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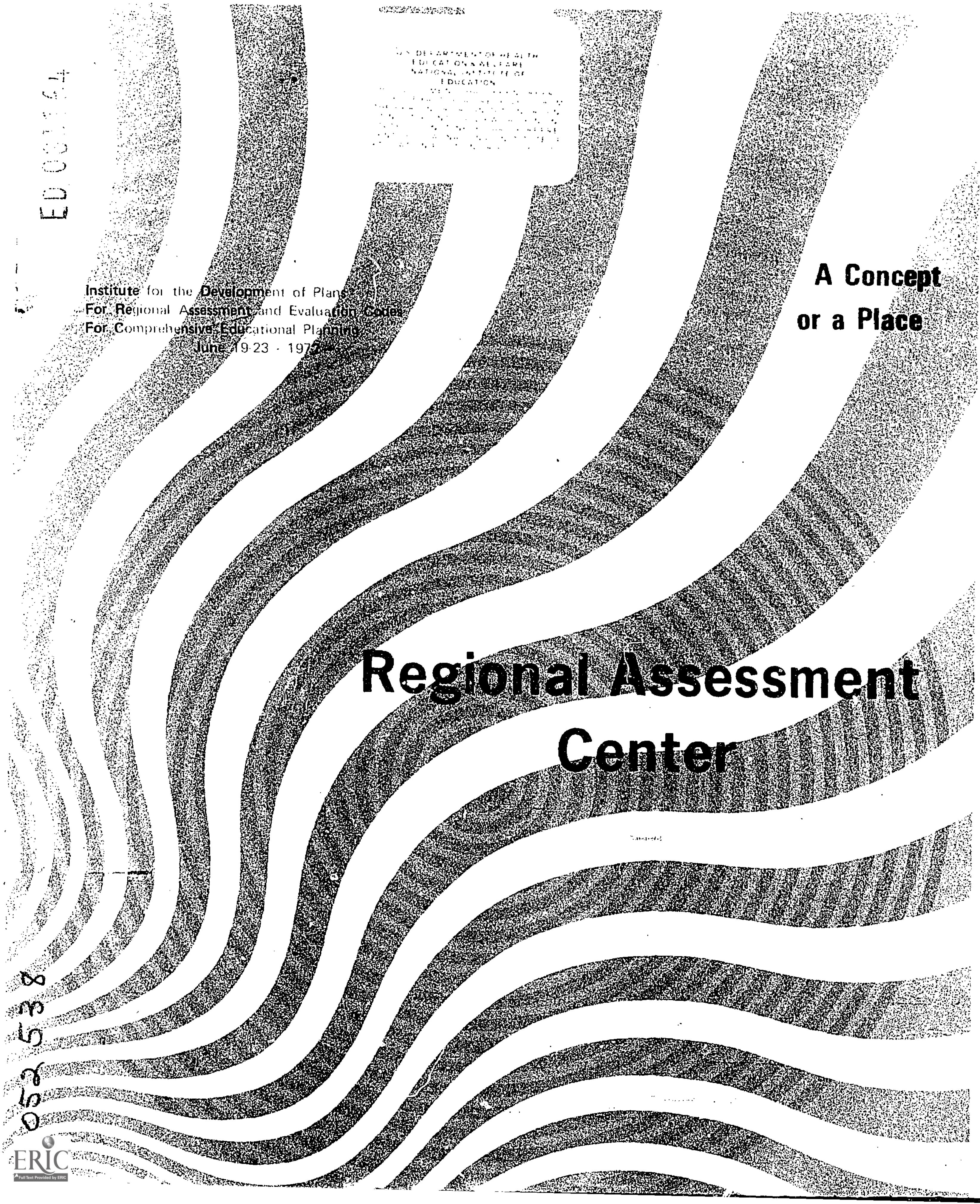
ABSTRACT

Presented are eight articles and five brief position papers given at an institute devoted to planning for early diagnosis and educational evaluation of handicapped children affected by a new Michigan law which mandates educational programs from the time of birth to the age of 25 years for all handicapped persons previously excluded from public schools. Topics considered by the papers are the initiation and development of a diagnostic center, community aspects of planning for the physically handicapped, the role of the ophthalmogist in preschool diagnosis, the role of social work, the role of the neurologist in the diagnosis and treatment of disease, alternatives in meeting the needs of the accoustically handicapped, the role of the occupational therapist in helping the child organize his brain, and the role of the psychiatrist in an application of the medical model which includes the concept of health. The position papers on regional assessment and evaluation centers offer a philosophical orientation to assessment, a breakdown of the population to be served, suggestions for staffing, a listing of critical resources, and recommendations for physical facilities and location. (DB)



Institute for the Development of Plans
For Regional Assessment and Evaluation Codes
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A Concept
or a Place

Regional Assessment
Center

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FOREWORD

With the enactment of P.A. 198 of 1971, the Legislature of the State of Michigan mandated educational programs for all persons. The new law specifically directed that those handicapped persons previously excluded from public schools be provided programs of training and education from the time of birth to the age of 25 years. The purpose of the Institute was to lay general plans for early diagnosis and educational evaluation of the young people affected by mandatory special education. The first four days of the Institute were devoted to hearing presentations from specialists in the disciplines relating to special education as a guide to the development of a series of position papers. On the final day the position papers were produced.

"Somewhere A Defination Exists"

A SPATE OF QUESTIONS

Arthur Benson, Ohio State University

Somewhere a need has been expressed, somewhere a definition exists for a comprehensive assessment and diagnostic center.

What is the need? Who is to be served? What now exists? Will the needs you articulate reflect only a professional interpretation of what people need? Will they reflect the needs of the consumer, of the community?

The diagnostic and assessment center concept is now under considerable criticism. You will have to ask why and be prepared to say what you are going to do that is different.

Will you describe children in the conventional diagnositc and administratively convenient terms? Will you run the increasing risk of placing children so that courts may later decide they have been discriminated against?

Traditionally we operate on a category basis with limited concern for the child. As soon as he is referred elsewhere, he is the responsibility of another agency. If you have a concept of advocacy for the individual child, there must be coordination between agencies.

You must be prepared to deal with the problem of professional territoriality. There is a common body of knowledge about human behavior. If the professional groups are going to insist that only the disciplines, signed, stamped and certified can deliver the services, we are through. We must emphasize the common areas, rather than the unique phases of disciplines. We have trained more people in the past few years than ever before and we are nowhere near delivering the needed services. Therefore, we must recognize that paraprofessionals can carry out many of the activities that have been reserved to the M.D., the nutritionist, the psychiatrist, the occupational and physical therapist. The professionals will have to relinquish their performance as technicians. There are a whole range of skills in these areas that do not require five to ten years to develop. Our certification procedures have limited our degree of freedom in solving our problems.

You have to have a base. Are you going to build a building? It will be related to beliefs you have about the services. Is it a base for specialized observations? Is it a center service training? Will it contain classrooms? The services should be carried out in the settings in which you find children as much as it is possible. You have to think about inservice training; maybe some of that could be done in universities where people can get credit, but families, volunteers and others will need inservice training too. One way to house this kind of training would be to have a building with observation rooms, and demonstration facilities.

Rooms should be flexible and multipurpose. You can build rooms in which people function as clinicians, or you can build them in order to develop a comprehensive program for the child in which he can function with other people. Society's problems are not articulated in terms of disciplines. It is our way of trying to get a handle on the problem, but we cannot look at a problem and handle it functionally if we are going to look at it from a point of view of a discipline. Room design and arrangement will reflect one point of view, or the other.

You will have to think about the kind of diagnosis you propose. Diagnosis frequently means a one-shot, frozen picture of the child at one point in time. Very small samples of behavior are used to pin a label on the child. The diagnostic process should not consist of finding out what the child has acquired, but how does he know what he knows, how does he learn? What are his systems of reward and motivation? You will have to build a framework for moving, changing hypotheses about the child. You will be concerned with maturational processes and motor development processes. You have to have people trained to carry out the prescription and the prescriptions must be capable of modification all the time. A test does not give us enough information to project a future for a child. If you see the center as a static place to which people come and go away, we continue the problem we have right now: not having enough data about how the child learns and not knowing how to change the data we have into directions for those teachers and parents who must work with the child.

In a rural area, where there are vast distances to cover, we have to develop people in the communities who can serve as back up. Even in a city, where psychiatrists are available, a psychiatrist cannot act on a one to one basis with a child for six hours a day, but he can be a consultant for those who do.

Since the Idea is to give education the basic responsibility for children from birth to 25 years of age, you must be prepared to use other resources. You are challenged to a much broader kind of cooperation than has been required before.

The purpose of the educational aspect will have to be to cope. We have to be concerned with much more than the academic aspects. Education becomes the advocate for the child and the family, and must assume the responsibility of seeing that one agency does not refer the child to another only to get rid of the problem. Education has the further responsibility of educating the community to a state of awareness in which parents of others recognize the symptoms of handicaps and intervention can take place at the earliest possible age.

"Unless We Plan"

COMMUNITY ASPECTS OF PLANNING FOR THE PHYSICALLY HANDICAPPED

Margaret Schilling

Children and their families had a life before they were referred to a center and they will have one afterward. Unless we plan for it, the findings and recommendations of the assessment center will have little effect and will bring about little change.

Although the problem will have been present before the center first admits the child, all of us who work with children will be cognizant of the over-whelming need for prevention. So very many handicapped children need not have been handicapped if good preventive techniques had been applied. Why a rubella baby in 1972? Why the massive increase in children who do not thrive because mothers were so poorly nourished in the pre-pregnancy years? Why the increasing number of children born with handicaps whose parents are on hard drugs? We've done an excellent job over the years in decreasing the number of adult accidents in industry, but have you looked at the statistics of paraplegic young people who are the result of accidents while swimming or riding a snowmobile or driving a fast car? Genetic studies have given us a body of knowledge in recent years, but how readily available is this to concerned families? Perhaps if we could reassign our values and stress prevention, we might see a considerable reversal in the statistics of children with physical handicaps.

Another community aspect which precedes the structured evaluation at the center is the provision for early detection. In spite of the multiplicity of services that are available within our most sophisticated urban areas, there are large numbers of children who are not under treatment, who are not diagnosed and are not under any clinical or ongoing medical supervision up until the age of five or six, when the families attempt to get them into public schools. It is better than it was years ago, but there are still massive numbers of children, particularly born to our foreign born or our disadvantaged or to our black families who do not receive adequate post-natal or early-infant care.

Since the millenium of prevention and early detection is not here, let us begin to consider what aspects of community planning are possible, for it is of little value to recommend "group recreation" if there is no possible "group" that would accept a child. Why suggest that the young person be involved in vocational training if transportation will not get him there?

Probably the aspects of community planning which come most readily to our minds are the educational services available to the physically handicapped. Recent legislation has brought about a considerable number of rather dramatic beginning some years ago with Phillips Amendment and increasing numbers of legislative proposals over the ensuing years, culminating finally in the Mandatory Education Act to become effective in September of '73. School systems are beginning to look both at at a wider age range, 0 through 25, as well as a wider range of intellectual and physical abilities. A number of years ago public school for a child under five was rare, and certainly programs for children with IQ's below thirty were equally rare. There are many children who have grown up in our state who have actually never attended public school one day of their lives, not because of inability to learn, but because either transportation or the physical facilities within the school system did not allow that severely involved child to get from classroom to classroom, classroom to play area, or classroom to lavatory. In addition to the mere physical barriers which have stopped many of our children from receiving education, there have been the emotional hang ups---school principals who did not want a child wearing long-leg braces in the regular classroom because of their phobias that this child might fall and therefore injure himself; because of their realistic fears that he might fall on the playground or that he might fall during a fire drill and therefore endanger the lives of other children.

Beyond the schools, the child and his family continue to live a life. School is only a segmented period of time, a certain number of hours a day for a certain number of weeks out of the year. What happens to the child in the hours he is not under the supervision of a school system?

Perhaps my greatest concern is really what happens to the parents of the child with a physical handicap. The private agencies have not been aware of their role in meeting the needs of the parents of the physically handicapped because they thought they did not understand the disease entity. Many agencies have turned off on the parents, feeling that the problem of the physically handicapped was so different from the problems involved in the management of other children. More and more we will find that the program for parents has become an integral part of the treatment for the physically handicapped child. Unless parents know something about the etiology; recognize the need for medical, dental, opthalmology supervision, understand the fact that the child will probably always be as they see him now, and unless they are able to live with this comfortably, we are going to have an increasing number of shattered families. In our agency, for example, we are seeing a decreasing number of separated parents particularly when we can get the child under early care and where both parents are in counseling. Families who seem the most shattered are those who had no knowledge in the early months of the child's disease or developing handicap and where parents lived with anxiety, regret, and guilt until the marriage broke apart.

Recreation seems to be one of the next aspects of community planning which has troubled many of us dealing with physically handicapped children. The average group work agency has not actually accepted its responsibility for providing recreational facilities for handicapped children nor have most of the Departments of Public Parks and Recreation. Only in isolated instances will you find a pool available for swimming for handicapped children or a camp designated for handicapped children. Many of these are run by the public sector, but there are also many of them run by the private sector. It is futile and frustrating to say to a family, "Your child should have a group work experience through Boy Scouts," and send them back to a community where the scout leader has no knowledge of what he is dealing with or how to handle it.

Many of the facilities in our community involve some degree of transportation, and this is the great bugaboo on which most of us are hung up. Public transportation just does not look at the person with a handicap. That first high step up on a bus is something that most of us can't negotiate even in a tight skirt, let alone a youngster on crutches. It is not mandatory that the bus pull into the curb so that the child could climb up from the sidewalk---nor is it mandatory that busses be equipped with a secondary step which could be dropped down merely by pushing a lever at the driver's seat---nor is there any mandatory provision that if the handicapped child or young adult gets on, the bus can wait a moment until he is seated, preferably in a front seat which has been saved for him. All these things would be so simple to mandate, but because we are involved with the public sector we don't seem to have taken the initiative in doing it.

Bills on architectural barriers have passed our legislature, but constant vigilance by the advocates of the handicapped will be necessary if the laws are honored in the observance rather than in the breech.

The delivery of health services to the physically handicappped is another whole area of concern. There still remain physicians, dentists, opthalmologists who do not want the physically handicapped child in their private practice, and whose buildings are situated so that the physically handicapped can not get there. We have many parents who tell us that when they take their child to the dentist as part of their family with all of the other children he will treat all of the others but not the one with a physical handicap. Mostly we are still dependent upon the public clinic, hospital, or health center for ongoing care for the handicapped.

When it comes to long-term planning or vocational planning for these children and young adults, there are great blocks of service which are not delivered to the more severely involved. Vocational rehabilitation has moved rapidly in the last several years and has begun to recognize its responsibility for the disadvantaged, for the children in ghettos, and many of the physical disabilities which were not part of their caseload a number of years ago; but it is still extremely difficult for them to accept a severely involved physically handicapped child.

Industry gives you lip service that it does hire the physically handicapped person, but I am still convinced that to them the physically handicapped person is a guy who wears double earphones, not a person who is ambulating on crutches. The actual impact of the physically handicapped person in industry is almost nil. Except in private factories employing a few people, you will not find a truly physically disabled person employed. The federal government has done more in this field than some of the private sector.

Those of us who deal with the person with a physical handicap and his family in the early years must begin to recognize that within our mores the job is the measure of success. We must help our friends and families to recognize that there may be other satisfactions beside the job. It is difficult for us to see this now, but perhaps as industry moves toward a shorter and shorter work week and as we shorten the life working years of many who are now adults, the handicapped person who never works may not stick out as much like a sore thumb.

Long-term planning really should be a part of the intake process. Whenever we looked at a child and his family regardless of how young the child, what have we thought about in terms of what will happen to him five, ten, fifteen, twenty-five years from now? Have we told his family about the possibilities for their assistance? What do they know about the social security amendments, aid to the disabled, vocational rehabilitation disabilities? How have they provided within their own family structure; in their wills, in the establishment of trusts, in insurance policies, for long-term care?

Some thought must be given to the vacuum within which we exist. We must begin to plan for those services which are beyond the walls of the clinic or school in order that the child may have a fruitful and long-term life and that his parents may exist with him in some degree of happiness and security fulfilling their role as parents, not their role as parents of a handicapped child.

"Age Five Is Too Late"

ROLE OF THE OPHTHALMOLOGIST

Albert D. Reudemann

Many of the problems of the ophthalmologist relate to people who have visual problems.

Visual problems relate to the economic well being of the individual. If you have a visual problem you may or may not be able to perform. If you can't perform in a certain way, then you have to perform in another way, and that gets you into the area of rehabilitation.

In working with children, we are more and more aware that retinal problems are much more prevalent than we used to think. When the cornea, or the lens doesn't work right, you have to maintain the function of the retina, or the visual cells behind. If they are not stimulated adequately, they may not function properly either. When you think in terms of the development of visual function in an infant, you have to think of function being ongoing when the child is six months old.

The ordinary person is a two-eyed beast. You must think not only of the unilateral ocular function, but you must think about the ability of the person with two eyes if he in fact has them. If he has two eyes, he must be able to use the two eyes together, because if he doesn't use two eyes together, he's going to have interference. He's going to be bothered with the other eye.

In a second area of detecting the problem of function, you have the problem of cataracts. Cataracts is a reasonably common disease, especially of children whose mothers had rubella in the first trimester of pregnancy. This has almost been epidemic in this country in the last few years, even though it was described by an Australian doctor inthe 1940's, which shows you that reaction to knowledge doesn't develop very quickly. The problem here becomes one of protecting the retinal function when the vision, the optical instrument has been damaged.

Now the cataract is a clouding of the lens of the eye, which is directly between what you are looking at and what you see with. Yesterday I examined a 20-month old girl who had a cataract in one eye and the other eye was apparently normal. What you get into here is a definition of normalcy. In order to advance that hypothesis a bit, I want you to think in terms of vision. We talk about vision as if we know what we are talking about. As an opthalmologist, I can tell you quite kly we don't know what vision is or what constitutes vision, because our tests for vision are very inadequate. What we do with the eye charts and eye testing devices are the grossest kind of tests there are. You can cheat them by a million methods. They are not adequate tests of function, and that is what we are talking about.

When we come to the examination of visual acuity, I can tell you that we don't understand visual acuity. We don't test for it very well. And when we are talking about infants, it is close vision, not distance vision that matters.

The things that intrigue an infant are not twenty feet away. Everything he is interested in is within arm's length. Babies don't give a damn about what's out there. When you get right down to it, neither do we as adults. If you want to worry about where you want vision to function the best, you worry about functioning right here because that is where everything is. Even if you want to talk about space, which we will someday, what we'll have to see will be right there in the space capsule. You might as well be a near sighted beast that can't see more than five feet.

The evaluation of function in a pre-school youngster is the evaluation of function in a middle aged kid. I think the day will come when we don't talk about the evaluation of pre-school youngsters any more because they are middle aged kids. Where we are going to be looking is at the newborn, the immediately post-newborn, and certainly at the first year. A five year old has developed all the bad habits he will have the rest of his life and if they haven't been coped with, they are not going to be readily copeable.

The age of five is too late. We have to deal with the problem when it occurs, or before it occurs.

To do something about these kids in time to help them, we will have to have better, computerized instrumentation. The ERG is going to be too expensive for a long time for screening of every newborn, but I forsee the day when you can have ERG set up in every ophthalmolic office.

Most important, right now, we have to educate the public to the need for early diagnosis and treatment of visual disorders. I question age zero as being early enough. First trimester counseling may be too late. There are some hereditary visual defects that are serious enough to indicate pre-conception counseling.

"Tremendous Resources Just Beyond The School"

ROLE OF SOCIAL WORK

BETTY WALSH

Whatever the plans we lay for assessment centers, the overriding purpose must be problem identification and problem solving. We can use as major tools group dynamics, and the interdependence of systems, including the family.

In recruiting social workers, you will find some where social work was fifty years ago and some where it will be in the future. The role of the social worker should change according to the needs of the community and with the function of the agency. You can help the social worker work with you on a team. It might mean teaching a course in child development, pushing for policy changes, assessing the community, or placing a problem in context.

If we work as a team, we will have a pool of skills for an assortment of problem. The team need not be clinical. The nature of the problem should dictate the composition of each team. Team members should include community leaders, business people, students and certainly parents.

Most people working for schools are caught up in the mileau of the schools and fail to realize the tremendous resources just beyond the school grounds. Teachers fail to understand whom they are teaching for the same reason. For instance, if the teacher every year rode a bus her students ride to get to school, she might have a better idea of what they go through to get there and and how to greet them.

We have to understand the people we are serving to know how to behave ourselves. In some areas making an appointment ahead of a visit is not appropriate. Some people feel that they must make of their home what it is not.

As professionals, we are entering a new era. The jockeying for status, the territorality must go. We must recognize that there is a difference between credentials and competence if we do the job that must be done. This will mean that you no longer have to stay within the boundaries that kept you safe and it will also conserve energy.

There are some practices we have to avoid. We don't want to identify deviant kids and then slot them to keep them deviant. We want to stop doing things to children and their parents in their behalf without involving them. Sometimes I think there should be someone from the American Civil Liberties Union on every team.

We've done tremendous jobs in helping parents accept institutional placement, but we haven't been much help when the child returns to the family and the community. We forget how important beginnings and endings are. We must become more sensitive to what happens to people as they move through space and time.

"We Look For Treatable Diseases"

ROLE OF NEUROLOGY

Dr. Francis Judge

The neurologist will want to know the prenatal history, family history, birth history and the developmental motor milestones. Even more important than the motor milestones are the higher intellectual functions that precede the development of speech. We pay close attention to congenital physical malformations. If there are more than two of these there is a very good chance that there is some type of abnormality within the central nervous system. The circumference of the head is the single most important parameter in infancy in giving us some prognostication of the child's ability. If the headsize is three standard deviations below normal, there is only one chance in 20 million that he will have normal intellectual development.

Lesions of the skin and eye are significant since they frequently occur in conjunction with disorders in the central nervous system. We are interested in general growth pattern, in hearing and in speech. We test for agnosias---inability to interpret sensory stimuli. We examine the motor system, gross strength, reflexes, coordination. Then we turn to laboratory aids. You are aware of PKU in which treatment must begin on day 1. PKU occurs one in 20,000; there are other, less frequent metabolic diseases, for which we test in early infancy if there is a history of the disease in the family.

Basically we try to look for the treatable diseases or for information on which we could base genetic counseling.

The children most frequently seen by neurologists are those with seizures. Next most frequently we see learning and behavioral disorders. This usually comes at the instigation of school authorities. If it comes earlier, it is usually from the parents because of the child's hyperkynetic behavior and inability to discipline the child. At this stage we call it the harried mother syndrome. You see sitting in the waiting room a mother disarrayed, befrazzled and bedraggled; the child has gone through your waiting room, uprooted your potted plants, ripped up the magazines and walked on everything including the walls and ceiling. But most of the referrals come when the child is subjected to the rigors of our educational system. The child cannot sit still; his attention span is short; he doesn't learn by experience; he reacts poorly to discipline.

We often see children who have reading problems. The school authorities want to know if the child has dyslexia, which is very rare--less than one half of one per cent of all learning problems. About five per cent is what we call minimal cerebral dysfunction syndrome.

We see cerebral palsy, a non-progressive disorder of the central nervous system which has all kinds of etiology. About fifty per cent of these children will have some impairment of their learning ability. Some have seizure disorders as well. The prognosis for cerebral palsy is related to the intellectual ability he child.

We see children for failure to thrive---delayed motor development, retarded speech.

It is extremely difficult for parents to accept many diagnoses of the neurologist. Therefore we spend a lot of time in counseling the parents in setting realistic goals for the child. It is a great mistake to be too specific about prognosis. It is a part of the responsibility of anyone working with these children to help the parents avoid the temptation to shop around. Neurologically handicapped children will nearly always have emotional problems because they do not integrate their environment as a normal child does. They act funny, they don't obey. The mother reacts to this by screaming a little louder, by throwing up her hands, maybe having tension headaches, maybe by yelling at her husband. The whole environment is changed around the child. The anger, the resentment his mother has is not permitted. She is not supposed to hate her child. The father, who is home mostly after the child is tucked in bed, cannot understand why she is behaving as she is. Usually the parents are pursued with guilt for the behavior of this child and this is a gross error. There is no mother who really feels she is a good mother. There is always something wrong. If the kid gets a cold or gets pneumonia, she will think back, "I didn't make him put on his coat last week when he was playing outside. I should have, but I just didn't and it's my fault that he is sick." In a more serious problem, the mother always finds something she did wrong that she considers contributory to the child's condition.

Ideally the referral to the neurologist comes through the pediatrician, who can settle 95 per cent of the problems.

The basic indicators for referral to a neurologist from a school system are two years retardation in reading, seizures and gross abnormalities in psychological testing.

"Be Aware Of Alternatives"

NEEDS OF ACCOUSTICALLY HANDICAPPED

Dr. Angelo Angelocci, Speech and Hearing Center
Eastern Michigan University

Services for deaf children at an assessment center should start before the child is conceived. Hearing loss does tend to run in families, so genetic counseling should be available for persons who have hearing handicaps and for those who have a family history of deafness.

With currently available resources, it is possible to test the response to sound of the fetus during pregnancy.

Post natal testing is so easy and inexpensive it could be conducted with almost every infant born. If simple tests, based on startle reflex or eye blink are not satisfactory, computerized electro encephalogram or electrodermal diagnosis can be used. Unfortunately, it may be a long time before this is done routinely.

The simplicity of informal audiological testing creates one problem that we have to be aware of. New parents with a history of hearing loss in the family do so much of it that the kids quit responding. We have had to send parents home with the recommendation that they bring the child in two weeks later and not do any testing of their own in the mean time.

Public awareness and parent participation have provided more services through a longer life range for the deaf than for any other category of handicapped people. Clinics and infant programs are fairly wide-spread. For parents living in those areas in which clinics do not exist, the John Tracy Clinic provides free materials, with weekly program kits for parents use. There are a number of ideas here which might very well adapted to other handicaps.

Formal education of the deaf begins at three or four years of age. The critical junior high school programs stress social adjustment and pre-vocational training. As the child becomes older he is eligible for Vocational Rehabilitation services as well as those of the many agencies which deal primarily with the deaf and those whose chief function is assisting persons with other handicaps who might also be deaf.

The staff of an assessment center should be aware of the many alternatives for the deaf and of the controversy which surrounds most of them. For instance, the integration of the deaf with hearing persons is not wholeheartedly favored by the deaf themselves. Many are more comfortable with and communicate better with other deaf people. Putting amplification equipment in a crib is an ideal early way to accustom the deaf infant to sound. Others believe this destroys residual hearing and interferes with the development of use of visual clues. It is no longer accepted by all that the person speaking should turn the deaf child toward him; he will become too dependent on visual clues.

The parents should certainly be a party to the decision on whether the child shall be educated to oral or manual communication. The latest term is Total Communication, by which its proponents mean exposure of the child to the full spectrum of language modes---gestures, finger spelling, signing, lip reading, amplification and oral training.

In many cases there has to be a decision on whether the child should be sent to a state or a private residential school.

Among those professionally involved with the care and education of the deaf child, the social worker has the most freedom to find out what is going on in the community and the family. The otologist can give the medical prognosis necessary for educational placement. The psychologist has perhaps the most difficult responsibility, since the tests used for intellectual assessment of the deaf child are based on language. Until recently there was virtually no training in administering tests that were not based on verbal response. Also most of our tests are based on Standard English and are not valid with families in which Black English is used.

The audiologist, who determines the range of hearing and prescribes the hearing aid, and the educator of the deaf are the most indispensible members of the team.

I hope that in planning the assessment centers that we don't think it should be staffed by professional people only. Lay people, such as parents and those who have handicapping conditions, must be involved in helping us come to the best available choices for educational programming.

"A Child Must Organize His Own Brain"

ROLE OF OCCUPATIONAL THERAPY

Barbara Knickerbocker

Whatever our professions, in the assessment center we will be looking at the same child. In the case of children who are termed hyperactive, we are looking at a child who has disorganized behavior.

Let us look at him together. He has disordered input; disorganized motor output--he's a clumsy child who falls over himself; disorganized social and adaptive behavior--he cannot be next to others without poking and fighting and disorganized academic performance.

The basic premise is that there has been some interruption in the normal process by which information is taken into the brain, how it is processed and how it is acted upon. It may be that the interruption has its origin in genetic or environmental factors, or it may be trumatic.

Early motor learning has a profound effect on subsequent academic performance. Sensory deficit, such as tactile, auditory or visual, will inhibit the degree of motor activity and the degree or organization which the child can bring to the learning process.

The organization of motor performance takes place in the early child development years--nursery school and even before.

Perhaps the most important thing you can do here is to establish a common philosophy. You can't pinpoint what you are going to do tomorrow and three months from now. You can agree on your common understandings and on what areas you can move most rapidly, which areas are going to require second echelon intervention, and what third echelon measures that we can take.

The first tenent of my treatment philosophy is that a child must organize his own brain, or central nervous system. He can be helped to do so with experiences that promote sensory system organization, intersensory integration and motor control. By intersensory integration, I mean how the child organizes the tactile information that comes through the skin and the kinesthetic information that comes through his muscles and joints with what he hears, sees and smells.

The second tenent is that sensory motor organization is fundamental to the development of pre-academic and academic skills. By pre-academic, I mean all the early motor skills that have to do with normal childhood activities--climbing on the jungle gym, running, jumping. I really encourage early programming in the gymnasium from kindergarten on.

Third, carefully selected toys and activities normal to childhood can be used in my field of therapy, but they are not limited to my profession. They should be used in school programs. Consider the scooter board. It is a activity that most children enjoy. I have seen a seven year old trying to use one but who was so poorly organized that he couldn't even get on. I treat the child who has not developed organization between the hemispheres of his brain--this is the child who at ten does not hold his paper down with one hand when he writes with the other. After three weeks of play on the scooter board, he will begin to use his hands in conjunction with each other. A little later he can usually cross the midline. We have merely produced the skills he needed all along.

Systematic analyses and proper graguation of tools and methods of therapy are essential to create and to accelerate change in motor behavior.

Maximum external structure and organization are provided by the tools of therapy. My tools are an indoor jungle gym, a scooter board, a carpeted barrel, certain kinds of inflatables. These enable me, as a therapist, to be very non-instructive, and say to a child, "Show me what you can do." I set no goals for him and have no expectations, and this stimulates him to his best performance. After watching hundreds of children, I can place this child on a continuum of motor development.

Through proper analysis and proper graduation of tools and therapy, the therapist will be able to recognize the point at which a child can successfully initiate function.

Change can be expedited by helping the parent understand the child's behavior and directly involving them in the program. A parent is required to be present when I work with a child. I send recommendations for activities for the next two weeks and suggestions of what to watch for in the child's development to the parent the next day. What I do one hour in therapy is not going to change that child, but what I enable the parents to do does make the change.

Finally, the intensity of the problem can be reduced by recognizing what portion of the child's disorganized behavior is inherent and to what extent environmental factors may modify or exacerbate the problem.

"The Medical Model Includes The Concept Of Health"

THE ROLE OF THE PSYCHIATRIST

Dr. Ray Waggoner, M.C.

There are lots of tests; there are lots of skills and techniques that we all learn, but they never substitute for the judgment and experience we all have as clinicians. If we have an intuitive bet about a child, it is very important to follow it up.

The disciplinary background of a psychiatrist is that of a physician and it centers around individual patient care. Most psychiatrists are trained first of all in making the diagnostic assessment and in providing individual treatment for the patient. This may be in a variety of models---in a one-to-one setting, one hour a week to five hours a week. There may be as few as two sessions or sessions may go on regularly tor five years. There may be group treatment or family treatment.

The well trained child psychiatrist has concern with what goes on inside a child, inside the family members and then with the interaction between the individuals.

Consultation

Another area of special skill may be in the area of consultation. One can seek consultation in a variety of forms. It may be focused on the individual child, it may be on a whole school. There may be consultation that centers on issues. Rather than a specific child, there may be a group of children who share a common problem. There could be seminars [illegible] discussions that deal with clinical issues involved, but h[illegible] specific reference to planning or the treatment of an in[illegible] child.

Consultation can also have to do with administrative issues, particularly with policies that affect concepts, goals, issues [illegible] operation of an agency.

[illegible] mention these different psychiatric roles because it is imp[illegible] that persons or agencies who call on a psychiatrist be very careful and very explicit in defining what they want the consultant to do. Problems develop when the consultee and the psychiatrist have not defined what it is the psychiatrist is expected to do.

The psychiatrist can participate in education on a variety of levels, ranging from seminars to classroom teaching in grade schools or high school. In some schools, the psychiatrist is just available to talk with groups of kids on the process of their normal development. In a Chicago project, a psychiatrist has spent time talking to first grade children from a very deprived neighborhood about what they expected of school.

In his role of consultant, a psychiatrist could function as a coordinator of diagnostic procedures.

Teacher

I firmly believe, with rare exeptions, that the responsibility for an individual child should remain with the classroom teacher. It is important that these areas of responsibility be clearly deliniated in the beginning to avoid buck-passing.

Just a word about medical models; they can be terribly misused. As I see it, the medical model includes the concept of health. Regardless of what kind of pathology there is, there is no chance for getting well, or being cured, if there is no health surrounding that pathology.

One of the reasons only a few children should be in a hospital is the tendency, the minute a child walks through the door, to see the child as all ill and to see everything he does as somehow or other related to his illness. I don't think we can call anything pathological unless we have the data to prove it. If we don't have the data, we'd better just call it something we don't understand.

Teams

The team you form should have leaders. They should change according to the nature of the problem, but it is my experience that unless someone is in charge, very little work is done.

If you want to try something new, set up some sort of evaluation procedure so that your new idea can be looked at as objectively as possible. If it happens that there is more than your subjective feeling that the kids are doing better, you should have the data to support a recommendation to others.

We don't provide a continuum of care for kids. What could be more damaging for a child who is going through a period of development, who is having trouble with his development, and for whatever reason there are inconsistencies in his development, than to be exposed to inconsistencies in the programs we are trying to provide for him?

Position Paper I

PHILOSOPHICAL ORIENTATION

Regional Assessment and Evaluation Centers for Comprehensive Educational Planning were conceived to assure the explicit charge in P.A. 198 of 1971 that every handicapped person in Michgan from age 0 to 25 shall have an appropriate, comprehensive and quality education.

The function of these assessment centers will be the following:

1. To educate parents, prospective parents, and the general public in the prevention of handicaps;
2. To accept children at the earliest possible age for the evaluation of suspected handicapping conditions;
3. To offer consultative services to parents and school personnel to facilitate optimal development of these children;
4. To offer ongoing consultative services to handicapped persons through age 25.

Identifying and providing services to this population shall be the function of the centers. This may involve total curriculum planning based on maturational, phsyical, emotional and social factors which could involve a variety of approaches and would include the handicapped child. The setting up of separate special programs for groups of children should be of secondary importance. The focus of education must be to cope with life rather than to adapt to an academic regimen.

Services presently provided by local and intermediate districts are not comprehensive enough to meet the demands of P.A. 198. The Assessment and Comprehensive Planning model will utilize existing personnel and facilities and will provide the elements now lacking. The model will coordinate available resources with acknowledged and newly recognized needs. It shall be a liaison between individuals, agencies, specialists and educators.

Computerized records of each child shall be kept with notations of services rendered. The range of disciplines involved in any individual planning team shall vary with the nature of individual problems. Involvement of non-professionals is required to keep professional groups aware of community needs and desires. A system of continuous re-evaluation of services and programs should be designed.

Reducing the incidence of handicapping conditions requires education and counseling for the general public. Public service announcements in the mass media should inform young parents of normal developmental stages and conclude with the telephone number of the nearest center of intake agency. These announcements should be prepared by a communications specialist in collaboration with child development specialists.

New parents should receive literature from public health nurses on the normal patterns of development and instructing in promoting their child's mental, social and emotional growth. Pamphlets published by HEW, State Department of Education, Kent County, Intermediate District. Oakland Schools and the John Tracy Clinic, among others, should be reviewed for use. Existing courses in Home and Family Living should be offered to young adults in and out of high school.

Committee Chaired by Charlotte Pierce

Counseling should be readily available to the public on genetics and prenatal care. Parents of handicapped children should be presented alternatives to reduce the incidence of death or neglect of unwanted children.

To prevent the individuals from falling into limbo between agencies, central computerizes files should be maintained, based on referrals from members of the medical profession, from public health departments, well baby clinics and all public and private agencies.

Diagnosis should be followed by remediation and prescriptive teaching. When there are not appropriate agencies or classroom programs, training should be given parents and educators to carry out recommendations made by the educational planning team. Pre-school children and severely handicapped may need specially provided resources, personnel or facilities. The curriculum should incorporate a variety of teaching techniques at a full range of developmental levels.

Both parents and educators may need general inservice training in child development and behavioral management. Interpretive teams should go into schools and homes to demonstrate techniques and materials prescribed for individual children.

Counseling for life skills shall include alternatives to job training for those children who cannot become employable, as well as DVR vocational assessment, job training and placement.

Parents should have counseling on all possible agencies, social security benefits, and alternatives available to them and their child.

The success of this program will depend on five factors:

1. The willingness of public and private agencies to become cooperatively involved.
2. The availability of trained, dedicated staff.
3. The willingness of both administrators and staff to be child-centered.
4. The degree to which staff skills complement each other and the willingness of persons in different disciplines to work together.
5. Funds.

Position Paper II

POPULATION TO BE SERVED

Committee Chaired by Barbara Saur

The long range goal of Regional Assessment Centers should be to provide comprehensive service to handicapped individuals from birth to the age of 25, utilizing existing resources where possible and initiating the training and/or the development of facilities requisite to the provision of comprehension services.

Consistent with the major goal is the instruction in high school of young people who will be parents, in the basics of genetics, child development and community resources.

Cooperation with existing agencies must be established to develop interaction, the exchange of information and the development of inservice training programs. These agencies include, but are not limited to child guidance clinics, welfare departments, family services, health departments, medical societies, clinics, local physicians, public and non-public schools, recreational organizations, courts and the business community. Parents shall be involved as individuals and as special interest groups.

Continuous programs of training and education shall be developed for the above mentioned groups.

Community needs shall be frequently and regularly assessed and evaluated with the purpose of incorporating new knowledge and techniques into the services offered.

Programs shall be added, deleted or changed to meet the needs of changing populations. Continuing research and evaluation of the center's programs relative to its target population shall be maintained.

Training, evaluation and information shall be shared among the regional assessment centers with possible regional councils as the vehicle for exchange.

Six short range goals have been set to assure that the centers will not be overwhelmed in their infancy. Achievement of these goals will, in time, lead to the accomplishment of the long range goals.

Initial orientation and training programs shall be held for the center staff and related agency personnel.

A community information and orientation program shall be drafted and carried out to assure proper understanding of the function of assessment centers.

There shall be free and open communication between the centers and all those persons and agencies involved with the population to be served. This is a prime goal and will likely mean a person to be directly responsible for this charge.

Initially, the priority population to be served should be children from birth to school age.

Inservice programs shall be established for the parents and guardians of the children to be served at the same time the services are first offered. In cooperation with local physicians, hospitals and other medical agencies, the centers should provide information and training for expectant parents.

Children not in the priority population should be served when staff time, competencies and facilities become available. School referrals should be handled on a basis of need, rather than first come-first served. Programs for children who are in school should augment the school program, not replace it.

Position Paper III

STAFFING

Committee Chaired by Joan Levenson

As a multidisciplinary agency, the Assessment Center will require the services of a variety of staff members. Emphasis should be placed on the quality of service provided, rather than on occupational title or course work background. In some cases it may be necessary to employ one or more individuals in each category on a full time basis. In other instances, the services could be provided on a contractual, part time basis in order to meet the changing needs of a community and the differences between communities. It is possible that in some cases one individual could serve in more than one capacity.

A work group approach should be utilized. Each work group should be task oriented, flexible and composed of those members of the staff required to reach a diagnosis or develop alternate solutions and plans of action. In addition, relevant members of the community, parents, handicapped persons and others who could contribute to the work of the group should be included.

The Assessment Center should be headed by a coordinator. This person should be primarily an expeditor and facilitator, and should provide a climate for the optimum utilization of the interdisciplinary approach. The staff positions and responsibilities for a complete Assessment Center are as follows:

Coordinators

1. Posess a broad, general knowledge of the disciplines involved and be able to communicate with staff, clients and community.
2. Promote cooperation between community agencies and the Assessment Center.
3. Be responsible for the total operation of the Center.

Nurse

Casefinding and medical liaison between home, school and Assessment Center.

Optometrist

Prescribe low vision aids.

Audiologist

Screen for hearing loss and hearing aids.

Physical Therapist

Occupational Therapist

Speech and Language Therapist

Psychologist

To provide comprehensive psychological services.

Social Worker

To provide comprehsnsive social work services.

Career Counselor

1. Coordinate information about client relative to future vocational plans.
2. Develop educational programs along vocational lines.
3. Act as liaison between client, community employment and rehabilitation resources.

Master Special Education Teachers

Provide ongoing educational assessment and individual educational prescriptions.

Curriculum Resource Constultants

Assist in obtaining curriculum and media materials for the purpose of implementing educational prescriptions.

Parent Counselor

Train and assist parents in their handling of a handicapped child and providing a stimulating environment.

Research and Evaluation Coordinator

Evaluate effectiveness of the Assessment Center.

Public Relations Consultant

Disseminate information and material.

Clerical and maintenance personnel as needed.

The services of the following persons could be acquired as needed: Lawyer, nutritionist, genetic counselor, computer programmer, physiatrist.

Medical Specialists on a consultant basis.

Orthopedist Neurologist Otologist Psychiatrist Dentist	Diagnose at earliest possible time--offer treatment at appropriate ages and refer, where necessary, to other services.

General Practitioner or Pediatrician

To recognize, diagnose, treat and make referral regarding childhood and developmental problems and debilitating diseases.

Position Paper IV

RESOURCES

Committee Chaired by Don Smalligan

Before identifying the critical resources for Assessment Centers, we made four assumptions:

1. The first task of an Assessment Center will be to inventory the resources already present in its area, to establish a liaison with those resources, and to [illegible] with them for their involvement in assessing and filling the needs of the 0 to 25 mentally, physically, emotionally handicapped population.

2. It is also assumed that there will be a basic diagnostic team available in each locality which will have carried out a diagnostic study on which the work of the assessment center can be based.

3. It is assumed that sufficient funding will be provided to intermediate districts to develop resources and to buy diagnostic services as needed.

4. A fourth assumption is that the basic staffing.pattern of an assessment center will be made up of the most frequently used disciplines--professionals who believe in a team approach for assessment, and, who have sufficient diagnostic acumen to recognize critical resources for any given individual.

Training Resources

1. Centers will provide for wide variety of training for staff members. Since the fields of early childhood development and learning disorders are in a state of growth and change, it is imperative that staff members have a varied and flexible training program. Training would include planned workshops for specific areas of concentration, state and national conventions and workshops, inter-regional cross training, local cross training and formal training.

2. Centers will provide for equipment and materials necessary to complete educational and psychological assessment and for educational planning and programming.

Assessment Resources

1. Centers will purchase or otherwise arrange for medical services necessary for diagnosis of physical or mental disorders in any client referred for assessment. Services will include, but not be limited to general medicine, pediatrics, psychiatry, neurology, otology, ophthalmology, orthopedic, dental, physical therapy, speech and hearing, language services, occupational therapy, x-ray, or other laboratory procedures.

2. Centers will utilize the services of other public agencies in assessment and treatment for clients when those agencies can provide better evaluation of the client. Agencies will include, but not be limited to mental health clinics, public health clinics, public welfare, social services, probate court, non-profit organizations, civic organizations, state supported universities, educational training facilities and vocational rehabilitation.

3. Centers will collaborate with educational units for educational planning and programming for students requiring individualized instruction. Units will include regional and local media centers, special teachers, teacher counselors for various areas of disability, school diagnosticians, school social workers, and the referring agencies.

4. Centers will purchase or otherwise arrange with medical and private agencies for educational or psychological assessment of the client. Public Information Resources

Public Information Resources

1. Centers will provide for a resource person who can furnish information and education to community groups. Information and education programs shall be designed to alert parents to the symptoms of handicaps for early identification.

Two publications of the Michigan Department of Education - "Where Vocational Rehabilitation Fits In" and "Special Education-Vocational Rehabilitation" - describe the materials presented. The two publications and other materials on vocational rehabilitation are available on request from the Michigan Department of Education.

Position Paper V

PHYSICAL FACILITIES AND LOCATION

Committee Chaired by Bill Cannon

Regional assessment is primarily on a concept of service, which may or may not be tied into a physical center or centers. Physical facilities should be developed only after the service system is fully conceptualized.

Secondly, we feel that the responsibility for the organization of the regional assessment service lies within the jurisdiction of the state planning regions. Within the regions, the ultimate responsibility rests with the Intermediate School districts.

Types of Physical Facilities

This sub-committee feels that assessment services could be organized in three different ways.

A. Centralized

In this type of organization, all or most of the services will be provided in a single physical plant, much as medical services are provided in a hospital setting. This type of organization is most likely to be found in densely populated metroplitan centers.

B. Centeralized With Satellites

In this type of organization, it appears that the highly specialized services would be available at one or two population centers. However, it might be that these services would have the capability to become mobile to reach outlying areas as needed. Under this concept, the less highly specialized services would likely be available in many of the outlying areas, possibly in satellite locations such as a school building or church.

C. Non-Centralized

In this type of organization, there would not be a physical center as such within the region. The assessment services would be organized and coordinated by a region assessment director who might have an office in a central location within the region, but who might spend much of his time out in the region, especially sparsely populated areas. All records would be maintained in the office of the regional assessment director, who would be ultimately responsible for the delivery of assessment services to those children who are in need of such services.

Finally, this sub-committee feels that assessment services should be on-going and comprehensive. It should not be merely a diagnosis and prescription service, but should also involve program planning and implementation. Assessment should be comprehensive in that it deals not only with the child but with his parents, teachers and peers. Plans should be developed for the continuing evaluation of the programs and/or services recommended and implemented. Should recommendations or programs not be feasible, workable or successful, it will be the responsibility of the regional assessment service to work out solutions to those problems as they arise.

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