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COMMENTS ON CHAPTER 1 OF THE RULES AND  
REGULATIONS TO IMPLEMENT C.R.S. ARTICLE 10.5  
OF TITLE 27, CONCERNING PERSONS WITH  
DEVELOPMENTAL DISABILITIES

Presented to:

The Division of Developmental Disabilities

Presented by:

The Colorado Interagency Coordinating Council

November 5, 1992

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STATEMENT OF SUPPORT AND ANALYSIS OF CURRENT DEFINITION  
OF DEVELOPMENTAL DELAY IN THE  
STATE OF COLORADO

VERBAL COMMENTS / EXECUTIVE SUMMARY

**I. INTRODUCTORY COMMENTS**

Thank-you for this opportunity to comment. My comments are related to the proposed definition of developmental delay, and summarize the key points in the accompanying paper.

Prior to beginning, I would like to note that the process undertaken to develop a definition for developmental delay in infants and toddlers was lengthy and detailed. It spanned two years and incorporated a **meticulous** review of the literature on related psychometric issues, and a survey of the number of children who were identified using current definitions in **all 50 states**. Also monthly meetings were held over a 24 month period to wrestle with ideas from interested parties who include Parents Community Center Boards Members, Day Care Providers, members from First Impressions, and many others with an interest in early childhood development.

The result of these **extensive** public comments and **heated** discussions, was the currently proposed definition. This definition, while not perfect, incorporates the most psychometrically sound methodology for defining delay, and represents the thinking of a majority of **informed** early interventionists in our state.

I will divide my brief comments into two areas focusing on first, the problems with the current Division definition, and second, the rationale for our support of the proposed definition.

**II. PROBLEMS WITH CURRENT DIVISION DEFINITION**

There are significant problems with the definition of delay currently utilized by the Division for Developmental Disabilities.

1. **The first serious problem is that the current definition is not psychometrically sound.**

Utilizing the current definition a child must have performance which is 20% delayed, to qualify for services. A key question is: **"20% of what?"**

Presumed is the answer, "20% of the child's age." The current definition relies on what are called "age scores." The **serious psychometric problems** with age scores are detailed in the accompanying paper, but in summary, age scores are not used because:

First, use of age scores does not agree with what we know about children and child development. Even if a 4 year old can only pass items that the average two year old passes, he or she is not functioning "like a two year old." It is much more accurate to compare him or her to other 4 year olds, than to give the impression that he or she can be accurately compared to a two year old.

Second, the further away from "average" a child is, the **less accurate** the age score will be. The children targeted by early intervention services are obviously functioning significantly below average for their age. This is **where age scores are the least accurate**.

Third, age scores are based **interpolation and extrapolation**, which are statistical manipulations of data, and provide only **crude estimates of how children are performing**, since they are not based on any data from real children.

Fourth, it is easy for parents and others to **misunderstand the meaning of age scores**. Most experts state emphatically that age scores **should never be used** because they are more subject to misinterpretation than any other type of score.

2. **The second serious problem relates to the "at-risk" section of the current definition.**

The current definition states that children with a "lesser handicap" can be admitted if there are "physiological factors surrounding the child's gestation or birth." Since **all children have physiological factors surrounding their gestation and birth using the current definition, all children are eligible for early intervention services**.

3. **The third major problem with the current definition is that it was developed in 1984, and never submitted to the rules making process which includes public comment; an important issue such as this, with so many public policy implications should have been.**

In trying to understand how and why the Division arrived at use of the current definition, a **detailed** review of the history of legislation relating, to early intervention services, was undertaken to trace the basis of the current definition of delay. Detail on this review is included in the accompanying paper.

In summary, it was determined that with the exception of a few judicial decisions, the definition of delay was not specified at the federal level. Thus, it is up to each State to determine an objective and culturally fair definition of eligibility for services.

From where then, did the definition of developmental delay as used by Colorado and many of the States come from? Three possibilities are reported in the accompanying paper.

First, in the late nineteenth century and early twentieth century, when the testing movement began, Binet, Cattell and others based their work on information about how people at each age performed on specific tasks. Thus this emphasis on age-related functioning has been handed down over the decades from this early beginning. As psychometric and statistical techniques have become more sophisticated, the use of the definitions based on familiar age-appropriate functioning did not keep pace with the new advanced knowledge about more accurate and meaningful methods of measuring ability.

Second, school-age children were qualified for services in the 1970s based on a generally agreed upon standard of 1 1/2 to 2 years delay. When funding became available for young children the 1 1/2 year standard did not apply, since 18 month old children would have to be functioning below the 1 month level to qualify for services, and children younger than 18 months could never qualify since they would never be 1 1/2 years delayed!

Thus some professionals made a rough estimate that a 20% or 25% delay would equal the 1 1/2 year delay needed to qualify school age children for services. This practice in effect has set a precedent, based upon a rough guess about the equivalent "percent delay" that a young child would have to exhibit in order to be "equally delayed" to a school-aged child.

As can be seen, tracing the development of the history of the definition of developmental delay takes on the quality of "folk history" or "legend" handed down over the years. The reliance on age scores does not stem from psychometric theory, but rather from years of use and tradition. It is time to rethink the methodology utilized to establish delay, and develop practices founded on science rather than belief systems and tradition.

### III. RATIONALE FOR SUPPORT OF THE NEW DEFINITION BY THE COLORADO INTERAGENCY COORDINATING COUNCIL:

The new definition is strongly supported by the Colorado Interagency Coordinating Council because it provides a sound "anchor point" and an objective methodology

to define the children who should be eligible for early intervention services in this state.

The proposed definition has the following advantages:

- 1) It is psychometrically accurate, and adheres to contemporary standards for the identification of infants and toddlers with developmental delays;
- 2) It provides a tool for more equitable access to services for all young children and their families, because the interpretation of the definition can be based on objective criteria;
- 3) It is more precise and useable since it can be operationalized.
- 4) It is intended to be consistent with the definition used by the State for P.L. 99-457, Part H.

One key issue in testing is the importance of ensuring that the scale used is sensitive to all young children in Colorado, regardless of their cultural background, race, ethnicity, and so on, as detailed in the accompanying paper. **Acceptance of the proposed definition will encourage the use of scales that are much more sensitive to diversity in cultural backgrounds than scales which rely on age scores.**

The final issue that I will talk on today relates to a critical concern to service providers in the State of Colorado, and in many ways is the crux of the concern about the proposed definition.

**What is the likelihood that more children would be identified if the definition is changed, thus resulting in such an overwhelming number of children being declared "eligible" that our current service system would be unable to provide services for these youngsters?**

In an effort to answer this question, a survey of the definitions that all fifty states are using was obtained, and is reproduced in the accompanying paper. A telephone survey was conducted of all the states using a definition similar to the proposed definition to determine how many children in those states receive services.

The details are reported in the accompanying paper. In summary, it is clear that the States which are using standard scores to define eligibility **are not identifying more children than states using an age score definition**. The states which use definitions similar to the proposed definition are identifying between 1% and 2% of their population, which is the same as Colorado is now identifying.

The number of children identified has much more to do with other factors, than it does with the type of definition that is used in the state. **There is overwhelming evidence to suggest that changing the definition in Colorado will not mean that more children are identified, than are currently identified, using the current definition.**

#### **IV. CONCLUDING REMARKS**

The many changes seen in this country over the past 20 years related to early intervention have been **evolutionary and slow**. We hope that as resources continue to grow in early childhood, the issue of eligibility for services can continue to be revisited, and that collaboration between the Division, the Interagency Coordinating Council, and other groups interested in the welfare of children in Colorado will result in even a more enlightened process for determining eligibility for services.

Thank-you again on behalf of the Colorado Interagency Coordinating Council, and the many other organizations and individuals who helped draft the proposed definition, for this opportunity to give this public testimony.

STATEMENT OF SUPPORT AND ANALYSIS OF CURRENT DEFINITION  
OF DEVELOPMENTAL DELAY IN THE  
STATE OF COLORADO

WRITTEN COMMENTS

I. INTRODUCTION

A. Purpose of This Paper

This paper has been written in response to the rules submitted by the Department of Institutions, Division for Developmental Disabilities, (rule # 1.3.19, page 19). The Division is proposing new regulations for the definition of developmental delay for young children, ages birth through 2 years, 11 months.

B. Problems with the Current Definition

There are significant problems with the definition of delay currently utilized by the Division for Developmental Disabilities which are detailed in this paper. The primary problems with the current definition are that:

- 1) The definition is not psychometrically sound;
- 2) The definition of the "at-risk" population ("children displaying a lesser handicap") is sufficiently vague as to be construed to mean that all children are eligible for early intervention services, thus in effect becomes meaningless;
- 3) The definition was developed in 1984 and no longer comports to contemporary views of valid methodology for defining developmental delay;
- 4) The current definition was never submitted to the rules making process which includes public comment; an important issue such as this, with so many public policy implications, should have been.

C. Rationale for Support of the New Definition by the Colorado Interagency Coordinating Council:

The new definition is strongly supported by the Colorado Interagency Coordinating Council because it provides a sound "anchor point" and an objective methodology to define a population of children who should be eligible for early intervention services in this state.

The proposed definition has the following advantages:



- 1) It is psychometrically accurate, and adheres to contemporary standards for the identification of infants and toddlers with developmental delays;
- 2) It provides a tool for more equitable access to services for all young children and their families, because the interpretation of the definition can be based on objective criteria;
- 3) It is more precise and useable since it can be operationalized.
- 4) It is intended to be consistent with the definition used by the State for P.L. 99-457, Part H.

It is hoped that as information about the population and resources continue to grow in early childhood, the issue of eligibility for services can continue to be discussed, and that communication between the Division for Developmental Disabilities, the Interagency Coordinating Council, and other groups interested in the welfare of children in Colorado will result in even a more enlightened process for determining eligibility for services for young children and their families.

The subsequent written presentation outlines our support for the assertions made in the introduction above, and incorporates the following sections:

- II. Description of the Problems with the Current Division Definition
  - III. Rationale for ICC support of the Proposed Definition
  - IV. History of the Definition of Developmental Delay: Where did the current definition come from?
  - V. The Basis for Classification Decisions which Determine Eligibility
  - VI. Issues of Cultural Diversity and Sensitivity
  - VII. Incidence and Prevalence of Developmental Disabilities in Young Children
  - VIII. Conclusion
- References
- Acknowledgments
- Appendix: Tables A - F

## II. DESCRIPTION OF THE PROBLEMS WITH THE CURRENT DIVISION DEFINITION

The ensuing discussion provides detail related to the problems with the current definition noted above in the introduction. These problems are divided into the following sections:

- a) psychometric problems with the current definition;
- b) a summary of key disadvantages with the current definition based upon "age equivalency scores;"
- c) issues related to the wording of the "at-risk" section of the current definition; and
- d) issues related to public policy.

### A. Psychometric Problems with the Current Definition

There are several scoring methods for establishing eligibility for services. The two methods relevant to this paper are:

1. A system based upon Age Equivalency Scores: included in the current definition utilized by the Division for Developmental Disabilities in the State of Colorado;
2. A system based upon Standard Scores: included in the proposed definition for new regulations for the Division.

The current definition utilized by the Division for Developmental Disabilities in the state of Colorado is:

"An applicant must have substantial delays in two or more developmental areas as documented by a professionally accepted instrument or procedures administered or supervised by an appropriately trained and qualified professional. Substantial delays are those of at least 20% of age appropriate functioning. Developmental areas include: sensory development; motor skills development; communication skills; self-help skills; social/emotional development; and cognitive development." (Uniform Eligibility Criteria, May 1984)

In addition, children with syndromes which have a significant risk of resulting in a developmental disability (such as Down Syndrome) are eligible.

A key question related to the psychometric integrity of this definition is: "20% of what?" Inherent in the current definition is the assumption that a single score can be determined for any particular age group, that defines "normal" performance in that age group. What score would that be? Would it be the average score, a

score that represents 50% of the children? Or would it be some score less than average below which children could be determined to be developmentally delayed?

The current practice is to use a test (not necessarily a well standardized, reliable or valid measure) to determine what the child's age score is, and then to calculate whether this score represents a delay of 20% of the child's chronological age. The steps in determining whether a child is eligible for services using the current definition of 20% delay are:

1. determine the child's age in months;
2. determine what 20% of the child's total months of age is;
3. subtract that number of months from the child's actual age in months; and finally,
4. call the result an "age score" which describes performance on a test in years and months.

For example, if the child is exactly 4 years old (48 months), then 20% of his/her age would be 20% of 48 months or 9.6 months. Thus utilizing the current definition, if the child is 9.6 months or more delayed, or functioning at the 38 month level, then she or he would be eligible for services. Table A attached, denotes how many months delay would be necessary for eligibility using the current definition, in the age groups from birth to 6 years.

In order to understand the meaning inherent in this definition, it is important to explore what an age score represents. Age scores (known age equivalent scales in testing) try to express what is typical of a child at a given age. They are calculated by testing a large number of children and determining the average score for children in each age group. The term "average score" refers to what 50% of the children would score at a particular age.

For example, a child who earns an age score of 4-0, has correctly performed the same number of items as the "average child" who is 4 years, 0 months of age. The tasks do not have to be performed in the same way that a 4 year old child would perform, in terms of the process or pattern of performance, but the total number of tasks performed correctly must be the same.

In other words, if a 4 year old child has a wide spread of abilities, (very common in children with developmental delays), then the total number of items that the child got credit for will be added together to determine his/her age score. If that total number is the same number that an "average two year old" would get correct, then the 4 year old will be given an age score of 2-0, even though she or he may have correctly performed many items above the two year level, and perhaps even completed items above his/her own age level.

These scores are accurate only for children in the specified age group who are functioning at the fiftieth percentile (50%). (For example, a score of 2 years 0 months accurately describes 2 year olds who are functioning exactly at the 50%.) However, in order to figure out what a particular performance would be for a child who has delays, year and month values are obtained by interpolation and extrapolation, and by smoothing values, all of which are statistical techniques. In other words, the performance of children with delays is inferred based on estimates, rather than being based on real data about children. "The resulting scores do not reflect scores actually obtained by children" (Sattler, 1982 p. 18).

Although age scores were frequently used during the early history of psychological testing, there are several serious problems associated with using age scores to identify children with developmental delays:

1. Use of age scores does not agree with what we know about children and child development. Even if a 4 year old can only pass items that the average two year old passes, he or she is not functioning "like a two year old." It does not mean that the child would have performed in the same way on a test covering two year old content. He or she does not have the same brain or development that a typical two year old has. It is much more accurate to compare him or her to other 4 year olds, than to give the impression that he or she can be accurately compared to a two year old.

Use of age scores encourages "typological thinking" where the average 4 year old is a statistical abstraction; there is no such thing as a "typical 4 year old." Four year olds have a large variety and range of behaviors.

2. Age scores are accurate at the 50%, but the further away from the exact average for his or her age a child is, the less accurate the age score will be. Thus, children may appear to be more delayed than they really are when they are far away from average. The children who are designated as "eligible for services" are significantly below average for their age, and thus their age scores are significantly distorted.

In a normal distribution, half of the children tested will receive age scores below their own age since an age score is constructed based upon what 50% of the children receive.

3. Age scores are based on the performance of 50% of the children at a certain age. However, there are many children who receive scores

below the 50 percentile who are still within normal limits. For example, a child in the 40 percentile is still within normal limits.

4. Age scores "represent at best little more than educated guesses" (Angoff, 1984 p. 23). This is because they are not based on data on children, but rather are obtained by extrapolation from existing data, a very unreliable procedure.
5. Relying on age scores, "encourages the improper use of test scores" (Angoff, 1984 p. 25), and "is more subject to misinterpretation by laypersons and test users than other types of normative scores" (Crocker & Algina, 1986, p. 450). A child who is only moderately above or below the average can appear to be as much as a year or more above (or below) average. "In our opinion, [age] scores should never be used. These scores are readily misinterpreted by both lay and professional people. In order to understand the precise meaning of [age] scores, one must generally know both the mean and standard deviation and then convert the developmental score to a score of relative standing" (Salvia & Ysseldyke, 1991 p. 101).
6. Performance on different tests can not be compared if age scores are used. "Score systems such as age equivalents should be meticulously avoided whenever score comparisons are to be made" (Reynolds, 1984-85, p. 471).
7. Age scores do not provide an index of how that child is doing compared to other children in the same age group unless the child is exactly at the 50%, which is rarely true for children with developmental delay conditions.
8. Growth and development shows a decrement over time so that the difference between age scores between 1 and 2 years is much greater than the difference between age scores of 5 and 6.
9. Most of the professional associations whose members are involved with testing children have published statements regarding their negative opinions about age scores. These include the American Psychological Association, the International Reading Association, The National Council on Measurement in Education, and the Council for Exceptional Children.
10. All test publishers, especially those known for publishing well standardized, reliable and valid scales, have moved away from the use of age norms in their test manuals. Many even describe the reasons

they do not include age norms in the manual. For example, one manual states, "The problems associated with the use of [age norms] are serious enough that we have decided to omit them from the manual. . . Almost all authors of textbooks that deal with psychoeducational assessment argue convincingly against their use. . . The statistical shortcomings are such that when these scores are used for purposes of diagnosis or placement, the consequences for students are too serious to ignore. . ." Because the continued use of [age norms] is professionally indefensible, the Board of Directors of the International Reading Association asked that examiners abandon the practice of reporting and interpreting test performance in [age norms], and that test authors and publishers eliminate such norms for their tests." (Hammill & Larsen, 1991 p.66-67). The publisher provides a formula for examiners in case the regulations of the state agency requires the scores be reported as age norms, but strongly advises against their use.

**B. Summary of Key Disadvantages with the Current Definition Based upon "Age Equivalency Scores"**

1. These scores do not take into account what we know about children; a 4 year old with an age score of 2 years is not like a two year old.
2. You cannot tell which scores are within normal limits, only what is average for a certain age.
3. Scores for delayed children are based on estimates and statistical manipulation of data, not scores of real children.
4. You cannot compare scores on different tests, or across different domains.
5. It is easy for parents and others to misunderstand the meaning of age scores.
6. Most professional associations and test publishers strongly advise test users not to use age norms.

**C. Issues Related to the Wording of the "At-Risk" Section of the Current Definition**

One caveat of the definition states that children with a lesser handicap can receive services if documentation is provided which indicates that there are "physiological factors surrounding the child's gestation or birth. . ." because

the child will be "at risk of developing a significant delay" (Uniform Eligibility Criteria, May 1984). This criteria is sufficiently vague as to be construed that all children are eligible for early intervention services, since all children have physiological factors relating to their gestation and birth.

It is likely that this clause in the definition refers to adverse physiological factors. Yet even if the word adverse were inserted into this part of definition, the wording is sufficiently vague as to qualify extremely large numbers of children.

#### **D. Issues Related to Public Policy**

The current definition utilized by the Division for Developmental Disabilities was developed in 1984, and no longer comports to contemporary views of valid methodology for defining developmental delay as described in sections A. and B. above. In addition, the current definition was never submitted to the rules making process which includes public comment. An important issue such as this, which potentially impacts so many young children in our state, and has so many public policy implications, should have been subjected to public comment and review, prior to being established as the criteria by which eligibility for services is determined.

### **III. RATIONALE FOR ICC SUPPORT OF THE PROPOSED DEFINITION**

The new definition is strongly supported by the Colorado Interagency Coordinating Council because it provides a sound "anchor point" and an objective methodology to define the population of children who should be eligible for early intervention services in this state.

The proposed definition has the following advantages:

1. It is psychometrically accurate, and adheres to contemporary standards for the identification of infants and toddlers with developmental delays;
2. It provides a tool for more equitable access to services for all young children and their families, because the interpretation of the definition is based on objective criteria;
3. It is more accurate and precise, and thus useable, since it can be operationalized;
4. It permits comparisons between performance across age, and across several domains of development;

5. It is consistent with the definition used by the State for P.L. 99-457, Part H.

One main advantage of utilizing a standard score system (which includes percentiles, stanines, derived standard scores, quartiles, t-scores, standard deviations, etc.) is that the numbers of children who are eligible for services can be estimated. In addition, use of standard scores allows for comparison between various scales and measures since all standardized scores are related to each other in a systematic manner. Age scores cannot be directly correlated with any of these standard score systems (Reynolds, 1981; Reynolds, 1984-85; Salvia and Ysseldyke, 1991).

Table B indicates the relationship of standard deviation, percentile, and derived standard scores at each standard deviation score cutpoint between -1.0 and -2.4.

#### **IV. HISTORY OF THE DEFINITION OF DEVELOPMENTAL DELAY: WHERE DID THE CURRENT DEFINITION COME FROM?**

A review of the history of legislation in the United States relating to services for young children with developmental disabilities was undertaken in order to trace the basis by which children have been designated as developmentally delayed since special services were mandated beginning in the 1960s. The following section includes: A. a brief review of legislation and judicial decisions related to young children; and B. a description of the derivation of the current Division definition of delay.

##### **A. Legislation and Judicial Decisions Related to Young Children**

The number and quality of programs serving young children with developmental disabilities has rapidly expanded over the last 20 years. The following provides a synopsis of the evolution of legislative and judicial decisions related to services for young children with developmental disabilities. A brief review of this history provides a context for the discussion of the evolution of the definition of eligibility for services provided in Section B. below. Table C provides a brief summary of the chronology of federal activities relating to early childhood education, detailed below.

The rubella epidemic of 1964-65 had a major impact on the initiation of services for children with handicapping conditions. Over 20,000 children were born with rubella anomalies including over 5,000 whom were both deaf and blind as well as having other impairments. In 1965, federal legislation Public Law (PL) 89-313 was passed as an amendment to Title I of the Elementary and Secondary Education Act (ESEA), to provide direct payment to states for children with disabilities, birth



through 20 years of age, when services were provided in state operated programs. Though the legislation was not targeted toward children with disabilities, it was critical because it provided funds for programs for all children with disabilities, including infants. Title I was later renamed Chapter 1, and is still in effect today.

Head Start was begun in 1964, through the Economic Opportunity Act. As a result of the Economic Opportunity and Community Partnership Act of 1974 (PL 93-644) it was mandated that no less than 10% of the children in Head Start have handicapping conditions.

The provision of services to the children effected in the Rubella epidemic, created a demand for services for all children with handicapping conditions. This led to the passage of PL 89-750 in 1966 (ESEA Amendments) which established the first federal grant program for the education of children with disabilities at the local rather than state level. In addition PL 89-750 established the Bureau for the Education of the Handicapped (BEH) and the National Advisory Council, today known as the National Council on Disability.

In 1968, PL 90-247, (ESEA Amendments) which created regional centers for evaluation and services to all deaf-blind and multi-handicapped children was passed. This act established discretionary programs that supported the expansion and improvement of services in special education.

In 1968, additional federal support for early childhood services was mandated with the passage of the Handicapped Children's Early Education Program (HCEEP) (PL 90-538, which established experimental model programs and "seed money" for innovative programs for young children with handicapping conditions.

In 1970 special education programs were brought under a single legislative authority, by the Education of the Handicapped Act (EHA). Since HCEEP programs were included in the consolidation, early childhood was recognized as an integral part of the overall special education program. Section 611 of the law proposed that funds be used for the early identification and assessment of children under age 3. This act was the precursor to PL 94-142 which would later significantly expand the rights of children with disabilities.

Additional services were mandated through Section 504 of the Rehabilitation Act of 1973 (PL 93-112), through a civil rights provision which disallowed discrimination against "handicapped preschool children."

Early in the 1970s two court cases were settled which set a precedent for education rights of children with disabilities. The Pennsylvania Association for Retarded Citizens (PARC) v. The Commonwealth of Pennsylvania, 1972 was a class action suit that resulted in the judgement that states must provide access to

publicly supported education for children who were mentally retarded, preferably in programs for children who were not handicapped.

In 1972, in *Mills v. the Board of Education in Washington D.C.*, a judgement was made that the District of Columbia must provide all children with a disability with a public education, regardless of the severity of the disability.

In 1974, the Education of the Handicapped Amendments (PL 93-380) were passed which mandated that states set a goal for serving all "handicapped children" ages birth to 21 years, although states could evade locating and serving all children by tying their goals to a restricted time-line for their state plan. PL 93-380 instigated "Child Find" programs and State Implementation Grants, enabling states to set up comprehensive plans to serve young children with developmental disabilities in the "least restrictive environment". PL 93-380 was critical because the focus on fully educating all children with disabilities began with this act.

In 1975, Congress passed a compulsory special education law, the Education for All Handicapped Children Act (PL 94-142), mandating a free public education for all school-aged children who were handicapped, however, children ages 3 - 5 were exempted if services to that age group was "inconsistent with state law or practice" [PL 94-142, 1975, Section 612 (2) (B)].

One important feature of PL 94-142 was to ensure that services were provided to children with handicapping conditions in a fair and nondiscriminatory way. Although a specific definition of "handicapping condition" was not included in the law, the law included the following mandates to attempt to make sure that the services would be provided in an equitable manner:

1. that the tests were not biased racially and culturally;
2. that the child's native language be used, if possible;
3. that the tests be validated for the purpose for which they were used;
4. that personnel be specifically trained prior to utilizing any test;
5. that the test be broader than intelligence, assessing the child's educational needs;
6. that decisions about children be based on more than a single test score;
7. that evaluations be made by a multidisciplinary team rather than a single professional;
8. that children be assessed in all areas related to their condition i.e. health, vision, hearing, intelligence, academic ability, communication, motor skills, and social and emotional status.

These specific mandates were included in an effort to establish standards nationwide that were sensitive to all children, and based on current "best practice"

knowledge at the time the legislation was passed. The impact on children ages 0 to 5 was limited because services were not mandated for preschool children. Compliance with requirements for school age children became an overriding priority in states, and the decision to make children eligible based on "1 1/2 to 2 years delay" at school age became widespread (Reynolds, 1981). States were awarded grant based on actual "child count" data for the first time.

In addition, Section 619 of PL 94-142 provided the Preschool Incentive Grant Program to stimulate development of programs for preschoolers, also based on actual numbers of children with disabilities ages 3 through 5.

In 1976, HCEEP was expanded to include State Implementation Grants which encouraged planning for the expansion of early childhood services. As a result, planning groups, staff training, and the development of standards and guidelines was instituted in many states.

In 1977 HCEEP added another new component, the Early Childhood Research Institutes. The funded institutes each selected a particular focus, and information from these projects significantly expanded the knowledge base in early childhood. HCEEP was vital in creating expanded networks for interaction among experts in early childhood.

In 1983 the EHA was amended by PL 98-199 which incorporated major changes to the state planning component of HCEEP. The mandate from congress was to assist states in "planning, developing, and implementing a comprehensive delivery system for the provision of special education and related services to handicapped children birth through five years of age (Section 623 (b) (1)). This law broadened the age range for the Preschool Incentive Grants to include infants and toddlers for the first time.

In 1986, the Education of the Handicapped Amendments were passed extending the rights and protection of the law for full services to eligible preschoolers, with substantial incentives for states to serve 3 to 5 year old "disabled children" (part B Section 619). It also specified early intervention services "for handicapped infants and toddlers and their families" (part H of 99-457). The law states that those children who are "experiencing developmental delays as measured by appropriate diagnostic instruments and procedures," are eligible for services, but leaves the specific definition of delay to the States. PL 99-457 specifies that a multi-disciplinary assessment be utilized to develop an Individualized Family Service Plan (IFSP) for each child. Although, elements of the IFSP are mandated, the definition for eligibility for services is not mandated federally.

The intent of this amendment is not to change the numbers of children who are eligible for service but to assist agencies by not requiring that children be "labeled"

in order to receive services. The amendment provides the option of using a definition of delay which is more developmentally appropriate than one which requires children to be diagnosed or categorized prior to service provision. States have the discretion to develop eligibility criteria, but "the provision should not be construed . . . to deny eligibility to a child who would otherwise be eligible under other categories in section 602(a) (1) of the Act" (House of Representative Report 102-198, Sept. 1991).

In a subsequent report (1986) the intent of allowing States to define "developmental delay" was clarified. "It is not our intent to permit a State to totally ignore or establish standards of measurement or other definitional provisions that preclude addressing any one of the five developmental areas included in the definition. It is expected that the definition will encompass levels of functioning in all five developmental areas" (House of Representatives Report 99-860 p. 7).

Congress strengthened and expanded this legislation in 1991, by enacting the Individuals with Disabilities Education Act (IDEA), PL 102-119, which requires that all preschool children "who are handicapped, regardless of severity of their handicap, and who are in need of special education and related services are identified, located, and evaluated" (CRF 303.128 (a)(1)). In addition, the mandate for infant/toddler services was strengthened, as well as the mandate for family-centered services.

IDEA (1991), and the Rehabilitation Act (1973) reinforce each other in five important ways:

1. both require that schools implement a systematic child find effort to identify children with disabilities;
2. both mandate a Free and Appropriate Public Education (FAPE), without regard to the severity or description of the child's disability;
3. both clarify that related services and education are provided at no cost to the family;
4. both require that testing and evaluation procedures are not biased, or limited to a single instrument;
5. both emphasize that children with disabilities should be educated in settings with their nondisabled peers.

Recently, Congress enacted the Omnibus Budget Reconciliation Act, 1989, and the Title V Maternal and Child Health Services Block Grant, 1990. These pieces of legislation emphasize the need to identify children with disabilities and provide services through existing agencies and funding streams.

In addition, a judicial action in 1990, significantly expanded the eligibility for services of low-income children with disabilities. In a Supreme Court decision,

Sullivan v. Zebley, requirements for changes in determination of eligibility for SSI disability benefits by the Social Security Administration were made. The new regulations published in February, 1991, require that children receive an individualized functional assessment of their ability to perform age-appropriate activities. It is anticipated that more children with disabilities will be eligible for SSI benefits under the new rules because the guidelines for determining whether the child can qualify for services have been clarified, and broadened. Table D summarizes the levels of delay needed for children to qualify as eligible for SSI based upon developmental delay in each domain of development (Mental Health Law Project, 1991). It can be seen that these criteria are significantly less stringent than those criteria suggested in the proposed definition by the Division of Developmental Disabilities.

#### **B. Derivation of the Current Division Definition of Delay**

The definition of the population eligible for services, as well as the specific demographic and health characteristics of that population has changed during the years reviewed above. Since many of the States use a definition of eligibility for services which is based upon a percent delay (such as that used in Colorado), an attempt to trace the derivation of that definition of eligibility was undertaken.

An effort was made to ascertain what the **specific eligibility guidelines** were for each of the pieces of legislation or court decisions referenced above. It was determined that with the exception of a few judicial decisions, such as Sullivan v. Zebley, **the definition of delay was not specified at the federal level.** Thus, in almost all federally funded mandates, it is and has always been within the purview of the States to determine meaningful and operationalizable definitions of delay.

#### **From where then, did the definition of developmental delay as used by Colorado and many of the States come from?**

A review of related literature suggests three possibilities. In the late nineteenth century and early twentieth century when the testing movement began, Binet, Cattell and others were collecting information about how individuals at each age performed on specific tasks. Several researchers feel that this emphasis on age-related functioning has been handed down over the decades from this early beginning, and was profligated by Gesell and others when developmental assessment became more widespread. As psychometric and statistical techniques have become more sophisticated, the use of the definitions based on familiar age-appropriate functioning did not keep pace with the new technical knowledge about methodologies for determining delay which were psychometrically accurate.

A second theory relates to the increased emphasis on qualifying school aged children for services in the 1970s. Especially with the Learning Disabled

population, older traditional definitions were not useful, since the traditional definitions were intended for children with mental retardation. In many cases it was desirable that school aged children (especially so called "Learning Disabled" children) be determined to be eligible for the new expanded services mandated by federal law; however these children were not eligible based upon traditional definitions for mental retardation. Thus professionals began to rely on the general standard of 1 1/2 to 2 years delay to determine eligibility for services for school-aged children (Reynolds, 1981). Although the figure 1 1/2 to 2 years delay seems to have been generally accepted in the professional community, a thorough review of the literature did not disclose any origin or scientific basis for the amount: 1 1/2 year delay.

When funding became available for young children it was obvious that the 1 1/2 to 2 years standard did not apply, since 18 month old children would have to be functioning below the 1 month level to qualify for services, and children younger than 18 months could never qualify since they would never be 1 1/2 years delayed!

Thus professionals made a kind of estimate of delay needed for young children to equal the 1 1/2 to 2 years delay at school age. A very rough estimate was made by some professionals that a 20% or 25% in young children was generally the equivalent of a 1 1/2 to 2 years delay for school aged children. This practice in effect has set a precedent, based upon a rough guess about the equivalent "percent delay" that a young child would have to exhibit in order to be "equally delayed" to a school-aged child. **The fact that the amount of delay needed to qualify at school age was not based on a scientific decision in the first place, makes this practice especially questionable.**

The third theory relates to the definition of mental retardation which was established by the American Association for Mental Deficiency. Based on work by Doll and others delays in years were established for defining mental retardation in the 1930s. It is felt by many that the maintenance of age-related definitions is a hold-back to the thirties, when the standard was to define mental retardation based on approximate year levels of functioning.

As can be seen, tracing the history of the definition of developmental delay takes on the quality of "folk history" or "legend" handed down over the years. The reliance on age scores does not stem from psychometric theory, but rather from years of practice and tradition. It is time to rethink the methodology utilized to establish delay, particularly in young children, and develop practices founded on science rather than belief systems and tradition.

## V. THE BASIS FOR CLASSIFICATION DECISIONS WHICH DETERMINE ELIGIBILITY

Basically, in order to determine whether a child is eligible for services an important decision must be made: the child must be classified as either eligible or ineligible for services based upon some criteria. In current practice, classification decisions are based on a variety of indexes. The decision is critical because it determines whether a child is eligible for early intervention, special education services, remedial education services, allied health services (such as physical, occupational or physical therapy) and other special services.

Eligibility decisions are required because the federal government programs want to ensure that the children and families receiving services have actually been targeted for services, that is, that they are eligible at government expense for services.

In much of the early childhood legislative history described above, such as PL 99-457, the task of defining eligibility has been left to the States. It is an important and difficult task. Whether the definition of eligibility is narrow or broad defines the number of children who will receive services, impacts the type of service that will be provided, and ultimately determines the cost of early intervention in the state (Shackelford, 1992).

Several States, including Colorado, have commissioned studies to determine the prevalence of children with specific kinds of developmental delays, in an effort to estimate the cost of providing services to those groups of children, prior to committing the limited resources of the state to those services (Benn, 1991; Knudtson, Strong, Wiegardt, Grier, & Bennett, 1990; Gould, 1990). States which are experiencing financial difficulties particularly have found it necessary to limit the eligible population by restricting their definition (Shackelford, 1992). The group of children known as "at-risk" for delay is especially problematic (in terms of cost), since a broad and inclusive definition, although worthy from a humanitarian viewpoint, might be so expensive as to be prohibitive to a State.

There are many different categories and different standards used nationwide to indicate whether children are eligible for special services. Table E indicates the many different categories that are used to determine eligibility for special services, in the fifty states (Salvia & Ysseldyke, 1991). It can be seen that states do not all use the same name for the same handicapping condition; there are also different standards for classification of eligibility. For example, in Pennsylvania, individuals are classified as "mentally retarded" if they have an IQ score less than 80, whereas in Minnesota, they must have an IQ score less than 70 to be classified in the same way. In early childhood, there has been a strong movement towards the establishment of noncategorical identification procedures, which abrogate categorizing a child (Smith & Schakel, 1986).



"Although there are many problems apparent in the use of tests to make classification decisions, most federal and state regulations require that decisions be test based. The requirement is designed to protect the students. If teachers, diagnosticians, and administrators were allowed to make classification and eligibility decisions on the basis of subjective impressions, classification could be haphazard and capricious" (Salvia and Ysseldyke, 1991 p. 10). The use of standards (such as standard scores to determine eligibility) provides a tool for more equal access to services.

A review of the factors contributing to many valid questions about the utility of using test scores to classify children for services is illuminating (Meisels, 1991). First, there are scales which have been accepted for widespread usage, even though research clearly indicates that they have been poorly standardized, are not reliable, and do not demonstrate validity. In the instance of one widely used scale, 80% of the children who actually demonstrated problems were missed upon screening (Greer, Bauchner, & Zuckerman, 1989). Secondly, some scales have been marketed aggressively in the absence of data which identifies their practical utility or accuracy, leading unsophisticated test users to purchase tests which were later determined not to answer relevant questions regarding performance of young children. Third, there are a plethora of "home-made" instruments which are used in local programs where they are "put-together" without regard to the reliability or validity of the scale.

The dilemma surrounding classification decisions stems from the current clear desire by our State and other States to provide infant/toddler services. Provision of services requires that an effort be made at accurate early identification of developmental delays. Hence the question "What objective criteria should be established to accurately classify children, and hence to determine eligibility for services?"

## **VI. ISSUES OF CULTURAL DIVERSITY AND SENSITIVITY**

The importance of using non-discriminatory procedures in assessment of young children has been stressed in the literature (McLean, Smith, McCormick, Schakel, & McEvoy, 1990). One key issue in testing is the importance of ensuring that the scales used are sensitive to the group being tested. If the background and experience of the child being tested differ significantly from the children who were included in the group upon which the norms for the test are based, then the resulting scores will not be applicable for the child being tested, and it is possible that an incorrect eligibility decision will be made. Cultural diversity is based on background and experience, not gender, skin color, race, ethnicity or religion.

Unfortunately, not all professionals who administer tests attend to the characteristics of the children included in the collection of normative data. All of



the tests which have norm groups representative of the general population use standard scores, and do not rely on age scores. Thus stating eligibility requirements in terms of age scores is more likely to result in reliance on scales which do not have norms with cultural sensitivity.

## **VII. INCIDENCE AND PREVALENCE OF DEVELOPMENTAL DISABILITIES IN YOUNG CHILDREN**

There has been concern expressed over the number of children who would be identified with developmental disabilities if the current definition (which is based on a percent delay) were changed to a definition based on a standard score (such as a specified standard deviation below the mean). The underlying concern is that the number of eligible children might significantly increase if the definition were changed.

In fact, there is no statistically accurate way to determine the number of children who are eligible for services based on the current definition. Changing the definition would allow the system to control the number of children who are eligible. Fewer children could be eligible by altering the standard score for eligibility. For example, if the system wished to target 1% of the population, then a standard deviation score of -2.3 could be utilized.

The critical point here is that with a standard score system the number or percent of children who are eligible can be determined by a program, whereas with an age score system, no such control exists. The only information known about numbers of children based on age scores, is that the number of children who receive a specific age score, in that particular age group is 50%. It cannot be determined, for example, how many 4 year olds will receive an age score of 3 years old, and thus the direct comparison of the numbers of children eligible for services utilizing the current definition, compared to the suggested definition, is not possible.

A subcommittee of the Colorado Interagency Coordinating Council prepared a short report to estimate the incidence and prevalence of infants and toddler in Colorado with developmental delays based upon the current definition of -1.5 standard deviations below the mean (Goldson, Ikle, Landry, Miller, 1991). This report includes incidence and prevalence data for many conditions, based upon national averages, research reports, and existing data pools in the state. The overall prevalence of children for each condition (such as Down syndrome, Fragile X syndrome, Fetal Alcohol syndrome, etc.) is noted, and the total number of 1810 children per year (3.4% of the total population) is projected if all children who are eligible for services based on available data, were identified. These are all conditions which have a high probability of resulting in later mental retardation.

Of critical concern to the State of Colorado, and agencies that provide services is: What is the likelihood of such a large number of children being identified if the definition is changed from a percent delay to a standard score, that the children would overwhelm the system, and thus not be able to receive any services?

In an effort to answer this question a survey of the definitions that all fifty states were using was obtained, and is reproduced in Table F. A telephone survey was conducted including all the states which are utilizing a standard score definition, and who are in the fifth year of implementation of PL 99-457, to determine the percentage of children in their state receiving services.

States which are using standard scores to define eligibility are not identifying more children than states using a age score definition. There does not appear to be a direct relationship between the number of children receiving services, and the type of definition used. For example, Arkansas, which uses an age score to identify and qualify children has 1300 of 6000 children in service (22%), whereas Idaho uses combination of age scores and standard deviations (whichever is less), and is only identifying 1.77% of their population. In Pennsylvania the standard of -1.5 standard deviations has resulted in some form of services to 10,812 children or approximately 2% of the population, of whom 5700 receive service on a daily basis (approximately 1 %). In Wisconsin, they are moving from an age score to a standard deviation score, and still allow the programs which are used to using age scores to continue to use them. "Our sense is that the standard deviation score provides a tighter index than the age score. The age score allows more children to be eligible than the newer standard deviation definition" (Personal communication with the Part H Coordinator, S. Robbins, Oct. 1992). Wyoming uses a standard deviation cutpoint of 1.5 (or a percent delay) and is identifying 1.75% of the total population. Utah uses a standard deviation definition but automatically includes any child with an established condition. They are identifying approximately 1% of the total population (1288 of 36,000 live births in 1991).

The number of children identified seems to have much more to do with the length of time that the mandate has been in the state to service young children, and other factors, than it does with the type of definition that is used in the state. **There is overwhelming evidence to suggest that changing the definition in Colorado to a standard score will not mean that more children are identified, than are currently identified using the current definition which is based on an age score.**

Incidence and precedence of developmental disabilities is, in a sense related to the determination of eligibility for which services? If more children were identified than are currently being serviced, what would the effect be on the current system of service provision? If greater numbers of children were identified, could the current system of early intervention (i.e. which may include occupational, physical, speech

and language and other early educational interventions) be continued as is if there were not an increase in funding?

Keeping in mind that **there is no evidence which indicates that changing the definition will increase the number of children identified**, it is important to also consider that changes in the service delivery system, might enable more children to receive intervention, utilizing a non-traditional service delivery model. For example, utilizing existing community resources, such as volunteers in the community, and professionals as consultants rather than as direct service providers has been demonstrated to be a cost-effective and efficient alternative to the traditional direct service model (Shonkoff & Meisels, 1991). The cost-effectiveness of a continuum of alternative service models which emphasize developmental surveillance and parental access to information rather than direct services, has been verified by many experts in the field (Shonkoff & Meisels, 1991).

## **FUTURE DIRECTIONS**

Although there are some problems with the use of a standard score to make determinations of eligibility, establishing a standard for the state will provide an anchor point for decisions about eligibility for services.<sup>1</sup> In other words, use of -1.5 standard deviations provides a yardstick for clinicians and parents regarding the amount of delay that is necessary for a young child to be considered eligible for services.

Recent research in the field of early childhood indicates that on a national level experts are struggling with how to make the definition even more equitable for all children. Suggestions include the provision of other methods for determination of eligibility such as determination based on informed professional clinical judgment, requiring the administration of several measures such as a home observation, a

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<sup>1</sup>. As long as there is a normal distribution of scores for a scale, and the sample upon which the scale is standardized represents the population, standard scores on two different tests will be comparable. A cutpoint based on a standard deviation takes into account different variance statistics for different scales. Thus, any standard score (standard deviation, percentile, etc.) could be equated for use with the proposed definition.

For example, if a scale has a mean of 100 and a standard deviation of 15 (such as the Weschler scales), -1.0 standard deviations below the mean is a score of 85. If a scale has a mean of 50 and a standard deviation of 10 (such as The First STEP), then -1.0 standard deviations below the mean is a score of 40. Both cutpoints will identify approximately the same number of children from a normal distribution.

developmental history, a developmental checklist, a health status exam, as well as standardized tests. Under the rules and regulations published by the Secretary of Education (CFR Sec. 303.300, the definition of developmental delay, states are required to designate the level of functioning used to determine eligibility, and to describe the procedures used to determine the existence of a developmental delay in each domain. Under Sec 303.322, states must ensure that informed clinical opinion is used in determining a child's eligibility if there are no standardized measures, or the standardized procedures are not appropriate for a given age or developmental domains. (Biro, Caulton, Szanton, & Garner, 1991; Benn, 1991; Meisels, 1991; Shonkoff & Meisels, 1991).

Another well respected viewpoint is that a functional approach is preferable, and that evaluation of both the child's and family's resources, concerns and priorities prior to a determination of eligibility for services should be made (Shonkoff & Meisels, 1991). Finally, there has been increasing emphasis on multi-dimensional approach that uses multiple sources of data over multiple time periods (Kochanek, Kabacoff & Lipsitt, 1987).

#### **VIII. CONCLUSION**

The Colorado Interagency Coordinating Council would like to take this opportunity to thank the Division of Developmental Disabilities for this opportunity to comment on the Rules and Regulations to implement C. R. S. Article 10.5 of Title 27, Concerning Persons with Developmental Disabilities.

The many changes seen in this country over the past 20 years have gradually evolved as federal policies and legislation has passed. Our capacity to provide services for young children with disabilities has been progressively enhanced by these measures. The process has been evolutionary and slow, with one change leading to development in another area. It is hoped that as resources continue to grow in early childhood, the issue of eligibility for services can continue to be revisited, and that collaboration between the Division for Developmental Disabilities, the Interagency Coordinating Council, and other groups interested in the welfare of children in Colorado will result in even a more enlightened process for determining eligibility for services for young children and their families in this state.

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The Colorado Interagency Coordination Council wishes to acknowledge and thank the following experts who have contributed time and knowledge to this report:

Stephen Bagnato, Jackie Barentine, Carol Berman, Diane Bricker, Jana Burdge, Kathy Emmons, Emily Fenichel, Whalen Gillingham, Jim Gyurke, Don Hammill, Mary Jones, Tom Kochanek, Joyce Lacy, Samuel Meisels, Duncan Munn, Cecil Reynolds, Susan Robbins, Gale Roid, John Salvia, Jo Shakelford, Evelyn Shaw, Jack Shonkoff, Barbara Smith, Lisbeth Vincent, and Mark Wolery.

This report was prepared by Lucy Jane Miller, Ph.D., OTR in consultation with other members of the Colorado Interagency Coordinating Council October, 1992. Questions or concerns should be addressed to Dr. Miller at:

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TABLE A: Age Score Required for Eligibility  
Based on 20% Delay Definition

<u>Age in Years</u>	<u>Age in Months</u>	<u>20% Delay in Months</u>	<u>Age Score Required for Eligibility</u>
	3	.6	2 mo.
	6	1.2	5 mo.
	9	1.8	7 mo.
1/2	12	2.4	10 mo.
	15	3	12 mo.
1 1/2	18	3.6	14 mo.
2	24	4.8	19 mo.
2 1/2	30	6	24 mo.
3	36	7.2	29 mo.
3 1/2	42	8.4	34 mo.
4	48	9.6	38 mo.
4 1/2	54	10.8	43 mo.
5	60	12	48 mo.
5 1/2	66	13.2	53 mo.
6	72	14.4	58 mo.



TABLE B: Relationship of Three Types of Standard Scores

<u>Standard Deviation Scores</u> (m = 0, sd = 1)	<u>Percentile Scores</u>	<u>Standard Scores</u> (m = 100, sd = 16)
-1.00	15.9%	84
-1.10	13.6%	82
-1.20	11.5%	81
-1.25	10.6%	80
-1.30	9.7%	79
-1.40	8.1%	78
-1.50	6.7%	76
-1.60	5.5%	74
-1.70	4.5%	73
-1.75	4.0%	72
-1.80	3.6%	71
-1.90	2.9%	70
-2.00	2.3%	68
-2.10	1.8%	66
-2.20	1.4%	65
-2.30	1.1%	63
-2.33	1.0%	63
-2.40	.8%	62

**TABLE C: Chronology of Federal Activities in  
Early Childhood Special Education**

1965	P.L. 89-10 Elementary and Secondary Education Act (ESEA) of 1965: First direct federal support for education of children with disabilities in elementary and secondary schools.
1965	P.L. 89-313 (ESEA Amendments): Payments to states for children with disabilities, birth through 20, in state agencies.
1966	P.L. 89-750 (ESEA Amendments): First federal support for children with disabilities at the <u>local</u> level. Established Bureau for Education of Handicapped and National Advisory Council.
1968	P.L. 90-247 (ESEA Amendments): Discretionary funds for expansion and improvement of Special Education Services.
1968	P.L. 90-538 Handicapped Children's Early Education Program (HCEEP) established.
1970	P.L. 91-230 Education of the Handicapped Act (EHA): HCEEP consolidated with other federal special education programs: states were provided direct financial support to serve children with disabilities ages 3 through 5.
1972	PARC Decision: Pennsylvania Assn. for Retarded Citizens vs. Commonwealth of PA: Mentally retarded children given access to public education programs.
1972	Mills v. Board of Education, Washington D.C.: Class action suit providing that all children with a disability regardless of severity, must receive public education.
1973	Rehabilitation Act PL 93-112: Still in effect today, addresses basic civil rights protection against discrimination in any program receiving federal assistance. Section 504 relates to children with disabilities.
1974	Education for All Handicapped Children Act (EHA Amendments) P.L. 93-380: Introduces new requirements for special education for preschool, elementary, and secondary students including mandates for time-lines to serve as children with disabilities, procedural safeguards, and integrated services.
1975	P.L. 94-142 Education for All Handicapped Children Act: Preschool Incentive Grants established; free appropriate public education (not mandated below age 6) state awards based on child count, 3-through 5-year-olds included in the count.
1976	* State Implementation Grants (SIGs) established.
1977	* First Early Childhood Research Institutes established.
1983	P.L. 98-199: State Plan Grants replaced SIGs.
1986	P.L. 99-457: Handicapped Infant and Toddler Program (Part H) established; services for 3-through 5-year-olds mandated by 1991-92.
1991	P.L. 102-119 Education of the Handicapped Act Amendments of 1990 - name changed to Individuals with Disabilities Education Act (IDEA).

TABLE D: Levels of Delay to Qualify for SSI

DOMAINS OF DEVELOPMENT AND FUNCTIONING FOR CHILDREN

Individualized Functional Assessment measures a child's behavior against the norms for age summarized here.

DOMAIN/BEHAVIOR	FIRST YEAR	AGES 1 AND 2	AGES 3-5	AGES 6-11	AGES 12-15
COGNITION	Begins organizing and regulating feelings and responses to environment	Responds to questions or instructions; refers to self and things in environment by pointing and naming, imitating actions of others	Understands, reasons, solves problems; uses acquired knowledge and concepts	Learns skills involved in reading, writing, mathematics	Applies skills and progresses in reasoning and problem-solving
COMMUNICATION	Makes appropriate visual, motor and vocal exchanges	Imitates, understands and uses intelligible words, forms short sentences	Tells, asks, predicts and relates information; follows/gives directions; expresses needs, feelings, preferences	Communicates to meet needs and to exchange information and ideas with peers/family and at school	Communicates to meet needs and to exchange information and ideas with peers or family
MOTOR ABILITIES (gross and fine skills)	Explores environment by moving body; manipulates environment by using hands	Moves body independently with increasing dexterity and independence; uses hands to do or get what's desired	Moves arms and legs and uses hands to manipulate small objects, with increasing coordination	Engages in age-appropriate play, physical education and self-care	Engages in age-appropriate sports, social events and self-care
SOCIAL ABILITIES	Forms and maintains relationships with primary caregivers	Expresses normal dependence and emotional bonding with primary caregivers, while increasing independence	Responds to social environment with appropriate self-control; shares, cooperates, helps, relates to group	Plays alone or with another child or in groups; develops friendships; relates to siblings, parents or caregivers	Develops friendships and reconciles conflicts
PERSONAL/BEHAVIORAL PATTERNS		Helps self or cooperates with others in meeting personal needs, learning new skills and adapting to environment	Helps self or cooperates with others in meeting needs, learning new skills and adapting to environment	Helps in caring for personal needs, safety; understands rules, authority; develops responsibility, respect for others	Takes care of personal needs and safety; responds appropriately to rules and authority; learns new skills
RESPONSIVENESS TO STIMULI		Responds appropriately to visual, auditory or tactile stimulation			
CONCENTRATION, PERSISTENCE AND PACE IN TASK COMPLETION			Engages in and sustains activities such as dressing, playing, etc., for time and at pace appropriate to age	Engages in and sustains activities such as playing, reading, etc., for period of time and at pace appropriate to age	Engages in and sustains activities such as studying, sports, etc., for time and at pace appropriate to age



TABLE F: Definitions of Eligibility by all 50 States

State	Status <sup>1,2,3</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Alabama	Yr 5 - EPI FY '91	25% delay in one or more areas	NO	Considering a study of serving at risk.
Alaska*	Yr 5 - EP2 Proposed	1. <u>From State Application:</u> Mild/moderate delay--Birth to 12 months: delay in months of less than 1/2 chronological age in two or more areas; over age 12 months: less than 6 months delay in two or more areas Severe/profound delay--Birth to 12 months: delay in months of more than 1/2 of chronological age in two or more areas; over 12 months: greater than 6 months delay in two or more areas 2. <u>From Legislation:</u> 15% below chronological or corrected age or 1.5 Standard Deviation (SD) below age in one or more areas	NO	1. Definition of eligibility from current state application. 2. Definition for developmentally delayed from current legislation.
American Samoa	Yr 5 - F.I. FY '91	25% delay or delay in months in one or more areas as follows: Age 6 months - 1-1/2 months delay Age 1 year - 3 months delay Age 1-1/2 years - 4-1/2 months delay Age 3 years - 9 months delay Under one year - clinical judgment can determine eligibility	NO	Will provide follow-up to at risk. Included in established conditions are infants of mothers with severe cardiopulmonary diseases and diabetes; mothers with history of substance abuse, AIDS, mental illness, and other medical conditions compromising the child's normal development.

1. "Yr 5" or "Yr 6" means the fifth or sixth year of funding, and not necessarily meeting the Part II full implementation requirements as of September 30, 1992.
2. "EP" means extended participation; the numbers "1" and "2" indicate the first or second year of extended participation.
3. "F.I." means state/jurisdiction is assuring full implementation.

\*States in their 2nd year of extended participation and \*\*birth mandated states have to meet third year requirements only for the 14 components (including eligibility definitions). Thus, OSEP has reviewed their applications for technical assistance purposes only, and many of these states' definitions are still being considered.

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Arizona*	Yr 5 - EP2 FY '91	50% delay in one or more areas	NO	
Arkansas	Yr 5 - F.I. FY '91	2 SD in one area or 35% delay in months for birth to 18 months; 2 SD in one area, 1.5 SD in two areas, or 25% delay in months for age 18-36 months	YES (Medical/ Biological)	At risk includes children who have medical conditions known to increase statistical risk for long-term medical and developmental problems including "medical conditions resulting from environmental problems like failure to thrive or child abuse."
California*	Yr 5 - EP2 FY '91	Significant difference between expected level of development and current level of functioning determined by qualified multidisciplinary team (MDT), including parents; atypical development determined by informed clinical opinion	YES	Risk factors or combination of risk factors assessed by MDT and parents in determining eligibility, taking into account multiplicity of risk factors and the strengths of the child and family; medical risk factors and developmentally disabled parents.
Colorado	Yr 5 - F.I. FY '91	1.5 SD in one or more areas or equivalent in percentile (7%) or standard scores	YES (Developmentally Delayed Parents)	At risk includes only children of parent with developmental disabilities (DD). Will study serving other "at risk" groups.
Connecticut*	Yr 5 - EP2 FY '91	2 SD in one or more areas; clinical judgment	NO	
Delaware*	Yr 5 - EP2 FY '91	1.5 SD in one area or 2 month delay for Birth to 12 months; 3-4 months delay for age 13-24 months; 5-6 months delay for age 25-36 months; atypical development; clinical judgment	NO	Extensive list of established conditions.
Department of the Interior -- Receives Part II allocation which then is distributed by the Department to tribes.				

1, 2, 3, 4, and 5\* (See footnotes at beginning of Table 1)

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
District of Columbia	Yr 5 - EPI FY '91	Abnormal physiological characteristics (prematurity, low birth weight, cognitive and motor delays) for birth to 12 months; 25% delay or 2 SD in one area for age 13-36 months	NO	Will refer and track at risk.
Florida*	Yr 5 - EP2 FY '91	Age less than 2 months - atypical development - clinical opinion Age 2-12 months - 2 months delay in one area; Age 13-24 months - 3 months delay in one area; Age 24-36 months - 4 months delay in one area	NO	Defined categories of at risk to be used during extended participation of fourth year to determine budget, policy and program implementation issues.
Georgia	Yr 5 - EPI FY '91	2 SD in one area; 1.5 SD in two areas; or informed clinical opinion when no appropriate measure is available	NO	List of established conditions, including atypical development and severe attachment disorders; defines atypical development.
Guam	Yr 5 - F.I. FY '91	25% delay or 1.5 SD in one or more areas; atypical development	YES	Extensive list of established conditions. Examples of atypical development. List of at risk conditions; at risk requires 5 or more biological and/or environmental factors.
Hawaii	Yr 5 - F.I. FY '91	MDT consensus; no level of SD or % delay specified	YES	Biological risk is documented by physician. Environmental risk is documented by Interim Care Coordinator.
Idaho	Yr 5 - F.I. FY '91	30% below age norm or 6 months delay, whichever is less, or 2 SD in one area; 1.5 SD in two areas; professional judgment	NO	Screens and tracks at risk (biological). Extensive list of established conditions.

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Illinois	Yr 5 - EPI FY '91	2 SD or 25% delay in one area; 1.5 SD or 20% delay in two or more areas or in one area with addition of other environmental risk factors; clinical judgment	NO (see comments and definition)	Track and monitor at risk. Established conditions include: medical disorders with well-known expectancies for adverse developmental outcomes; and history of events suggestive of biological insults to the developing central nervous system and increased probability of developing a delay/disability.
Indiana	Yr 5 - EPI FY '91	1.5 SD in one area or 20% below chronological age; 1 SD in two areas or 15% below chronological age in two areas	YES	Biological and environmental risk.
Iowa	Yr 5 - EPI FY '91	25% delay in one or more areas	NO	Birth mandate state.
Kansas	Yr 5 - F.I. FY '91	25% delay or 1.5 SD in one or more areas; 20% delay or 1 SD in two areas; clinical judgment	NO	Tracking, monitoring, and serving at risk are based on local discretion and local funding.
Kentucky	Yr 5 - EPI FY '91	2 SD in one area; 1.5 SD in two areas or equal to or less than 75% Developmental Quotient (DQ) in one area; or clinical judgment	NO	Will explore the development of a system to screen and track at risk; extensive list of established conditions. Part II DD definition compatible with age 3-5 DD.
Louisiana	Yr 5 - EPI FY '91	Delay in one or more areas, determined by MDT decision based on multisource data; decision making process described	YES (Biological)	List of established conditions and other biological factors; biological at risk only. Will study identifying and tracking environmental risk through pilot projects.



TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Maine	Yr 5 - EPI FY '91	Under 24 months of age; MDT professional judgment. Over 24 months of age: 1. Delay of 2 SD or 25% or more below chronological age in one area. 2. Delay of 1.5 SD or 15% below chronological age in two areas. 3. In one area with additional risk factors: delay of 1 SD or 10% below chronological age in one area of development with a high probability for further delay because of additional established conditions or biological factors.	NO (See #3)	Lists of established conditions and biological risk factors. Birth to 5 definition.
Maryland	Yr 6 - F.I. FY '92	25% delay in one area; atypical development/ behavior; professional judgment	NO	3-year study of serving at risk. "At Risk Discussion Paper" clarifies atypical vs. at risk; includes case illustrations of eligibility.
Marshall Islands -- Not currently eligible for this federal program.				
Massachusetts	Yr 5 - F.I. FY '91	Guideline: Developmental delay in one or more area: Age 6 months--1.5 months delay Age 12 months--3 months delay Age 18 months--4 months delay Age 24 months--6 months delay Age 30 months--7 months delay	YES	Biological; environmental requires 3 or more risk factors. Lists of child and family characteristics.
Michigan**	Yr 5 - EPI FY '91	Informed clinical judgment of MDT and parents; multiple sources of information including developmental history, observational assessment, recent health status appraisal, and an appropriate formal assessment measure	YES	Birth mandate state. Biological and environmental risk factors described; (requires 4 or more risk factors); parent and professional judgment.
Micronesia -- The Federated States of Micronesia is not currently eligible for this federal program.				

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Minnesota	Yr 5 - EPI FY '91	Substantial delay in one or more of the following developmental areas with the following criteria: <u>Cognitive</u> : total score of 1.5 SD below the mean <u>Communication</u> : 2.0 SD below the mean <u>Physical Development</u> : Motor: 2.0 SD below mean for children birth-18 months Physically Impaired: 1.0 SD below mean Hearing: medical documentation and informed clinical opinion Vision: medical documentation and informed clinical opinion <u>Social or Emotional</u> : Informed clinical opinion <u>Adaptive Development</u> : Informed clinical opinion <u>Noncategorical criteria</u> : delay in overall development demonstrated by a composite score of 1.5 SD below the mean	NO	State adopted the early childhood special education eligibility criteria as eligibility definition under Part II.
Mississippi*	Yr 5 - EP2 FY '91	1.5 SD or 25% delay in one area or clinical opinion	YES (Biological)	Will serve biological at risk. Will serve environmental at risk after all others have been served, as funds allow.
Missouri	Yr 5 - EPI FY '91	50% delay in one area or atypical development; professional judgment	NO	Extensive list of established conditions, including maternal drug use.
Montana	Yr 5 - EPI FY '91	50% delay in one area or 25% delay in two areas; clinical opinion	NO	
Nebraska**	Yr 5 - EPI FY '91	Developmental delay (no criteria)	NO	Birth mandate state.
Nevada	Yr 5 - EPI FY '91	25% delay in one or more areas; informed clinical opinion only may be used for birth to 12 months	NO	
New Hampshire*	Yr 5 - EP2 FY '91	Informed clinical opinion to determine developmental delay or atypical development in one or more areas; MDT decision and consensus	NO	Extensive list of established conditions.

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2,3</sup>	Definition of Developmental Delay	Serving At Risk	Comments
New Jersey	Yr 5 - EPI FY '91	33% delay in one area; 25% delay in two or more areas	NO	
New Mexico	Yr 5 - EPI FY '91	25% delay in one area or score that indicates significant delay as defined by that instrument; for less than 12 months of age, clinical judgment only can be used	YES	Biological and environmental at risk, or parent/caregiver has significant concerns regarding child's development.
New York	Yr 5 - EPI FY '91	2 SD or equivalent in one area or clinical opinion by MIDT	NO	
North Carolina	Yr 5 - F.I. FY '91	1.5 SD in one area or 20% delay in months for birth to 36 months; atypical development	YES	2 categories of risk: <u>Clinical High Risk</u> (established conditions); and <u>Potential Risk</u> (biological and environmental risk)--3 risk indicators required. Atypical development defined, including "substantial physical, sexual abuse, and other environmental situations that raise significant concern regarding a child's emotional well-being."
North Dakota	Yr 5 - EPI FY '91	50% delay in one area; 25% delay in two or more areas	NO	
Northern Marianas -- Part II grant award to this jurisdiction is made through a consolidated grant under Chapter 2 of the Education Consolidation and Improvement Act of 1981.				
Ohio	Yr 5 - F.I. FY '91	Child has not reached developmental milestones for chronological age--a "measurable delay"	NO	Will study feasibility of serving at risk.
Oklahoma	Yr 6 - F.I. FY '92	50% delay in one area; 25% delay in two or more areas	NO	
Oregon*	Yr 5 - EP2 FY '91	Child's developmental age is: 56-75% of chronological age in 3 or more areas 40-55% of chronological age in 2 areas less than 40% of chronological age in 1 area	NO	

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2,3</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Palau -- Part II grant award to this jurisdiction is made through a consolidated grant under Chapter 2 of the Education Consolidation and Improvement Act of 1981.				
Pennsylvania	Yr 5 - F.I. FY '91	25% delay or 1.5 SD in one area; clinical opinion	NO	Will track and screen at risk. Defines at risk.
Puerto Rico**	Yr 5 - EPI FY '91	Informed clinical opinion	NO	Birth mandate jurisdiction.
Rhode Island	Yr 5 - EPI FY '91	25% delay or 2 SD in one or more areas; 1.5 SD in two areas; or clinical opinion--observable atypical behaviors	NO	Describes single and multiple established conditions. List of child- and parent-centered conditions.
South Carolina	Yr 5 - EPI FY '91	2 SD or 30% below age in one area; 1.5 SD or 22% below age in two areas; or clinical judgment	NO	List of established conditions.
South Dakota	Yr 5 - EPI FY '91	25% delay or 6 month delay or 1.5 SD in one or more areas	NO	Impact study in progress; will determine whether to serve at risk. Will track biological and environmental at risk; environmental requires 3 risk factors.
Tennessee	Yr 5 - F.I. FY '91	25% delay in two or more areas; 40% delay in one area	NO	List of established conditions.
Texas	Yr 5 - EPI FY '91	Age less than 2 months--atypical behaviors or medical diagnosis Age 2-12 months--2 months delay in one area Age 13-24 months--3 months delay or more in one or more areas Age 25-36 months--4 months delay or greater in one area Atypical behavior	NO (see comments)	Local programs may serve at risk if state funds are available after all eligible children are served. List of established conditions, including prenatal substance exposure. Will track, monitor, and refer biological and environmental at risk.

TABLE F: Definitions of Eligibility by all 50 States (Cont'd.)

State	Status <sup>1,2</sup>	Definition of Developmental Delay	Serving At Risk	Comments
Utah	Yr 5 - F.I. FY '91	More than 2 SD or below 2nd percentile in one area; more than 1.5 SD or below 7th percentile in two or more areas; more than 1 SD or below 16th percentile in three areas; clinical opinion	NO	Tracking and monitoring at risk.
Vermont*	Yr 5 - EP2 FY '91	Clearly observable or measurable delay in one or more areas; clinical judgment including family	NO	List of established conditions.
Virgin Islands*	Yr 5 - EP2 FY '91	25% delay or 6 month delay--whichever is less; or 1.5 SD in one or more areas	YES	Biological at risk is determined by physician. Environmental at risk is determined by MDT; 3 or more risk factors are required for eligibility for environmental risk.
Virginia	Yr 5 - EP1 FY '91	25% delay in one area or atypical development	NO	Will study serving at risk; defines at risk; will require three risk factors. Atypical development defined. List of established conditions which includes "other physical or mental conditions at MDT's discretion."
Washington	Yr 5 - EP1 FY '91	1.5 SD or 25% delay in one area; informed clinical opinion	NO	Will continue to provide "family resources coordination" to those who are ineligible for Part II services. List of established conditions.
West Virginia	Yr 5 - F.I. FY '91	25% delay in one area; 6 month delay in two or more areas.	NO	List of established conditions, including HIV positive mother and prenatal drug exposure.
Wisconsin	Yr 5 - F.I. FY '91	25% delay or 1.3 SD in one area; clinical opinion--MDT decision; atypical development	NO	Will study serving at risk. Atypical development defined. List of established conditions, including "addiction at birth."
Wyoming	Yr 5 - F.I. FY '91	1.5 SD or 25% delay in one or more areas; clinical opinion	NO	