Members of the Joint Standing Committee on Education and Cultural Affairs

c/o Legislative Information Office
100 State House Station
Augusta, ME 04333

Dear Committee Members:

We are writing in reference to LD 386: An Act to Improve Operations at the Maine Department of Education.

Below please find the personal opinions of a group of professionals that work for an organization that has provided services to children with developmental and educational challenges and disabilities for almost 55 years. In our professional roles we currently provide diagnostic and treatment services which include an interdisciplinary Developmental Evaluation Clinic, development pediatrics, child psychological evaluation, pediatric occupational therapy, physical therapy and speech therapy services, clinical social work and child psychiatry. Many of the children we share with Child Development Services (CDS) are receiving services in our pediatric rehabilitation program, which provides services to medically complex children ages 0-5.

- We support the transition of responsibility for early intervention services for infants, toddlers and children who are 3 years of age from Child Development Services to the Department of Education.
- We support the transition of early childhood special education services for children ages 4-6 to school administrative districts.
- We strongly support the establishment of an Advisory Committee to establish a system of care that insures accountability, and provides children and their families with the necessary support and intervention that will lead to positive outcomes for children.

To contribute to that effort, we would like to raise concerns about both the current Primary Service Provider Model, and the current Coaching Model in early intervention services in Maine.

In the Primary Service Provider model, one member of the child's care team functions as the primary liaison between the family and other team members. The PSP receives consultation from the other team members. The practice of having one primary provider has its benefits such as allowing the family to bond and interact with fewer providers; however, the younger a child is determined to need services the more likely that child has significant challenges that require skilled intervention in specific areas. Most often, the primary provider is a special educator. Even the best special educator is a generalist with some knowledge in all five domains of development, but is not a clinically trained specialist. They are not always able to identify the need to call in the specialist.

> *One anecdote of this in Maine is a two-year-old child receiving services from a special educator in the home for global delays. The child received a cervical spine injury from a fall between visits from the special educator. Due to the injury, the child was in a cervical spine stabilizing brace, but otherwise feeling quite energetic and happy. During the visit from the special educator, the*

child was allowed and encouraged to jump on the couch, which had been a previous activity for regulation purposes. This special educator was unaware that any one in such a brace, as well as after a recent spinal injury, should not be participating in such an activity. The only way this significantly dangerous situation was brought to her attention was when an occupational therapist in a meeting overheard the special educator talking about the session. A much more common area of concern is when a young child is having feeding challenges and the primary provider generalizes knowledge from another case without first having the child's feeding challenges assessed by a feeding specialist. This has and will lead to dangerous situations and more increased feeding difficulties if not corrected moving forward.

In a parent-coached model (Coaching Model), the parent/caregiver becomes the learner as the early intervention (EI) provider coaches the caregiver to work with the child during the daily routine. There is often very little hands on work with the child. For example, a 2.5 year old child with identified speech and language delays had been receiving one hour weekly of parent coaching with a special educator and biannual speech-language consultation making little progress Eventually, a referral to direct evaluation and treatment by a speech pathologist (medical model) resulted in dramatic progress.

It should be clear that CDS services and medical model services are not exclusive of each other, and that optimum progress is often facilitated by a combination of educational model and medical model services.

Emma was referred to our physical therapy program at age 10 months due to delayed gross motor development resulting from a fractured leg. The pediatric physical therapist confirmed the motor delays, but also observed possible delayed social development, communication and play skills. At 18 months, Emma was seen by our interdisciplinary developmental evaluation clinic, and a primary diagnosis of Autism Spectrum Disorder was advanced.*

Emma received a combination of education and medical model services, which led to her making tremendous gains. She received evidence-based intervention via the Early Start Denver model. (CDS) In addition to the educational services, Emma was referred for Occupational Therapy, Genetics, Audiology and Ophthalmology. At age three. Emma was accepted into a local special purpose preschool (CDS), and interventions were put in place that supported Emma's many challenges, At the same time, she received both occupational therapy and speech therapy in the medical model.

At almost age 5, Emma is now communicating verbally. She is reading, helping with dressing and feeding and in the early stages of toilet training. Motor and visual problem solving skills are now falling within the average range for her age. . Having her needs clearly and accurately identified at the young age of 18 months led to early developmental intervention that would start her on a path of good outcomes. Emma's combination of evidence-based medical and educational model developmental services led to early diagnosis and treatment, giving her the tools to enter a kindergarten program with appropriate interventions and supports in place.

Finally, we believe there needs to be clarification of the concept of Least Restrictive Environment. The Maine Early Childhood Special Education Implementation Plan references determining if students are receiving their education in the Least Restrictive Environment, as IDEA requires that all students receive a Free and Appropriate Public Education in the least restrictive environment. We request that in this

pursuit of assessing and determining if the LRE is being provided, that it is critical to remember that the goal of an IEP is to create the LRE for a student to learn in, not just to be in the setting as close to mainstream as possible. LRE is a concept to ensure that a student is receiving the education and services they need, versus the LRE being just the physical location where those services are provided. A refocus and additional education is required to assist uniformity of the concept and implementation of LRE throughout the state.

We are honored to work with legislators, special education professionals, CDS and DOE in caring for the children in our community who have special needs. **We welcome any opportunity to serve on advisory groups, committees, work sessions or help in any way toward the goal of insuring the best outcome for these children.**

Thank you or the opportunity to comment.

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*name changed