent to which primary referral sources disseminate information to parents. All primary referral sources do not have appropriate and adequate information about the early intervention system.
- Evaluators do not use informed clinical opinion in determining initial and continuing eligibility as required by Federal regulations.
- ADHS impermissibly requires that children with diagnosed conditions also meet developmental delay criteria in order to be eligible for services.
- ADHS does not ensure that all services are for eligible children and their family are identified and provided.

- ADHS does not ensure that each family has one service coordinator who will act as the single point of contact for a child and family to assist families with all service coordination activities as required by Part C.
- ADHS does not ensure an appropriate IFSP team decision-making process for the identification of the unique needs of the child and family, and the services to meet those needs. ADHS also does not ensure an appropriate IFSP team decision-making process to determine the natural environment for provision of early intervention services for each child.
- Transportation is not provided to all families that need this service to enable them to receive early intervention services.
- ADHS does not ensure that the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child are identified and included in a statement of the specific services needed to meet the unique needs of the child and family on the IFSP.
- ADHS does not ensure that a written transition plan is developed and implemented for each child according to requirements in IDEA.

### **Education of Children and Youth with Disabilities:** **Part B of IDEA**

#### **Strengths**

OSEP observed the following strengths:

- ADE, through a grant from the Governor's Developmental Disabilities Council, has developed and implemented joint training for parents and educators on developing IEPs.
- ADE offers stipends to parents to facilitate parent involvement in various ADE-sponsored projects, such as the Annual Spring Parent Retreat and Special Show.
- ADE has developed a computerized correlation between IEP benchmarks and the general education curriculum at all educational levels. Teachers reported in interviews that the development of general education standards has facilitated the access of children with disabilities to the general curriculum.
- ADE has provided significant levels of statewide training in the area of functional behavior assessment. School district personnel across the State reported to OSEP that whenever a student exhibits a pattern of behavior that may result in continued disciplinary referrals or suspension, they have collected and analyzed data. The behavior analysis results in a creation of a behavior intervention plan and a functional behavior assessment.
- ADE funds ten regionally-based behavior intervention consultants to assist local school districts with addressing the behavior needs of children with disabilities.
- The department of special education in the El Dorado School District have incorporated a special education component into the regular education night school program. Special education students can now participate and are afforded the same opportunity to acquire credits or improve their performance in core subjects. In addition, they may voluntarily take these courses prior to taking them during the day, giving them a head-start in understanding the material and, in some cases, enabling them to take these classes in the general education classroom rather than in resource settings.

- Significant co-teaching efforts at all educational levels in the Conway School District has provided many opportunities for children with disabilities to participate and achieve success in the general education setting. Training is provided to general educators in the implementation of modifications and accommodations.
- ADE is participating in the establishment of a new licensure standards that will ensure greater competency of general education teachers to address the diverse learning styles and behaviors exhibited by children with disabilities. It is now mandatory that general educators receive six hours of training in special education rather than the previous three hours.
- ADE underwrites the cost of educational interpreters for the deaf working in schools to support opportunities for the hearing impaired to participate in general education settings.
- ADE has continued after the end of the grant period the activities begun during the OSEP Transition System Change Grant from 1990-1996. A Statewide cadre of Transition Consultants provide training, consultation and facilitation of the development of Regional Interagency Transition Teams.
- ADE sponsors "Agency Fest," an opportunity for various agencies that offer transition and adult services to showcase their services and provide information to school personnel and families.
- ADE provides a listing and description of available transition resources on its web site. This facilitates access to information in rural areas of the state and provides a ready reference for families and school personnel.
- ADE is improving services to children with disabilities by enhancing the skills and capacities of paraprofessionals. For instance, the state has hired a work experience coordinator who is responsible for training paraprofessionals to serve as job coaches for youth working on postsecondary transition activities at community job sites.
- ADE models collaboration through promoting joint training efforts with other agencies and special interest groups, such as the Parent Training and Information Center, Protection and Advocacy, Department of Human Services, Children and Family Services, foster parents, etc. ADE has also instituted a Superintendent's Academy, which has been attended by 225 superintendents who have completed ten hours of training relative to the requirements of IDEA.
- ADE sponsors a biennial Special Education Conference that is the premiere educational conference in the State of Arkansas, attended not only by parents, school district staff and agency personnel in Arkansas but also by participants from surrounding States. As indicated above, parents are provided stipends to attend this conference.
- ADE contracts with the Parent Training and Information Center to encourage parents' use of the mediation process. Information is disseminated about mediation through the Center as well as through ADE and local education agencies.
- The ADE has systems for collecting data regarding compliance monitoring, complaints, mediation, and due process hearings, which allow the generation of reports, survey data and specific information analysis. This data is used to identify training needs and areas for systemic improvement.
- ADE is currently sponsoring the development of an alternate assessment for children with disabilities who do not participate in the Statewide assessment program. This will be implemented in school year 2000-2001. Included will be the use of portfolio assessment and the development of scoring rubrics and models of performance measurement.

**Areas of Noncompliance**

OSEP observed the following areas of noncompliance:

- All children with disabilities who require extended school year services as part of a free appropriate public education are not provided extended school year services, in accordance with their IEP.
- ADE does not ensure that students with emotional disturbance or other behavioral needs received psychological counseling services if required to assist the student to benefit from special education.
- The necessary modifications and/or accommodations that would enable children with disabilities to participate in general education classes are not provided to all who need them. More children with disabilities would be able to participate in general education classrooms if additional personnel were available to support regular education staff (e.g., aides, additional teachers for co-teaching, related services personnel, etc.).
- ADE does not ensure an adequate supply of qualified special education, regular education and related services personnel
- The IEP invitation and participation of other agencies does not meet IDEA requirements regarding transition.

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## **INTRODUCTION<sup>1</sup>**

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Arkansas's 53,225 square miles is comprised of 600,000 acres of lakes, 18 million acres of forestland, and the State extends from the Delta flatlands in the southeast to the mountainous regions in the northwest. Arkansas is home to approximately 2.5 million people with 48% residing within metropolitan areas and 52% in rural areas. In the 1990 census report data, the population of Arkansas ranked 33<sup>rd</sup> among the States and the District of Columbia. The population in Arkansas is composed of approximately 82% White, 16% African-American, 1% Hispanic (but growing rapidly) and 1% other. Arkansas's population under the age of 18 comprised approximately 26% of the total population.

The Arkansas Department of Human Services (ADHS) is the lead agency responsible for provision of early intervention services to eligible infants and toddlers ages birth to three and the Arkansas Department of Education (ADE) serves children under Part B, ages 3 through 21.

### **Administrative Structures and Children Served**

#### **Part C**

Part C, Early Intervention in Arkansas was established by Arkansas Act 658 in 1987. Within the Department of Human Services, the Division of Developmental Disabilities Services (DDS) has the responsibility for the development, implementation, administration and monitoring of the Part C program.

Since its inception, Part C has continued to grow in the number of infants and toddlers and their families who are served through both direct services and networking from 335 in 1991 to 2,011 in 1998. In 1999, the Part C Early Intervention Program received a new name and logo, and is now known as First Connections.

The First Connections program, under the leadership of Developmental Disabilities Services (DDS), assures that a statewide, comprehensive, coordinated, multidisciplinary and interagency system of services is in place within Arkansas. The division maintains an administrative staff of six who have the responsibility for development, implementation, administration and monitoring of the program statewide. The staff is composed of the Early Intervention Coordinator who oversees the program, a program analyst who is responsible for data, two consultants who provide training, technical assistance, and monitoring, and two clerical support personnel.

DDS, as the single point of entry for Part C in Arkansas, employs 34 State DDS Service Coordinators. Each State service coordinator has the responsibility for three to five counties and is the person designated to visit with families in their homes and offer assistance through First Connections. Additionally, DDS contracts with 54 private non-profit entities that provide an array of services in addition to service coordination for the Part C program.

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<sup>1</sup> Some of the information in this section was provided by ADE and ADHS

## **Part B**

The Arkansas Department of Education (ADE), Special Education Unit is responsible for ensuring and administering programs under Part B. According to the December 1, 1999 child count, Arkansas is currently serving 60,868 students with disabilities, ages 3 through 21. For the 1999-2000 school year, Arkansas received 46 million dollars in federal funds under Part B and Section 619 of IDEA to support the provision of special education services for these children. ADE passed through approximately 38.3 million of these funds to local public agencies within the State. By the close of fiscal year 1999-2000, in excess of an additional 200 million of State funds had been expended on behalf of students with disabilities.

ADE has as a goal ensuring that every student within the public school system exits with a strong academic foundation and the skills necessary to achieve his or her potential. There are 310 public school districts in the state, with a current Average Daily Membership of 447,352 students (1999-2000 school year). These students are the focus of the ADE's mission "to provide the highest quality leadership, service, and support to school districts and schools in order that they may provide equitable, quality education for all students."

In addition to the 310 school districts, there are 15 regionally-based educational services agencies (cooperatives), 6 state operated/state-supported programs and a number of private-provider programs approved by ADE Special Education Unit that directly serve students with disabilities ages 3 to 21. Additionally, the ADE Special Education Unit, through extensive interagency agreements and/or memoranda of understanding, cooperates with other public and private agencies serving the children and youth of Arkansas.

Arkansas has a growing list of achievements, including its well-publicized and demonstrated commitment to enhancing its public education system. Significant strides have been made toward achieving the goals set forth in the Goals 2000 initiative, with noted improvements in the Ready to Learn, Student Achievement and Citizenship, and Mathematics and Sciences categories.

For ADE to meet the educational goals established for all students, as well as legal mandates relative to special populations of students, it continues to support the need for a Special Education Unit within the agency. Under the supervision of the Unit's Associate Director, Dr. Diane Sydoriak, 35 additional employees (25 full-time professional and 10 full-time clerical staff) are leading the special education effort in Arkansas. This Unit is responsible for the oversight, administration and implementation of federal and state laws and regulations governing the provision of educational services to all eligible children and youth with disabilities, ages 3 to 21. Responsibilities of the ADE Special Education Unit include, but are not limited to, the following:

1. Ensuring that public educational agencies have available to them a variety of human, material and financial resources to assist them in meeting federal and state mandates;

2. Overseeing the State's Comprehensive System of Personnel Development;
3. Providing technical assistance through consultation and professional development; and
4. Managing the dispute resolution systems available under IDEA.

### **Statewide Assessment Program**

Since the 1980s, the Arkansas General Assembly and State Board of Education have frequently reviewed and amended the minimum Standards of Accreditation for Arkansas public schools, each time elevating these standards. School districts are being encouraged and challenged to "raise the bar," to strive for excellence rather than mediocrity. Programs such as the Arkansas Smart Start Initiative are being implemented to promote student success in the early grades, thus establishing the necessary academic foundation for all students. The Smart Start Initiative emphasizes the State's Academic Standards, Professional Development, Student Assessment and Accountability. It is designed to improve reading and mathematics achievement for all students. The goal is not only to have all students on grade level by the end of grade 4, but also to ensure the achievement of *each* student.

Arkansas's Statewide Assessment Program is comprised of two testing programs: (1) Criterion-referenced test at grades 4, 8, 11 and 12 and (2) Stanford Achievement Test, Ninth Edition in grades 5, 7 and 10. Students with disabilities who are eligible under IDEA participate in both assessments and are provided with accommodations and modifications as determined by an IEP team. The testing accommodations provided are based upon the needs of the student as documented in the IEP and the demands of the testing event.

The Stanford Achievement Test, Ninth Edition, is a norm-referenced test. The criterion-referenced examinations are based on the Arkansas Curriculum Frameworks and designed to measure student accomplishment of the content standards therein. Students with disabilities participate in the assessments, unless it is deemed inappropriate by an IEP team. Schools, districts and statewide reports presently separate scores of students with disabilities from scores of students without disabilities. Students who are unable to take the assessment, even with the appropriate modifications and accommodations, will participate in an alternative assessment program. Currently, an alternative assessment program is being piloted in seven school districts.

## I. PART C: GENERAL SUPERVISION

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The State lead agency is responsible for developing and maintaining a Statewide, comprehensive, coordinated, multidisciplinary, interagency early intervention system. Administration, supervision and monitoring of the early intervention system are essential to ensure that each eligible child and family receives the services needed to enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay. Early intervention services are provided by a wide variety of public and private entities. Through supervision and monitoring, the State ensures that all agencies and individuals providing early intervention services meet the requirements of IDEA, whether or not they receive funds under Part C.

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

### **Validation Planning and Data Collection**

The State's Part C self-assessment committee gathered data to identify strengths and areas for improvement for the State's early intervention program. The committee identified the following promising practices in supervision and monitoring: a State monitoring process which includes a monitoring instrument and requirements for programs to assure compliance, the utilization of enforcement actions to address deficiencies, an increase in the number of interagency agreements with other entities that serve Part C eligible children, and improvement of interagency collaboration at the local level. The committee also identified additional promising practices: increased training opportunities, procedures to assure all funding sources are utilized prior to use of Part C funds, and positive efforts to involve parents in the Individual Family Service Plan (IFSP) process.

Arkansas has a three-year monitoring cycle to systematically monitor programs providing early intervention services. During the public input sessions, administrators and local program staff told OSEP they were monitored on a regular basis. A review of documents sent to OSEP by the State revealed a systematic monitoring process with activities for correction of identified deficiencies.

The State's self-assessment indicated that, due to insufficient data, the State is unable to determine if complaints, mediations, and due process hearings are conducted in a timely manner. The self-assessment also indicated that provider and parent manuals are needed to ensure adherence to Part C requirements and to provide parents with the tools to effectively participate in all decisions related their child's program. The State self-assessment committee also noted the need for increased public awareness activities for some agencies and in certain areas of the State. ADHS is currently addressing the public awareness issue by providing targeted funding to local

interagency coordinating councils and to develop new public awareness materials at the State level.

Based on information obtained through the self-assessment, the public input process, review of monitoring reports, local applications, and local and State procedures, OSEP identified the following concerns: (1) lack of comprehensive monitoring activities; (2) lack of sufficient monitoring materials to assure compliance with Part C; (3) insufficient appropriately trained staff, and; (4) insufficient training for identification on IFSPs of family needs, supports and family-centered services as well as natural environments.

To investigate the issues identified through its validation planning process, OSEP collected data from parents, service providers, State agency staff, local program providers and administrators across Arkansas related to the Lead Agency's responsibility for supervision and administration of the early intervention program. Analysis of the data collected resulted in identification of the following strengths, area of noncompliance and suggestion for improvement.

## **A. STRENGTHS**

### **1. Cooperative Activities with ADE on Training Paraprofessionals.**

ADE and ADHS have developed a cooperative, joint effort to train paraprofessionals which benefits both State agencies, thus reducing duplication of effort in training to ensure adequate staff for early intervention and special education needs. These paraprofessionals are trained for a variety of professions to serve children in both the Part C early intervention program and in special education.

### **2. Interagency Collaboration**

Formalized interagency collaboration at the local level among most public and private agencies providing services to eligible infants and toddlers encourages cooperation and identification of needed services for children and families. Some local districts meet on a regular basis to encourage this cooperative partnership in the provision of these services. Agency representatives are knowledgeable about availability of services and actively participate in interagency activities to serve this population.

## **B. AREA OF NONCOMPLIANCE**

### **Complete and Effective Monitoring System Not Implemented**

Under Part C, each lead agency is responsible for the general administration and supervision of programs and activities receiving assistance (34 CFR §§303.501(a) and (b)(1)-(4)). To meet these requirements, ADHS must adopt and use proper methods to monitor each program, including monitoring agencies, institutions, and organizations used by the State to carry out Part C, enforcing any obligations imposed on those agencies under Part C and its regulations, providing technical assistance, and correcting deficiencies. The State is obligated to monitor

these programs and activities used to carry out Part C, whether or not they receive funds under Part C, to ensure the State complies with all requirements of Part C.

ADHS has not ensured compliance with the requirements of Part C through adequate monitoring activities and procedures. OSEP reviewed the monitoring materials and monitoring reports submitted by the State. These monitoring materials do not address all of the relevant Part C regulations. The State coordinator acknowledged that the materials and activities used by Arkansas do not ensure compliance in all areas of child find, assessment and evaluation, development of the IFSP and other aspects of the regulations.

ADHS monitors early intervention records, the IFSP and other compliance issues on a three-year cycle. OSEP reviewed monitoring documents sent by the State and determined that ADHS has a systematic monitoring process with activities for correction of identified deficiencies. Nevertheless, these monitoring activities and materials do not ensure compliance with all regulations of Part C. Administrators and service coordinators in all areas of the State told OSEP that monitoring consists mainly of reviewing early intervention records, and OSEP found through its review of the documents that ADHS uses to monitor early intervention records that the documents did not adequately address all Part C requirements.

There are several other requirements that are not addressed in the State's monitoring materials or are not addressed adequately. Monitoring procedures and materials to ensure that all service coordination activities and requirements for development of the IFSP are in compliance with Part C are not part of State's Part C monitoring system. Other requirements not addressed include identification of family needs, including needed supports and services and their inclusion on the IFSP as family outcomes, mechanisms to ensure all children receive the services to which they are entitled through the IFSP team decision-making process, and proper procedures for determining eligibility.

In addition, monitoring activities are not in place to ensure that child find activities result in identification and evaluation of all eligible children in the State (34 CFR §303.321 (b)(1) or in an effective method of making referrals by primary referrals sources (34 CFR §303.321(d)(2)(i). Further, the State does not have methods in place to determine the extent to which primary referral sources disseminated information to parents of infants and toddlers with disabilities as required in 34 CFR §303.321(d)(2)(iii). Lack of State self-monitoring in these areas is a concern because parents, service providers, administrators and service coordinators told OSEP that many primary referral sources did not know about the First Connections program, and that many hospitals, doctors, and the Health Department clinics in local areas do not refer children to the early intervention system.

### **C. SUGGESTION FOR IMPROVED RESULTS FOR INFANTS, TODDLERS, AND THEIR FAMILIES**

#### **Training Activities**

The State Developmental Disabilities service coordinators and local case managers are required to take a training course for a specified number of hours and to pass a test to ensure adequate

knowledge of requirements. However, based on findings identified later in this report, service coordinators and case managers did not perform all of the required functions of service coordination and were not able to accurately describe the role and duties of associated with service coordination. Although ADHS provides many on-going training activities for service coordinators, case managers as well as service providers, many providers and case managers in all parts of the State reported they were not informed of these opportunities for ongoing training. The State staff, some State service coordinators and program administrators told OSEP there was training offered everywhere. Nevertheless, information on training activities is not reaching many case managers and providers of early intervention in all parts of the State. Methods for ensuring participation for all providers of early intervention, especially in areas of compliance, could be beneficial to Arkansas' early intervention system, ensuring compliance to Part C regulations to benefit eligible children and their families.

## II. PART C: CHILD FIND/PUBLIC AWARENESS

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The needs of infants and toddlers with disabilities and their families are generally met through a variety of agencies. However, prior to the enactment of Part C of IDEA, there was little coordination or collaboration for service provision, and many families had difficulty locating and obtaining needed services. Searching for resources placed a great strain on families.

With the passage of Part C in 1986, Congress sought to ensure that all children needing services would be identified, evaluated, and served, especially those children who are typically underrepresented, (e.g., minority, low-income, inner-city, American Indian and rural populations) through an interagency, coordinated, multidisciplinary system of early intervention services.

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

### **Validation Planning and Data Collection**

The State's self-assessment indicated an increase in the number of materials disseminated in a variety of languages, an increase in primary referral source participation, an increase in the number of families receiving appropriate service coordination upon referral and that local interagency coordination councils have developed and distributed public awareness materials for their areas. The self-assessment identified several areas of need. Even though the State is currently serving 1.93 percent of children, the State wants to ensure that all eligible children are receiving services. Based on its at-risk data and other data, the State determined that it is possible that the eligible population of 0 to 3-year-old children is higher than 2 percent of the population. The State also identified the need to increase the percent of children less than 12 months of age who are receiving services from 1.5 percent to 2 percent. The self-assessment committee also identified the necessity of continuing to monitor the changing needs of the State and determine the percentage of eligible children from multicultural populations and underrepresented groups receiving services or in need of services.

Public input meeting participants told OSEP that some physicians and clinics are not referring children for early intervention services, activities are not sufficient to identify eligible children in rural areas, public and private agencies that are sources of referrals are not aware of child find guidelines, and materials are not available for non-readers. These participants also told OSEP that there may not be enough evaluation personnel. In rural areas of the state, personnel will not evaluate children in homes or community settings. Further, obtaining prior authorization from physicians at times causes a delay in the provision of evaluation services.

At the end of the Validation Planning process, it was determined that additional data should be collected during the Validation Data Collection week regarding the following concerns/issues: (1) children not being served due to delays in referral by primary referral sources; (2) lack of available information designed for families to learn about early intervention services; (3) child find and public awareness activities not reaching all primary referral sources; and (4) insufficient culturally-competent public awareness materials.

To investigate these child find and public awareness issues, OSEP collected data from local programs and providers, parents, service providers, case managers, local programs, interagency collaborators and from central office staff personnel throughout Arkansas. OSEP reviewed and analyzed the data and identified the following strengths, areas of non-compliance and suggestions for improvement.

## **A. STRENGTHS**

### **1. Coordination with Medicaid**

ADHS First Connections staff worked with State Medicaid staff to ensure that all children in Arkansas who are eligible for Medicaid are referred to First Connections if their Medicaid primary care physician suspects a developmental delay. The result is that physicians who provide services to Medicaid eligible children are required by State Medicaid rules to refer those children who may be developmentally delayed to the First Connections program. Subsequently, there was a substantial increase in referrals to First Connections from these doctors, which helped the State in its obligation to identify all children who may be eligible for early intervention services.

### **2. Interagency Collaboration on Public Awareness.**

ADHS and ADE collaborate to produce public awareness materials at State and local levels. This collaborative effort is part of Arkansas' interagency agreement for the early intervention program. ADE provides printing assistance for all the First Connections public awareness materials. Local Interagency Coordinating Council staff told OSEP that local school systems also assist with printing local materials, as well as coordinating child find efforts.

### **3. Local Interagency Child Find Activities**

There is also collaboration among public and private agencies at the local level for finding eligible children. The local Developmental Disabilities Services Center, the special education cooperative for children 3-5, and the local health department in Fayetteville collaborate on organizing and conducting child find events. ADE prints public awareness materials for the lead agency at the local and State levels as part of their collaborative agreement.

### **4. Local Effort to Reach Primary Referral Sources**

Concerned about the lack of referrals from primary referrals sources, one local area implemented a public awareness campaign that included visits by local Interagency Coordinating Council

members to physicians and pediatricians in their area to explain the early intervention program and provide them with posters that have “tear-off” tabs containing a telephone number for referrals. This local area noted a significant increase in referrals from these referral sources as a result of this activity.

## **B. AREAS OF NONCOMPLIANCE**

### **1. Child Find Activities Not Coordinated**

The lead agency, with the assistance of the Council, must ensure that child find under Part C is coordinated with all other major efforts to locate and identify children conducted by other State agencies responsible for administering the various education, health, and social service programs relevant to Part C. 34 CFR §303.321(c). The lead agency also must include procedures for use by primary referral sources for referring a child to the appropriate public agency within the system. 34 CFR §303.321(d).

ADHS has not ensured that all public agencies collaborate in child find activities. Service coordinators and administrators from all areas visited told OSEP that many hospitals refer children to Children’s Health Management Services (CHMS) clinics and not to the First Connections program. They further said that although most if not all of these children in Children’s Health Management Services clinics would be eligible for early intervention and do receive many therapies, they are not referred to the First Connections program and are not receiving those services through an IFSP. By not ensuring that infants and toddlers who may be eligible for Part C services are referred to the State’s early intervention program, ADHS may be denying eligible children and their families the rights, protections, service coordination and services they would be entitled to receive under an IFSP.

Service coordinators, providers and administrators in four areas of the State told OSEP that the health department clinics do not refer children to the early intervention system. The Department of Health representative acknowledged that this was the case, and also stated that there had not been a directive to local health clinics on the requirements for referral to the early intervention system. This representative indicated that this issue would be brought to the State Interagency Coordinating Council to work on a solution to ensure referrals by local health department clinics to the early intervention system in a timely manner.

### **2. Dissemination of Information by Primary Referral Sources.**

States must have procedures in place to determine the extent to which primary referral sources, especially hospitals and physicians, disseminate information on the availability of early intervention services to parents of infants and toddlers with disabilities. §303.321(d)(2).

ADHS has not ensured that procedures are in place to determine the extent to which primary referral sources, such as hospitals and physicians, disseminate information to parents of infants and toddlers with disabilities about the availability of early intervention services.

Many parents, service coordinators and administrators stated that doctors and hospitals may refer children to private clinics and hospitals and are not referring to the First Connections program which would ensure all that eligible children and their families receive rights and services to which they are entitled. Service coordinators, parents, providers and administrators across the State told OSEP that not only were primary referral sources not providing information to parents, many doctors and hospitals do not know what First Connections is, nor do they understand the purpose of early intervention. The State Coordinator told OSEP that procedures are not currently in place to determine the extent to which primary referral sources disseminate information to parents about early intervention services.

## **C. SUGGESTIONS FOR IMPROVED RESULTS FOR INFANTS, TODDLERS, AND THEIR FAMILIES**

### **1. Effective Procedures for Primary Referral Sources in the Child Find System**

Each State's Child Find system must include a comprehensive child find system that includes the policies and procedures that the State will follow to ensure that all infants and toddlers in the State who are eligible for services are identified, located and evaluated. The procedures must provide for an effective method for primary referral sources to make referrals and to ensure that referrals are made no more than two working days after a child has been identified. 34 CFR §303.344 and §303.321(d)(2).

Service providers, service coordinators, case managers, parents, and administrators in four areas of the State told OSEP that many hospitals' staff and local physicians do not refer children who may be eligible to the early intervention system. They further stated that many doctors and physicians are not aware of the First Connection early intervention system and do not recognize the name or purpose of early intervention. Service providers, service coordinators, case managers and administrators told OSEP that many doctors refer children to private programs or their own clinics rather than to the early intervention program. Parents of eligible children also told OSEP that their doctor did not refer the child to early intervention, telling the parents to wait and see if the child "outgrows" the delay. The State may want to develop a plan to identify and implement activities that might be used in those areas where hospitals and physicians are not referring children to the early intervention system.

### **2. Availability of Public Awareness materials.**

Each State must establish a public awareness program that focuses on the early identification of eligible children and includes the preparation and dissemination to all primary referral sources of culturally-appropriate materials for parents on the availability of early intervention services. See 34 CFR §§303.320 and 303.321(d)(1) and (d)(2)(i)-(iii).

Parents, service providers and administrators from four areas told OSEP that they did not see or hear information to inform the general public about the early intervention program. They further stated that families in rural areas would have no way of finding out about early intervention. When asked, they stated that they did not see information that would enable parents to know

there is an early intervention program. Parents and providers stated that the early intervention program is not advertised.

Service coordinators, providers and administrators in three areas of the State stated that in spite of the availability of Spanish language materials, the percentage of Hispanic children in the program was not representative of the general population of Hispanics. These respondents also stated that they did not know of any efforts to inform the Hispanic community of the availability of services and to make Part C services accessible to this population. The State may want to institute procedures to assure information is reaching all segments of the population that would ensure identification of all eligible infants and toddlers who need early intervention.

### **III. PART C: EARLY INTERVENTION SERVICES IN NATURAL ENVIRONMENTS**

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

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

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

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

#### **Validation Planning and Data Collection**

The State's self-assessment committee identified the following promising practices in the area of Early Intervention Services: a steady increase in the number of children receiving services, an increase in the number of provider sites, and collaboration among multiple agencies and funding sources to provide services. The self-assessment committee also noted that Arkansas is currently serving 1.93% of the State's children aged birth to three, which is higher than the current

national average. The self-assessment committee identified areas of improvement as the need to increase awareness of the Central Directory to ensure sufficient service providers are available in all areas, and the need to identify means to increase training opportunities for service providers.

During the public input meetings, OSEP heard that service coordination is not working well, service coordinator's case loads were too high, families have a service coordinator and a case manager and neither performs all required service coordination duties, and families are not receiving assistance to locate needed resources. Participants at the public input sessions also stated concerns about supervision of case managers and service coordinators, that services received by a family depend on the services an agency provides and that the lead agency did not look at all options for service, only center-based options. Other participants state that the need for prior authorization delayed the initiation of evaluations and services.

From the State's monitoring reports, public input meetings, and other information, it was determined that additional data should be collected during the Validation Data Collection week in the following areas: (1) determination of eligibility; (2) adequate services; (3) provision of transportation; (4) service coordinators coordinating all services; (5) families obtaining their own services, and; (6) the process for identifying natural environments.

To investigate these child find and public awareness issues, OSEP collected data from local programs and providers, parents, service providers, case managers, local programs, interagency collaborators and from central office staff personnel. OSEP reviewed and analyzed the data and identified the following strengths and areas of non-compliance.

## **A. STRENGTHS**

### **1. Data Used to Identify Under-Served Populations**

Although Arkansas is already serving 1.93% of its infant and toddler population, higher than the 1.6% national average, the administration expressed a commitment to increase and expand child find and public awareness activities to assure identification of all eligible children. In order to ensure identification of children who may be eligible for early intervention services, ADHS recently analyzed a wide variety of data, including at-risk, demographic, economic, and prevalence information. Through this analysis, ADHS determined that the population of potentially eligible children may be closer to 3% of the infant and toddler population and intends to work towards this goal.

### **2. Requiring Centers to Include Non-disabled Children**

Prior to the 1986 passage of Part H of IDEA, ADHS operated centers for children who were delayed and in need of services. Since the implementation of Part H, now Part C, Arkansas has required centers to accept normally-developing children, aged birth to five, into these centers. Administrators of every center that OSEP visited stated that they are required to fully integrate children with disabilities and children without disabilities. Most centers have equal proportions of disabled and non-disabled children.

## **B. AREAS OF NONCOMPLIANCE**

### **1. Informed Clinical Opinion**

Each Statewide system of early intervention services must include the eligibility criteria and procedures, consistent with 34 CFR §303.16, that will be used by the State in carrying out programs under Part C. The State must define developmental delay by describing procedures, including the use of informed clinical opinion, that will be used to measure a child's development. See 34 CFR §303.300. The evaluation and assessment of each child must be conducted by appropriate qualified personnel trained to utilize appropriate methods and procedures and be based on informed clinical opinion. See 34 CFR §§303.322(a), (b)(1) and (c)(1) through (c)(3). Using informed clinical opinion to establish eligibility for Part C services is especially important if there are no standardized measures or if the standardized procedures are not appropriate for a given age or developmental area.

The use of informed clinical opinion is extremely important for infants and toddlers, as there are few standardized instruments to measure the developmental levels of infants and toddlers and evaluation instruments tend to be less reliable and valid for very young children. Standard scores or percentages may not identify a child in need of early intervention services. Requiring that the evaluation and assessment of each child be based on informed clinical opinion in determining eligibility helps to ensure that children needing early intervention services will be appropriately identified at the earliest possible age.

ADHS has not ensured that evaluators appropriately use informed clinical opinion in determining initial and continuing eligibility as required by Federal regulations.

Arkansas' policies and procedures include the directive that evaluators must use informed clinical opinion; however, OSEP determined through interviews that informed clinical opinion is not used as a separate basis to establish eligibility (and is only used in administering a test or protocol under 34 CFR §303.322(c)(1)). OSEP interviewed service providers, service coordinators, and administrators in all five areas. They told OSEP that regardless of informed clinical opinion, if a child did not meet the eligibility criteria according to a test protocol, the child was determined not eligible for early intervention services (unless the child met the diagnosed condition criteria). Evaluators stated that it was their understanding that a child would not be eligible for early intervention services unless the child demonstrated a 25% delay on a developmental protocol. They further stated that their informed clinical opinion is not a separate basis for establishing eligibility in addition to tests and protocols. Evaluators also stated that frequently children who were determined ineligible on the basis of the results of a test but whom the evaluators would have found eligible under an informed clinical opinion analysis, would qualify several months later when the delay was more pronounced. They noted that this practice did not support the concept of intervening early to prevent more serious delays.

Arkansas' application for Part C funds, including policies and procedures, allows and encourages the use of informed clinical opinion both in the administration of evaluations and assessments and the determination of eligibility. The application states that "Appropriate testing, observations, and informed clinical opinion shall be used to identify a developmental delay or

disability.” It further states that, “Most of the standardized, norm-referenced test instruments for children in this age range have questionable reliability and validity. The informed clinical opinion of qualified professionals, in conjunction with evaluation results and quantitative data, will be the primary basis for determining that a developmental delay or disability exists that constitutes eligibility for the program.” In addition, under the Components of an Entry Multidisciplinary Evaluation in Arkansas’ application, it states, “As a part of the evaluation process, the professional should exercise clinical judgment based on skilled observations and test scores,” and under the Arkansas model, the application states, “The informed clinical opinion of professionals on the multidisciplinary team results in a determination about eligibility. This determination is made following analysis and interpretation of all evaluation data, including formalized quantitative data and qualitative information.”

However, in practice, evaluators were not using informed clinical opinion to determine a child eligible unless the child’s test scores demonstrated a 25% delay. These evaluators are not implementing the State's own written policies.

In all areas, service providers, service coordinators and administrators stated that a child must be 25% delayed on a test protocol in one or more developmental areas to be eligible under Arkansas’ definition of eligibility, regardless of the informed clinical opinion of the evaluator that the child was in fact, developmentally delayed under the State's definition.

None of the evaluators interviewed had ever determined a child eligible using their informed clinical opinion if the child was not otherwise eligible according to the test results. When asked, evaluators stated they did not believe they were allowed to determine a child eligible based on their informed clinical opinion if the child was not also eligible by a 25% delay on the evaluation and assessment tests used by the State. One provider stated, “my opinion doesn’t matter, just the scores.”

## **2. Early Intervention Services Based on Additional Requirements and Not Eligibility as Defined Under Part C**

The term “infants and toddlers with disabilities” is defined as “individuals from birth through age two who need early intervention services because they (1) are experiencing developmental delays . . . in one or more of [five areas] . . . or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.” 34 CFR §303.16(a). Once a child is established as eligible under either criteria, an IFSP must be developed for the child that identifies all early intervention services designed to meet the unique developmental needs of that child. 34 CFR §303.12(a)(1); §303.16; §303.344(d). OSEP finds that the State has established impermissible additional eligibility criteria and failed to identify early intervention services based on a child’s individual developmental needs and instead has incorrectly required an eligible child to meet eligibility requirements for each service.

**a. Children with Diagnosed Conditions Not Identified as Eligible Unless They Meet Developmental Delay Criteria**

Infants and toddlers with disabilities means individuals from birth through age two who are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more developmental area, or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay as defined by the State. See 34 CFR §303.16(a).

Parents, service coordinators and providers in three areas of the State told OSEP that a child with a diagnosed condition or syndrome (as defined under Part C) would not be eligible for early intervention services if that child did not also demonstrate a 25% developmental delay. Service providers in one area stated that a child with cerebral palsy would typically be determined eligible and begin receiving services at about 15 months of age, but not earlier, as the child would not be delayed enough to demonstrate a 25% delay on the protocol until that age.

Parents, service providers and administrators told OSEP that parents of a children with Down Syndrome are typically told to come for an evaluation when their child is about six to twelve months of age to determine eligibility. One parent whose child had a diagnosis of Down Syndrome told OSEP that she was told her child was too young to be evaluated. She was told to return when the child was 6 months old to determine if the child was experiencing developmental delays measured by diagnostic instruments and procedures in one or more developmental areas, and therefore eligible for early intervention services. Parents in two other areas of the State related a similar experience with their child who had a diagnosis of Down Syndrome and would be eligible because of a diagnosis of a medical condition or syndrome according to the State's definition.

OSEP finds that the State has established impermissible additional criteria for eligibility. For a child with an established diagnosed physical or mental condition that has a high probability of resulting in developmental delay in Arkansas, rather than receiving services immediately upon identification, the State is impermissibly requiring that a child exhibit developmental delay as defined by the State. Once eligibility is established, early intervention services must be provided promptly to the eligible child.

**b. Failure to Provide All Services Needed for Eligible Children**

If a child meets the State's criteria for eligibility (regardless of whether the child is eligible due to a diagnosed physical or mental condition or due to developmental delay as defined by the State), Part C requires that, for eligible children, the IFSP must contain a statement of the specific early intervention services necessary to meet the unique needs of the child and family. See §§303.344(d) and 303.12. After the child is determined eligible for early intervention services, the IFSP team must identify those services needed to meet the child's and family's needs regardless of the percentage of delay in a particular area.

Service providers in all areas visited told OSEP that after a child is determined to be eligible for early intervention services, either because of a diagnosed physical or mental condition or by demonstrating a 25% delay in one or more developmental areas, the child must also exhibit a 25% delay in a specific developmental area in order to receive early intervention services to address that delay. OSEP was told by three administrators and by State staff that, infrequently, a child could qualify for service in an area of delay if the child did not meet the criteria of 25% delay in that area.

OSEP finds that ADHS has not ensured that the needs of each eligible child and his or her family are identified and all services needed are included on an IFSP for children who are eligible. Requiring a child who is deemed eligible for early intervention services to also meet eligibility criteria for each specific service negates the intent of early intervention and is inconsistent with the requirements for Part C. Part C allows States to define developmental delay; however, once it is determined that a child is eligible, the child is entitled to all early intervention services necessary to meet the child's developmental needs that are identified during the evaluation and assessment processes and development of the IFSP. 34 CFR §§303.16, 303.161, 303.344(d) and 303.12.

In addition, the State's application must reflect the requirements of Part C to ensure that services are identified for eligible children and the State does not impose additional criteria for eligible children to receive services. To ensure compliance with Federal regulations, the State must delete from its application for Part C funds the requirement that states, "To receive instructional services through the program there must be a specific instructional service area identified in which a 25% delay in one or more areas has been determined." Furthermore, the State should clarify to the public and to Part C evaluators and providers that children with diagnosed conditions are eligible for all early intervention service identified on their IFSPs as necessary to meet their developmental needs and do not need to meet any additional eligibility criteria.

### **3. Service Coordination - No Single Point of Contact**

Part C's service coordination requirements specify that each child eligible must be provided with one service coordinator who is responsible for coordinating all services across agency lines, and serving as the single point of contact in helping parents obtain the services and assistance they need. See 34 CFR §303.23(a)(2)(i)(ii). Service coordinators are further required to coordinate not only the provision of early intervention services, but other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided. Service coordinators must coordinate the performance of evaluations and assessments, facilitate and participate in the development, review, and evaluation of the IFSP, coordinate and monitor the delivery of services amongst all agencies, inform families of the availability of advocacy services, coordinate with medical health providers and facilitate the development of transition plans to preschool and other appropriate services.

Service Coordination is a critical element in ensuring that eligible children and families receive appropriate assistance to enable them to receive the rights, procedural safeguards, and the supports and services needed by the child and family. Without this service coordination, needed

services are delayed, not provided at all, or families must coordinate their own services. 34 CFR §303.23.

Service coordination is carried out by at least three different entities in Arkansas. The result is that many families have at least two individuals from different agencies who perform some, but not all, of the activities for service coordination required by the Part C regulations with no single individual who coordinates all of these functions for any particular child and family. All children and their families are assigned to a State service coordinator, and most children and families also have a case manager, and many have a center service coordinator, and a few families have all three. There is a State service coordinator who is an employee of ADHS and who serves not only the birth to three population, but birth to death population. Many of these State service coordinators have large caseloads, consisting of 60 to 120 cases. There are also private case managers who perform some, but not all, service coordination duties, and there are service coordinators at Developmental Day Treatment Clinic Services (DDTCS) centers who are responsible for service coordination at those centers.

The roles of each of these coordinators is unclear and inconsistent throughout the State. For example, in one part of the State, case managers told OSEP they completed the initial IFSP with the family, whereas in another part of the State they did not. Service coordinators employed by ADHS told OSEP they did not assist families in locating family supports and services, as that was the job of the case manager; and case managers told OSEP that if families needed certain supports and services, the case manager told parents to contact the service coordinator. Center service coordinators stated they only coordinated services provided in their center and if a family needed services not available through the center, they were told to contact the State's service coordinator. The personnel responsible for service coordination varies across the State. In some areas, case managers are responsible for some service coordination activities, and in another part of the State, case managers would not perform those duties.

ADHS has not ensured that each family has one service coordinator who will act as the single point of contact for a child and family to assist families with all service coordination activities as required by Part C.

Service coordinators, case managers, parents and administrators in all areas visited told OSEP that families frequently did not know who to go to obtain needed services, information or resources. Parents told OSEP that they did not know that they were entitled to ask their service coordinator, case manager or center service coordinator to assist them in obtaining resources. Most parents told OSEP that they consulted with their doctor to obtain such information.

When interviewed about the list of service coordination responsibilities outlined in the Part C regulations, these three groups of personnel who provide service coordination responded in a variety of ways. Sometimes all groups indicated they performed all of the duties, except coordinating medical services or other services; no one stated they coordinated these services. Sometimes these personnel indicated they fulfilled some of the responsibilities, but it was not consistent throughout the State. Parents told OSEP that if they needed services or resources not offered by their service coordinator or agency, they usually had to obtain them on their own. Typically, they stated that their service coordinator did not provide information about other

resources or services, and parents were unaware that service coordinators should assist in obtaining them. The service coordinator might provide parents with a list of possible resources, but does not provide assistance in obtaining these services. Service providers, service coordinators, case managers and local administrators in all areas of the State visited told OSEP that there are not enough personnel to fulfill the service coordination requirements. In addition, local administrators and service coordinators told OSEP that the supervision and training for these three entities is different, and that this results in unequal and insufficient provision of service coordination

#### **4. All Needed Services Not Included in the IFSP**

An IFSP must include a statement of all the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified (34 CFR §303.344(d), and must also include medical and other services that the child needs, but that are not required under Part C. See Note 3 following 34 CFR §303.344(e).

ADHS does not ensure that all the early intervention services or other services needed by the child and family are included on the IFSP. Service coordinators and case managers in three areas stated that only services provided by their agency were included on the IFSP, and other early intervention services provided by other agencies were not included on the IFSP. As an example, one blind child did not have vision services on the IFSP although they were provided to the child. The administrator told OSEP that their center did not provide the service so it was not put on the IFSP. Further, service coordinators and administrators stated that they did not consider services to support the family in enhancing the development of their child to be early intervention services.

In addition, service coordinators and case managers told OSEP that services such as social services, other health services, special feeding services, and child care for special needs children were not included on the IFSP even if the child or family needed them. Center-based service coordinators told OSEP that services not provided by the service coordinators' employing agency were not part of the IFSP, even if they were early intervention services needed by the child and/or the family. In a review of 33 IFSPs, services that could be identified as "other services" were found on only two IFSPs and steps to be taken to secure those services were not included. None of the IFSPs reviewed included a service from another agency. Although service coordinators and case managers in four areas visited told OSEP that many families received respite care, it was not included on the IFSP as an early intervention service or as an "other" service.

#### **5. Appropriate IFSP Team Decision-Making Process Not Used**

An integral part of service coordination is coordinating the decision-making process throughout development, implementation and revision of the IFSP. The Part C regulations require, at 34 CFR §303.344(d)(1), that the IFSP for each infant or toddler with a disability include, " a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes identified in [34 CFR §303.344(c)]."

**a. IFSP team process not used to identify needs and services**

An IFSP team, that includes the participants specified at 34 CFR §303.343, must develop all of the content of each child's IFSP, including the statement of specific early intervention services. The content of the IFSP must be based on the results of the evaluation and assessment process to identify unique needs of the child and the family, and the services appropriate to meet those. See 34 CFR §303.322(c)(3)(iii), §303.342 and §303.344.

ADHS has failed to ensure an appropriate IFSP team decision-making process for the identification of the unique strengths and needs of the child and family, and the services to meet those needs, as well as the natural environment for those services.

Parents, providers, administrators and service coordinators in four areas visited told OSEP that after a child has been determined eligible using developmental assessments, parents are asked where they would like services provided prior to the IFSP team decision determining specific services, frequency and intensity. These respondents told OSEP that in Arkansas, the decision is not made by the IFSP team, but rather by "family choice." The evaluations and assessments to determine the child's unique needs and specific services are completed only after parents choose a provider, based on where parents would like services, or on availability of a service provider, which is contrary to the IFSP process. Parents in three areas told OSEP that there is no IFSP team meeting to identify the need for services; instead, the parents meet with the service coordinator and home-based provider to select an agency to provide services. After the parent has selected the agency or individual provider, evaluations are completed in the area of need. The sections of the IFSP related to services, frequency, intensity and location are developed later by the provider, not the IFSP team, according to the parents.

**b. Natural environments requirement of the IFSP.**

34 CFR §303.12(b) states that to the maximum extent appropriate early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. 34 CFR §303.18 defines a natural environment as the settings that are natural or normal for the child's age peers who have no disabilities. 34 CFR §303.344(d)(ii) further requires that the natural environments where early intervention will be provided must be identified on the IFSP. If early intervention cannot be effectively achieved in a natural environment, the IFSP must contain a statement of the justification for not providing the service in a natural environment.

ADHS has not ensured that the discussion and decision about natural environments is part of the IFSP decision making process and meets requirements of the Federal regulations.

As noted above, during the IFSP decision making process, the question of whether the early intervention can effectively be provided in a natural environment is not discussed and the justification written on the IFSP for not providing service in a natural environment is "parent choice," which is inconsistent with Part C regulations. Although families may choose a provider for service, the identification of appropriate services to meet child and family needs and the location for those services must be the decision of the IFSP team using information gathered

during evaluation and assessment. Part of the IFSP team decision making process is the identification of the natural environment for a particular child and family.

OSEP was told by parents, service providers, service coordinators and administrators in all areas visited that the location of service delivery is based on the parent's choice and provider availability rather than the needs of the child and family as determined by the IFSP team. Service provider agencies and private providers usually have a pre-determined location for where they will provide services and providers told OSEP that parents did not get service if they did not want service in the location where the service was provided. Some agencies and providers only provide services in a center or clinic. Others will provide services in the home or a community location. Many provider locations are hospitals or clinics, settings in which only children with disabilities participate and which are not natural environments for peers who have no disabilities.

#### **6. Transportation Services Not Identified and Provided**

Transportation and related costs are early intervention services that must be provided if the IFSP team determines they are necessary to enable an eligible child and family to receive early intervention services. This includes the cost of travel, such as mileage, or travel by taxi, bus, or other means, and other costs (such as tolls and parking expenses) that are necessary to enable a child eligible under this part and the child's family to receive early intervention services. 34 CFR §303.12(d)(15)

ADHS has not ensured that families who need transportation to enable them to receive early intervention services are provided transportation. Although transportation is provided as a regular service to and from the Developmental Day Treatment Clinic Services centers, parents, service providers, service coordinators and administrators in three areas visited told OSEP that lack of transportation and failure to provide it prevents children and families from receiving timely evaluations and from receiving the early intervention services needed. To bring a child to early intervention services, families had to have their own transportation or, if eligible, could obtain transportation through a voucher. However, service providers reported that transportation is contracted to an agency and that the agency does not reliably provide the needed transportation; children miss early intervention service appointments because the transporter picks them up late (sometimes an hour or more late). A service coordinator reported that a child did not receive service for eight months because the family vehicle was out of service. Home services or an alternate means of transportation were not offered to this family. State staff told OSEP that a family would not be provided transportation if the family had a vehicle, even if that vehicle did not operate.

Parents told OSEP that the need for transportation was not discussed at the IFSP meeting. Administrators and service coordinators told OSEP that transportation is not available except through Medicaid or a voucher, and although they did the best they could to assist the family with transportation, they stated it was not the early intervention system's responsibility to provide it.

## **C. SUGGESTIONS FOR IMPROVED RESULTS FOR INFANTS, TODDLERS, AND THEIR FAMILIES**

### **1. Medicaid Procedures for Prior Authorization**

The State Medicaid plan requires prior authorization for payment before evaluations can be administered and services provided. Although this practice serves to ensure that Medicaid funds are used only for eligible children and to reduce the likelihood of Medicaid abuse, service providers and service coordinators reported to OSEP that evaluations and services are delayed because they wait for acceptance or denial of authorization.

State administrators are aware that Part C funds can be used to prevent a delay in evaluations and assessments, and implementation of services; however, providers and local administrators told OSEP that they were unaware that this was a possibility. See 34 CFR §303.527(b). Parents also told OSEP that it was very difficult at times to obtain authorization from their physicians. Service providers indicated that many doctors require an additional visit to obtain the authorization that, according to these providers, places a financial burden on some families who also have transportation difficulties. The State may want to monitor local programs in this area to ensure that all providers of service are aware of the procedures for ensuring that evaluations, assessments and the provision of early intervention services occurs in a timely manner according to the requirements of Part C. A Medicaid requirement for a specific standardized evaluation may be interfering with timely provision of services, and the State may want to discuss this issue with Medicaid staff to identify mutually acceptable procedures for determining the need for early intervention services.

### **2. Year Round Services to Assure Needs Are Met**

The Developmental Day Treatment Clinic Services centers that provide child care and early intervention services are open for eleven or twelve months a year (closing for holiday weeks), assuring generally uninterrupted services for children with disabilities. State staff told OSEP that there were only four centers not open during the summer months and those centers provided summer services at home for those children. The State administration assured OSEP that training has been conducted and centers are aware of their obligations to provide uninterrupted services. However, OSEP was told by service providers of several instances throughout the State where services were changed or reduced during one or more summer months due to personnel shortage, change in program, or other reasons, rather than an IFSP team determination of changes in service needed due to changes in child and family's need.

In a review of IFSPs, OSEP noted two IFSPs out of seven in one local area where occupational therapy was decreased during the summer months and case notes indicated "the number of prescribed sessions could not be provided due to therapist's increased caseload." Although in general, parents, service providers, and service coordinators stated that in most areas of the State, services were provided to children at home and in centers throughout the year, there were a few instances where this was not the case. Arkansas may want to ensure that its monitoring activities address this issue so that all children receive the services needed.

### **3. Voucher System Provider Enrollment**

Service coordinators and service providers told OSEP that sufficient providers were not available to provide services in the home or other community locations. Local administrators also stated that there were not enough providers on the voucher system and they could only use providers who had applied to the system. Service providers and administrators stated that the voucher program has not been opened for new enrollees for two years and more providers were needed. State administrators told OSEP that if the providers on the voucher system were not available, local administrators only needed to contact the State for a purchase order for that service until the provider could be enrolled in the voucher system. State administrators told OSEP that only two requests have been received in the past year to obtain a purchase order. Apparently not all providers and administrators are aware of this opportunity to assure service provision and the State may want to consider additional provision of information and training in this area. Administrators and service providers also told OSEP that therapists are reimbursed only for “touch time” -- time actually spent with a child. Travel time is not reimbursed; therefore, if the child is not at home, the therapist will not receive any payment for hours spent traveling to and from the child’s home. State staff agreed this is a disincentive to providing services in the home.

### **4. Training for Parents and Providers**

During the Validation Data Collection, OSEP heard from parents, providers, service coordinators and administrators that there were a variety of concerns about the IFSP process. Parents reported they did not have enough information to be able to understand the IFSP process and participate effectively in the development of their child’s IFSP. Service providers and service coordinators responded to OSEP’s monitoring questions with inaccurate information about many areas of the IFSP requirements, indicating a need for training about IFSP requirements. These same providers and coordinators expressed a need for an effective method to inform all early intervention personnel about available training. As noted earlier, the State conducted extensive training sessions throughout the State; however, the State needs to increase its efforts to ensure that parents, as well as personnel working with the birth through two population, know about training, and that training is provided in the areas of need.

## **IV. PART C: FAMILY CENTERED SYSTEM OF SERVICES**

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

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

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

### **Validation Planning and Data Collection**

The self-assessment committee identified the following promising practices in the area of family-centered services: more parent involvement based on increased parental response to surveys; interpreter services available to families in their local area; and an increase in parent involvement on State and local committees. The committee also noted that the focus is on family-centered training. Areas for improvement identified by the self-assessment committee included recommendations to continue efforts to increase parent participation, to encourage parental involvement at all levels of the State programs, to maintain data on the number of parents and family members utilized as trainers, and to develop parent manuals.

During the Validation Planning and the Validation Data Collection visits, providers, service coordinators and administrators told OSEP that the early intervention program was very family-friendly and that parents were generally satisfied. Providers expressed a belief that parents were included in all aspects of the IFSP process and that family needs were met. Parents did not concur with the viewpoint of the providers and service coordinators, stating that they did not receive assistance to locate resources and the concerns of their family were not included on the IFSP.

Based on the information collected from all of the Validation Planning activities, the following concerns were identified to be investigated during the Validation Data Collection week: (1) inclusion of the parents in the IFSP process; (2) identification of family supports and services, and (3) assistance provided to parents in locating resources and coordination of family services.

To investigate the issues identified through the validation planning process, OSEP collected data from local programs, parents and providers throughout Arkansas relative to the involvement of parents in the IFSP process and the training of parents and staff. Analysis of the data collected resulted in the identification of one area of non-compliance and one suggestion for improvement. Areas of non-compliance related to the Family Centered Cluster are also included in other sections of this report. (See section III, B, 3, Service Coordination , III, B, 5, Failure to Use the IFSP Decision Making Process).

### **AREA OF NONCOMPLIANCE**

#### **Family Supports and Services Not Included in the IFSP**

The family assessment is designed to identify the needs, resources, priorities, and concerns of the family and to identify the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child. 34 CFR §303.322(d). The IFSP must include a statement of the specific early intervention services necessary to meet the unique needs of the child and the family to achieve the outcomes. §303.344(d) (emphasis added). In addition, with the concurrence of the family, the IFSP must contain a statement of the family's resources, priorities and concerns. 34 CFR §303.344(b).

ADHS has not ensured that the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child are identified and included in a statement of the specific services needed to meet the unique needs of the child and family on the IFSP.

Service coordinators, case managers and administrators stated they did not have a specific method or mechanism to identify family needs, concerns, resources and priorities. OSEP finds that ADHS has not conducted family assessments in accordance with federal regulations. The social history used by most service coordinators does not lead to the identification of family needs or the supports and services needed by families to enhance the development of their child and that would be included on the IFSP. The State administrators, service coordinators, and case managers stated that if families identified a need, they would try to assist families in identifying resources, but supports and services needed for families were not identified on the IFSP.

Parents told OSEP during Validation Planning and Validation Data Collection, that although they did get some resource information from service coordinators, they generally had to obtain their own supports and resources. Parents from four areas of the State told OSEP that service coordinators did not inform them of what was available, or provide information about resources based on their circumstances, that would assist them with their child. Some parents did tell OSEP that their service coordinator or classroom teacher connected them with another parent or provided other assistance in terms of resources, but none of the parents reported ongoing inquiries from their service coordinator about possible needs the family may have or of receiving

more than minimal assistance. If the service coordinator asked about needs or concerns of the family, it was only when the child was first referred for early intervention and parents could not relate any ongoing assessments of family needs, concerns, priorities or resources. Service coordinators asked parents if they needed anything, but parents reported that they did not know what options were available. Another concern that parents told OSEP is that if a family was not eligible for Medicaid, no one suggested they might be eligible for services provided under one of the State's Medicaid waiver plans. Also, if a family was on a waiting list for a center, no one told them they could receive services in the home or other environments.

OSEP finds that ADHS has not ensured that services for the family are identified on IFSPs. None of the IFSPs reviewed by OSEP contained family outcomes to address family needs related to enhancing the development of their child. Service coordinators, case managers and administrators concurred that family supports and services or "other services" were not included on the IFSP. None of the 33 IFSPs that OSEP reviewed identified family outcomes on the IFSPs, rather they identified only child outcomes. There is no mention of family supports or services to address family needs in early intervention records reviewed by OSEP. When interviewed, parents identified a variety of needs for resources and supports, and only four records identified any family concerns, and none of these IFSPs addressed the identified concerns.

## V. EARLY CHILDHOOD TRANSITION

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

### **Validation Planning and Data Collection**

The State's self-assessment did not reveal any concerns in the area of transition. ADHS has an interagency agreement with ADE to ensure a smooth transition into special education services for eligible children. They identified areas of strength as collaboration between the State and local education agencies and a computerized process to notify local public school entities six months prior to the child's third birthday. The State's monitoring process identified no findings in the area of transition.

The information collected by OSEP during the Validation Planning activities included only one comment in the area of transition; a concern about timely referral to the Part B system. Nevertheless, as part of OSEP's monitoring activities that include investigation into joint concerns of Part C and Part B, OSEP decided to investigate general areas of transition to determine if activities occurred in a timely manner and transition plans were intact. The results of that investigation revealed one area of noncompliance.

### **AREA OF NONCOMPLIANCE**

#### **Written Transition Plans Not Included in the IFSP**

Each IFSP must include steps to be taken to support the transition of the child. 34 CFR §303.344(h). The steps must include discussion with, and training of, parents regarding future placements and other matters related to the child's transition, procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting, and with parental consent, the transmission of information to the local education agency, including evaluation and assessment information required in 34 CFR §303.322 and copies of

IFSPs that have been developed and implemented. In addition, the State must establish a transition plan for each child in accordance with 34 CFR §303.148.

ADHS has not ensured that a written transition plan is developed and implemented for each child according to Part C requirements. Service coordinators in the Developmental Day Treatment Clinic Services centers (DDTCSs) told OSEP that it was not necessary to write transition plans as the children remained in their center after their third birthday as their centers provide special education services under contract with the Department of Education for three to five year olds. Other State service coordinators told OSEP that they notified the school system of children who would be turning three years of age six months prior to their third birthday and the schools would then evaluate those children not continuing in the centers for determination of eligibility for Part B. However, these service coordinators did not write plans to ensure a smooth transition from Part C to Part B, and none of the IFSPs reviewed by OSEP contained written documentation of the steps to ensure a smooth transition.

## VI. PART B: PARENT INVOLVEMENT

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

### **Validation Planning and Data Collection**

**Prior Monitoring:** OSEP's 1995 monitoring report did not identify any findings of noncompliance in this area.

**Self-Assessment:** The Arkansas Part B Self-Assessment addresses "Parent Involvement" and organizes it around components identified in the OSEP "cluster charts." The Self-Assessment indicates that ADE uses a variety of sources to identify specific topic areas for information dissemination to parents and areas of needed training for parents; however, the sources are not identified. The Self-Assessment reports that ADE has made "a concerted effort to provide training and increase its information dissemination to parents and local education agency staff for the purpose of increasing parental involvement in the education of children and youth with disabilities." No information is yet available regarding parent participation in training opportunities.

The Self-Assessment reports that no State-level data are available regarding the participation of parents and youth with disabilities in the secondary transition planning process.

The Self-Assessment reports that ADE has taken "aggressive steps to increase the participation of parents on committees involved in the development of various training activities, as well as membership on the State Advisory Panel and the OSEP monitoring steering committee." No information is available regarding the impact of parent participation; however, the Self-Assessment reports that parent comments indicate the belief that their involvement has had a positive impact on the quality of products, policy and training.

**Public Input Process:** One of the focus questions asked during the public input meetings was: "How are parents involved in the education of their children with disabilities?" School staffs and the Parent Training and Information Center representatives report that it is difficult to obtain parent participation and that parents who do participate are passive. Some parents report that the special education process, the composition of the IEP team, and the attitudes of school staff are intimidating. In some instances, parents feel that they are educating their child's teacher regarding the disability and that more joint training of parents and school personnel is essential. Some parents believe that schools are not interested in partnerships and are reluctant to provide them explanations of their rights under the IDEA, although some parents also reported that they feel that they are partners with the school district when teachers are flexible, willing to listen to

parents, willing to make appropriate accommodations for children with disabilities, and have the support of local administrators. Some parents reported that they had participated in training for parents and educators on preparing IEPs.

At the end of the Validation Planning week, after discussing information obtained through the Self-Assessment and public input process, the Steering Committee and OSEP agreed that OSEP would collect additional data to evaluate reports from parents that (1) parents of children with disabilities are provided with written procedural safeguards, but many parents felt they needed more help in understand the written procedural safeguards and (2) training is insufficient to encourage parent involvement in the special education decision-making process.

To investigate concerns identified during the Validation Planning process, OSEP collected information through the review of children's records and State and local policies and procedures, and interviews of State personnel, local program administrators, teachers, parents and students.

OSEP reviewed and analyzed the data collected and identified the following strengths and suggestions for improved results for children and youth with disabilities.

#### **A. STRENGTHS**

##### **1. Development of Joint IEP Training Model for Parents and Educators**

ADE reported to OSEP that, through a grant from the Governor's Developmental Disabilities Council, ADE has developed and implemented joint training for parents and educators on developing IEPs. Parents and educators participated in the development of the training.

##### **2. Stipend for Parent Participation**

To facilitate parent involvement and participation in various ADE-sponsored projects, ADE told OSEP that it has provided stipends to offset costs incurred by parents, or ADE has directly absorbed the costs. Such projects include the Annual Spring Parent Retreat and *Special Show*, a "super" conference sponsored by the ADE.

#### **B. SUGGESTION FOR IMPROVED RESULTS FOR CHILDREN AND YOUTH WITH DISABILITIES**

##### **Need for Additional Training of School Staff and Parents**

Although ADE, through a grant from the Governor's Developmental Disabilities Council, has developed a successful training model for parents and educators on developing IEPs, staff in six of seven districts visited by OSEP reported no training for staff relative to parents' needs or involving parents in the special education process. They also reported no formal mechanisms for identifying or addressing parents' needs. Parents in these districts reported that they are unaware of any parent training offered by their local school district regarding special education.

Staff in five of seven districts reported that parent attendance at the IEP meetings is difficult to obtain. Attendance by parents at their child's IEP meeting seemed to depend on the age of the child. Parents of preschool and elementary age students often attended IEP meetings, but attendance by parents diminished for middle and high school students.

## VII. PART B: FREE APPROPRIATE PUBLIC EDUCATION IN THE LEAST RESTRICTIVE ENVIRONMENT

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

The IDEA '97 Committee Reports of the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Education and the Workforce emphasized that too many students with disabilities are failing courses and dropping out of school. Those Reports noted that almost twice as many children with disabilities drop out as compared to children without disabilities. They expressed a further concern about the continued inappropriate placement of children from minority backgrounds and children with limited English proficiency in special education. The Committees stated their intention that “once a child has been identified as being eligible for special education, the connection between special education and related services and the child’s opportunity to experience and benefit from the general education curriculum should be strengthened. The majority of children identified as eligible for special education and related services are capable of participating in the general education curriculum to varying degrees with some adaptations and modifications. This provision is intended to ensure that children’s special education and related services are in addition to and are affected by the general education curriculum, not separate from it.”

### **Validation Planning and Data Collection**

**Prior Monitoring:** In its 1995 monitoring report, OSEP reported deficiencies in the provision of extended school year services, a shortened school day for children and youth with disabilities, and insufficient qualified related services personnel.

**Self-Assessment:** The Arkansas Part B Self-Assessment addresses “Free Appropriate Public Education in the Least Restrictive Environment” and organizes the data around components identified in the OSEP “cluster charts.” The Self-Assessment indicates that the rate of identification of children with disabilities in Arkansas is comparable to national averages with the exception of the rate of identification of children with emotional disturbance which is less than the national average. The ADE has had a system for the collection and analysis of data on racial disproportionality since 1987.

While the Self-Assessment asserts that there are sufficient personnel to ensure that special education and related services are available to meet the unique individual needs of children with

disabilities, ADE is collaborating with institutions of higher education to address shortages in areas such as visual impairment, physical therapy, occupational therapy, and projected shortages in special education.

Under the State's Comprehensive System of Personnel Development, a variety of training opportunities is available to school district staffs around the State. ADE provides training for paraprofessionals and maintains a paraprofessional registry at the State level. ADE conducts annual needs assessments throughout the State.

The Self-Assessment reports that ADE currently has no mechanism for identifying either high school completion rates or dropout rates for youth with disabilities. A system for disaggregating this data is currently under development.

While the Self-Assessment identified significant efforts to provide training in the provision of functional behavioral assessments and the development of behavioral intervention plans, it expressed concern that functional behavior assessments are not appropriately implemented for all students who need them. It also identified a need for local education agencies to increase the use of mental health services for children with behavioral needs.

The Self-Assessment indicated that the State Board of Education adopted rules and regulations in 1997 for the participation of students with disabilities in Statewide assessments, such as the Stanford 9. ADE is in the process of developing an alternate assessment to be implemented during the 2000-2001 school year. The Self-Assessment also indicated that ADE has adopted performance goals and indicators for children with disabilities that are consistent with those adopted for nondisabled children.

**Public Input Process:** Three of the focus questions asked during the public input meetings were: (1) "Are students with disabilities receiving the special education and related services that they need?" (2) "How do students with disabilities participate with nondisabled students?" and (3) "Do all students, regardless of placement, have access to the same curriculum as their nondisabled peers?" Responses indicated that some parents believe there is a significant delay in the identification process – that it takes months for evaluations to be completed. Participants also reported that personnel shortages in occupational and physical therapy, mental health services, hearing services and vision services result in delays in evaluations and/or services. Many administrators and teachers indicated that the number and type of forms for IEPs required by the State, especially in the area of transition, take too much time to complete and take away from direct services to children with disabilities. Several participants stated that evaluations for assistive technology devices and services are difficult to obtain and that there is confusion about what assistive technology is appropriate for children with disabilities.

Participants concurred that children with emotional disturbance are under-identified. Some participants stated that there is no certification in this area in the State while others reported that there have been no graduates from Arkansas State University in this area of disability for the past five years.

Some participants reported that there is confusion across the State about the requirements of IDEA related to the general curriculum. In addition, participants reported that many teachers are

unwilling or unable to modify the general curriculum to accommodate the needs of children with disabilities. They reported that more training is needed for both regular and special education staff to understand these requirements as well as requirements for educating children with disabilities in the least restrictive environment.

Participants reported that evaluations obtained at parent expense are considered by the school district but that the school district evaluations are given more weight.

At the end of the Validation Planning week, after discussing information obtained through the Self-Assessment and public input process, the Steering Committee and OSEP agreed that OSEP would collect additional data regarding reports that (1) personnel shortages affect evaluation time lines and the provision of appropriate services to children with disabilities; (2) children with emotional disturbance may not be identified; (3) modifications and accommodations may not be provided when required by the child's IEP and may not be provided on State-wide assessments; (4) assistive technology may not be provided, at no cost to the parent, when required by children with disabilities; (5) independent educational evaluations are not considered unless parents indicate that the school district evaluation does not address all areas of the child's need; (6) extended school year services are not always available when needed to ensure the provision of a free appropriate public education; (7) functional behavioral assessments and behavior intervention plans are not utilized appropriately; and (8) progress on IEP goals and objectives is not reported to parents at least as often as progress is reported for nondisabled children.

To investigate the concerns identified during the Validation Planning process, OSEP collected information through the review of children's records and State and local policies and procedures, and interviews of State personnel, local program administrators, teachers, related service providers, students and parents.

OSEP reviewed and analyzed the data and identified the following strengths, areas of noncompliance and suggestions for improved results for children and youth with disabilities.

## **A. STRENGTHS**

### **1. Correlation of the General and Special Education Curriculum**

ADE has developed a computerized correlation between the general education curriculum at all educational levels and IEP benchmarks. When a teacher identifies specific benchmarks on an IEP, the program identifies the corresponding general education objective. Teachers reported that the development of consistent general education standards has facilitated the access of children with disabilities to the general curriculum.

### **2. Training for Functional Behavioral Assessment and Behavior Intervention Plans**

School district personnel across the State reported to OSEP that whenever a student exhibits a pattern of behavior that may result in continued disciplinary referrals or suspension, they collect and analyze data regarding the antecedents to the behavior, the behavior exhibited and the result of consequences applied. This behavioral analysis results in the creation of an individualized

behavior intervention plan, as part of the IEP, to intervene in the behavior and interrupt the pattern. This information constitutes a functional behavioral assessment, is coordinated and managed by school psychology specialists, and is available to teams for consideration should a manifestation determination become necessary. This process is a direct result of significant levels of Statewide training provided by ADE.

### **3. Establishment of a Network of Behavioral Intervention Consultants**

ADE has established a network of regional behavior intervention consultants to assist local school districts with addressing the behavior needs of children with disabilities. ADE funds ten regionally-based consultants who consult on areas such as functional behavior assessments, positive behavior supports and behavior intervention plans. All consultants participate in local CASP teams (single point of entry to community mental health services).

### **4. Nightschool Program in El Dorado**

The department of special education in the El Dorado School District has incorporated a special education component into the regular education night school program. This program runs from 3-6 p.m. and provides children who have failed or are failing core courses with opportunities to make up credits and/or improve their performance. Special education students can now participate and are afforded the same opportunity to make up credits or improve their performance in core subjects. In addition, they may voluntarily take these courses prior to taking them during the day, giving them a head start in understanding the material and, in some cases, enabling them to take these classes in the general education classroom rather than in resource room settings.

### **5. Co-teaching in Conway to Promote Participation in General Education Settings**

Significant co-teaching efforts at all educational levels in the Conway School District has provided many opportunities for children with disabilities to participate and achieve success in general education settings. In addition, it provides training in the implementation of modifications and accommodations to general educators as well as training special educators in general curriculum subject areas.

### **6. New Licensure Requirements for General Educators**

ADE told OSEP that it is participating in the establishment of new teacher licensure standards that will ensure greater competency of general education teachers to address the diverse learning styles and behaviors exhibited by children with disabilities. It is now mandatory that general educators receive six hours of training in special education rather than the previous three hours.

### **7. Reimbursement for Interpreters**

The ADE underwrites the cost of educational interpreters for the deaf working in schools to support opportunities for the hearing impaired to participate in general education settings.

## **B. AREAS OF NONCOMPLIANCE**

### **1. Extended School Year Services Not Made Available and Provided**

34 CFR §300.300 requires that a free appropriate public education be made available to all children with disabilities. In addition, 34 CFR §300.13 requires that extended school year services be provided in accordance with an appropriate IEP that meets Part B requirements.

As discussed below, OSEP determined that ADE did not ensure that all children with disabilities who require extended school year services as part of a free appropriate public education are provided extended school year services, in accordance with their IEP.

OSEP finds that extended school year services are not available for all children with disabilities who need such services in order to receive a free appropriate public education in Arkansas. Teachers and administrators in six of seven districts visited reported that the manner in which they implement State extended school year services criteria results in only the most severely-disabled children receiving extended school year services and, if the criteria were applied differently (i.e., regression measured over longer breaks), more children would require extended school year services. The criteria allow for regression/recoupment (a primary determining factor) to be measured over any school break. Teachers reported that breaks used to measure regression/recoupment almost exclusively were two weeks at Christmas and one week at spring break. Only one occupational therapist who OSEP interviewed reported using the summer break to measure regression. In addition, teachers and administrators in three of seven districts reported that extended school year services are not based on individual student needs. Each student found eligible for extended school year services receives services for the same number of hours and days per week as well as the same number of weeks (concurrent with regular summer school for purposes of efficient transportation utilization), regardless of individual student needs.

### **2. Related Services (Psychological Counseling Services) Not Provided**

§300.300(a)(3)(i) requires that services provided to children with disabilities address all of the child's identified special education and related services needs. Public agencies must provide psychological counseling to each child with a disability who requires that related service to benefit from special education. §300.24(b)(9)(v).

OSEP found that ADE failed to ensure that children with disabilities, including children with emotional disturbance or other behavioral or emotional needs, received psychological counseling services if required to assist the student to benefit from special education.

Teachers and administrators in four of seven districts reported that IEP teams routinely do not include psychological counseling services on students' IEPs, regardless of individual student need. In two of the four districts, school psychology specialists reported that they were trained to provide counseling services but that their districts only allowed them to conduct evaluations. In one of these two districts, guidance counselors were trained to provide some counseling services but were unable to provide ongoing counseling services to students with behavioral needs because of the size of their caseload (1:450). Sometimes, students received psychological

counseling services through outside agencies by referral from the school, but these services are not provided at no cost to the parent and are not identified on the students' IEPs even where such services were needed in order for a student to receive a free appropriate public education. In two of the previously-mentioned four districts, and one additional district, some students received psychological counseling services but they were not identified on their IEPs.

School psychology specialists and administrators in three of seven districts reported that the specialists were utilized solely for testing and evaluation. These individuals are qualified to provide counseling services to children with disabilities as well as supports to general and special education teachers in working with students with emotional disturbance and behavioral needs. Also, there are no State standards for school psychology specialist caseloads; therefore, they are expected to provide services to significant numbers of students, with and without disabilities. The high caseloads allow minimal time for any direct counseling services.

### **3. Students Not Placed in the Least Restrictive Environment**

Section 300.550 (b)(2) requires that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids in services cannot be achieved satisfactorily. In addition, §300.347(a)(3)(iii) requires that the IEP for each child must include a statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modification and supports for school personnel that will be provided for the child to be educated and participate with other children with and without disabilities.

OSEP finds that ADE has not ensured that in all cases, children with disabilities are placed in the least restrictive environment. Special education teachers, regular education teachers and administrators in three of seven districts visited indicated that regular education teachers failed to provide modifications and/or accommodations that would enable children with disabilities to participate in general education classes.

Personnel in five of seven districts indicated that children with disabilities would be able to participate in general education classrooms if additional personnel were available to support regular education staff (e.g., aides, additional teachers for co-teaching, related services personnel, etc.). In five of seven districts, personnel indicated that training for regular education teachers regarding both disability category characteristics and the implementation of modifications and accommodations would facilitate the participation of children with disabilities in general education classrooms.

### **4. Insufficient Supply of Qualified Special Education, Regular Education and Related Services Personnel to Ensure Children Receive FAPE**

The IDEA regulations at 34 CFR §300.300(a) requires that children with disabilities are provided services that address all of the child's identified special education and related services needs. In addition, each State must analyze State and local needs for personnel to serve children with disabilities. 34 CFR §300.381. As reported earlier, the Self-Assessment indicated that Arkansas

has sufficient personnel to provide special education and related services while at the same time it indicated that ADE is working with institutions of higher education to address personnel shortages in a variety of areas.

OSEP finds that ADE did not ensure that, in all instances, each child with a disability is provided services that address all of the child's identified special education and related services needs. Personnel in four of seven districts reported that special education and/or related services staff had to choose between providing services identified on students' IEPs or completing evaluations within the required three-year time line. Speech pathologists in these districts indicated that IEPs reflect less service than needed by students in order to maintain caseload requirements. In five of seven districts, personnel indicated that although staffing was within State ratios, it was inadequate to provide all services required by children with disabilities and identified on their IEPs. Area of noncompliance number 2 above established a shortage of personnel to provide psychological counseling services.

## **C. SUGGESTIONS FOR IMPROVED RESULTS FOR CHILDREN AND YOUTH WITH DISABILITIES**

### **1. Need to Identify Children with Emotional Disturbance**

School personnel in five of seven districts indicated they do not identify all students that they believe may have emotional disturbance. Although these students are often being identified under different disability categories, the concern raised by personnel in the five districts is that unless the student is labeled "emotionally disturbed," he/she may not get all the necessary special education and related services (counseling) that are needed. It is important that the IEP identify the special education and related services needed based on the unique needs of the child and that students receive the necessary special education and related services, regardless of the disability category. Public input indicated confusion about qualified personnel to teach these students. In addition, staff in the five districts indicated confusion about the identification process and the eligibility requirements for emotional disturbance.

### **2. More Opportunities for Co-Teaching**

Teachers and administrators in four of seven districts indicated they implemented successful co-teaching models that created additional opportunities for students with disabilities to participate in the general education classroom. They indicated that more co-teaching would facilitate participation of additional students in the general education classroom; however, lack of administrative support, scheduling difficulties and personnel shortages prevented implementation of additional co-taught classes.

## VIII. PART B: SECONDARY TRANSITION

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The National Longitudinal Transition Study states that the rate of competitive employment for youth with disabilities out of school for three to five years was 57 percent, compared to an employment rate of 69 percent for youth in the general population. The Study identifies several factors that were associated with post-school success in obtaining employment and earning higher wages for youth with disabilities. These include completing high school, spending more time in regular education, and taking vocational education in secondary school. The Study also shows that post-school success is associated with youth who had a transition plan in high school that specifies an outcome, such as employment, as a goal. The secondary transition requirements of IDEA focus on the active involvement of students in transition planning, consideration of students' preferences and interests by the IEP team, and the reflection, in the IEP, of a coordinated set of activities within an outcome-oriented process which promotes movement from school to post-school activities. Through parent and student involvement, along with the involvement of all agencies that can provide transition services, student needs can be appropriately identified and services provided that best meet those needs.

### **Validation Planning and Data Collection**

**Prior Monitoring:** OSEP's 1995 monitoring report found that ADE had not ensured that representatives of agencies likely to be responsible for providing or paying for transition services were invited to transition planning meetings.

**Self-Assessment:** The Self-Assessment reported that under the OSEP Transition Systems Change Grant from 1990-1996, ADE established a State-wide cadre of Transition Consultants to provide training, consultation and facilitation of the development of Regional Interagency Transition Teams. ADE continued funding all transition efforts after the grant period ended. Interagency agreements with vocational education/workforce education and vocational rehabilitation have facilitated the establishment of a computerized referral system for tracking referrals to various agencies and the responses of these agencies. Significant training efforts have centered on the transition planning process and a State database identifies all training participants. No data were provided regarding high school completion rates, dropout rates or transition outcomes for youth with disabilities.

**Public Input Process:** Two of the focus questions asked during the public input meetings were: (1) "Describe the planning process that takes place for students aged 14 and older to ensure a successful transition to work, independent living or additional educational services (e.g., college, technical school)?" and (2) "Are students receiving the services needed?" Responses indicated that there is a lack of vocational opportunities/options for special education students. Agencies other than local education agencies are limited, usually by available funding or staffing, in what they can provide after a student graduates from high school. Participants indicated that there are too many students placed in sheltered workshops rather than being provided skills and training for competitive employment. Most agencies will not become involved with students until the spring of their senior year which shortens available planning time and may prevent the provision of appropriate services to prepare the student for available opportunities. Participants indicated that there is a significant amount of paperwork required by the State for transition planning and

that while it may “look good on paper, the services just aren’t happening.” In addition, participants indicated that time spent completing the extensive paperwork significantly reduces the amount of time that can be spent in productive transition planning.

At the end of the Validation Planning week, after discussing information obtained through the Self-Assessment and public input process, the Steering Committee and OSEP agreed that OSEP would collect additional data regarding reports that: (1) agency linkages are not facilitated; and (2) opportunities for agency involvement, community experiences, and employment are insufficient in rural areas of the State.

OSEP reviewed and analyzed the data and identified the following strengths, and area of noncompliance.

## **A. STRENGTHS**

### **1. Continued Support of Systems Change Grant Activities**

As indicated in the Self-Assessment, ADE chose to continue the activities begun during the OSEP Transition Systems Change Grant from 1990-1996, after the end of the grant period. This includes the establishment and maintenance of a Statewide cadre of Transition Consultants to provide training, consultation and facilitation of the development of Regional Interagency Transition Teams.

### **2. Agency Fest**

Annually, ADE sponsors “Agency Fest,” an opportunity for various agencies that offer transition and adult services to showcase their services and provide information to school personnel and to families. This activity has been replicated on a regional or school district basis in several areas of the State.

### **3. Directory of Transition Resources on the Web Site**

ADE provides a listing and description of available transition resources on its web site. This facilitates access to information in rural areas of the State and provides a ready reference for families and school personnel.

### **4. Training Paraprofessionals to be Job Coaches**

ADE is improving service to children with disabilities by enhancing the skills and capacities of paraprofessionals. For instance, the State has hired a work experience coordinator for one of its cooperatives. This person is responsible for training paraprofessionals to serve as job coaches for youth working on postsecondary transition activities at community job sites.

**B. AREA OF NONCOMPLIANCE****Representatives of Agencies Likely to be Responsible for Providing or Paying for Transition Services Not Invited to IEP Meetings**

34 CFR §300.344(b)(3)(i) of the regulations in effect at the time of the monitoring visit required that, if a purpose of the meeting is the consideration of transition services for a student, the public agency shall invite a representative of any other agency that is likely to be responsible for providing or paying for transition services. 34 CFR §300.344(b)(3)(ii) of these regulations states that if an agency invited to send a representative to a meeting does not do so, the public agency shall take other steps to obtain the participation of the other agency in the planning of any transition services.

As discussed below, OSEP found that ADE does not ensure that the IEP invitation and participation of other agencies meet IDEA requirements regarding transition.

In all seven school districts visited, review of student records showed that agency representatives who were likely to be responsible for providing or paying for transition services were not invited to attend meetings where transition services would be considered. IEPs reviewed did not reflect inclusion of these agencies. OSEP found no other methods used to obtain agency participation in transition planning. Personnel in two of the seven districts were making many contacts and linkages but told OSEP that they did not document these activities due to the paperwork burden.

## IX. PART B: GENERAL SUPERVISION

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

### **Validation Planning and Data Collection**

**Prior Monitoring:** OSEP's 1995 monitoring report identified no areas of noncompliance regarding general supervision.

**Self-Assessment:** The Self-Assessment indicates that ADE has designed and implemented systems for timely and effective monitoring and dispute resolution. Local education agencies are monitored on a three-year cycle. ADE uses a variety of enforcement actions, including, when necessary, the use of monetary sanctions. While significant numbers of due process hearings reflect extensions beyond the 45-day Part B time line, the State has taken action to ensure that all extensions are appropriate and properly granted. ADE is developing systems for collecting and analyzing data regarding high school completion rates and dropout rates for children with disabilities.

**Public Input Process:** One of the focus questions asked during the public input meetings for Part B was: "How is the State involved in ensuring that appropriate services are provided to children with disabilities (e.g., monitoring, training, technical assistance, etc.)?" Responses indicated that due process hearings do not always occur within Federal time lines. Participants indicated that while special education teachers are interviewed during the monitoring process, there is no contact with regular education teachers that could provide the State with information regarding barriers to placing students in general education classrooms. Participants indicated that parents are not included in the monitoring process nor does the State seek feedback regarding the effectiveness of the monitoring process. Many participants indicated that monitoring would be more effective if it focused on outcomes rather than "check-off" process compliance. Several participants indicated that ADE demonstrates strong, effective leadership in special education and that the provision of technical assistance and training is also effective.

At the end of the Validation Planning week, after discussing information obtained through the Self-Assessment and public input process, the Steering Committee and OSEP agreed that OSEP

would collect additional data regarding reports that (1) due process hearing decision time lines are not met and (2) complaints are not investigated and resolved in a timely manner.

OSEP reviewed and analyzed the data and identified the following strengths, and suggestion for improved results for children and youth with disabilities.

## **A. STRENGTHS**

### **Training**

ADE models collaboration through promoting joint training efforts with other agencies and special interest groups, such as the Parent Training and Information Center, Protection and Advocacy, Department of Human Services, Children and Family Services, foster parents, etc. ADE has also instituted a Superintendent's Academy, which has been attended by 225 superintendents who have completed ten hours of training relative to the requirements of IDEA. ADE reports that the academy was very well received by the participants.

### **Special Education Conference**

ADE sponsors a biennial Special Education Conference that is the premiere educational conference in the State of Arkansas, attended not only by parents, school district staff and agency personnel in Arkansas but also by participants from surrounding States. As indicated above, parents are provided stipends to attend this conference.

### **Mediation**

ADE contracts with the Parent Training and Information Center to encourage parents' use of the mediation process. Information is disseminated about mediation through the Center as well as through ADE and local education agencies.

### **Data Collection and Analysis**

ADE has systems for collecting data regarding compliance monitoring, complaints, mediation, and due process hearings, which allow the generation of reports, survey data and specific information analysis. ADE uses these data not only to identify compliance issues, but also to identify Statewide training needs and areas for systemic improvement.

### **Alternate Assessment**

ADE is among the first group of States to work collaboratively through the Council of Chief State School Officers to develop effective alternate assessment for children with disabilities who do not participate in the Statewide assessment program. This will be implemented in school year 2000-2001. Included will be the use of portfolio assessment and the development of scoring rubrics and models of performance measurement.

**B. SUGGESTION FOR IMPROVED RESULTS FOR CHILDREN AND YOUTH WITH DISABILITIES****Improvement of Due Process Hearing Time Lines**

In a number of cases, hearings are held beyond the required Federal 45-day time line. ADE has identified this as an area for improvement because a number of requests result in multiple extensions and although the extension requests are appropriately documented, ADE has proposed policies and procedures to facilitate conducting hearings in a shorter time. Included in ADE's proposed policies and procedures are limitations on the numbers of extensions that can be granted in an individual case, which may ameliorate delays in having hearing decisions issued.