

ג'זנט יר  
מכון ברקדיל לגרונטולוגיה  
והתפתחות אדם וחברה בישראל

JOINT (J.D.C.) ISRAEL  
BROOKDALE INSTITUTE OF GERONTOLOGY  
AND ADULT HUMAN DEVELOPMENT IN ISRAEL

---

JDC Evaluation Paper

---

EVALUATION OF THE EDDY SHORE  
OBSERVATION CENTER

JUDITH BENDEL



S-7-81

### **THE INSTITUTE**

is a national center devoted to research, experimentation and education in gerontology and adult human development. It was founded and is funded by the the American Jewish Joint Distribution Committee (AJDC) with the assistance of the Brookdale Foundation and the support of the Government of the State of Israel. Its research is policy- and program-oriented, multidisciplinary and, primarily, of an applied nature.

The Institute tries to identify socially relevant problems and to recommend alternative solutions to problems of the health and social services and policies. It attempts to bring together academic and governmental experts and other public officials and citizens in order to link research findings with their implementation.

The findings and conclusions presented are those of the author or authors and do not purport to represent the views of the Institute, and of other persons or groups associated with it.

EVALUATION OF THE EDDY SHORE  
OBSERVATION CENTER

JUDITH BENDEL

S-7-81

<u>TABLE OF CONTENTS</u>	<u>PAGE</u>
LIST OF TABLES	iii
PREFACE	v
ABSTRACT	vii
1. INTRODUCTION	1
<u>STAGE A</u>	
2. FOLLOW-UP OF PROGRAM GRADUATES	3
3. STUDY OBJECTIVES	4
4. METHODOLOGY	5
4.1 Study Subjects	5
4.2 Data Collection Procedures	5
5. PRESENTATION OF DATA	10
5.1 Clientele	10
5.2 Program Results	16
5.3 Program Effectiveness	19
5.4 Variables Affecting Program Effectiveness	24
5.5 Factors Relevant to Recommendations re Educational Frameworks	25
5.6 Summary	27
6. DISCUSSION AND CONCLUSIONS	30
6.1 Clientele	30
6.2 Program Results	34
6.3 Program Effectiveness	36
6.4 Variables Affecting Program Effectiveness	40
6.5 Factors Relevant to Recommendations re Educational Frameworks	41
6.6 Summary	42
<u>STAGE B</u>	
7. FORMATIVE EVALUATION OF THE EDDY SHORE OBSERVATION UNIT	44
8. STUDY OBJECTIVE	45
9. METHODOLOGY	46
9.1 Study Subjects	46
9.2 Data Collection Procedures	46

9.3	Data Collection Instruments	46
9.4	Data Analysis	47
9.5	Study Limitations	48
10.	PRESENTATION OF DATA	50
10.1	Program Goals	50
10.2	Program Implementation	52
10.3	The Curriculum	55
10.4	Communications System	58
10.5	Evaluation	61
10.6	Impact of Respondents' Professional Affiliations on Program Implementation	63
10.7	Summary	63
11.	DISCUSSION	65
11.1	Program Goals	65
11.2	Program Implementation	65
11.3	Physical Facilities	66
11.4	Curriculum	67
11.5	Communications System	70
11.6	Evaluation	72
11.7	Summary	73
12.	RELATIONSHIPS, CONCLUSIONS AND RECOMMENDATIONS	74
12.1	Goals vs. Implementation	74
12.2	Goals vs. Results	77
12.3	Program Results vs. Implementation	79
	BIBLIOGRAPHY	82
	APPENDIX A	83
1.	Definitions	83
2.	I.Q. Tests	84
	APPENDIX B: Tables	85

LIST OF TABLES

1. TEXT TABLES

- TABLE 1: Symptoms upon Admission, by Number and Percentage  
TABLE 2: Educational Frameworks Attended by the Participants after Completion of Observation Period  
TABLE 3: Program Goals as Reported by the Professional Staff

2. APPENDIX B

- TABLE 4: Age Distribution of Participants  
TABLE 5: Parents' Countries of Origin  
TABLE 6: Family Size of Participants  
TABLE 7: Occupation of Participants' Parents  
TABLE 8: Participants' Special Social Problems  
TABLE 9: Diseases in the Family, by Type of Disease  
TABLE 10: I.Q. Scores as Recorded upon Admission and Completion of the Program  
TABLE 11: Type of I.Q. Test Used upon Admission and Completion of the Program  
TABLE 12: Location of I.Q. Test Administration upon Program Admission and Completion  
TABLE 13: Sources of Referral  
TABLE 14: Participants' Previous Educational Frameworks  
TABLE 15: Medical and Other Examinations upon Admission  
TABLE 16: Present Educational Framework, by First Framework  
TABLE 17: Recommendations and Decisions with Regard to Types of Educational Frameworks  
TABLE 18: Recommendations of the Eddy Shore Unit, by Decisions of the Municipal Placement Committee  
TABLE 19: Length of Stay in First Educational Framework  
TABLE 20: Length of Stay in First Placement when Framework Coincided with Recommendation, by Type of Framework  
TABLE 21: Length of Stay in First Placement when Framework did not Coincide with Unit's Recommendation, by Type of Framework  
TABLE 22: Reasons for Leaving First Framework, by Length of Stay in Framework

List of Tables (Cont'd)

- TABLE 23: Reasons for Leaving Educational Framework, by Type of Framework
- TABLE 24: Children in Intermediate Educational Frameworks
- TABLE 25: Present Educational Frameworks, by Recommendations of the Eddy Shore Team
- TABLE 26: Participants' I.Q. Scores upon Admission, by I.Q. Scores upon Program Completion
- TABLE 27: Length of Program Participation, by Length of Stay in First Educational Framework after Program Completion (where Placement was as Recommended by Eddy Shore Team)
- TABLE 28: Symptoms upon Admission Compared to First Educational Framework upon Program Completion
- TABLE 29: WIPPSSI I.Q. Test Scores upon Program Completion, by Length of Stay in First Educational Framework
- TABLE 30: Symptoms upon Program Admission Compared to Recommendation of Eddy Shore Team
- TABLE 31: I.Q. Scores upon Program Admission, by Placement Recommendations from the Eddy Shore Team
- TABLE 32: I.Q. Scores upon Program Completion, by Placement Recommendations from the Eddy Shore Team

PREFACE

Three years ago, as part of its overall reorientation and reorganization, JDC-Israel established a department of planning, evaluation and research. Such a department, it was felt, was an essential component of a program which had shifted its emphasis from the direct delivery of services to the aged - JDC's major activity in Israel since before the establishment of the State - to a much broader involvement with health, education and welfare in the country through a large number of self-contained projects.

JDC-Israel views its role in terms of helping initiate and demonstrate approaches to dealing with the health, education and welfare of the population in fashions that strive to develop efficient, high quality services. All such efforts are undertaken in conjunction with local partners who have the mandate and responsibility for delivery of services, and who undertake the continuation of pilot projects deemed successful. Both planning and evaluation become, in such an approach, crucial.

Since its inception JDC's planning, evaluation and research department has undertaken a number of studies on various projects. Of them, this report is the first to be published. The Eddy Shore Observation Unit is an activity in which the JDC has been involved over the past five years. It was a program "ripe" for assessment: it had accumulated experience, developed modi operandi, and had treated significant numbers of children. The evaluation was undertaken in order to examine all of these so as to enable the planning of the Unit's

future mode of functioning. Since completion, the evaluation study has been an important instrument in planning processes that were instituted and has contributed to the rearticulation of the Eddy Shore Observation Unit's work.

Dr. Judith Bendel and her associates - Ety Tatar, Naomi Rubinstein, and Susan Nashman - have produced an excellent study, often conducted under adverse conditions resulting from inadequate baseline materials. They have proven to be very able sleuths as well as researchers. Dr. Norman Cohen, JDC's consultant on child development programs has, throughout the study, been an active and key advisor. Kurt Aharonson and Miriam Dayan have been very helpful in assisting the data collection process. Joe Lockard very efficiently edited the manuscript and helped prepare it for publication. Finally and significantly, members of the Eddy Shore Observation Unit staff were willing participants in the evaluation process. To all - I wish to express gratitude and congratulations on having brought this task to its successful conclusion.

David Harman  
Chief Scientist  
JDC-Israel

ABSTRACT

The Eddy Shore Observation Unit's staff engages in the observation, diagnosis and treatment of preschool children with a low level of function in relation to their chronological age. The purpose of the Unit is to determine the cause of this developmental delay, define educational and therapeutic needs, provide treatment accordingly, and assist in the referral of children to a variety of frameworks where their particular problems or limitations can be treated. This is done to the end of achieving the maximal development of the children's potential.

An evaluation study was undertaken in order to determine the program's usefulness and to enable further planning and development. The study was executed in two stages. The first stage was a follow-up investigation of the 139 children who had completed the program since its inception. An attempt was made to define the factors that had an impact on the program results. The results were determined according to the following criteria: the acceptance of the Eddy Shore team's recommendations by the municipal placement committee, the "correct" distribution of the program graduates, and the congruence between their present educational frameworks and the Unit's recommendations. Information was collected from various sources to describe the Unit's clientele in terms of selected characteristics and the findings identified some common denominators.

The program was found useful for approximately two-thirds of its participants with regard to their succeeding educational framework. Length of stay in the Observation Unit, symptoms upon admission, and

I.Q. scores upon admission did not appear to have an impact on the program results. The Unit's recommendations were based neither on symptoms nor on I.Q. scores, a finding that could point to the importance of such a program.

The second part of the study employed a formative evaluation. The evaluation consisted of assessing the goals of the program, the implementation and the results, and studying the relationships between them.

Since the Unit's goals were not uniformly and clearly perceived by its staff and because the program did not provide all possible opportunities to achieve them, these goals were not fully met. Recommendations were made for possible modifications aimed at achieving improved results.

1.        INTRODUCTION

The Eddy Shore Observation Unit performs a unique and important task. Its multidisciplinary staff engages in the observation, diagnosis and treatment of preschool children aged 3 - 7 with a low level of function in relation to their chronological age. The cause of retardation in these children is generally not known. Proper diagnosis can often prevent a child from being stigmatized as mentally retarded. It can assist in referral of children to a variety of frameworks where their particular problems or limitations can be treated so as to achieve the maximal development of their potential.

The Observation Unit is the only one of its kind in Jerusalem and in the entire country. (The Jerusalem Child Development Center operates an observational nursery school but it serves a population of ages 0 - 3).

The Unit has been in operation for nine years. One hundred and thirty-nine children have been observed on its premises but the program received no evaluation until now.

The importance and uniqueness of this program requires an evaluation of its operation. Such an evaluation will enable further planning and development of the program and such other programs. This study, therefore, is an attempt to evaluate the program at the Eddy Shore Observation Unit.

This was a two-stage study. The first stage was a follow-up investigation of the children who completed the program and was aimed at measuring the results of the program. The second stage was a formative evaluation in which the various components of the program content were studied in

terms of their appropriateness for achieving the goals. The program results were studied in terms of the goals achieved.

Such a comprehensive evaluation enabled the investigator to arrive at conclusions as to the usefulness of the Observation Unit. In addition, suggestions were made for modifications in the existing program and for further research to contribute to our knowledge and understanding of this important area of concern.

STAGE A

2. FOLLOW-UP OF PROGRAM GRADUATES

In order to evaluate the Eddy Shore Observation Unit's program, the components of the program had to be identified and defined. One method of determining effectiveness is through results, but no measures of the program's outcome could be obtained at the Unit. As a first step towards evaluation, the results of the program needed assessment.

The criterion chosen for measuring program results was the "suitable placement"<sup>1</sup> of the program participants in various types of educational frameworks after they left the Unit. For this purpose, the children who completed the program had to be followed-up from the point they left the Observation Unit to date.

The first stage of the study was concerned with locating these 139 graduates in order to determine the results of the program.

Information was gathered about demographic characteristics, social and medical background, symptoms bearing on referral, I.Q. scores, and the results for the individual child in terms of recommendations, placement, length of stay in placement and special problems. The interrelationships of these variables were studied in an attempt to identify some of the components that had an impact on the results.

---

<sup>1</sup>For a definition of "suitable placement" as used in this context, see Appendix A.

3. STUDY OBJECTIVES

The problem set for Stage A was to assess the program results so as to provide an evaluation.

The study objectives were:

- a) to follow-up the children who completed their observation period at the Unit;
- b) to describe the Unit's clientele in terms of selected characteristics;
- c) to define the variables affecting the program results;
- d) to determine the success of the program.

4. METHODOLOGY

A short feasibility study was made to investigate the possibilities of evaluating the project systematically. This required a check of the available data. The data which were not available but needed to be collected, were described. This feasibility study enabled the investigator to plan the evaluation system, based on the nature of the program and the types and availability to data.

4.1 Study Subjects

The subjects for the first stage of the study were all children who attended the Eddy Shore Observation Unit from September 1971 (when the Unit was established) through June 1979. The group included those children who participated in the program for any length of time and who terminated participation by June 1979.

The subjects were included in the study if they could be located and if at least 60% of the information sought was obtained. A total of 139 children participated in the program. One child died and the information about eight children was insufficient. These were excluded from the study. Therefore, the total number of subjects used for the study was 130.

4.2 Data Collection Procedures

4.2.1 List of Study Subjects: A list of study subjects was compiled from the personal files of those who attended the Observation Unit. This list was found to be incomplete when the total number of children registered did not equal the total given to JDC in annual reports.

The Ministry of Social Affairs completed these records by checking the

special education attendance receipts given to families whose children attended the Eddy Shore Nursery School and the Observation Unit.

4.2.2 Sources of Information: The information about each child was collected from several sources. When information about the same child was available from more than one place, all sources were searched for complementary information and confirmation of the accuracy of the data previously obtained.

The various sources of information are described below:

- a) Personal files at the Eddy Shore Day Care Center. Thirty out of the 137 children's files could not be located. Most of the remaining 107 files were lacking part of the information this study was concerned with.
- b) Files available at the Services for the Mentally Retarded. Children defined as mentally retarded (I.Q. under 75) should have records at this service. Thirty-five out of the 137 children had files at this source.
- c) Files available at the Municipality of Jerusalem's Psychology Services. Sixty-one of the Observation Unit's graduates had records at this source. The children were tested there either prior to admission to Eddy Shore, upon completion of the program, or both, to determine their mental and functional abilities.
- d) The municipal placement committee. Children requiring special education frameworks, such as the graduates of the Eddy Shore Observation Unit, are placed through this committee; 64 children out of 137 had files with the committee.

- e) The Jerusalem Child Development Center. This CDC was one of the main sources of referral to the Observation Unit. Information about 10 children was secured from this source. It had referred many more children, but there were difficulties in locating their files.
- f) The Bikur Holim Pediatric Neurology Department. Information about 11 children was obtained from the department's records. These children had been examined in the hospital and some had obtained treatment there.
- g) Schools and other educational frameworks. Teachers or school directors were asked to confirm whether a child was currently attending their institution. The personal files of children attending special education frameworks were examined at the institutions. Regular school files were used only when no records could be obtained at the above-mentioned sources or when the information obtained was insufficient. This was meant to avoid revealing a child's past when it was not generally known.
- h) Family or guardians. A child's family or guardians were contacted for information only when none of the sources mentioned above could provide sufficient information. The families were contacted mainly in order to trace the educational frameworks the child had attended and sometimes to fill in information on social and demographic characteristics.

Information about 102 children was obtained from at least two sources of information besides the Eddy Shore files. Ten had records at only one other source and 26 had no records other than at the Observatory Unit.

4.2.3 Information Sheet: The data concerning each child were recorded on information sheets drawn up for that purpose. The information sheet included demographic characteristics, family, social and medical background, the source of referral, symptoms, physical and mental state upon admission and completion of the program, length of stay in the program, and a follow-up of educational frameworks. In addition, any other special information concerning the child was collected.

The information sheet included 28 items and was designed for open-ended data recording.

4.2.4 Data Analysis: The list of possible answers to each question on the information sheets was prepared and given a code number, after which each fact sheet was coded on score sheets. The coded forms were key punched and programmed for analysis.

The items on the information sheets were analyzed for the following purposes:

- a) to determine the clientele of the Observation Unit;
- b) to determine the results of the program in terms of the type of educational framework to which the graduates were referred and in terms of present education framework;
- c) to determine the effectiveness of the program. For this purpose the following relationships were studied: the first placement and the Eddy Shore team's recommendations, duration of stay in former placement, type of framework, reasons for leaving, and

present educational framework compared to the team's recommendations. The I.Q. scores of participants upon their beginning and completion of the program were also studied.

- d) to determine whether the following variables affected the effectiveness of the program: I.Q. scores upon admission and completion of the program, symptoms upon admission, and length of participation.

5. PRESENTATION OF DATA

5.1 Clientele

Age: Table 4, Appendix B, describes the age range of the Unit's graduates. At the time of the study, the age range was 5 - 11 with most of the children aged 7 - 11 (that is, born in 1969-73). This means that at the time the children attended the Observation Unit their age range was 2 - 7. The largest group, about one-third of the children, were born in 1969, making them approximately 11 years old at the time of the study. But these children did not enter the Observation Unit at the same point; upon admission they ranged in age from 2 - 7.

5.1.2 Family Background: About one-third of the participants' families were of Asian origin (32%). The second largest category was of children born to parents of mixed origin, with one Israeli-born parent (23.8%). The next largest category was of children born to parents of African origin (17.2%). This data is presented in Table 5, Appendix B. The size of the family was usually 3 - 7 members, but most frequently it had five members (28.6% of the families). The least frequent (1.6%) were large families of 11 -13 members (see Table 6, Appendix B).

Close to half (43.7%) of the participants' fathers were service workers or other non-professional workers in industry, construction and transportation. The least frequent paternal occupation was administrative, managerial, or clerical work (about 6.3% respectively). Other occupations were each represented by about 10% of the families (see Table 7, Appendix B).

Most of the mothers (67.3%) were not employed outside their homes. Among those who worked were 12 service workers and similar numbers in the academic and scientific professions (see Table 7, Appendix B). The special social problems of the childrens' families are presented in Table 8, Appendix B. For 27 out of 130 children (27%), special social problems such as divorce, the long-term hospitalization of one parent, etc., were recorded. Five of these children were in foster families. Another 10 children were also placed in foster families, but for no special social problem and the reason for placement remained unexplained. Another five children were one-parent orphans. Four children were adopted. Thus, a total of 45 children (41%) had some type of special problem.

5.1.3                    Medical Background:    In 116 of the 130 families (89%) at least one family member had a major disease. The distribution of diseases in the families is presented in Table 9, Appendix B. Neurological disorders were the most frequent, being recorded in 61 families (46.9%), followed by psychiatric disorders in 47 families (36.1%). Endocrinal, metabolic, nutritional and allergic diseases were recorded in 23.8% of the families.

The data concerning family diseases and disorders were also noted by family member. Fifty-one out of 130 fathers (39.2%) were known to have special medical problems. The most frequently recorded diseases were psychiatric disorders and hereditary problems that could affect the fetus. Each of these problems appeared in a respective one-third of the cases. A few also had infective and parasitic diseases, and diseases of the

bones, muscles, joints and connective tissues.

Illnesses were also recorded for 66 out of the 130 mothers of participants (50.8%). In a similar manner to the fathers, the most frequent were psychiatric disorders and hereditary problems that could affect the fetus, each appearing in about one-third of the cases. Some 15% also had neurological disorders.

Forty participants had brothers or sisters with known diseases. Most frequently (75%) these were neurological disorders.. A few (12.5%) had psychiatric disorders.

Neurological disorders were also common among other relatives (10 out of 20 for whom diseases were recorded). Endocrinal, metabolic, nutritional and allergic disorders were even more frequent among relatives (13 out of 30).

With regard to the children who were the study subjects, neurological disorders were the most commonly recorded (16 out of 50 children who had an illness, i.e. 38%). Endocrinal, metabolic, nutritional, and allergic diseases and disorders of the respiratory system were noted in some of the participants (a respective 12% and 14% of the cases).

5.1.4            Symptoms upon Admission: All children admitted to the Observation Unit were described as functioning at a low level compared with others of the same chronological age. The cause of their retardation had not been determined. Table 1 presents the symptoms that led to admission.

The children's most frequent symptom upon admission was speech disorders (48%). Other common symptoms were developmental disorders

Table 1: Symptoms upon Admission, by Number and Percentage\*

Symptoms	No.	%
Speech disorders (incl. delay)	62	47.6
Vision impairment	10	7.6
Hearing impairment	10	7.6
Disorders of motor development (balance, muscle tone, flexibility, slowness, clumsiness, awkward-redundant movements)	56	43.1
Disorders in cognitive development (comprehension, concentration, memory)	37	28.4
Behavioral problems (hyperactivity, passivity, aggression, stubbornness, insufficient communication with adult or peer group)	51	39.2
Emotional problems (variations in level of function, changing moods, peers, dependency, lack of self-confidence)	36	27.6
Low I.Q.	17	13.1
Physical handicaps (strange appearance, size, etc.)	18	13.8
Neurological diseases and epilepsy	1	0.7
Other diseases	4	3.1
No clear symptoms	9	6.92

\* Symptoms were specified for 125 children. Some of the children had more than one symptom and therefore the total number of symptoms was over 125 and the percentage was more than 100%

of the motor system (43%), behavioural problems (39%), emotional disturbances (28%), and disorders in cognitive development (28%). Vision impairment, low I.Q. scores and physical handicaps were reported for about 8% of the participants respectively. Symptoms upon admission were not clearly stated for eight children. At least two different symptoms were registered for 96 children, three symptoms were recorded for 63 children and four for 22 children. The most dominant symptom could not be obtained from the available records.

5.1.5 Intelligence and Functional Level upon Admission:

I.Q. upon admission was not available for 57 participants. For the other 75 children, the I.Q. scores most often showed mild retardation, i.e. scores of 55-69 (see Table 10, Appendix B).<sup>2</sup> Normal intelligence (I.Q. of 85 and above) and borderline retardation (75-84 I.Q.) were recorded for a respective 40.7% of the children. Some (13 out of 73) had moderate retardation (I.Q. 40-54) and a few (5 out of 73) performed as severely retarded (I.Q. 25-39). The same number (5) could not be tested on the I.Q. examinations that were utilized.

The I.Q. score was usually based on one type of test only. Twenty-three children were tested twice with two different types of I.Q. tests. Seven children were tested with three different examinations and only three were tested four times.

Mental age was recorded for some children rather than an I.Q. score. However, 75 out of 130 children (57.7%) had no mental age recorded upon

---

<sup>2</sup>For categories of mental retardation, see Appendix A.

admission. For the other 55, the mental age was often recorded as a score without exact dates to indicate the chronological age at the time the score was obtained. Therefore the information was meaningless for describing the clientele.

The I.Q. test most frequently used upon admission was the Leiter test<sup>3</sup>, which was used for about one-third (40) of the children (see Table 11, Appendix B). The second most frequently utilized test was the Stanford Binet (used for 24 children, about 18%), followed by the WIPPSI test.

Table 12, Appendix B, presents data concerning where the tests were administered upon admission. The tests were most frequently given at the Observation Unit (41 out of 80, or 51%). Eighteen tests (about 22%) were given at the Jerusalem Child Development Center and fifteen (19%) were administered by the municipal Psychology Services.

5.1.6. Sources of Referral: Table 13, Appendix B, shows the distribution of the sources of referral. The most common source of referral to the Unit was the Jerusalem Child Development Center (69 out of 130 children, or 53%). The rest of the children were referred from a wide range of sources: the municipal Psychology Services (10 children, 8%), mother-and-child centers (9 children, 6%), the Services for the Retarded (6 children, 5%) and the Center for the Child and nursery schools referred a few as well.

No source of referral could be obtained for 12 children (9%).

---

<sup>3</sup>For definitions of the various I.Q. tests, see Appendix A.

5.1.7            Previous Educational Framework: Eighty out of 130 (about 65%) subjects attended an educational framework outside of their parents' home prior to admission to Observation Unit (see Table 14, Appendix B). The majority (55, or 42%) attended the regular educational system. Twenty out of the above 80 (15%) attended special education frameworks. A few (one or two children in each case) were in integrated education frameworks, special frameworks for the physically handicapped, or live-in institutions.<sup>4</sup> Five of the children attended more than one educational framework prior to Eddy Shore.

5.1.8            Medical and Other Testing: Of the 130 children, 56 had recorded results of medical examinations or other tests such as visionhand integration tests or language skill tests. About 13% of the subjects (17) underwent at least two kinds of tests other than I.Q. Table 15, Appendix B, shows that language skills were the most frequently examined - for 37 children or 50% of the total tests. The next most frequent test was the E.E.G. (about 25% of the tests), followed by vision-hand integration tests (about 15%).

---

<sup>4</sup>See Appendix A for definitions.

5.2 Program Results

The distribution of children among the various educational frameworks, immediately after completion of the Observation Unit's work, was viewed as the immediate "result" of the program. As will be explained later, such "results" are not the only function of the Unit's program. The tenure of the children in their present educational frameworks<sup>5</sup> was viewed as the program's long-term result and an indication of the "correctness" of the first placement. The data on the first educational framework are presented in the first part of Table 2, while the results in terms of present educational framework are presented in the second part.

The two most common frameworks for first placement were the regular educational system and special education for emotionally disturbed children. Twenty-two children (17%) attended each of these frameworks and the rest were scattered among the other types of educational frameworks. An exception were the frameworks for the profoundly retarded, which were not attended by any of the Observation Unit's graduates. Twenty-three children (17%) were placed in other frameworks for various levels of mental retardation.

At the time of the study, the most frequently attended educational framework for the program's graduates was the regular educational system, attended by 35 children (27%). Twenty-seven (21%) attended frameworks for the mildly retarded, and 19 (15%) for the emotionally disturbed.

---

<sup>5</sup>The term "present educational framework" refers to the framework attended at the time of the study.

Table 2: Educational Frameworks Attended by the Participants  
after Completion of Observation Period

Type of Framework	First Educational Framework		Present Educational Framework	
	No.	%	No.	%
Regular educational system	23	17.7	35	26.9
Integrated education	11	8.5	2	1.5
For mildly retarded children	17	13.1	27	20.9
For moderately retarded children	5	3.8	3	2.3
For severely retarded children	10	7.7	8	6.2
For profoundly retarded children	--	--	--	--
For children with minimal brain dysfunction	20	15.4	9	6.9
For emotionally disturbed children	22	16.9	19	14.6
Live-in institutions	6	4.6	9	6.9
Special education for physically handicapped	2	1.5	2	1.5
Other	1	0.8	2	1.5
Parents' home	--	--	2	1.5
Unknown*	13	10.0	12	9.3
TOTAL	130	100.0	130	100.0

\*Several children were located at their present educational framework, but the educational framework in which they were placed immediately after completion of the program could not be ascertained. Of the 12 for whom the present framework was unknown, 4 were adopted and therefore the present allocation could not be obtained. One child left the country.

A comparison of the present educational framework with the present one (see Table 16, Appendix B) showed that 61 children (63% of those for whom information was obtained about first and present frameworks) attended the same framework as when first placed. However, there were more children in regular educational frameworks (24 vs. 18) than there were when they were first placed. Four of these children were first placed in an integrated educational framework, which is preparatory to regular education. Thus it can be considered that 65 children (68%) were in the same educational framework. Some children who were first placed in frameworks for children with minimal brain dysfunction (see Appendix A for definition), and emotionally disturbed and physically handicapped children, were also in regular education.

More children were found to attend frameworks for the mildly retarded than there were first placements for such frameworks (25 vs. 15). These transfers included children originally placed in frameworks for minimal brain dysfunction, for the emotionally disturbed, for the severely retarded and integrated education.

The number of children in frameworks for the severely retarded and emotionally disturbed was the same as the number first placed there. Fewer children were in integrated educational frameworks (2 vs 9), the others having been sent either to frameworks for the mildly retarded or regular education. The frameworks for minimal brain dysfunction also contained fewer children (9 vs 20).

5.3 Program Effectiveness

The program results, as presented above, could not be considered a measure of program effectiveness since placement was not a direct function of the Unit's recommendations. It is the Municipality's placement committee that decides. With this in mind, program effectiveness was measured according to several variables: the acceptance of the Eddy Shore recommendations by the municipal committee, the "correct" distribution of graduates among the various frameworks (i.e., for an extended period of time, as long as the framework was found suitable), and conditionally, the present educational frameworks when they were the same as recommended by the Unit.

5.3.1 Acceptance of Recommendations: The recommendations of the Eddy Shore team and the decisions of the Municipality's placement committee is presented in Table 17, Appendix B. Recommendations were put before the municipal committee concerning the placement of 90 out of the 130 children (69%). No record of recommendations could be obtained for the other 40 children. The committee, however, made decisions regarding the placement of 94 children.

The most frequent Eddy Shore recommendation was to refer a child to regular education (18 children - 14%). The municipal committee's most frequent decision regarding placement was to send children to frameworks for minimal brain dysfunction (22 children - 17%). Comparison of the Eddy Shore recommendations with the committee's decisions (see Table 18, Appendix B) reveals that only 73 children were discussed by both sides. Of these, they concurred on the referral of 47 children (64%). In most

cases the agreement lay in the placements in frameworks for minimal brain dysfunction (91% of the time), followed by frameworks for emotionally disturbed children (80% of the time), and frameworks for the mildly retarded (73% of the time).

The discrepancies between the two were most obvious with regard to children recommended by the Eddy Shore team for regular education. They agreed upon 6 out of 14 and the remaining eight were directed by the committee to a variety of other frameworks. Further, the committee decided to send five children to frameworks for the moderately retarded, though the Eddy Shore team had different recommendations for four of them. Twenty children were placed in frameworks for minimal brain dysfunction, although the Eddy Shore team felt that nine of them (45%) should be referred to other frameworks.

Information was obtained for 117 of the program participants on actual first educational framework, 23 more children than were placed by the municipal committee (see Tables 2 and 17, Appendix B). Of these 23 children, about half were placed in regular education and the rest in other frameworks.

5.3.2                    Length of Stay in First Educational Framework: Length of stay was calculated for each framework individually. For example, when there was a specific policy against transferring a child during the course of a school year, the child spent the year there regardless of whether or not that framework answered his/her needs. In such a case, one year was considered a short stay. But when a framework has its own trial period (usually several weeks to three months) and bases

its decision regarding the child's stay on the results of its observations, three months is considered a short stay. A stay beyond that period would be considered a "medium" or long-term stay. In order to avoid deceptive data concerning length of stay, the reasons for leaving a framework were studied along with the teachers' comments concerning a child's adjustment.

Table 19, Appendix B, presents the Unit's graduates' length of stay in the educational framework they first attended after completing their term at Eddy Shore; 52 out of 105 children (49%) stayed a long period at the framework in which they were placed. Thirty-six children (34%) had a "medium" length of stay and 17 (16%) remained for just a short period of time. The length of stay was not clear for 25 children.

The length of stay of the fifty children placed as recommended by the Eddy Shore team was examined with regard to type of framework (see Table 20, Appendix B). The data show that those children who attended a framework for the mildly retarded as their first placement were generally those who stayed for an extended period (7 out of 9 children). About half of those placed in regular education (4 out of 7) stayed there for an extended period. All those who were sent to live-in institutions stayed there.

Those who had a "medium" length of stay in their first framework all attended integrated educational systems. There was no specific framework common to those who spend a short time in their first placement.

There was no clear pattern regarding the length of stay of the 23 children placed other than as recommended by the Unit's team (see Table 21,

Appendix B). About one-third of the children stayed either a long, "medium" or short period, regardless of framework type.

The reasons for leaving the first framework are presented in Table 22, Appendix B. The most frequent reason was that the framework recommended a transfer, owing to failure to integrate. This reason was given for 12 children, about one-third of those who left their first placement. In the cases of six children (18%), the parents removed the child on their own initiative. Another six children completed their studies and continued at another framework.

At least 12 (10.2%) of the 117 children whose first placement was known were still in the framework they first attended after completing the Unit's program, although the framework was not suitable. No relationship was found between the reasons for leaving the first placement and the type of framework (see Table 23, Appendix B).

5.3.3 Intermediate Educational Framework: Forty-three of the participants (33%) attended intermediate educational frameworks between their first placement and their framework at the time of the study (see Table 24, Appendix B). Seven of them attended more than one intermediate framework. The most frequently attended intermediate frameworks were for the moderately retarded and regular education (34% and 32% of the children, respectively).

5.3.4 Recommendations vs. Present Educational Framework: The data presented in Table 25, Appendix B, show that 50 out of the 83 children (60%) are at present in the same type of framework as recommended by the Eddy Shore team. Many of those recommended for integrated schools

(7 out of 12) are at present in regular schools. As will be discussed later, it can be considered that 57 children (69%) are within their recommended framework. These are, for the most part, children who were directed to regular education (14 out of 15), frameworks for the emotionally disturbed (9 out of 12), and for the mildly retarded (11 out of 15).

Six out of the 12 children recommended to frameworks for minimal brain dysfunction were there at the time of the study. Of the other half, the majority (4) were in frameworks for the mildly retarded. Two of the four children recommended for live-in institutions were there at the time of the study; one was in a framework for the mildly retarded and one was at home.

Half the children who at the time of the study were in frameworks for the mildly retarded (11 out of 12) were indeed recommended to this type of framework. The rest were referred to a wide range of different frameworks.

5.3.5                    Improvement of I.Q. Scores: The Director of the Observation Unit suggested that the changes in I.Q. scores and the mental age of the program participants between beginning and completing the program, could be viewed as a measure of results. An attempt was made to compare these scores. The data are described in Table 26, Appendix B. Examination of these data shows that there were only 19 out of 130 children (15%) for whom such a comparison could be made. Four children could not be tested at all. This comparison is meaningful only when the same type of I.Q. test is administered both upon admission to and completion of the program. The scores of only 13 children (10%) answered all these requirements. Six out of the 13 indeed improved their I.Q.

scores, six remained at the same level and one seemed to have regressed. An examination of the types of tests used in this comparison revealed that improvement was noticed most frequently when the WIPSSI test was used.

#### 5.4 Variables Affecting Program Effectiveness

The following variables were studied to see whether they contributed to the program's effectiveness: length of program participation, symptoms upon admission, and level of intelligence.

5.4.1 Length of Program Participation: The comparison between length of program participation and length of stay in the first placement, in cases where the type of placement was as recommended by the Eddy Shore team, is presented in Table 27, Appendix B.

Most of those children who were placed as recommended remained for an average or lengthy period in their first placement, regardless of the period they spent in the Observation Unit. Close to half of the 48 children (22) stayed 7 - 12 months in the Unit's program. Over half (27) stayed up to two years and some (6) stayed over two years, but very few (3 out of 48) stayed less than a year.

5.4.2 Symptoms upon Admission: The childrens' symptoms upon admission were studied to see whether they influenced placement after completion of the program. The data presented in Table 28, Appendix B, indicate that there is no relationship between these variables.

The only symptom which might have influenced placement was behavioral problems. More children with this symptom (about one-third of those with such problems) were placed in educational frameworks for the

emotionally disturbed than in any other type of framework. There was no clear pattern of placement for children with emotional disturbances, although they were placed more frequently in frameworks for minimal brain dysfunction and for the emotionally disturbed.

5.4.3            Intelligence as a Factor in Effective Placement:    The I.Q. scores obtained at the end of the program were viewed as a factor which could have an impact on placement effectiveness. To that end, the childrens' length of stay in the framework where they were placed was compared to the level of I.Q. scores. Since the most frequently used I.Q. test on completion of the program was the WIPPSI (see p. 24), these scores were compared with the length of stay in the cases of children (50%) who recieved this test (see Table 29, Appendix B).

In general, no relationship was found. Children stayed in their first placement for long, short or average terms regardless of their intelligence level.

5.5            Factors Relevant to Recommendations re Educational Framework

5.5.1            Symptoms upon Admission:    The recommendations of the Observation Unit's team were examined with regard to the dominant symptoms the child presented when first admitted to the Unit. These data are presented in Table 30, Appendix B.

The most frequently recorded symptom was speech disorders (for 43 children, or about one-third of the participants). Children with speech disorders were recommended to a variety of frameworks, mostly to integrated education and frameworks for the mildly retarded. Some were directed to regular education and several times the recommendation was to frameworks for

minimal brain dysfunction.

The second most frequently recorded symptom was behavioural problems (40 children). About 25% of those who had this symptom were referred to frameworks for the emotionally disturbed; eight (20%) of the children were recommended to integrated education and six (15%) were directed to regular education.

Twenty-one children had symptoms indicating emotional problems, but only five (16%) were directed to frameworks for the emotionally disturbed. None of the children with impaired vision were recommended to special education other than within mental retardation frameworks.

5.5.2            I.Q. Scores upon Admission: The I.Q. test scores upon admission to the Unit were examined in relation to the recommendations made by the Eddy Shore team. Inspection of the data in Table 31, Appendix B, shows that the recommendations did not take the I.Q. score into account. Children were recommended to regular education when their intelligence ranged between moderate retardation and normal. Children with mild retardation were recommended to all the various types of educational frameworks.

The I.Q. scores obtained on the basis of tests administered upon completion of the program were compared with the placement recommendations. Table 32, Appendix B, shows that 36 children were tested at the Unit and received a valid recommendation for placement. Fourteen of the 36 were classified as having borderline retardation and were recommended to a variety of frameworks: regular education, the integrated system, frameworks for mildly retarded children with minimal brain dysfunction, and frameworks

for the emotionally disturbed. Most of those (11) who were diagnosed as having normal I.Q.s were recommended to regular or integrated education. Four of those who were diagnosed as mildly retarded were recommended to frameworks for the mildly retarded; the others were recommended to frameworks for minimal brain dysfunction, for the emotionally disturbed, and for the moderately retarded.

Those who were recommended to frameworks for neurologically impaired children ranged in I.Q. from normal to mildly retarded. Those who were recommended to frameworks for the emotionally disturbed had I.Q.s ranging from borderline to moderate retardation.

#### 5.6 Summary

The findings of the follow-up study enabled the ascertainment of certain facts concerning the clientele, the determination of the results of the Eddy Shore Observation Unit program, and identification of some of the variables that had an impact on the results. The description of the clientele was based on several family criteria, participants' personal characteristics, and some background details.

The participants' ages ranged between 3 - 7 years. A large percentage of the participants were of Asian-African descent. In a majority of the families, the fathers were non-professional workers and the mothers did not work outside the home. Neurological or psychiatric disorders were present in many of the families. Many also had special social problems, such as divorce or the long-term hospitalization of one parent.

The children had combinations of various symptoms, but no one specific dominant symptom was common to all.

I.Q. scores were not available for a large number of children, but the ones available showed a wide range of intelligence, most commonly mild or borderline retardation. Some of the I.Q. scores were obtained at the Unit, mainly using the Leiter I.Q. test.

For the majority of the children, no results of medical or other types of tests were recorded. Some children had attended an educational framework - usually regular education - prior to their admission to the Observation Unit. The majority were referred to the Unit by the Jerusalem Child Development Center. The program results were described on the basis of the childrens' distribution among the various types of educational frameworks after completion of the program and by their present distribution.

The findings show that 68% of the children (65) were in the same type of educational framework at the time of the study as they were when first placed after completion of the program.

Program effectiveness was measured on the basis of the following criteria: acceptance of the Unit's recommendations by the municipal placement committee; length of stay in first placement; congruence between the Unit's recommendation and the present placement; and I.Q. score differences between the beginning and completion of the program.

Most of the children were effectively placed (i.e., stayed for an average or lengthy period in their first placement), even though the Unit's recommendations were accepted only 64% of the time. Unsuitable placements were made most often regarding children with minimal brain dysfunction. The I.Q. score differences could not be obtained because of lack of data.

The variables studied in order to determine their impact on the results were: the participants' length of stay in the Observation Unit, their symptoms, and I.Q. scores upon beginning and completing the program. None of these variables appeared to influence the program results. Two factors were examined in order to identify the variables upon which the recommendations were based: the childrens' symptoms upon admission and I.Q. score differences. Neither was found to have an impact on the recommendations.

6. DISCUSSION AND CONCLUSIONS

6.1 Clientele

6.1.1 Age: Early diagnosis of the problems which cause developmental delay makes possible timely intervention and treatment to reduce that gap which has already opened and avoid a cumulative developmental gap which might otherwise be irreversible. Despite a need for timeliness, the Eddy Shore Observation Unit deals with children of a wide chronological range, up to seven years old. Further, children born in the same year are admitted to the Unit at different ages. This may be attributed either to delay in detecting a problem's existence or to deficient outreach efforts. It can be speculated that this delay makes the Unit's task more difficult with regard to both diagnosis and treatment.

6.1.2 Family Background: There were several common denominators in regard to family background. First, a high percentage of the families were of Asian-African origin. Second, in a majority of the families the fathers were non-professional workers and the mothers were housewives. Third, many of the participants' families had a history of neurological or psychiatric disorders. About 40% of the children had special social problems. No common social denominator was found for all the participants; however, information was gathered about selected family problems of the type obvious to an outsider. Information was not gathered on problems less obvious to someone without a close relationship with the family, although

such problems may have a strong impact on the child's development.

It was beyond the scope of the study to find other common denominators. Such a search might be expanded and regarded as a partial indication of a "population at risk" towards which to direct outreach efforts.

6.1.3            Symptoms upon Admission: The data describing the symptoms upon admission show that the children had a wide range of problems. Most of the children had more than one problem. It was not clear whether the dominant problem was not recorded as such because of a deficient records system or because it was not feasible to rank the symptoms. In any case, diagnosis of the symptoms' causes is essential in order to tender the most effective long-term treatment. The wide range of symptoms and their combinations shows that there was no selection of participants on the basis of symptoms. The Unit's staff must therefore be composed of highly qualified and experienced professionals, so as to provide complementary treatment and cover a wide range of specialties.

6.1.4            Level of Intelligence and Mental Age upon Admission:  
A low I.Q. score was not often recorded as the symptom that led to admission to the Eddy Shore Observation Unit, although all the children were described as functioning at a low level compared to their chronological age. For 53% of the participants (57 children) neither I.Q. scores nor mental age upon admission could be obtained. This may not be the most meaningful measure, but it is widely used in the educational system. For this reason, at least for the time being, I.Q. scores cannot be ignored. Such I.Q. tests can be utilized not only to assess intelligence, but also for diagnostic purposes. When neither I.Q. scores nor mental age

were available, the so-called "low level of functioning" remained unclear.

The fact that 57% of the children (13) had a recorded I.Q. score shows that the Unit did make some effort to obtain scores. However, in this case, the one-time administration of one type of test did not give a very accurate measure of the child's development or of the test tasks in which the difficulties appeared. About half of the available I.Q. scores were assessments made at the Unit itself. It is possible that the reason for not utilizing more than one I.Q. test, and even for not testing every child, could be the lack of qualified professional staff. On the other hand, the results of I.Q. tests administered elsewhere were generally not available in the Unit's files. This may indicate a lack of communication with the sources of referral.

The I.Q. scores available from the point of admission indicated that the children's low functional level was not expressed in the scores. The problem, therefore, was not mental retardation. It was of consequent necessity to plan the treatment with this information in mind.

On the other hand, some of the I.Q. scores indicated mental retardation at various levels. If a low I.Q. score is not a function of mental retardation, the real problem may never be discerned. Therefore, I.Q. scores can also be viewed as an indication of the importance of a program such as that which the Eddy Shore Observation Unit maintains.

6.1.5                   Medical and Other Testing upon Admission: Only 43% of the children underwent medical and other tests. It is possible that more of the children were examined, but there was no record which the investigator

could track down. It may be useful for the staff to make themselves aware of prior examinations by family physicians or others and, in case of need, be able to consult with the relevant professional even if, for reasons of medical ethics, the results of prior examinations could not be recorded in the Unit's files.

Some of the tests can be and were done at the Unit itself; e.g., language skills examinations. Although 62 children showed symptoms of speech disorders, only 37 were given a language skills test. This raises the question as to why tests were not administered to children with symptoms that indicated a possible need. It was beyond the scope of this study to determine the criteria on which the decision was based about what tests to administer to which child. This question may be viewed as another indication of the possibility that there are an insufficient number of qualified staff members for testing purposes.

6.1.6            Previous Educational Framework: The high percentage of children that had attended an educational framework prior to their admission to the Observation Unit was another indication of the late problem detection, as was discussed above. Over 40% of the children dropped out of the regular educational system. Not only does this have many implications for all concerned, particularly the child, but it delays diagnosis and treatment.

6.1.7            Sources of Referral: About half of the children were referred by one source (the Child Development Center) and the remainder were referred by a range of sources. Well-defined criteria for admission to the Unit are required in order to direct the various sources of

referral so as to avoid troubling the wrong applicants and using the staff's valuable time in reviewing unsuitable applications.

In general, the information obtained about the clientele did not indicate any specific criteria for admission to the program, except that no children were admitted when the cause of retardation was known. There was also no indication of any requirement for previous attempts to diagnose the problem through medical examinations, I.Q. tests, or other types of tests.

## 6.2 Program Results

### 6.2.1 Distribution of Children among Educational Frameworks:

The data on the distribution of the children among the first educational frameworks after their completion of the Observation Unit's program shows that about two-thirds of the children continued to attend that same type of framework. That is, the immediate "result" of the program was consistent with the long-term "result" some 68% of the time. This matching occurred frequently when the placements were in the regular educational framework and in frameworks for the mildly and severely retarded.

Children were often sent to the regular educational system after initial placement in other frameworks requiring normal intelligence. If the specific problem was overcome successfully, they were considered as no longer in need of special education and were transferred back to the regular system. Success in the regular educational framework could be considered a good indication that the initial placement decision was the suitable one. The children who were sent to the frameworks requiring a

normal level of intelligence and who were later sent to frameworks for the mildly retarded, were apparently unsuitably placed from the first. Further, unsuitable placements were made with regard to children who were thought to have minimal brain dysfunction problems. The right decision was made in the case of those who still attended frameworks for children with minimal brain dysfunction and the few who had been transferred to regular educational frameworks by the time of the study. However, for those children who were transferred to frameworks for the mentally retarded, emotionally disturbed or physically handicapped, it seems that the framework for minimal brain dysfunction was not the right choice.

These results may be an indication that there were difficulties in assessing children with minimal brain dysfunction in general. However, it is important to note that a considerable number of children among those who were diagnosed and treated correctly are no longer in need of special education and have been integrated into the regular educational system.

6.2.3                    Intermediate Educational Framework: The fact that many of the children who left their first educational framework were in intermediate frameworks before their present placement could be viewed as a result of improper diagnosis. The impression gained is that the placements were made on a trial-and-error basis and if the framework turned out to be unsuitable, the child was transferred elsewhere. This caused delays in treatment and problems for the children and all those connected with them. Since the final placement

decision was made by the placement committee, which often did not accept the Observation Unit's recommendations, this can be viewed as evidence of the need for the Unit's recommendations.

6.2.4 I.Q. Score upon Program Completion: The I.Q. scores and mental age upon completion of the program were apparently not considered by the Unit as a measure of results since I.Q. scores were available for only 86 children (66%). Mental age test results were on hand for 65 children (50%). As mentioned above concerning I.Q. scores upon admission, these data should be available even if not necessarily considered as a measure of program results.

### 6.3 Program Effectiveness

6.3.1 Acceptance of Recommendations: The fact that the recommendations of the Eddy Shore team could be obtained for only 90 of the children (about 70%), raises some questions. This may indicate that the team had no clear-cut recommendations with regard to nearly a third of the children who completed their program (i.e., that there was no diagnosis for 40 children). It is possible that recommendations were made, but the reports misplaced. Another possibility is that the recommendations were communicated orally.

The municipal committee discussed the placement of 97 children and of these, 73 had received a recommendation from the Unit. The above explanations could indicate the reasons for this discrepancy, i.e. 24 children. It is still not clear how the remaining 33 children in the sample (130 total) were placed and why they were not referred to

the placement committee. In any case, the recognized procedures were not employed for 30% of the children.

The Eddy Shore recommendations were accepted by the municipal committee in only 64% of the cases. This is a high rate of disagreement. Since it is the Observation Unit's purpose to diagnose the problem and recommend the framework which will most effectively answer the needs of the individual child, it could be expected that the recommendations would in general be accepted and the placement arranged accordingly. Obviously, in some instances it was not possible to accept the recommendations because of technical problems; but this does not explain the high rate of disagreement.

From discussions with members of the municipal committee, it became clear that the recommendations of the Eddy Shore Unit were not believed fully trustworthy and that while taken into consideration, they were not taken for granted. According to the committee members, in several instances the Eddy Shore team made recommendations to unsuitable frameworks because they did not consider the suitable framework to be good. For example, some children were recommended to frameworks for the mildly retarded although they were severely retarded, this because a specific school for the severely retarded was not considered to be doing the maximum for its children. This was corroborated by several former staff members of the Unit. Even if the Eddy Shore team was correct in its judgement and had the child's welfare in mind, it was the wrong recommendation and the child did not benefit from it. Albeit an infrequent practice, it was enough to cause the committee to distrust the reliability of

the recommendations received.

As a result, the committee frequently relied on I.Q. tests administered at the municipal Psychology Services and based their placement decisions on those results, which often corroborated the Eddy Shore recommendations. This served to justify the Eddy Shore team's claim that the municipal placements were made on the basis of very superficial diagnosis and lack of familiarity with the child. If children are placed without much consideration given to the team's recommendation, doubts must be raised about the program's usefulness - not because of the quality of its recommendations, but because of a lack of cooperation. If the right diagnosis is made but disregarded, then efforts put into the program are wasted.

6.3.2            Length of Stay in First Placement: When children left their first placement the most common reason was that they failed to integrate into the framework due to its unsuitability. When parents removed a child on their own initiative it was difficult to determine whether the placement was indeed unsuitable or whether the parents had private reasons. On the other hand, there was a group of 12 children who did stay in their first placement for an extended period though it was an unsuitable framework. According to the directors, this was either due to parental desires, or because a more suitable framework was not available, or because transfer arrangements were somehow delayed. Nevertheless, this does not invalidate the choice of criteria.

Data concerning length of stay in the first placement indicates that close to 70% of the children were placed "correctly", since they

attended the framework well beyond the trial period. At least part of the 13% who attended a framework for a short period may have continued inasmuch as it was only their first year there. It was difficult to determine the effectiveness of placement for those who remained for a moderate period in their first placement; they often stayed beyond the trial period for technical reasons and not because they were found to be suitably placed. This explains the discrepancy between the number of those who were suitably placed according to this criterion as opposed to that which compared present framework with first placement. Since the children were placed as recommended by the municipal placement committee, it was difficult to determine the aptness of the Eddy Shore recommendation by examining length of stay in the first placement. It could only be determined whether the placement was the suitable one if indeed it was the same as that recommended by the Eddy Shore team. This team appeared to have made the suitable recommendation most frequently for those who were mildly retarded and least frequently for children with minimal brain dysfunction.

6.3.3 Recommendations vs. Present Educational Framework:

Integrated education is often considered to be a preparatory framework for the regular educational system. Therefore, the seven children who spent some time there and were transferred to regular education could be considered as having been recommended for their present framework. This makes a total of 57 children (69%) who remained in the recommended framework.

Nevertheless, the number of children who were not at the type of

framework recommended by the Eddy Shore team was considerable. This indicates that not only was the placement committee's decision unsuitable, the Unit's recommendation was suitable too. Presumably, if the placement was improper, children would drop out of their first placement and later attend a more suitable framework, which might be the one originally recommended. Such was not the case. It further appears that the Eddy Shore team made improper recommendations for 26 out of 83 children (31%) for whom both a recommendation was given and present framework could be located, and who were not attending the framework originally recommended.

6.3.4            I.Q. Score Improvement: The changes in I.Q. scores between the beginning and completion of the program could not be used as a measure of the program's results since scores could be compared for only 15% of the children. The lack of I.Q. and mental age data was discussed above. Not only was there an insufficient number of tests, but the tests administered upon program admission and completion were of different types.

6.4            Variables Affecting Program Effectiveness

6.4.1            Length of Stay in the Observation Unit: The rate of suitable placement among those children who stayed in the Unit for a period of 7 - 12 months was similar to that of those who stayed longer. It may be speculated that one year of observation would be sufficient. Without experimentation it is difficult to predict whether those who stayed longer would have been successfully placed if they had stayed only one year. Extra time may have made a difference in the quality

of the diagnosis and treatment.

6.4.2            Symptoms vs. First Placement: The symptoms themselves did not have an impact on placement after completion of the Unit's program. This is evidence that an attempt was made to diagnose the cause of the symptom and not to place the children according to what appeared to be the problem.

6.4.3            I.Q. Score upon Program Completion: Level of intelligence was not a factor that had an impact on the effectiveness of placement. There was no specific group of children that could be classified on the basis of intelligence and for whom placement was more effective than for others.

6.5            Factors Relevant to Recommendations re Educational Frameworks

6.5.1            Symptoms upon Admission: In the same way as the placement committee's decision was not based on symptoms, no meaningful relationship was found with regard to the effect of symptoms on Eddy Shore's placement recommendations. The importance of this finding was discussed earlier in regard to the first placement after completion of the Observation Unit's program.

6.5.2            I.Q. Scores: I.Q. scores had no impact on the Unit's recommendations, even when the I.Q. test was administered by the Unit itself.

The fact that no account was taken of I.Q. scores upon admission may be viewed as evidence that the staff relied on its own observations in order to determine the source of the problem, rather than use scores which

might be meaningless. This could be considered as further evidence for the need for the Observation Unit. The fact that the Eddy Shore team administered I.Q. tests upon completion of the program, yet did not base its recommendations on the scores, seems to indicate that the team tried to detect the cause of poor performance rather than consider the performance itself. A child who performs as mildly retarded may do so because of social deprivation; therefore, by placing the child in integrated education there is a chance that the gap will be minimized. If there are emotional disturbances, the I.Q. score may be affected once the problem is treated.

In general, the factors that might have an impact on the recommendation could not be identified. Further research is needed for this purpose.

#### 6.6 Summary

The findings concerning the children's characteristics indicate the need for and the importance of the Eddy Shore Observation Unit in the diagnosis and treatment of children with underfined problems. The data suggest that such a Unit requires a special combination of highly qualified professional staff and that the program seems to have insufficient staff. On the other hand, these same findings may be viewed as evidence of a lack of proper organization, as well as of insufficient communication between the Unit and other agencies concerned with child welfare.

The findings concerning the program indicate its success with regard to 69% of the children (57), for many of whom the stigma of mental retardation was avoided. Difficulties in diagnosis were evidenced for the other 31% of the children (26). This caused delay in

appropriate treatment and difficulties for all those connected with the children, even if the Observation Unit was not solely responsible. Deviations from regular placement procedures were discovered, as well as a relatively low degree of acceptance of recommendations made by the Unit. This evidenced a less than cooperative relationship with the municipal placement committee.

Two variables with regard to client population have a potential impact on the program's implementation: the children's relatively late chronological age upon admission and their similarities in family background. The variables expected to have an impact on the effectiveness of the program indicated that one year of attendance at the Observation Unit could be regarded as sufficient. Symptoms and I.Q. scores had no impact on program effectiveness. The Unit's recommendations were unsuitable in one-third of the cases, but no variables were identified that might have impact on the recommendations.

STAGE B

7. FORMATIVE EVALUATION OF THE EDDY SHORE OBSERVATION UNIT

The formative model for determining the effectiveness of instructional systems -

".....help(s) to identify and define all the elements in a program and stud(ies) their relationships. The evaluation plays a major part in making the program a clearly defined system.....The evaluator's responsibility is to examine or analyze the program in such a way as to make its operation more effective." (Lindvall & Cox, 1970)

Bloom et al. (1971) discuss the usefulness of formative evaluation in curriculum construction, instruction and educational improvement. The opposite of this process is posited to be grading, certification, progress evaluation, or end-of-term research on the effectiveness of a curriculum, course of study or educational plan.

The Eddy Shore Observation Unit is an ongoing program which has not been evaluated since its inception. Therefore, formative evaluation was chosen in order to identify the program goals, their implementation, results and relationships. The study enabled the identification of program strengths and weaknesses and facilitated suggestions as to where modifications would be useful for further planning and development.

8.                    STUDY OBJECTIVES

The purpose of this study was to evaluate the program of the Eddy Shore Observation Unit in order to indicate whether it achieves its goals and does so in an efficient manner.

The study objectives were:

- a) to identify the program goals;
- b) to identify the content, methods and materials used in the Observation Unit;
- c) to identify the Unit's organizational and communications system;
- d) to identify the systems used to evaluate the progress of the children and of the program;
- e) to describe the relationships between the goals, the program's implementation and its results.

## 9. METHODOLOGY

### 9.1 Study Subjects

The study subjects for the second stage were all professional staff members who came into direct contact with the children at the Observation Unit: the teachers, teachers' aides, social worker, psychologist, speech therapists, occupational therapists, music teacher and educational counselors. Five former members of the staff also participated. All subjects who were contacted agreed to participate in the study. The total number of participants was 26.

### 9.2 Data Collection Procedures

The Director of the Eddy Shore Day Care Center approved the second stage of the study and provided a list of all the professional staff employed. The staff members were then contacted to arrange interviews. Since no records were available at the Unit itself, an outside source provided a list of former staff members. Five participants were chosen arbitrarily from this list and were similarly contacted.

### 9.3 Data Collection Instruments

9.3.1 The Interview: The interview included a brief explanation of its purpose. The participants were informed that the interview was confidential and were asked to give honest opinions that would be used only for the purposes of the study. The interviewers were directed to ask the questions as they appeared in the outline and to avoid interpretation as far as possible. The interview included fifty items, all requiring open-ended responses.

9.3.2                    Observations: Information was gathered by observation to complement that obtained by staff interviews. The observations also confirmed that the staff did in practice carry out the program in the manner they described it.

The primary targets for observation were the activities of the children, teachers and teachers' aides, and the class organization, teaching methods and materials used.

In order to minimize bias, the observations were made by an experienced special education teacher who was not familiar with the Eddy Shore program and had no vested interest in it. The observer joined the research team specifically for the purpose of observation. Her technique was to sit in the least noticeable location in the classroom and not interfere with anything that took place.

9.4                    Data Analysis

The descriptive data from the interviews was analyzed to assess the program's implementation. Response frequencies were tallied for each question and arranged according to categories which corresponded to the purpose of the study. These categories were as follows:

- a) program goals;
- b) program implementation - clientele, staff, physical facilities, program content, and communications system;
- c) program results;
- d) study of relationships.

The questions within each category were further analyzed in terms of the respondents' professional background. The responses enabled the researcher to examine whether all the staff within each professional affiliation group employed similar methods or whether the different professions complemented each other.

#### 9.5 Study Limitations

For various reasons, including interview technique, biases may have registered in the data. The respondents may also have been influenced by reservations with regard to the study.

In an educational framework like that of the Observation Unit, the process may be influenced by such factors as the general atmosphere, the children's interaction with non-professional personnel, etc.

This study was confined to the professional staff who came into direct contact with the children, and did not include administrative staff, maintenance workers, housekeepers or family.

With regard to the staff, only the specific profession was taken into account, not personal attributes such as age, sex, social status and family background. Professional attributes such as education and experience were not considered either, although these may have some impact on the program.

The perceptions of the family or caretakers concerning the various components of the program could not be obtained, despite their potential value for giving deeper insights into the Unit's functioning.

The program results may have been influenced by many other outside

factors including a lack of communication with the referral agent and the frameworks to which children were referred, insufficient frameworks for the further education of the Unit's graduates, the staff's qualifications and many others.

The study results are specific to the Eddy Shore Observation Unit and cannot be generalized to other such programs.

10. PRESENTATION OF DATA

10.1 Program Goals

The general goals of the program at the Eddy Shore Observation Unit - as stated by the Director, the Unit's information leaflet, and its reports to the JDC - are as follows:

- a) to observe and diagnose exceptional children in early childhood for the purpose of determining the cause of developmental delay;
- b) to give such children educational treatment and rehabilitation;
- c) to define the children's abilities, and educational and therapeutic needs;
- d) to help the parents through support, guidance, counselling or therapy to overcome the difficulties caused by having an exceptional child in the family;
- e) to coordinate the various community services for treatment of the children; and,
- f) to serve as a center for professional training and research in the areas of special education, psychology, social work, rehabilitation and medicine.

The objectives of the program are:

- a) to observe the children for an extended period of time for the purpose of diagnosis;
- b) to utilize educational methods for the purpose of identifying the most effective methods for the individual child;
- c) to determine a suitable educational framework for the individual

child after leaving the Unit; and,

d) to involve the parents in the process of diagnosis and treatment.

The general program goals as expressed by the professional staff are presented in Table 3. These goals were: general diagnosis, diagnosis for the purpose of determining the most appropriate educational framework, treatment for the purpose of preventing retardation, and a combination of general diagnosis and suitable treatment.

Table 3: Program Goals as Reported by the Professional Staff

Goal	Number of responses*	Percentage of responses*
Diagnosis in general	5	20.0
Diagnosis and suitable treatment	11	44.0
Diagnosis for determining educational framework	3	12.0
Treatment (prevention of retardation)	7	28.0
Unclear	1	4.0

\*Some of the respondents gave more than one answer, therefore the total number of responses is over 20 and the percentage is over 100%.

Examination of the program goals according to professional affiliation revealed that none of the goals stated were common to any specific professional group.

The personal goals of each staff member with regard to his/her work at the Observation Unit were: general diagnosis and treatment, personal

learning experience, helping individual children to advance on curriculum items, rehabilitating the family in general and with regard to the exceptional child in particular, and raising the children's functional level.

The most frequently mentioned goal was diagnosis of the children's problems and treatment to enhance their functioning. Some of the teachers' aides felt that their goal in the classroom was learning and expanding their own experience. Other goals mentioned by the individual staff members were: teaching creativity, raising the children's functioning to a level similar to that of other children of the same chronological age, reinforcing the children in all possible areas, and studying the "child's personal world" to facilitate learning and rehabilitation. Two staff members felt that their classroom goals depended on the needs of the particular child.

## 10.2 Program Implementation

10.2.1 Clientele: The clientele of the Eddy Shore Observation Unit was described in Stage A (see p. 10). In general, about 25-30 children attended the Unit each year, the participants' age range was 3 - 7 years, and the families were of Asian-African or mixed origin with one Israeli parent. The number of family members usually varied from 3 to 7, and the father was most often a non-professional worker and the mother a housewife. There were records of medical problems in 116 families, the most frequent being hereditary problems and psychiatric disorders. A wide range of symptoms led to referral to Eddy Shore, but the most common was speech difficulty.

All the teachers and most of the other staff members found a common denominator in the children's problems. Only four out of the 20 staff members (none of them teachers) felt that the problems were unique to each child.

10.2.2            Staff: The professional staff of the Observation Unit consists of 21 members, of whom 20 are directly involved with the children's treatment. These staff include:

- 1 Director (half-time)
- 6 Teachers
- 6 Teachers' aides
- 4 Therapists (occupational, speech and music therapists, all part-time)
- 1 Social worker (half-time)
- 1 Psychologist (part-time)
- 2 Counselors (one part-time)

Some student teachers assist the staff.

Most of the staff members (16 out of 20) had at least a Bachelor's degree in Special Education or a field directly related to their work at the Observation Unit. Some had higher degrees, including one staff member with a Ph.D. Six had teaching certificates and two (teachers' aides) were high school graduates.

Few of the staff members were involved in continuous enrichment of their professional background. However, many of them (7) regularly participated in special conferences and enrichment programs.

The majority had at least three years of experience in special education and the rest had more than eight years experience.

At the time of the study (1979-80), over half of the staff had recently begun their employ or were working for their second year at Eddy Shore.

The staff turnover seemed to average 2 - 3 years, with over 25% staying more than three years. Reasons for leaving were varied. There were personal reasons, such as family moves, and others were discharged by the management.

Slightly less than half of the staff received guidance regarding their function in the Observation Unit. Another third received no guidance whatsoever. As for orientation to the specific needs of the Observation Unit, no written job descriptions were available at the Unit. Orientation was given orally, usually by the Director. The staff generally accepted the general description of their professions as their roles. The teachers' aides, volunteers and students were seen by half the staff as functioning in conjunction with the teachers, especially with a view to providing individual attention.

10.2.3 Physical Facilities: At its inception, the Observation Unit was located on the second floor of a building on Hebron Road, a building now used solely for the Eddy Shore kindergarten. However, the main office (in the kindergarten building) still serves both frameworks.

At present, the Unit is situated in two nearby stone buildings on Bethlehem Road. They were not planned for their present use. The buildings are surrounded by a fence which also encloses a small play area with some swings, climbing equipment, tricycles and a sandbox. In the

larger of the two buildings there are three classrooms, a kitchen, bathrooms, an office and a counsellor's room. The second building has two classrooms and a counsellor's room. There is a hall in the larger building where the children often play.

The classrooms are small but the staff are able to manage. Each classroom contains several tables, a corner for imaginative play and role-playing (a housekeeping corner, doctor toys), and an area for quiet motor activities (block manipulation, etc.) and individual self-directed play (letter games, etc.). There are also shelves with manipulative materials.

Most of the staff at the Observation Unit did not find the physical facilities sufficient. The reasons mentioned were that rooms were too small, that quiet areas were not available, and that there were not enough rooms, especially music and exercise rooms or a sound-proof room for hearing tests. The floors are tiled and cold.

### 10.3 The Curriculum

10.3.1 Instruction Groups: The children at the Observation Unit were divided into six groups. Each group usually had four to nine children. There were two groups of seven to nine children, and some of the therapists had groups of ten children. In addition, individualized instruction or therapy was provided to the children according to specific need. About 60% of the children received speech therapy regularly. About 15% had regular sessions with the psychologist.

The age range differed between the groups. In three of the groups there was a one-year range (i.e., the children were three to four, four to five, and five to six years old, respectively). In three other groups

the range was two years, in two groups it was three years, and in two groups the children were born in the same year.

According to the staff, the children did not all begin their participation in the groups at the same time. Most often the staff knew in advance when a new child was expected. A majority of the respondents (13 out of 20) felt that this fact had some impact on their work with the group. Some of the staff felt that difficulties were created when the group had to adjust to the situation and other staff members felt that it damaged the new child, inasmuch as class progress had to continue and less time could be devoted to the newcomer. Only a few felt that the timing of a child's joining the class had no impact.

Some (5) felt that it was hard on the children who had to overcome further difficulties in adjustment when they joined a group in which the children were already familiar with each other. On the other hand, four staff members felt that latecomers benefited from extra attention.

Most of the staff members (23 out of 25) said that it was clear to them why the individual child was referred to the Observation Unit. Only two said that they were not always aware of the reasons.

10.3.2            Curriculum Contents: According to most of the staff members (13 out of the 20, about 70%), there was a general curriculum plan for the entire group. Over half the staff (12) described the main objectives of the curriculum as teaching concepts such as family, religious tradition, self-image, numbers, etc. These objectives were confirmed by the former teachers interviewed. The goal of two other staff members was therapy and the curriculum was therefore built around

the child's interests. Seven staff members did not specify their curriculum objectives.

About half of the staff (9) developed the curriculum themselves. The teachers' aides did not make decisions with regard to the curriculum. They perceived it as the responsibility of the teachers or of the entire team.

Almost all of the staff (19) had an individual curriculum plan for each child, besides the general group curriculum. One therapist did not develop such plans. The individualized curriculum was developed by the staff member who treated the child, according to half the staff. The counsellor, the social worker and teachers' aides did not view themselves as having this responsibility.

Only seven staff members reported that there was a common denominator between the general curriculum and the individualized one. According to one person, the counsellor, they differed completely.

Approximately one-third of the staff said that each class session was planned in detail. Some (5 out of 20) had detailed plans for longer periods, but one-third had no plans.

10.4            Communications System

10.4.1            Communication among Staff Members: The Observation

Unit's staff was asked about the primary channels of communication employed with regard to information about a child. Half of the staff replied that they usually communicated with other staff members in formal staff meeting, while the other half said that communication took place via informal conversations. Formal staff meetings occurred once a week.

The respondents did not consider written staff reports as a primary channel of communication. However, when asked whether they wrote reports and how frequently, approximately half of the staff said that they compiled daily reports. Only five (out of the 20) did not summarize their activities in writing. When asked who in particular used their reports, about 40% of the respondents said that the reports were placed in the child's file and that anyone concerned could benefit from them. While some of the staff members (3 out of 20) felt that the reports were for their own use, others (3) did not know who used them, and a few (a teacher and a therapist) felt that their reports were for the use of the municipal placement committee or the place of referral.

Most of the staff members (60%) said that they read the reports of other staff members with regard to children with whom they had direct contact. Some 20% read them, but not on a regular basis. Only one teacher said that she did not read the reports. Some of the staff were replaced by other workers in the afternoon and were in communication with their replacements. No specific person could be identified with whom the staff communicated most frequently. That individual varied for the different staff members.

Communication among the staff members was examined with regard to the

following components:

- a) Problems raised with regard to a particular child in the group:  
half (10 out of 20) respondents consulted with other staff members.  
Several (7) tried to solve the problem alone.
- b) Reporting the curriculum plan: no common practice could be described. Teachers reported to various sources. Many (8) did not report to anyone.
- c) Educational methods: nearly half of the staff (9) consulted with outside professionals.
- d) Educational materials: about one-fourth of the staff consulted with other staff members; however, another fourth did not consult with anyone.

According to half of the staff, when they came across a problem that could not be solved because of some deficiency in professional training, they generally sought outside professional guidance. Many used literature or tried to solve the problem alone.

10.4.2                    Communication with Child Welfare Agencies: The staff at the Eddy Shore Observation Unit were asked about their sources of information with regard to several items involving agencies or outside professionals. When asked for information on the sources of referral, about half of the staff said that they obtained the information from the child's personal file. However, 25% (5 out of 20) were not aware of the source of referral.

Nearly 60% of the staff received information on family background from

the files. The rest of the staff relied on internal meetings and oral briefings from the social worker or other staff members. The level of intelligence or mental age was unknown to almost half of the staff. A quarter were aware of this information and obtained it from the files, while another quarter learned this in the course of a general background briefing. More than half the staff (11 out of 20) know the relevant information about children's special medical problems or medical treatment. The source of information was again most frequently the personal files. About 25% of those who had this information could not remember its source.

Upon completion of the observation period, a short letter which includes recommendations and a general description of the child's progress at the Unit is attached to the raw file materials. This is then sent to the municipal placement committee and sometimes to the specific framework to which the child is referred. More information is available from the Psychology Services and is brought to the committee's discussions. Generally, there is no direct communication between the two.

The directors of the various educational frameworks were surveyed concerning whether they found useful specific information regarding the educational methods and materials found to be most effective with individual children. Most of the directors responded that they preferred not to receive preconceived notions, but rather to find their own way in planning the child's treatment.

10.4.3                    Communication with Family: Staff members indicated that several means of communication existed between staff and parents.

These interactions were most often initiated by staff rather than by parents. About 25% of the staff (teachers and teachers' aides) communicated with the parents on a weekly basis when the parents came to observe their children in the classroom. Staff-initiated conferences with parents were reported by 25% of the staff. Approximately 20% of the staff (teachers, teachers' aides and the social worker) said that they made home visits. Two staff members mentioned other means of communication, such as correspondence and conferences initiated by the parents. Only two staff members reported that they did not communicate with the childrens' families.

A parental discussion group has been set up to meet with one of the teachers and an outside consultant. The effect of the discussion group was not explored.

It should be noted that this information was not verified by the children's families.

#### 10.5 Evaluation

Program Evaluation: The effectiveness of the Observation Unit's program was viewed by about half of the staff (9 out of 20) in terms of an improvement in prognosis. Others (3) found that effectiveness was obvious because the prognosis was more favourable than at the outset. A similar number (3) felt that the program was effective, because after its completion parents were better able to tackle their child's problems. Another three respondents believed the program to be effective inasmuch as the staff was highly qualified and dedicated. A few (2) said that effectiveness was shown by the children's progress during their participation in the program. One teacher felt that the very fact that a child could

receive help unavailable elsewhere was a measure of the program's effectiveness.

10.5.2            Staff Self-Evaluation: There appeared to be no common self-evaluation system among staff members. Some (4 out of 20) received their feedback when they observed the children's progress. Others (2) compared diagnoses upon admission with the children's condition upon completing the program. Relationships with families and children's reactions to staff members were considered as feedback by the social worker and a therapist, respectively.

Most of the staff members reported some deficiency in their professional backgrounds. The major areas mentioned were child psychology, neurology and special education for preschool children. As well, every staff member reported difficulties with regard to diagnosing the children. They had similar difficulties in treating specific symptoms.

The staff endeavored towards professional enrichment, but not in a systematic and organized manner. Most often they found their own means of doing so or participated in occasional conference or in-service days.

Almost all of the staff (19 out of 20) stated that they were satisfied with their work at the Observation Unit and viewed this as an indication of success.

10.5.3            Evaluation of the Child: When surveyed about their means for evaluating the children's progress, an approximate third of the staff (7 out of 20) said that they employed a guideline questionnaire especially designed for that purpose by one of the counsellors. Some (25%)

used tests or relied on obvious changes in behaviour as measures of improvement.

10.6            Impact of Respondents' Professional Affiliations on Program  
Implementation

The various aspects of the program were examined with regard to the respondents' professional affiliations. In general, the program goals and the approach of the various professionals varied according to profession. However, the professional affiliation of the staff members had no impact on other aspects such as program content, methods, material used, staff interaction, etc. The responses of the five former staff members corroborated the responses of the present staff on this topic.

10.7            Summary

The goal of the program was the diagnosis of the causes of retardation and their treatment. While the most frequently mentioned personal goal was to diagnose correctly and to treat the child accordingly, this goal was nevertheless not given by the majority of the staff. The target population was felt to be children with developmental delay for whom the reason for retardation had not been diagnosed.

The staff consisted of multi-disciplinary, skilled and experienced personnel. Staff turnover was relatively low. However, there was little orientation or personnel guidance within the Unit with regard to its unique requirements.

The physical facilities were found wanting, but passable.

Instruction groups consisted of 4 - 9 children with a teacher and teacher's

aide. The chronological age of the children was homogeneous, but not all the children began the program at the same time, a fact which affected both children and staff.

The curriculum consisted of a general plan for all participants and an individualized plan for each child. There was not always a common denominator between the two.

The most common curriculum objective was to teach various concepts. The curriculum was usually planned by the individual staff member. The sessions were not always planned in detail.

The staff used a wide variety of educational methods and materials for treatment. Diagnostic techniques were less developed. The program's completion point for individual children was viewed differently by the staff members.

With completion of the program, recommendations were given to the municipal placement committee. The recommendations were based on a combination of reports by the various staff members. Communication among staff members was not structured and much of it was based on informal conversation.

There was no one specific person with whom staff members communicated regarding their work. Communication with other child welfare agencies was mainly in writing. Meetings with the family were generally initiated by the staff.

As for the evaluation system, no specific criteria could be obtained either with regard to the program's evaluation or the child's progress.

11. DISCUSSION

11.1 Program Goals

Some of the general goals did not seem to be clear to all staff members in the Unit, inasmuch as they were not mentioned by any of them. For example, such goals as treating family difficulties caused by an exceptional child, coordinating child welfare services in the community, or serving as a training center, were not viewed by the respondents as general program goals, although several mentioned them as personal goals. The data do not indicate any staff consensus about general program goals or a general congruence between personal and program goals. Moreover, goals were not shared within the various professional groups. When staff members do not work toward achieving the same goals, then program plans will differ. Such lack of coordination is likely to lead to inconsistent approaches in the comprehensive planning of the children's treatment and thus to cause confusion and delay.

11.2 Program Implementation

Clientele: The various characteristics of the clientele were discussed in Stage A. Although no dominant problem of the children could be objectively ascertained, the staff felt that the children had common problems. Yet they could not point to anything specific. It is possible that the staff regarded the existence of general developmental delay or the combination of problems as common to all the children,

although this does not constitute a specific problem. Since certain staff members considered the children to have common symptoms, it is possible that this influenced their approach to the group.

11.2.2            Staff: The Observation Unit has a qualified multi-disciplinary staff. The description of the size and type of its clientele and the attendant number of problems requiring psychological, psychiatric or medical evaluation raises the question of whether the services of (at least) a full-time psychologist and social worker could be utilized, as well as those of a physician and psychologist and a part-time social worker. The physician was present only occasionally and was not fully involved with the diagnostic process.

The low staff turnover can be viewed as an indication of interest, challenge, dedication and of good staff relationships.

Because of the program's unique nature, it would be helpful to institute a special staff orientation scheme, along with well-defined job descriptions. The lack of such an orientation can explain the discrepancies in how the staff members view the program goals and the individualized interpretations of their assignments. The available staff appears to do a great deal within their self-perceived role definitions.

### 11.3            Physical Facilities

While the facilities were far from ideal, they seemed to be utilized in a very efficient manner. The equipment was partially transferable; for example, tables could be used separately for individual work or pushed together for large group activities. Corners were available for various types of play. Materials on the shelves were used to

encourage the children to initiate learning situations for themselves. This also gave the teachers an indication of assertive behaviour in the children or the lack of such.

A more spacious and suitable building is not feasible at this point. It may be possible, however, to solve the problem of cold floors. It would also be useful to have the office facilities separated from those of the nursery for the retarded (this process has already started). The purpose of the program is to prevent the stigmatization of children admitted to the Observation Unit. If parents who have to register a child or take care of other administrative arrangements must enter a building clearly marked as a nursery for retarded children, it might lead to the mistaken impression that the Unit's children are retarded and therefore induce reluctance.

Hearing tests could be administered elsewhere, although this is somewhat less convenient, but probably more practical and economic than maintaining the expensive and sensitive equipment for relatively rare occasions.

#### 11.4 Curriculum

11.4.1 Instruction Groups: The size of the groups at the Unit was not uniform and sometimes larger than initially planned. There were up to nine children in each group instead of the intended seven. The child-staff ratio seemed somewhat high for the purpose of close observation and diagnosis.

The age range within the groups indicated a division made on the basis of criteria other than chronological age, since it is a meaningless criterion where there exists a variety of serious problems.

The staff pointed out the fact that children joined the groups at different points and thus created difficulties for the child, the group and the staff. It was beyond the scope of this study to examine the reasons for this situation and no alternatives can be suggested. However, since this impacts on the program, the problem needs further investigation.

11.4.2            Curriculum Content: Curriculum development was left up to the individual staff members and there was no evidence of coordinated planning. Some of the staff did not consider themselves as responsible for individualized curriculum planning, but saw it as the responsibility of others. For example, the therapists considered it the responsibility of the counsellor or the specific staff member treating the child. The social worker also attributed the responsibility to the counsellor. However, all the counsellors felt that it was the responsibility of the therapists and social worker. The want of a common denominator between the individualized and general curricula, and the lack of detailed curriculum planning in general, may be explained by the fact that it was not clear who was responsible for the task and the staff consequently acted on personal initiative. It is perhaps difficult to effectively coordinate a comprehensive program utilizing all available resources when staff responsibilities are unclear and when the curriculum is not planned in detail.

11.4.3            Program Completion: The fact that different staff members had different views of when their task was completed could indicate different role perceptions and directly affect a child's length of stay. Certain staff members might want to keep children longer if they felt that the maximum level of function had not been achieved in

relation to potential. On the other hand, a staff member who diagnoses the problem after a short period of time, might feel that the assignment is completed and that any additional time the child spends in the Unit would not be related to achievement of the initial goal.

Those who could not state when the program was completed apparently had no clear conception of its goals.

Recommendations were not made on the basis of defined criteria. The staff appeared to discuss children on the basis of what seemed relevant or unique to a specific child. Therefore, it was not possible to ascertain the criteria for placement recommendations. The staff was confused about the entire concept of placement criteria. For example, placement recommendations based on available educational frameworks did not correspond with the program goals. Nor could the recommendations which were based on dominant symptoms, be considered as having been founded on useful criteria.

11.4.4            Educational Methods and Materials: The wide range of educational methods and materials used was an indication of the staff's initiative and understanding as well as of the fact that they were able to discover the most efficient and effective methods for the individual child. It was not clear whether the staff members coordinated their methods or whether each simply utilized preferred methods. An examination of the diagnostic methods indicated that no specific techniques were generally employed. This could lead to unstructured observation, which might result in misdiagnosis.

11.5                    Communications System

11.5.1                    Staff Communications: The lack of coordination with regard to the curriculum can be explained by the channels of communication. Half of the communication was informal, although there was a staff meeting every week. The staff meetings were used for the discussion of topics other than curriculum planning and a thorough exchange of information about each child. Written reports were not always used or considered as a channel for communication. The files were incomplete and therefore could not be considered a good source of information.

There were no organized channels of communication, regardless of the topic that needed discussion, although certain subjects by definition required specific professional advice or a uniform reporting system. It is difficult to coordinate efforts on the basis of unstructured communication where there is no specific staff member around whom to center communications.

In addition, it is important that there be communication with the afternoon staff since this is necessary for complementary activity after the regular sessions.

11.5.2                    Communication with Child Welfare Agencies: When the staff sought information from outside sources they generally did so by gleaning the files. In other words, the staff relied on reports rather than on direct communication. This may be the reason for the misinterpretation or lack of relevant information. It is also possible that valuable information was not reported and was not therefore available. The majority of the files at the Unit were incomplete. Most

of the I.Q. scores were not in the files and the investigator had to obtain them elsewhere. This means that the staff did not have the information at all, or received it through unstructured, possibly unreliable channels of communication.

For some topics - i.e., family background - the main source of information was the child's personal file, instead of reports from the social worker. Some staff members, among them the social worker, felt that their reports were for personal use and thus did not include them in the files, or included them only partially.

The letters of recommendation sent to the municipal placement committee were normally not accompanied by any other manner of communication, so sometimes insufficient information was relayed.

The fact that often there was no communication with the framework to which the child was referred after program completion, leads to the belief that many of the efforts put into finding the most effective educational methods and materials for the individual child, were wasted. This information was not passed on and the methods were discontinued (unless the staff at the new framework went through the same process to establish the optimal educational methods). It can be argued that this information was not transmitted because the directors of the various institutions were not interested in it. However, it is possible that if there was a structured communication system between the Unit and the other educational frameworks, the Unit's conclusions with regard to treatment would be more valued and better accepted.

11.5.3            Communication with Family: Most staff members initiated communication with the parents. It is beyond the scope of this study to discuss the importance of such communication. However, it should be mentioned that without the family's awareness of and cooperation with the efforts of the team, the achievement of results would be more difficult.

11.6            Evaluation

11.6.1            Program Evaluation: There was no specific criterion for evaluation of the program and no structured measures were utilized. The program was evaluated on the basis of the staff members' subjective impressions, which naturally could be biased.

11.6.2            Self-Evaluation: The staff did not employ any objective means of self-evaluation and again relied on subjective impressions. Moreover, their responses to the self-evaluation question indicated that they used the wrong means. For example, comparing the diagnosis of the child upon admission with their own diagnosis upon program completion cannot be used as self-evaluation since it does not show whether their diagnosis was any better than the first one (Besides, if there was a diagnosis upon admission, why would the child have been admitted to the Unit, the purpose of which is to diagnose?)

11.6.3            Evaluation of the Child: It was possible to evaluate the child's progress objectively, using the Unit's well-developed questionnaire to describe the level of functioning. This could also be used as a guideline for observation and as a basis for curriculum development. Yet the questionnaire was employed by only one-third of the staff. The lack of a structured evaluation system was an indication of

the lack of awareness of the importance of ongoing evaluation. This could lead to routine work habits in which the achievement of the Unit's purpose is missed.

11.7            Summary

It was pointed out that the goals of the program were not viewed uniformly by the staff and corresponded only partially to the goals stated by the Unit's management. This could lead to discrepancies in planning a comprehensive program.

Various points indicated a lack of coordination and a potential impairment of teamwork. These included an incomplete multidisciplinary staff; a lack of job descriptions and staff orientation; the different entrance points of the children to the groups; an individualized conception of role and of curriculum planning; a lack of defined criteria for measuring children's achievements and for making placement recommendations; unstructured channels of communication; incomplete sources of information; and, a lack of an evaluation system.

However, the following characteristics reflect on the positive aspects of the program's implementation: a wide variety of educational methods and materials; the maximal utilization of available facilities; consistent communication with the children's families; and, the high qualifications of the staff who were performing their best within their self-perceived role definitions.

12. RELATIONSHIPS, CONCLUSIONS AND RECOMMENDATIONS

12.1 Goals vs. Implementation

In order to achieve its primary goal - the observation and diagnosis of exceptional children during early childhood to determine the cause of developmental delay - the Observation Unit provided facilities which were not ideal, but which were utilized efficiently to enable observation of a variety of individual and group activities.

The majority of the staff were qualified in their own professional fields. However, they were not qualified to diagnose the children's problems. The experience of educating children with a range of problems that had been previously diagnosed often trained the teachers to identify the problems.

The professionals at the Observation Unit who were qualified to make diagnoses were the psychologist and the physician. The physician was not involved in the diagnostic process, although some of the diagnoses required a neurologist or a physician. The psychologist was only a part-time staff member for a population of 26-30 children who were all in need of attention. A psychiatrist was not available, although some of the diagnoses could only be finalized by a qualified psychiatrist.

These facts indicate that the program goal could be met only if the child was referred to a suitable outside professional. Therefore, the Unit could achieve its goal only partially and had to arrive at an unconfirmed diagnosis based on the staff's experience.

It may be beyond the financial resources of the Unit to employ a diagnostic

staff. The closest the available staff could come to achieving the goal was to identify the possible problem, which also may be worthwhile since it saves time when a final diagnosis is made by a qualified person. But study of the channels of communication revealed that there was very little contact with outside professionals and that communication with other child welfare agencies was also deficient. Placement recommendations were tendered to a municipal committee which was concerned with placing children on the basis of confirmed diagnoses. It may be concluded that the Eddy Shore team's partial achievement of this goal is thought by others to constitute full achievement and this might deceive the committee. Either the implementation should make it possible to achieve the goal, or if this is not feasible, the goal should be changed to accord with reality.

The second goal was to provide educational and rehabilitative treatment. As mentioned previously, the program made available a qualified staff that employed a wide variety of methods and materials for individuals and groups and utilized its facilities to the maximum to achieve that goal. This in itself was very important since there is no other framework in Jerusalem where children with undefined problems can receive educational treatment. However, the instruction groups were quite large and this left insufficient time for the educational treatment of individual children. The child-staff ratio was rather high for the therapeutic staff and the social worker and this led to the exclusion of children from treatment or the failure to give them treatment as often as needed. The lack of a structured communication system resulted in deficient coordination with regard to curriculum planning and evaluation, as well as in a dearth of

reliable information, both of which could lower the quality of treatment.

It may be concluded that the implementation of these particular aspects should be modified if the goals are to be achieved.

In pursuit of the set goal of defining the children's abilities and educational and therapeutic needs, the curriculum provided individualized instruction and therapies, i.e., speech therapy, occupational therapy, and educational and psychological counselling. Here again the high child-staff ratio may have impaired the achievement of the goal.

However, even if this goal was achieved, the fact that the individualized treatment as planned by the Unit was discontinued by the educational frameworks to which the children were referred, is a sign of wasted effort.

A part-time social worker was employed to achieve the goal of helping parents cope with the difficulties caused by having an exceptional child in the family. Many of the participants' families had special social problems and a part-time social worker was unable to give support, guidance, counselling and therapy to all the needy families. Good communication between staff and parents assisted in achieving this goal. Many of the staff, however, did not regard this as a program goal and their interaction with the parents was often motivated by the desire to understand the children's problems and family backgrounds. Communication did not always occur on a continuous and structured basis; therefore, the intensity of interaction was often not sufficient to achieve the goal.

Communications with the relevant child welfare services were neither structured nor extensive. Since the part-time social worker could not

both undertake all the needed work within the Unit and contact and coordinate the various services, the program could not provide even the opportunity to meet this goal. Moreover, none of the staff members regarded communication with such services as a program goal and therefore did nothing to further it.

The Unit offered training programs for teachers, social workers and home care personnel. In that way it served as an observation center for professional training and research, although not all related professional training programs (such as medical and rehabilitation programs) took advantage of its availability. The reasons for this were not examined.

The program's implementation provided a partial opportunity to achieve most of the set goals. The lack of clarity and differing perceptions of purpose led to implementation which was not fully aimed at the goals. Organizational modifications are needed, particularly in the communications system and program coordination. The program as implemented does not provide the opportunity to diagnose the children's problems and thus the goal needs to be reconsidered, restated or clarified unless major changes are made in the program's implementation.

#### 12.2 Goals vs. Results

In general, the program results showed that the goals set were only partially achieved. The first goal - observation and diagnosis of exceptional children - was achieved in about two-thirds of the cases. That is, all the children were observed and diagnosed, but the diagnosis was "correct" (according to the criteria used) for about 68% of the children. This could be considered an acceptable rate of accuracy.

Those who were diagnosed "correctly" were able to receive the suitable treatment and thus to reach their maximum potential, regardless of whether it was within the regular or special educational frameworks. The program's goal was not met for the 32% of the children for whom the diagnosis was "incorrect". It was not clear whether this was because the perceived goal was not the real one or whether the means of implementation did not suffice to meet the goal.

The program results did not indicate whether the second goal - providing educational and rehabilitative treatment - was achieved. This was because the results of the children's progress were not assessed in a structured manner on the basis of defined criteria or specific techniques, but often according to the staff's subjective impressions.

The special developmental questionnaire used as guideline was not filled in for every child upon admission and completion of the program. Instead, a short summary of progress was written up upon program completion.

Improvement in I.Q. scores might have been another objective measure, but these tests were not given to all the children; and if they were, most of the time the same type of examination was not repeated, so that the results could not be compared.

It appears that the third goal - defining the children's abilities and educational and therapeutic needs - was only partially achieved since the recommendations were found unsuitable for about 30% of the children. In many cases where children were given "incorrect" recommendations to a specific type of educational framework, their abilities and educational and therapeutic needs had not been well defined.

It was beyond the scope of this study to examine the goal of helping parents to overcome difficulties caused by having an exceptional child in the family.

No evidence could be obtained of coordination with the relevant community services. On the contrary, a lack of cooperation with the municipal placement committee was evident; they accepted the Unit's recommendations in only about 64% of the cases. When the directors of other schools were surveyed they stated that they did not use the recommendations given by the Eddy Shore team (or those of any other previous educational framework).

It can be concluded that only some of the program goals were achieved, and then but partially. No information was available on the achievement of other official goals.

### 12.3 Program Results vs. Implementation

The study results pointed out the importance of an institution such as the Eddy Shore Observation Unit. Less than one-third of the clientele was placed in frameworks for retardation, although it had been suspected that most of the children would need such frameworks before they came to the Unit.

The finding that only two-thirds of the children were placed in a suitable educational framework could not be attributed to such variables as length of stay in the program, general symptoms upon admission, or to I.Q. The staff did make an attempt to discover the source of the problems, but they were not qualified to make diagnoses. Often they arrived at the right diagnosis on the basis of their experience; but the diagnosis was "wrong" for more than 30% and thus there resulted "wrong" recommendations followed by unsuitable placements and further delays in treatment. The

placement was sometimes found to be suitable when it was different from that recommended by the Unit.

This indicates that the cooperation and coordination with other child welfare services need improvement. If there had been better coordination, these services could have been utilized in order to assist in the diagnostic process. This would also have ruled out the situation in which so many of the Unit's recommendations were not accepted.

The fact that a one-year stay at the Observation Unit was generally found sufficient indicated the possibility that children sometimes stayed longer than necessary (although for reasons sometimes beyond the Unit's control). Moreover, there were no defined criteria concerning the period needed for participation in the program. This explains why the length of stay may sometimes have been too long.

The organization and administration were deficient. The program results could not be obtained with regard to the children's progress or I.Q. score improvements, because the data were not available or were available in a form that made it difficult to obtain meaningful results. The disorganized filing system may have stemmed from the unstructured communications system, the lack of coordination and supervision, and the absence of accountability for curriculum planning and implementation.

That children were admitted at a relatively late age was not the Unit's responsibility, since its goals did not intend it to reach out to children in need. Nevertheless, it directly affected the program's implementation and possibly its results as well.

The study results evidence the importance of employing a built-in and on-going evaluation system. This may prevent situations where the program results are not assessed and there is no awareness that the goals are not achieved. With minimal additional cost, an evaluation system can be planned and implemented within the present framework of the Unit.

BIBLIOGRAPHY

- Anastasi, A. Psychological Testing, New York: Collier Macmillan, 1968
- Bloom, B.S.; Hastings J.T.; Madaus G.G. Handbook on Formative and Summative Evaluation of Student Learning, New York: McGraw Hill, 1971.
- Cook, D. Baseline Rehabilitation Center: Outcome and the Effectiveness of Evaluation Recommendations. Arkansas Rehabilitation Research and Training Center, University of Arkansas. Arkansas Rehabilitation Services, July 1977.
- Lindvall C.M., and Cox, R.C. The I.P.I. Evaluation Program, Area Mimeograph Services in Curriculum Evaluation, University of Pittsburgh, 1970.
- Ministry of Labour and Social Affairs. The Services for the Mentally Retarded, Jerusalem, July 1974.
- Oakland, T. Psychological and Educational Assessment of Minority Children, New York: Brunner and Muzel, 1977.
- Rossi, P.H., and Williams, W. Evaluating Social Programs, New York: Seminar Press, 1977.

Appendix A

1. Definitions

Suitable Placement - When a child attended an educational framework, for an extended period of time, i.e. beyond the trial period that the specific framework set for newly admitted children.

Minimal Brain Dysfunction - The term includes perceptual motor impairment, mild neurological impairment, specific learning disabilities and attention deficit disorders.

Integrated Education - Special classes or special classes in specific areas for exceptional children within the regular education system.

Mental Retardation - "Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period" as defined by the American Association of Mental Deficiency.<sup>1</sup> The National Insurance Institute uses the following categories to describe the various levels of mental retardation:<sup>2</sup>

Borderline retardation	I.Q. 65-74
Mild Retardation	I.Q. 55-65
Moderate Retardation	I.Q. 40-54
Severe Retardation	I.Q. 30-39
Profound Retardation	I.Q. 0-29

---

<sup>1</sup> The Services For the Mentally Retarded, Ministry of Labour and Social Affairs. Jerusalem, 1979, p.9.

<sup>2</sup> Ibid, p. 10.

2. I.Q. Tests

WPPSI - Wechsler Preschool and Primary Scale of Intelligence. The scale is designed for children aged 4-6½. Includes verbal and performance tests, some of which have a time limit of 50-75 minutes.

Leiter - International Performance Scale. An individual performance scale, designed to cover a wide range of functions similar to those found in verbal scales tasks such as matching identical colors, shapes, forms or pictures, etc. There is no time limit. The scores are in terms of mental age and I.Q. ratio.

S.B. - Stanford-Binet. Individual scale that can be administered to only one person at a time. A standardized performance test which also includes an interview, for children aged 2 to adults.

C.M.M.S. - Columbia Mental Maturity Scale. For children aged 3-10. The test requires identifying a drawing that does not belong with the others, the choice to be indicated by pointing or nodding. A promising test for children with severe motor or hearing handicaps.

Terman - Test of mental ability.

APPENDIX B: TABLES

TABLE 4: Age Distribution of Participants

Ages	No.	%
11+	44	34.1
10	21	16.3
9	27	20.9
8	15	11.6
7	15	11.6
6	5	3.9
5	2	1.6
4	--	--
TOTAL	129*	100.0

\*The date of birth of one participant was unclear.

TABLE 5: Parents'\* Countries of Origin

Country	No.	%
Israel	7	5.7
Asia	39	32.0
Africa	21	17.2
Europe	13	10.7
America	2	1.6
Mixed - (Africa-Asia)	9	7.4
Mixed - (Israel-Others)	29	23.8
Other mixed	2	1.6

\*Refers to mother and father jointly.

TABLE 6: Family Size\* of Participants

No. of Family Members	<u>Number and Percentage of Families</u>	
	No.	%
3	10	7.9
4	17	13.5
5	36	28.6
6	17	13.5
7	15	11.9
8	8	6.3
9	6	4.8
10	7	5.6
11	2	1.6
12	2	1.6
13	2	1.6
14	0	-
15	4	3.2
TOTAL	126	100.0

\*The sizes of four children's families could not be ascertained.

TABLE 7: Occupation of Participants' Parents

Occupation	Number and Percentage of Parents			
	Father		Mother	
	No.	%	No.	%
Academic and scientific professions	13	11.6	10	9.3
Administrative and managerial workers	3	2.7	2	1.9
Clerical and related workers	4	3.6	5	4.7
Sales workers	9	8.0	--	--
Service workers	25	22.3	12	11.2
Agricultural workers	--	--	1	0.9
Professional production workers in industry, mining, construction and transportation.	16	14.3	3	2.8
Other workers and non-professional industry, construction and transportation	24	21.4	2	1.9
Not working and retired	18	16.1	72	67.3
TOTAL	112	100.0	107	100.0

TABLE 8: Participants' Special Social Problems

Type of Social Problems	Number and Percentage of Problems	
	No.	%
Living with foster family	15	11.5
Adoption	4	3.0
Divorce, long-term hospitalization of a parent, etc.	27	21.0
One parent dead	5	3.8
No problems recorded	79	60.7
TOTAL	130	100.0

TABLE 9: Diseases in the Family, by Type of Disease

Type of Disease	Number and Percentage of Diseases											
	Father*		Mother**		Brothers & Sisters***		Other Relatives +		Participating children ++		The Family Unit	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Infective and parasitic diseases	2	3.9	4	6.0	--	--	1	3.3	1	2.0	6	4.6
Neoplasms	2	3.9	--	--	1	2.5	1	3.3	--	--	4	3.1
Endocrine, metabolic, nutritional & allergic diseases	7	13.7	4	6.0	2	5.0	13	43.3	9	18.0	31	23.8
Obstetrical and gynaecological problems	19	37.2	26	38.8	1	2.5	--	--	2	4.0	28	21.5
Blood diseases	--	--	4	6.0	--	--	1	3.3	2	4.0	7	5.4
Circulatory disorders	3	5.9	2	3.0	1	2.5	2	6.7	4	8.0	11	8.5
Neurological disorders	4	7.8	10	14.9	30	75.0	10	33.3	26	52.0	61	46.9
Psychiatric disorders	17	33.3	26	38.8	5	12.5	6	20.0	1	2.0	47	36.1
Sensory disorders	2	3.9	1	1.5	2	5.0	4	13.3	9	18.0	15	11.5
Disorders of the respiratory system	--	--	2	3.0	--	--	1	3.3	8	16.0	11	8.5
Diseases of the digestive system	1	1.9	1	1.5	--	--	--	--	1	2.0	3	2.3
Diseases of the genitourinary system	2	3.9	--	--	--	--	--	--	--	--	2	1.5
Diseases of the skin	--	--	1	1.5	--	--	--	--	--	--	1	0.7
Diseases of the bones, muscles, connective tissues	4	7.8	4	6.0	1	2.5	--	--	5	10.0	14	10.8
TOTAL	N=51		N=67		N=40		N=30		N=50		N=130	

\* The number of diseases was larger than 51 since 19 fathers had more than 1 disease

\*\* The number of diseases was larger than 67 since 18 mothers had more than 1 disease

\*\*\* The number of diseases was larger than 40 since 3 brothers/sisters had more than 1 disease

+ The number of diseases was larger than 30 since 9 other relatives had more than 1 disease

++ The number of diseases was larger than 50 since 18 participating children had more than 1 disease

TABLE 10: I.Q. Scores as Recorded upon Admission and Completion of the Program

I.Q. Score	Number and Percentage of I.Q. Scores			
	I.Q. upon Admission		I.Q. upon Completion	
	No.*	%*	No.**	%**
Normal and above (85 and over)	25	19.2	32	24.6
Borderline retardation (70-84)	28	21.5	38	29.2
Child retardation (55-69)	28	21.5	28	21.5
Moderate retardation (40-54)	13	10.0	10	7.6
Severe retardation (25-39)	6	4.6	3	2.3
Profound retardation (0-24)	--	--	2	1.5
Could not be tested (N = 130)	6	4.6	1	0.7

\* For 73 children, the I.Q. test was administered at admission; some of these children took more than one test. Therefore, the total number of tests exceeds the number of children and the percentage is over 100.

\*\*For 83 children, the I.Q. test was administered at completion of the program; some of these children took more than one test. Therefore the total number of tests exceeds the number of children and the percentage is over 100.

TABLE 11: Type of I.Q. Test Used upon Admission and Completion of the Program

Type of Test	Number and Percentage of Tests Administered			
	Admission		Completion	
	No.*	%*	No.**	%**
WIPPSI	20	19.6	60	57.6
Leiter	40	39.2	18	17.3
SB	24	23.5	11	10.5
CMMS	5	4.9	5	4.8
TERMAN	2	1.9	6	5.7
Others	11	10.7	4	3.8
TOTAL	102	100.0	104	100.0

\* The total number of children who were tested and the type of tests administered were known, was 67. For some children there was more than one test and therefore the total number of tests was more than 67.

\*\* The total number of children who were tested and the type of tests administered were known was 77. For some children there was more than one test and therefore the total number of tests was more than 77.

TABLE 12: Location of I.Q. Test Administration upon Program Admission and Completion

Location	Number and Percentage of Tests			
	Admission*		Completion**	
	No.	%	No.	%
Eddy Observation Unit Shore	41	51.2	48	51.6
Psychology Services	15	18.7	18	19.3
Child Development Center	18	22.5	9	9.6
Mental Health Hospital Center	--	--	--	--
Pediatric Ward	1	1.2	4	4.3
Center for the Child	1	1.2	1	1.1
Services for the Retarded	2	2.5	1	1.1
School or Kindergarten	--	--	9	9.6
Other	2	2.5	3	3.2
Total number of tests	80	100.0	93	100.0

\* In 57 instances, the places where the tests were administered to the children, were known. Some were tested more than once, therefore the number of tests is higher than 57.

\*\* The total number of children who were tested was 71. Some were tested more than once, therefore, the total number of tests is higher than 71.

TABLE 13: Sources of Referral

Sources of Referral	Number and Percentage of Sources of Referral	
	No.	%
Jerusalem Child Development Center	69	53.1
Mental Health Center	4	3.1
Psychology Services	10	7.7
Hospital Pediatric Wards	8	6.2
Mother-and-Child Centers	9	6.9
Kindergartens and Day Care Centers	2	1.5
Center for the Child	2	1.5
Services for the Retarded	6	4.6
Others*	8	6.2
Unknown	12	9.2
TOTAL	130	100%

\* Other sources of referral were physicians, clinical psychologists, social workers and local councils.

TABLE 14: Participants' Previous Educational Frameworks

Type of Framework	Number and Percentage of Participants*	
	No.	%
Regular education	55	42.3
Integrated education	1	7.6
Special education	20	15.3
Special education for physically handicapped	1	7.6
Live-in institutions	2	1.5
Informal framework: foster family or parental home	50	38.4
Other	6	4.6

\* Five children attended more than one framework previous to attending Eddy Shore, therefore the total is over 100%

TABLE 15: Medical and Other Examinations upon Admission

Type of Examination	Number* and Percentage of Examinations	
	No.*	%
E.E.G.	18	24.6
Vision Tests	--	--
Hearing Tests	4	5.4
Head X-rays	1	1.3
Blood Tests	--	--
Language skills (Reynell, Peabody)	37	50.6
Vision-Hand Integration (I.T.P.A. - V.M.I.)	11	15.1
Others	2	2.7
N=56		

\* Seventeen children underwent two different tests; therefore, the total number of tests is more than 56.

TABLE 16: Present Educational Framework, by First Framework

First Framework	Present Framework																					
	Regular education		Integrated education		Mild retardation		Moderate retardation		Severe retardation		Children with minimal brain dysfunction		Emotionally disturbed		Special education - physically handicapped		Other		Parents' home		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Regular education	15	83.3	--	--	1	5.6	--	--	--	--	--	--	1	5.6	--	--	--	--	1	5.6	18	18.8
Integrated education	4	44.4	2	22.2	2	22.2	--	--	--	--	1	11.1	--	--	--	--	--	--	--	--	9	9.4
Mild retardation	--	--	--	--	13	86.7	--	--	--	--	--	--	2	13.3	--	--	--	--	--	--	15	15.6
Moderate retardation	--	--	--	--	--	--	3	60.0	1	20.0	--	--	1	20.0	--	--	--	--	--	--	5	5.2
Severe retardation	--	--	--	--	1	12.5	--	--	7	87.5	--	--	--	--	--	--	--	--	--	--	8	8.3
Children with minimal brain dysfunction	3	15.0	--	--	6	30.0	--	--	--	--	8	40.0	2	10.0	1	5.0	--	--	--	--	20	20.9
Emotionally disturbed	1	5.3	--	--	3	15.8	--	--	--	--	--	--	13	68.84	--	--	2	10.5	--	--	19	19.8
Special education - physically handicapped	1	100.0	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	1	1.0
Other	--	--	--	--	--	--	--	--	--	--	--	--	--	1	100.0	--	--	--	--	--	1	1.0
All frameworks combined	24	25.0	2	2.1	26	27.1	3	3.1	8	8.3	9	9.4	19	19.8	2	2.1	2	2.1	1	1.0	96	100.0

TABLE 17: Recommendations and Decisions with Regard to Types of Educational Frameworks

Type of Framework	Recommendations by Eddy Shore		Decisions of Placement Committee	
	No.	%	No.	%
Regular education	18	13.8	13	10.0
Integrated education	14	10.8	9	6.9
For borderline - mild retardation	16	12.3	15	11.5
For moderate retar- dation	3	2.3	5	3.8
For severe retardation	5	3.8	9	6.9
For profound retardation	--	--	--	--
For children with minimal brain dys- function	13	10.0	22	16.9
For emotionally disturbed	12	9.2	14	10.8
Live-in institutions	4	3.1	5	3.8
Physically handicapped	1	0.8	1	0.8
Other	4	3.1	1	0.8
Unknown	40	30.8	36	27.7
TOTAL	130	100.0	130	100.0

TABLE 18: Recommendations of the Eddy Shore Unit, by Decisions of the Municipal Placement Committee

Framework recommended by the Unit	Decision of the Placement Committee																			
	Regular education		Integrated education		For mildly retarded		For moderately retarded		For severely retarded		For children with minimal dysfunction		For emotionally disturbed		Live-in institutions		Other		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Regular educational system	6	42.9	1	7.1	1	7.1	1	7.1	--	--	3	21.4	1	7.1	--	--	1	7.1	14	19.2
Integrated education	1	11.1	5	55.5	--	--	1	11.1	--	--	2	22.2	--	--	--	--	--	--	9	12.3
For mildly retarded	--	--	1	6.7	11	73.3	1	6.7	--	--	2	13.3	--	--	--	--	--	--	15	20.6
For moderately retarded	--	--	--	--	1	50.0	1	50.0	--	--	--	--	--	--	--	--	--	--	2	2.7
For severely retarded	--	--	--	--	--	--	--	--	4	80.0	--	--	--	--	1	20.0	--	--	5	6.8
For children with minimal brain dysfunction	--	--	--	--	--	--	1	8.3	--	--	11	91.7	--	--	--	--	--	--	12	16.5
For emotionally disturbed	--	--	--	--	1	10.0	--	--	--	--	--	--	8	80.0	1	10.0	--	--	10	13.7
Live-in institutions	--	--	1	50.0	--	--	--	--	--	--	--	--	--	--	1	50.0	--	--	2	2.7
Special education for physically handicapped	--	--	--	--	--	--	--	--	--	--	1	100.0	--	--	--	--	--	--	1	1.4
Other	--	--	--	--	--	--	--	--	1	33.3	1	33.3	1	33.3	--	--	--	--	3	4.1
All recommendations combined	7	9.6	8	11.0	14	19.2	5	6.8	5	6.8	20	27.4	10	13.7	3	4.1	1	1.4	73	100.0

TABLE 19: Length of Stay in First Educational Framework

Length of Stay	Number and Percentage of Children	
	No.	%
Short period (up to one year)	17	13.1
Medium period (up to two years)	36	27.7
Long period (over two years)	52	40.0
Unknown	25	19.2
TOTAL	130	100.0

TABLE 20: Length of Stay in First Placement when Framework Coincided with Recommendation, by Type of Framework

Type of Framework	Short period (up to one year)		Medium period (2 years)		Long period (over 2 years)		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Regular education system	1	14.3	2	28.6	4	57.1	7	14.0
Integrated education	--	--	6	100.0	--	--	6	12.0
For mildly retarded children	--	--	2	22.2	7	77.8	9	18.0
For severely retarded children	2	50.0	--	--	2	50.0	4	8.0
For children with minimal brain dysfunction	4	36.4	5	45.5	2	18.2	11	22.0
For emotionally disturbed children	2	18.2	4	36.4	5	45.5	11	22.0
Live-in institutions	--	--	--	--	2	100.0	2	4.0
TOTAL NUMBER OF RECORDS	N=9		N=19		N=22		50	100.0

TABLE 21: Length of Stay in First Placement when Framework did not  
Coincide with Unit's Recommendation, by Type of Framework

Type of Framework	Short period (up to one year)		Medium period (2 years)		Long period (over 2 years)		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Regular educational system	--	--	2	66.7	1	33.3	3	13.0
Integrated education	--	--	4	80.0	1	20.0	5	21.7
For mildly retarded children	1	25.0	1	25.0	2	50.0	4	17.4
For moderately retarded children	--	--	--	--	1	100.0	1	4.3
For severely retarded children	--	--	--	--	1	100.0	1	4.3
For children with minimal brain dysfunction	1	50.0	--	--	1	50.0	2	8.7
For emotionally disturbed children	1	100.0	--	--	--	--	1	4.3
Live-in institutions	--	--	1	100.0	--	--	1	4.3
Special education for physically handicapped	1	100.0	--	--	--	--	1	4.3
Other	1	25.0	1	25.0	2	50.0	4	17.4
TOTAL NUMBER OF RECORDS	N=5		N=9		N=9		23	100.0

TABLE 22: Reasons for Leaving First Framework, by Length of Stay in Framework

Length of Stay	Reasons for Leaving											
	Framework recommended transfer due to lack of integration		Parents decided to remove		Termination of program		More suitable alternative available		Other		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Short period (maximum 1 year)	4	44.4	3	33.3	1	11.1	--	--	1	11.6	9	26.5
Medium period (2 years)	5	38.5	2	15.4	2	15.4	1	7.7	3	23.1	13	38.2
Long period (over 2 years)	3	25.0	1	8.5	3	25.0	--	--	5	41.7	12	35.3
All periods of stay combined	12	35.3	6	17.7	6	17.7	1	2.9	9	26.4	34	100.0

TABLE 23: Reasons for Leaving Educational Framework, by Type of Framework

Type of Framework	Framework recommended transfer due to lack of integration		Parents decided to pull out		Termination of program		More suitable alternative available		Other		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Regular Educational system	1	3.0	--	--	1	3.0	--	--	1	3.0	3	9.1
Integrated education	1	3.0	1	3.0	1	3.0	--	--	--	--	3	9.1
For mildly retarded children	2	6.1	2	6.1	--	--	--	--	1	3.0	5	15.2
For moderately retarded children	--	--	--	--	--	--	1	3.0	--	--	1	3.0
For severely retarded children	1	3.0	2	6.1	--	--	--	--	1	3.0	4	12.1
For children with minimal brain dysfunction	3	9.1	--	--	1	3.0	--	--	1	3.0	5	15.2
For mentally disturbed children	4	12.1	2	6.1	1	3.0	--	--	3	9.1	10	30.3
Special education for physically handicapped	--	--	--	--	--	--	--	--	2	6.1	2	6.1
TOTAL	12	36.4	7	21.2	4	12.1	1	3.0	9	27.3	33	100.0

TABLE 24: Children in Intermediate Educational Frameworks

Intermediate Educational Framework	Number and percentage of children	
	No.*	%
Regular education	14	10.8
Integrated education	1	0.7
For borderline-mild retardation	1	0.7
For moderately retarded children	15	11.5
For severely retarded children	--	--
For profoundly retarded children	--	--
For children with minimal brain dysfunction	4	3.1
For emotionally disturbed children	3	2.3
Live-in institutions	6	4.6
Special educational framework for other than mental retardation	--	--
Parents' home	6	4.6
Other	--	--
No intermediate educational framework	87	66.9

\* The total number of intermediate educational frameworks is more than 130, as there were seven children who attended more than one intermediate educational framework; therefore, the percentage is over 100 percent.

TABLE 25: Present Educational Frameworks, by Recommendations of the Eddy Shore Team

Framework Recommended	Regular education		Integrated education		Mild retardation		Moderate retardation		Severe retardation		Children with minimal brain dysfunction	Emotionally disturbed		Live-in institutions		Special education for physically handicapped		Other		Parents' home		TOTAL		
	No.	%	No.	%	No.	%	No.	%	No.	%		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Regular education system	14	93.3	--	--	1	6.7	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	15	18.1	
Integrated education	7	58.3	2	16.7	1	8.3	--	--	--	--	1	8.3	1	8.3	--	--	--	--	--	--	--	12	14.5	
For mildly retarded children	--	--	--	--	11	73.3	--	--	1	6.7	--	--	2	13.3	--	--	--	--	--	--	1	6.7	15	18.1
For moderately retarded children	--	--	--	--	1	33.3	2	66.7	--	--	--	--	--	--	--	--	--	--	--	--	--	--	3	3.5
For severely retarded children	--	--	--	--	1	20.0	--	--	3	60.0	--	--	--	--	1	20.0	--	--	--	--	--	--	5	6.0
For children with minimal brain dysfunction	1	8.3	--	--	4	33.3	--	--	--	--	6	50.0	1	8.3	--	--	--	--	--	--	--	12	14.5	
Emotionally disturbed	--	--	--	--	1	8.3	--	--	--	--	--	--	9	75.0	1	8.3	--	--	1	8.3	--	--	12	14.5
Live-in institutions	--	--	--	--	1	25.0	--	--	--	--	--	--	--	2	50.0	--	--	--	--	--	1	25.0	4	4.8
Special education - physically handicapped	--	--	--	--	--	--	--	--	--	--	--	--	--	--	1	100.0	--	--	--	--	--	1	1.2	
Other	--	--	--	--	1	25.0	--	--	4	1.8	--	--	1	25.0	2	50.0	--	--	--	--	--	4	4.8	
All recommendations combined	22	26.5	2	2.4	22	26.5	2	2.4	4	4.8	7	8.4	14	16.9	6	7.3	1	1.2	1	1.2	2	2.4	83	100.0

TABLE 26: Participants' I.Q. Scores upon Admission, by I.Q. Scores upon Program Completion\*

Test Score upon Admission	I.Q. Score upon Discharge				TOTAL
	Normal & above (85 and over)	Borderline retardation (70 - 84)	Mild re- tardation (55 - 69)	Moderate retardation (40 - 54)	
Normal & above (85 and over)	1	--	1	--	2
Borderline retardation (70 - 84)	2	5	--	--	7
Mild retardation (55 - 69)	1	3	--	--	4
TOTAL	4	8	1	--	13

\* In cases where the same type of examination was used and where the testing was done at Eddy Shore.

TABLE 27: Length of Program Participation, by Length of Stay in First Educational Framework after Program Completion (where Placement was as Recommended by Eddy Shore Team)

Length of Stay	3 Months		3 - 6 Months		7 - 12 Months		13 - 18 Months		19 - 24 Months		24 Months		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Short period	--	--	--	--	5	22.7	--	--	2	18.2	2	33.3	9	18.8
Medium period	--	--	2	100.0	9	40.9	3	50.0	4	36.4	1	16.7	19	39.6
Long period (over 2 years)	1	100.0	--	--	8	36.4	3	50.0	5	45.5	3	50.0	20	41.7
Total number of responses	N=1		N=2		N=22		N=16		N=11		N=6		48	100.0

TABLE 28: Symptoms upon Admission Compared to First Educational Framework upon Program Completion

First Framework	Number* and Percentage of Symptoms																					
	Speech disorders		Vision impairment		Hearing impairment		Disorders in motor develop.		Disorders in cognit. develop.		Behavioral problems		Emotion. problems		Low I.Q.		Neuro-logical disease		Other disease		No clear symptoms	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Regular education	8	14.8	--	--	3	42.8	6	12.0	3	9.1	6	13.6	5	17.3	--	--	--	--	--	--	1	50.0
Integrated education - special education	6	11.1	1	16.6	1	14.3	4	8.0	5	15.0	7	15.9	1	3.4	1	7.7	--	--	1	33.3	--	--
For mildly retarded	9	16.6	--	--	--	--	8	16.0	6	18.2	6	13.6	5	17.3	1	7.7	--	--	--	--	--	--
For moderately retarded	2	3.5	--	--	--	--	4	8.0	2	16.1	1	2.3	2	6.9	--	--	1	100.0	--	--	--	--
For severely retarded	5	9.3	--	--	--	--	8	16.0	3	9.1	5	11.4	--	--	5	38.4	--	--	1	33.3	--	--
For children with minimal brain dysfunction	11	20.4	--	--	1	14.3	9	18.0	7	21.2	5	11.4	8	27.6	2	15.4	--	--	--	--	--	--
For emotionally disturbed	12	22.3	3	50.0	1	14.3	9	18.0	6	18.2	14	3.18	7	24.1	4	30.8	--	--	1	33.3	1	50.0
Special education for physically handicapped	1	1.9	1	16.6	1	14.3	1	2.0	--	--	--	--	1	3.4	--	--	--	--	--	--	--	--
Other	--	--	1	16.6	--	--	1	2.0	1	3.0	--	--	--	--	--	--	--	--	--	--	--	--
TOTAL	54	100.0	6	100.0	7	100.0	50	100.0	33	100.0	44	100.0	29	100.0	13	100.0	1	100.0	3	100.0	2	100.0

\*Many children displayed more than one symptom.

TABLE 29: WIPPSSI I.Q. Test Scores upon Program Completion, by Length of Stay in First Educational Framework

I.Q. Score	Short period (up to 1 year)		Medium period (2 years)		Long period (over 2 years)		TOTAL	
	No.	%	No.	%	No.	%	No.	%
Normal and above (85 and over)	2	4.0	7	14.0	8	16.0	17	34.0
Borderline retardation (70 - 84)	6	12.0	8	16.0	5	10.0	19	38.0
Mild retardation	5	10.0	4	8.0	3	6.0	12	24.0
Moderate retardation (40 - 54)	1	2.0	--	--	1	2.0	2	4.0
TOTAL	14	28.0	19	38.0	17	34.0	50	100.0

TABLE 30: Symptoms upon Program Admission Compared to Recommendation of Eddy Shore Team

Recommendation	Number* and Percentage of Symptoms																					
	Speech dis- orders		Visual impair- ment		Hearing Impair- ment		Disorder in motor develop.		Disorder in cogni- tive devel.		Behavioral problems		Emotion- al problems		Neuro- logical diseases		Low I.Q.		Other diseases		No clear symptoms	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Regular educational system	8	18.6	2	50.0	1	16.6	6	16.2	4	13.8	6	15.4	6	19.4	--	--	--	--	1	33.3	--	--
Integrated education	10	23.2	2	50.0	2	33.6	3	18.1	5	17.2	8	20.5	6	19.4	--	--	2	22.2	2	66.7	--	--
For mildly retarded	9	21.0	--	--	--	--	9	24.4	6	21.0	4	10.3	5	16.1	--	--	1	11.1	--	--	1	100.0
For moderately retarded	--	--	--	--	--	--	3	8.1	1	3.4	1	2.6	--	--	--	--	--	--	--	--	--	--
For severely retarded	2	4.6	--	--	--	--	4	10.8	1	3.4	3	7.7	--	--	--	--	1	11.1	--	--	--	--
For children with minimal brain dysfunction	6	14.0	--	--	1	16.6	5	13.5	5	17.2	5	12.8	6	19.4	--	--	2	22.2	--	--	--	--
For emotionally disturbed	4	9.3	--	--	--	--	6	16.2	5	17.2	10	25.6	5	16.1	--	--	2	22.2	--	--	--	--
For special education for physically handicapped	1	2.3	--	--	1	16.6	1	2.7	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Other	3	7.0	--	--	1	16.6	--	--	2	6.8	2	5.1	3	9.6	1	100.0	1	11.1	--	--	--	--
TOTAL	43	100.0	4	100.0	6	100.0	37	100.0	29	100.0	39	100.0	31	100.0	1	100.0	9	100.0	3	100.0	1	100.0

\*Many children displayed more than one symptom.

TABLE 31: I.Q. Scores upon Program Admission, by Placement Recommendations from the Eddy Shore Team

I.Q. Scores upon Admission	Eddy Shore Recommendation															
	Regular education		Integrated education		Framework for borderline mildly retarded		Framework for modera- tely retar- ded		Framework for children with minimal brain dysfunction		Framework for emotion- ally distur- bed		Other		All education frameworks combined	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Normal and above (85 and over)	4	33.3	3	60.0	--	--	--	--	2	18.2	3	37.5	--	--	12	28.6
Borderline retardation (70 - 84)	4	33.3	1	20.0	2	50.0	--	--	6	54.5	--	--	--	--	13	31.0
Mild retardation (55 - 69)	2	16.7	1	20.0	1	25.0	1	100.0	3	27.3	1	12.5	1	100.0	10	23.8
Moderate retardation (40 - 54)	2	16.7	--	--	--	--	--	--	--	--	1	12.5	--	--	3	7.1
Severe retardation (25 - 39)	--	--	--	--	1	25.0	--	--	--	--	--	--	--	--	1	2.4
Untestable	--	--	--	--	--	--	--	--	--	--	3	37.5	--	--	3	7.1
TOTAL	12	100.0	5	100.0	4	100.0	1	100.0	11	100.0	8	100.0	1	100.0	42	100.0

TABLE 32: I.Q. Scores upon Program Completion, by Placement Recommendations from the Eddy Shore Team

I.Q. Scores upon Completion	Eddy Shore Recommendation																	
	Regular education		Integrated education		Framework for borderline mildly retar- ded		Framework for modera- tely retar- ded		Framework for severely retarded		Framework for children with minimal brain dysfunction		Framework for emotion- ally distur- bed		Other		All education frameworks combined	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Normal and above (85 and over)	5	45.5	4	36.4	1	9.1	--	--	--	--	1	9.1	--	--	--	--	11	30.5
Borderline retardation (70 - 84)	3	21.4	3	21.4	2	14.3	--	--	--	--	2	14.3	3	21.4	1	7.1	14	38.9
Mild retardation (55 - 69)	--	--	--	--	4	44.4	1	11.1	--	--	2	22.2	2	22.2	--	--	9	25.0
Moderate retardation (40 - 54)	--	--	--	--	--	--	--	--	--	--	--	--	1	100.0	--	--	1	2.8
Severe retardation (25 - 39)	--	--	--	--	--	--	--	--	1	100.0	--	--	--	--	--	--	1	2.8
TOTAL	8	22.2	7	19.4	7	19.4	1	2.8	1	2.8	5	13.9	6	16.7	1	2.8	36	100.0

ג'זינט ישראל  
מכון ברוקדייל לגרונטולוגיה  
והתפתחות אדם וחברה בישראל

JOINT (J.D.C.) ISRAEL  
BROOKDALE INSTITUTE OF GERONTOLOGY  
AND ADULT HUMAN DEVELOPMENT IN ISRAEL

---

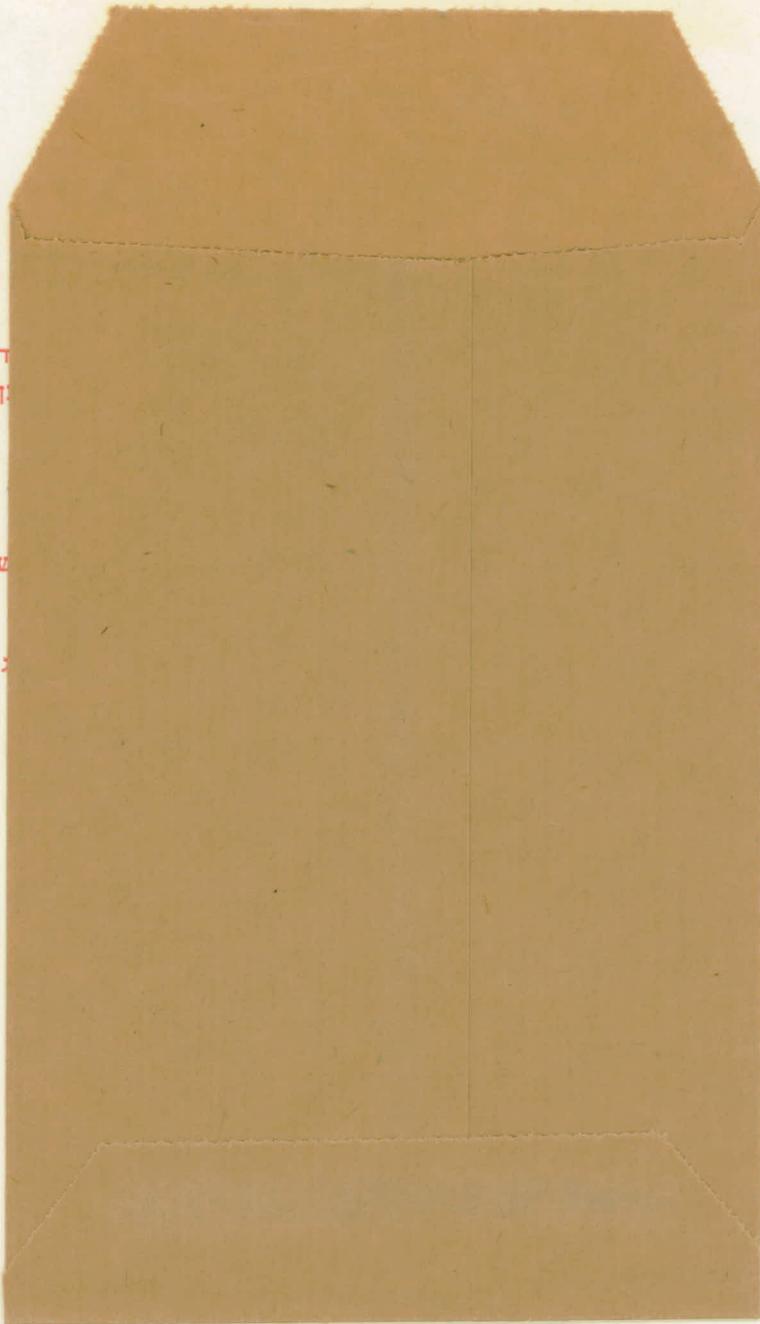
דו"ח הערכה - JDC

---

הערכה של כתות תצפית על שם אדי שור

יהודית בנדל

מ-7-81



## המכון

הוא מכון ארצי  
ופועל במסגרת  
ברוקדייל בניו

בפעולתו מנסה  
והשירותים ה  
מהאקדמיות ה  
מחקר הלכה ל

המימצאים וה  
של המכון או

ד ב-1974  
מן של קרו

הבריאות  
מומחים  
ש מסקנות

את אלה

3309-30

BR-S-7-81

Evaluation of the Eddy shore observation

Bendel, Judith



5657 20





הערכה של כתות תצפית על שם אדי שור

יהודית בנדל

## ת ק צ י ר

צוות כיתות התצפית ע"ש אדי שור עוסק באבחון ובטיפול בילדים בעלי רמת-תפקוד נמוכה ביחס לגילם הכרוניולוגי. מטרת היחידה היא לקבוע את סיבת העיכוב בהתפתחות, להגדיר את הצרכים החינוכיים והטיפוליים, לתת את הטיפול המתאים, ובסיום התכנית לסייע בהפניית הילדים למבחר מסגרות לימודים בהן יטפלו בבעיותיהם או במגבלותיהם המיוחדות. המטרה היא להגיע לרמת ההתפתחות הפוטנציאלית המירבית.

מחקר ההערכה נעשה על-מנת לקבוע את חשיבות התכנית ולאפשר המשך תכנונה ופיתוחה. בשלב ראשון נעשה מעקב על 139 ילדים שסיימו את התכנית מאז תחילתה. נעשה נסיון להגדיר את הגורמים שהשפיעו על תוצאות התכנית. התוצאות נקבעו בהתאם לקריטריונים הבאים: קבלת המלצות צוות אדי שור לועדת השמה של העירייה, השמה "נכונה" של בוגרי התכנית וההתאמה בין המסגרת החינוכית הנוכחית וההמלצה של כיתות התצפית. מידע שנאסף ממקורות שונים איפשר את תיאור משתתפי התכנית על-פי מאפיינים נבחרים וכן מציאת מכנים משותפים ביניהם.

התכנית הועילה לכשני-שליש מן המשתתפים לגבי מסגרת-ההמשך החינוכית. נמצא כי השהות בכיתות-התצפית, הסמפטומים בזמן הקבלה ומנת-המשכל בזמן הקבלה לא השפיעו על תוצאות התכנית. המלצות כיתות התצפית לא הושתתו על הסמפטומים או על מנת-המשכל, ממצאים אלו מדגישים חשיבותה של תכנית מעין זו.

בחלקו השני של המחקר נעשתה הערכה פורמטיבית. ההערכה כללה קביעת מטרות התכנית, יישומה ותוצאותיה, וכמו כן נבדקו היחסים בין מרכיבים אלה.

מכיוון שמטרות כיתות-התצפית לא היו ברורות לכל אנשי הצוות, ומכיוון שהמתכננים לא ספקו את האמצעים ליישום התכנית כך שתאפשר השגת חלק מן המטרות המוצהרות, הושגו המטרות רק בחלקן. ניתנו המלצות להכנסת שינויים שיביאו לשיפור התוצאות.