

SCHOOL READINESS AND LANGUAGE MINORITY STUDENTS: IMPLICATIONS OF THE FIRST NATIONAL EDUCATION GOAL

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Note: Every attempt has been made to maintain the integrity of the printed text. In some cases, figures and tables have been omitted or reconstructed within the constraints of the electronic environment.

The National Education Goals were adopted by the president and the governors in 1990 and are supported by President Clinton. Goal 1 states that all children in America will start school ready to learn. Investing in the quality care and education of the nation's youngest children is increasingly seen as key to solving many of America's education problems. If we can only get children ready for school, the argument goes, other education reforms will follow--student achievement will improve, dropout rates will decline, levels of adult literacy will increase, the skills of the U.S. work force will be strengthened, and economic productivity will rise.

While the importance of ensuring that all children are ready for school is inarguable, it is by no means perceived to be an easy task. More than half of registered American voters polled in 1992 believed that children are worse off today than when they were growing up; less than a third thought that conditions for children had gotten better ("National Poll Shows," 1992). A 1991 Carnegie Foundation survey of kindergarten teachers found that 42 percent believed that children were coming to school less prepared to learn than those enrolled five years earlier; only 25 percent believed that the situation was improving (Boyer, 1992). And a 1992 survey conducted by the American Academy of Pediatrics and the National PTA found that nearly two-thirds of elementary teachers believed that the proportion of children with health problems that impair learning is increasing ("Students' Poor Health," 1992).

Ample evidence exists to confirm suspicions that conditions for children in the United States have deteriorated markedly in recent years. Data collected by the Center for the Study of Social Policy (1992) indicate that conditions worsened for children during the 1980s on six out of nine indicators of child well-being:

1. the percentage of low birthweight babies increased 3 percent;
2. the percentage of births to single teens increased 14 percent;
3. the percentage of children living in poverty increased 22 percent;
4. the percentage of children living in single-parent families increased 13 percent;
5. the juvenile custody rate increased 10 percent; and
6. the teen violent death rate increased 11 percent.

These and other disturbing trends have helped focus an unprecedented amount of attention on the urgent need to improve the quality of children's lives and to help prepare them for school. But what exactly does it mean to come to school ready to learn? In particular, what does this goal mean for language minority students? The latter question is especially important for educators and policy makers because:

1. language minority students will form an increasingly greater share of school populations, particularly in urban school districts;
2. poor and minority children, many of whom are limited English proficient, are more likely to be at risk

- on measures of health care and access to preschool programs; and
3. the belief persists that coming to school ready to learn implies that children should come to school knowing English, a belief which has led to policies harmful to both children and their families. In this paper, we address each of these issues and examine the implications of the first National Education Goal for language minority students.

DEFINING READINESS

The expectation that all children should start school ready to learn is a puzzling notion, since children are learning from the moment that they are born. Many educators have voiced concern that the wording of this goal is equally puzzling--too much of the burden of readiness seems to rest on individual children rather than on schools, which should also be ready to receive children (Goal 1 Technical Planning Subgroup, 1991; Prince, 1992).

Defining readiness is not a simple task. In fact, Kagan (1990, 1992) claims that scholarly debates on how to define readiness and how to measure it have gone on for decades. One view is that children are "ready" if they have developed sufficient attention spans, motivation, maturity, and cognitive abilities to acquire new knowledge and skills. Another view is that children are "ready" if they are able to adapt successfully to formal school settings by demonstrating abilities such as recognizing colors, copying shapes, counting, sitting still--in short, "specific skills or experiences that the dominant culture values" (Meisels et al., 1992:5). As Kagan (1992) points out, these divergent views of readiness have resulted in equally divergent instructional approaches, school policies, and teacher opinions about who is ready to enter school and who is not.

A PRELIMINARY DEFINITION

In order to reach a national consensus about what it means to come to school ready to learn, the National Education Goals Panel appointed a Resource Group of early childhood education experts to (a) propose a definition of readiness and (b) suggest ways that children's readiness might be assessed so that the Goals Panel can measure annual progress toward this Goal (see Appendix

A). The Resource Group concluded that even though we already know a great deal about conditions that foster children's potential for learning, we lack accurate, direct measures that can tell us "the extent to which children do, in fact, have the knowledge, skills and attitudes needed for formal learning" (Goal 1 Resource Group, 1991:6).

The Resource Group recommended that a three-part national Early Childhood Assessment System be developed, consisting of a before-school assessment, a school entrance assessment, and an in-school assessment, to provide comprehensive information to policy makers about the status of the nation's children. The purpose of such an assessment system would not be to gather information for the diagnosis or placement of an individual child. Rather, its purpose would be to collect information at a broad group level in order to understand changes in conditions affecting children's well-being over time.

The Resource Group emphasized that any attempt to measure readiness should focus on the whole child, rather than focusing on only one or two traditional narrow indicators of readiness such as verbal ability. The holistic definition of readiness which they proposed covers five dimensions of children's growth and development (National Education Goals Panel, 1992:19):

Physical Well-Being and Motor Development--the various aspects of a child's health and physical growth, ranging from being rested, fed, properly immunized, and healthy, to the development of skills and abilities for running and jumping and using crayons and puzzles;

Social and Emotional Development--the sense of personal well-being that allows a child to participate fully

and constructively in classroom activities by taking turns, following directions, working independently and as a group member, and developing friendships;

Approaches Toward Learning--the qualities of curiosity, creativity, motivation, independence, cooperation, interest, and persistence that enable children from all cultures to get involved in and maximize their learning;

Language Usage--the uses of oral and written language (e.g., talking, listening, scribbling, composing, and being read to) that enable children to communicate effectively with others and express their thoughts, feelings, and experience; and

Cognition and General Knowledge--the familiarity with basic information, including patterns and relationships, causes and effects, and solving problems in everyday life.

Readiness, according to the Resource Group, is distributed along a continuum in each dimension; it is not an absolute standard that a child must meet. That is, there is no cut-score to sort children as "ready" versus "not ready." An individual child might be more ready for school in terms of her cognitive development, for example, but less ready in terms of her social and emotional development. This multidimensional definition views readiness as "a pattern of qualities, a cluster of conditions and characteristics that, taken together, enable children to take full advantage of the opportunities and demands of formal schooling" (Goal 1 Resource Group, 1991:5). How those qualities might be measured was the next question to be addressed.

ASSESSING YOUNG CHILDREN

A Technical Planning Subgroup consisting of experts in early childhood education, child development, and assessment was appointed by the Goals Panel to expand the preliminary definition of readiness and to look in greater depth at the complex issues involved in assessing young children (see Appendix B). The Technical Planning Subgroup's charge was to examine first the issues involved in the in-school component of the assessment, which would be administered to a sample of children during kindergarten.

The Subgroup recommended that such an assessment system gather information on the five dimensions specified by the Resource Group (Goal 1 Technical Planning Subgroup, 1991). They also recommended that this information be gathered at several points during the kindergarten year and from multiple sources (parent reports, teacher reports, performance portfolios, and profiles of children's skills, knowledge, and development). To reduce the costs of data collection and to prevent the assessment from being misused to label or stigmatize individual children or groups of children, the Subgroup further recommended that a sample of children be assessed every three years, rather than assessing all kindergartners every year. Finally, they recommended that a national body be created to oversee the development, implementation, and evaluation of the proposed assessment system.

At present, the Technical Planning Subgroup is developing a richer definition of the five dimensions of learning and development in consultation with other early childhood specialists, who have agreed to help elaborate the meaning of the five dimensions, critique the suitability of existing instruments which propose to measure these dimensions, and address issues of large-scale assessments of readiness and assessment of young minority children and children with disabilities. Early childhood specialists addressing the Language Usage dimension and the issues involved in testing young minority children include Duran (1992) and Garcia & Figueroa (1993).

ASSESSING LANGUAGE MINORITY CHILDREN

Some of the critical questions to be tackled as the dimensions of learning and development are refined and the assessment system is created are (a) how diverse groups of children will be assessed equitably, (b) whether languages other than English will be used to assess language minority children and to interview their parents,

and (c) how a balance will be struck between the need to respect cultural differences and the need to make some judgments about children's preparedness to participate successfully in the formal school culture (see Prince, 1992). Perhaps the most difficult theoretical issue to be addressed is that "school readiness" is a concept that is both culturally defined and culturally interpreted. As one highly respected anthropologist pointed out to the Goals Panel, there is a grave danger that normal developmental differences among groups of children may be misinterpreted as "evidence" that minority children are not ready for school (Prince, 1992:51):

Culturally speaking, different minority groups develop differently, for example, in the area of social relations. Asian Americans (e.g., Chinese) and Native Americans do not follow the same trend of early social development as the mainstream. In the area of social development these and similar populations are likely to come out quite differently, although it does not mean that they are not ready for school. But how will the results of the assessment be interpreted by those who do not understand the cultural basis of the differences?

DEMOGRAPHIC PROJECTIONS

This fundamental question--how the results of the assessment will be interpreted--increases in importance as the numbers of language minority children entering school continue to grow. Although estimates differ according to data sources and definitions, sources are consistent in their conclusions that the number of language minority children in the U.S. is rapidly increasing. Data compiled by the U.S. Department of Education (1992) show that approximately 2.3 million students (nearly 6 percent of total public and nonpublic school enrollment) were identified as limited English proficient (LEP) in 1991, a 14 percent increase since 1990. LEP student populations grew by more than 5 percent in thirty-four states during that time. Two states alone accounted for more than half of the increase: Florida gained more than 22,000 LEP students in one year's time, while California gained nearly 125,000.

According to 1990 U.S. Census data, the number of school-age children who do not speak English at home has increased 38 percent over the past ten years (Population Reference Bureau, 1992). Latest figures show that 6.3 million children, or nearly 14 percent of those age 5-17, speak a non-English language at home. The proportion of children age 5 and younger who speak a language other than English at home is likely to be even greater than 14 percent since, for many, kindergarten is their first formal encounter with English.

Ensuring that language minority students are prepared for school will be the most critical for large, urban school districts, where LEP students tend to be concentrated. According to the Council of the Great City Schools (1992), LEP students constituted about 5 percent of the nation's school enrollment in 1990-91, but 13.5 percent of the enrollment in the Great City Schools (i.e., the 47 largest cities in the country; these cities enrolled more than 80 percent of the nation's urban school-age children in 1990-91). In cities such as Boston, El Paso, Fresno, and Oakland, approximately 1 out of every 4 students is LEP. In San Francisco and Long Beach, the proportion approaches 1 out of 3. In Los Angeles, the proportion climbs to nearly 40 percent and by every indication is expected to continue to rise.

Although LEP populations tend to be concentrated in urban areas, they are by no means homogeneous. The number of different languages spoken by students exceeds 40 in 17 of the nation's largest school districts, equals or exceeds 60 in 9, equals or exceeds 80 in 4, and equals or exceeds 100 in Chicago and New York City (Council of the Great City Schools, 1992). Even smaller cities which have not had extensive experience planning instructional programs for large populations of LEP students in the past are witnessing increased diversity in their public school systems: 25 languages are spoken by students in Oklahoma City, 28 in Atlanta, 37 in Nashville, 42 in Minneapolis, and 45 in Portland. Ensuring that language minority children are prepared for school is a challenge that is no longer restricted to only a handful of cities.

CONDITIONS AFFECTING YOUNG CHILDREN'S PROSPECTS FOR SUCCESS

Three objectives subsumed under Goal 1 address conditions affecting children's prospects for success that should be the fundamental right of all children: quality preschool experiences, loving and nurturing activities in the home, and sound health care and nutrition. These three objectives state that:

- All disadvantaged and disabled children will have access to high quality and developmentally appropriate preschool programs that help prepare children for school.
- Every parent in America will be a child's first teacher and devote time each day helping his or her preschool child learn parents will have access to the training and support they need
- Children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low-birthweight babies will be significantly reduced through enhanced prenatal health systems.

Despite the acknowledged importance of preschool education, parent training and support, and a healthy start in life, there is growing evidence that poor, minority, and limited English proficient children are less likely than others to have access to the kinds of early experiences and preparation that will help them be successful in school later on. Recent data show distinct patterns of differential access to both preschool and health care.

Preschool participation. U.S. Census data reveal that the percentage of women in the U.S. work force with children under the age of 6 rose from 46 percent in 1980 to 60 percent in 1990 (Population Reference Bureau, 1992). The steep increase in the percentage of working mothers with preschoolers has swelled demand for quality early care and education programs that provide children with enriching learning experiences.

Boyer (1992), citing evidence from The School Readiness Act of 1991, argues that the benefits of preschool education are both educational and financial. By age 19, individuals who had been enrolled in Head Start programs were more likely to graduate from high school, enroll in higher education, be literate, and be employed than were those without early education. Moreover, they were less likely to be on welfare or to have been arrested.

The benefits of preschool education are not realized by all children, however. Figure 1 shows that in 1991, only about 40 percent of 3- to 5-year-olds from families with incomes of \$30,000 or less were enrolled in preschool, compared to 75 percent of 3- to 5-year-olds from families earning more than \$75,000 (U.S. Department of Education and Westat, Inc., 1991). And while the percentage of 3- to 5-year-olds enrolled in nursery school has increased for Blacks, Hispanics, and Whites over the past twenty years, intergroup differences have widened (see Figure 2). In 1991, White children were twice as likely as Hispanic children to be enrolled in nursery school (U.S. Department of Commerce and Management Planning Research Associates, Inc., 1992).

Since preschool programs are not subject to the same open-enrollment requirements as public schools, evidence suggests that individual programs may selectively deny care to some children. As seen in Figure 3, a 1990 study of U.S. childcare settings found that 86 percent of center-based preschool programs accepted limited English proficient children, while only 31 percent of regulated home-based programs did so (Kisker et al., 1991). Among the preschool centers that did accept LEP children, only 44 percent had bilingual staff. These findings suggest that "access to high quality and developmentally appropriate preschool programs" may be problematic not only for disadvantaged and disabled children, but also for language minority children, even though they are not specifically mentioned in the first objective under Goal 1.

Due to the constraints of the electronic environment, the following figures have been omitted:

FIGURE 1: Preschool Participation. Percentage of 3- to 5-year olds enrolled in preschool 1991.

FIGURE 2: Trends in Nursery School Enrollment. Percentage of 3- to 5-year olds enrolled in nursery school, 1973-1991.

FIGURE 3: Admissions Policies of Preschool Programs. Percentage of programs that accept non English speaking children, 1990.

Health care. Boyer (1992:12) contends that "if there is one right that every child can claim, it is the right to a healthy start." However, statistics on prenatal care, birthweight, health insurance coverage, immunizations, routine health care, and continuity of health care clearly show that not all children have been granted equal access to a healthy start.

In 1989, for example, American Indian/Alaskan Native, Black, and Hispanic mothers were less likely than Asian/Pacific Islander or White mothers to receive initial prenatal care during their first trimester of pregnancy, which is the most critical period of fetal development (see Figure 4). Differences were also apparent among ethnic subgroups (see Figure 4a). Although 83 percent of Cuban mothers received early prenatal care, only 57 percent of Mexican-American mothers received early care (U.S. Department of Health and Human Services, 1992).

Mothers who receive early and continuous prenatal care have a greater chance of giving birth to a baby who is above the standard for low birthweight (i.e., at or above 5.5 pounds). Low birthweight is a condition that may increase a child's risk of developing learning and behavioral problems later in life. In a study of children age 4-17, children who were born low-birthweight were more likely to be enrolled in special education classes, to repeat a grade, or to fail school than children who were born at a normal birthweight (McCormick et al., 1990).

But as shown in Figure 5, low-birthweight is a health risk that is not randomly distributed among groups. Black infants are twice as likely as those from other racial/ethnic groups to be born low-birthweight (U.S. Department of Health and Human Services, 1992). Among Hispanic subgroups, Puerto Rican infants fare worst (see Figure 5a)

Recent research indicates that health insurance coverage is associated both with variations in routine health care and with continuity of health care (Cornelius et al., 1991). Figure 6 shows that in 1988, Hispanic children aged 4 and younger were less likely than children from other racial/ethnic groups to be covered by private health insurance plans or Medicaid during the previous year (U.S. Department of Health and Human Services and Child Trends, Inc., 1991).

Minority children were also less likely than White children to be immunized against measles, rubella, diphtheria, tetanus, pertussis, polio, and mumps in 1985 (U.S. Department of Health and Human Services, 1992). While the percentage of White children age 1-4 who had been vaccinated against these childhood diseases ranged from 59-69 percent, in each case less than half of the minority children had completed their immunization series (see Figure 7).

Although most preschool-age children in 1988 had visited a doctor within the previous 12 months, far fewer had visited a dentist (see Figure 8). Less than half of Black and Hispanic 3- to 5-year-olds had been to a dentist within the previous year, compared to 57 percent of White children (U.S. Department of Health and Human Services and Westat, Inc., 1992).

Public health officials are nearly unanimous in recommending that families with young children need the continuity that a regular source of health care can provide. But in 1988, Black preschoolers were less likely

than Hispanic or White children to have a regular source of care for both routine and sick care (see Figure 9). And Hispanic preschoolers were less likely than Black or White children to have a usual place for care when they were sick or injured, or to have a person available who knew their medical history and who could give their parents advice over the telephone (U.S. Department of Health and Human Services and Westat, Inc., 1992).

It is clear from these data that many children from minority groups are at a great disadvantage when it comes to receiving the types of services and care needed to come to school with "healthy minds and bodies." In addition to being one of the most rapid periods of physical growth and development (second only to the period between conception and birth), the preschool years are also the most critical period of language development. Just as children will fail to thrive physically if their health and nutrition needs are not met, they will fail to thrive linguistically if their language needs are not met.

Due to the constraints of the electronic environment, the following figures have been omitted:

FIGURE 4: Prenatal Care. Percentage of mothers who began prenatal care during the first trimester of pregnancy (by racial categories) 1989.

FIGURE 4a: Prenatal Care. Percentage of mothers who began prenatal care during the first trimester of pregnancy, 1989. Breakdown by ethnic categories.

FIGURE 5: Birthweight. Percentage of live births at low birthweights, 1989 (by racial categories).

FIGURE 5a: Birthweight. Percentage of live births at low birthweights, 1989. Breakdown by ethnic categories.

FIGURE 6: Health Insurance. Percentage of children aged 4 and younger covered by health insurance plans, 1988 (by racial categories).

FIGURE 7: Immunizations. Percentage of children age 1 - 4 who had been vaccinated for various childhood diseases, 1985.

FIGURE 8: Routine Health care. Percentage of school age children who received medical and dental care within the previous 12 months, 1988 (by racial categories).

FIGURE 9: Continuity of Health Care. Percentage of children age 5 and younger who had a regular source of health care, 1988 (by racial categories).

LANGUAGE LEARNING DURING THE PRESCHOOL YEARS

Primary language acquisition is a phenomenally complex process that young children seem to master with great speed and ease, compared to adults learning a second language. By the time they enter kindergarten, most children have developed an average vocabulary of more than three thousand words (Boyer, 1992).

This impressive ability has contributed to the misperception that very young children are better language learners than older children and adults, despite research evidence to the contrary (e.g., Ervin-Tripp, 1974; Snow & Hoefnagel-Hohle, 1977; Snow, 1978; Genesee, 1981). As Wong Fillmore (1992) points out, this erroneous belief has led to educational policies which push English instruction earlier and earlier, down into the preschool years, on the assumption that the younger children are when they are exposed to English, the faster and more completely they will learn it.

In fact, learning a second language is not quite as fast or as effortless for children as it might appear. The rate at which children learn a second language can vary considerably, depending on multiple factors such as age, strength of native language skills, amount of exposure to the second language, attitude, and language aptitude (see Hakuta, 1986).

Even under the best of circumstances, it is unreasonable to expect most children to have fully mastered their first language (let alone a second) by the time they enter kindergarten, because the process of learning the more formal aspects of language continues for years (Chomsky, 1969, 1972). Even though children generally develop conversational fluency in a second language in about two years, it may take as long as five to seven years to develop the more demanding academic language skills needed to function in an all-English classroom (Collier, 1989; Cummins, 1981a; Ramirez et al., 1991a, 1991b).

The danger involved in pushing English too soon, Wong Fillmore (1992) warns, is that in the process of learning English very young children can actually lose the ability to speak and understand their home language, sometimes to the degree that they can no longer communicate with their own parents. Wong Fillmore documents cases of immigrant families in the United States in which the children have become so alienated from their parents and so ashamed of their native language that they do not acknowledge it when their parents use it, even though it is the only language that their parents can speak. By the time the parents realize what is happening, Wong Fillmore claims, it is too late for them to do anything about it.

These depressing accounts are completely at odds with the goal's objective that "every parent in America will be a child's first teacher and devote time each day helping his or her preschool child learn." Without a common language, family structures break down and inter-generational communication of culture--songs, games, riddles, nursery rhymes, poems, stories, values, social norms, religious beliefs, and family history--is lost.

Neglecting to nurture native language skills during the earliest years has academic costs as well as social and emotional ones. Boyer (1992) claims that children who do not develop adequate speech and language skills early on are up to six times more likely to have difficulty learning to read in school than children who do. Since research suggests that strong skills developed in the native language will transfer successfully to a second (e.g., Cummins, 1981b; Lambert & Tucker, 1972; Swain, 1978), it is imperative that adults support children's developing verbal and literacy skills in their home language. This does not mean that language minority children should be kept from learning English, as Wong Fillmore (1992:345) emphasizes:

The problem is timing, not English. The children have to learn English, but they should not be required to do so until their native languages are stable enough to handle the inevitable encounter with English and all it means.

What, then should parents, preschool teachers, and other caregivers do to build children's native language skills to prepare them both for school and for learning English?

HELPING LANGUAGE MINORITY CHILDREN GET READY FOR SCHOOL

In a newly published guide for parents, the U.S. Department of Education recommends that the single most important way for children to develop the knowledge they need to succeed in reading is for [parents] to read aloud to them "Beginning early" (Paulu, 1992:28). This guide lists fifteen things that parents can do to help their children get ready for school (Paulu, 1992:59):

- Listen to them and pay attention to their problems.
- Read with them.
- Tell family stories.
- Limit their television watching.

- Have books and other reading materials in the house.
- Look up words in the dictionary with them.
- Encourage them to use an encyclopedia.
- Share favorite poems and songs with them.
- Take them to the library--and get them their own library cards.
- Take them to museums and historical sites, when possible.
- Discuss the daily news with them.
- Go exploring with them and learn about plants, animals, and geography.
- Find a quiet place for them to study.
- Review their homework.
- Meet with their teachers.

These parent-child activities can be done in the language of the home--nowhere does the guide claim that they must be done in English. However, in many cases it will be necessary to change attitudes as well as delivery of services. Wong Fillmore (1992) urges parents and teachers to work together to reduce the possibility that English will displace children's home languages, by encouraging parents to use the home language to speak to their children rather than trying to use English, as parents are usually told to do.

In addition to the things that parents can do to help prepare their child for school, Nissani (1990) offers a number of suggestions to teachers and other caregivers to help them design appropriate programs for young language minority children. Nissani encourages teachers to use the child's home language, if possible, to promote further development of the home language; to involve parents in all aspects of the program; to create culturally and linguistically relevant learning environments by incorporating materials and activities that are of special relevance to the children; and to respect cultural differences in values, child rearing practices, and socialization goals and find out more about them through contact with parents.

CONCLUSIONS

We began by raising two questions: "What does it mean to start school ready to learn?" and "What does this goal mean for language minority children?" If the nation is truly committed to ensuring that all children start school ready to learn, there are at a minimum, six immediate needs of language minority students that must be addressed:

1. Improve access to health care for poor and minority children and their families, many of whom are limited English proficient. This need is the most urgent of all, and will surely have the most serious consequences if unmet.
2. Ensure that preschool admissions policies do not deny limited English proficient children access to programs that can help prepare them for school.
3. Increase the number of bilingual preschool teachers, and train all preschool teachers to use strategies that will support native language development, incorporate the home culture, and build children's self-esteem. The fact that less than half of the center-based preschool programs that accepted limited English proficient children were found to have bilingual personnel is a glaring inequity in light of the importance of home-school communication and the importance of nurturing native language skills.
4. Ensure language minority parents access to the training and support that they need to be effective parents. This training and support should include encouragement in the use of the home language with their children, native language literacy classes, and access to good native language children's books in libraries and preschools so that they can read and tell stories to their children at home.
5. As the Early Childhood Assessment System is developed, the National Education Goals Panel must continue to seek expertise on language development issues and involve the language minority community. The members of the Technical Planning Subgroup on School Readiness acknowledge that assessing diverse groups of children equitably, in ways that do not label, stigmatize, or classify them, will be one of the greatest challenges that lies ahead, and they underscore the need to involve experts

from the language minority and disability communities.

6. Finally, if educators and policy makers are truly committed to the idea that parents are a child's most important teacher, the language of the home must be respected, not eradicated. There is no more important education goal than nurturing the bonds between parents and their children.

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APPENDIX A

GOAL 1 RESOURCE GROUP ON READINESS FOR SCHOOL

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APPENDIX B

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AUTHOR NOTES

Any opinions, findings, conclusions, or recommendations presented in this paper are those of the authors and do not necessarily reflect the views of members of the National Education Goals Panel.

The authors wish to thank Nicholas Zill and Mary Jo Lawrence from Child Trends, Inc.; Phil Kaufman from Management Planning Research Associates, Inc.; and especially Justin Boesel, Babette Gutman, and Allison Henderson from Westat, Inc. for assistance with data analysis.

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The National Clearinghouse for Bilingual Education (NCBE) is funded by the U.S. Department of Education's Office of Bilingual Education and Minority Languages Affairs (OBEMLA) and is operated under contract No. T292008001 by The George Washington University, School of Education and Human Development. The contents of this publication do not necessarily reflect the views or policies of the Department of Education, nor does the mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. This material is located in the public domain and is freely reproducible. NCBE requests that proper credit be given in the event of reproduction.