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ABSTRACT

Selections from proceedings of a 1982 forum on collaboration between health and education groups serving disabled students and their families include an overview of the state of the art and suggestions for future cooperative ventures. In the keynote address, Senator L. Weicker, Jr., cites damaging effects of cutbacks in federal funds for special education and rehabilitation. Papers by M. Reynolds, H. Hickey, and H. Richardson, Jr., address the current status of education, allied health, and pediatrics. Responding to the state of the art papers are a consumer, E. Ellis, and a parent, J. Wittenmyer. Four papers describe cooperative program initiatives that emphasize sharing responsibilities with and communicating information to other disciplines. Prior to summary comments from the perspectives of education and allied health, forum issues and recommendations are considered in terms of obstacles to coordination and policy recommendations for national, state, and local efforts. (CL)

ALLIANCES IN HEALTH AND EDUCATION FOR DISABLED CHILDREN AND YOUTH: DIRECTIONS FOR THE 80s

A Forum sponsored by the American Society of Allied Health Professions in cooperation with the American Association of Colleges for Teacher Education

March 25-27, 1982
Arlington, Virginia

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Foreword

In March 1982, the American Society of Allied Health Professions (ASAHP), in cooperation with the American Association of Colleges for Teacher Education (AACTE), convened a forum for chief administrators of allied health and teacher education training programs. The focus of the forum was an exploration of the health and educational needs and rights of youngsters with disabilities and their families as they relate to personnel preparation. The allied health and teacher education administrators (including deans, directors, and others responsible for curriculum development) were joined by administrators of medical training programs as well as representatives from state and federal health and education agencies.

For the first time, teams of chief administrators from one institution or community joined with similar teams from other parts of the country to explore:

- *Trends in Health and Education for Meeting the Needs of Youngsters with Disabilities and Their Families;*
- *Strategies for Improving the Quality of Personnel Preparation to Meet New Roles and Responsibilities;*
- *Implications for Developing Cooperative Programs in Health and Education; and*
- *Strategies for Building Alliances and Creating New Organization Patterns for Cooperative Programs.*

The following pages contain selections from the proceedings of that forum including major papers, participant recommendations, cooperative program initiatives, and some of the follow-up activities resulting from the forum.

In publishing this document, the American Society of Allied Health Professions (ASAHP) hopes to further the theme of the forum, *i.e.*, collaboration among the many health and education groups serving youngsters with disabilities and their families. The society is pleased to provide the following material from the forum which offers both a theoretical framework and some very practical approaches for health and education professionals providing services and, in a special way, for those administrators who are in a position to effect curriculum changes.

The materials contained in this document are the result of the expertise and dedication of a number of people, including the Advisory Council, Staff, Faculty, and Resource Consultants of the Allied Health Child-Find and Advocacy Project. The Project's Advisory Council and Steering Committee provided the conceptualization for the Forum's content and design, while the Project Staff identified, obtained, and assembled materials used by the participants in their deliberations, including a 350-page Resource Manual.

With sincere appreciation to each of our contributors, I wish to acknowledge particularly the hours contributed by project staff including Mirdza Kains, Project Specialist, Education Policy Fellow; Cecilia Wolfe, Administrative Assistant; Jennifer Edson, Project Assistant; Jessica Samuels, and Jacqueline Smalls, Graduate Interns from Howard University; Janet Coscarelli, Project Consultant; and Ann Dunleavy, Editorial Consultant.

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BACKGROUND AND LEGISLATIVE FRAMEWORK

The Forum: Alliances in Health and Education for Disabled Children and Youth is part of a three-year grant awarded in 1980 to the American Society of Allied Health Professions by the Office of Special Education and Rehabilitative Services (OSERS). The grant's purpose has been to involve allied health professionals in efforts to meet the education and education-related health needs of children with handicaps. These needs were addressed in two significant pieces of legislation, *i.e.*, Public Law 94-142 (1975) and Section 504 of the Rehabilitation Act of 1973 (as amended in 1977).

ASAHP believes that an understanding of and response to this legislation is vital to the health professional's role. In a recent ASAHP publication, *Alliances in Health and Education: Serving Youngsters with Special Needs*, the implications of the law for health professionals are discussed at length.[1]

Participants at the Forum were provided detailed information on the legislation. Some of the highlights are included here.

Public Law 94-142, the *Education for All Handicapped Children Act*, assures all handicapped children a free appropriate public education which emphasizes special education and related services designed to meet their unique needs. Within the law, the following definitions maintain:[2]

- Handicapped Children: Those youngsters who are mentally retarded, hard of hearing, deaf, orthopedically impaired, other health impaired, speech impaired, visually handicapped, seriously emotionally disturbed, or children with specific learning disabilities *who, by reason thereof, require special education and related services.*
- Special Education: Specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.
- Related Services: Transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children.
- Least Restrictive Environment: Each state must establish procedures to ensure that:

  ... To the *maximum extent appropriate*, handicapped children, including children in public or private institutions or other care facilities, are *educated with children who are not handicapped*, and that special classes, separate schooling or other removal of handicapped children from the regular educational environment occurs *only* when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

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[1] Edited by Carolyn M. Del Polito, Ph.D. and Josephine G. Barresi, M.A., "Alliances in Health and Education: Serving Youngsters with Special Needs" contains six units and an Instructor's Guide. For further information, write ASAHP, Suite 300, One Dupont Circle, Washington, DC 20036.

[2] To obtain a copy of P.L. 94-142, write to your member of the U.S. House of Representatives, or to one of your U.S. Senators. To obtain a copy of the final regulations for P.L. 94-142, get a copy of the *Federal Register* for Tuesday, August 23, 1977 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price $1.50. To obtain a copy of the final regulations for Section 504 of P.L. 93-112, get a copy of the *Federal Register* for Wednesday, May 4, 1977.

Section 504 of the Rehabilitation Act of 1973 assures that: "No otherwise qualified handicapped individual in the United States as defined by Section 7(6) shall, solely by reason of his/her handicap, be excluded from the participation in, be denied the benefit of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Taken together, Public Law 94-142 and Section 504 guarantee the following rights and protections to America's children who are identified as "handicapped" under the law:

- A free appropriate public education for all children and youth requiring special education and related services;
- Comprehensive nondiscriminatory assessment procedures;
- Individualized education programs (IEPs) including parental involvement in planning and decision making;
- Education in the least restrictive environment (LRE), that is, education with nonhandicapped children to the maximum extent appropriate; and
- Procedural safeguards:

Further, the legislation guarantees to parents, guardians, or surrogate parents the right to:

- Examine records;
- Obtain independent evaluations;
- Assign a surrogate parent;
- Receive written prior notice of school actions, in their native language;
  (Note: Regulations require written permission be obtained in addition to notice.)
- Present complaints;
- ~~Receive an~~ impartial due-process hearing with further rights to:
  - Representation by counsel;
  - Present evidence;
  - Cross examine and compel the attendance of witnesses;
  - Obtain a written or electronic record;
  - Receive written findings of facts and decisions;
  - Appeal to the state and;
  - Initiate civil action in court.

The child remains in current educational placement during a hearing unless the parents and school agree otherwise.

The Education for All Handicapped Children Act has existed for seven years; yet still today there are large numbers of American youngsters with handicapping conditions who are not receiving appropriate educational and related health services. While some allied health professionals (*e.g.*, audiologists, occupational and physical therapists and speech-language pathologists) have long been involved in initiatives for children and youth with handicaps, most have not. The American Society of Allied Health Professions (ASAHP) believes professionals who work in health-care settings have special access to the majority of these children, and can positively impact local, state and national efforts in identifying the unserved youngsters in this country and ensuring their referral to appropriate educational settings.

ASAHP's promotion of "alliances in advocacy" has focused on *all* the related-health professions, not merely on those, like speech-language pathologists and physical therapists, whose work regularly involves persons with handicapping conditions. The Society's initiative has involved such others as physician and nurse assistants, dental hygienists, dieticians, and medical records professionals whose health-care setting roles bring them into regular, often very early contact with children with handicaps. ASAHP recognizes all health professionals may not possess the technical expertise to assist youngsters and their families; it also recognizes, however, as professionals in the health-care system, they will be perceived to possess such competence and, therefore, need to be prepared.

Given the hard realities of the economic situation facing administrators in higher education, particularly those who direct professional training programs, and given the increasing difficulties associated with providing cost-effective, quality services for youngsters with disabilities and their families, ASAHP's Forum came at a most appropriate time.

As evidenced in the data which follow, the need for new and refocused leadership in building and implementing collaborative models for cooperation—among professions, among academic programs, and among institutions and agencies—was reinforced throughout the Forum's deliberations, and seen as an essential ingredient for addressing the inadequacies of the service delivery system in meeting the needs and rights of youngsters with handicapping conditions.

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The Honorable Lowell P. Weicker, Jr. of Connecticut provided the following keynote address at the American Society of Allied Health Professions' (ASAHP) first National Forum on "Alliances in Health and Education for Disabled Children and Youth: Directions for the 80s."

Meeting the Needs of Disabled Youngsters: A Shared Responsibility

Senator Lowell P. Weicker, Jr.

Senator Weicker serves on the Labor and Human Resources Committee where he chairs the Subcommittee on the Handicapped. Along with his advocacy initiatives for disabled persons, Senator Weicker is well known for his championing of energy development and conservation, individual rights, ethics in government and a vigilant attention to the Constitution. His political career has been marked by drafting of legislative answers to challenges as diverse as ocean development and urban redevelopment.

As a member of the Senate Appropriations Committee, Senator Weicker is Chairman of the Subcommittee on State, Justice, Commerce and the Judiciary, playing a key role in determining the budgets of those government agencies. He ranks second on the influential Defense Subcommittee, reviewing the nation's military programs, and on subcommittees with responsibility over the budgets of the Departments of Education, Health and Human Services, Housing and Urban Development (HUD) and the District of Columbia.

In addition, he is the Chairman of the Senate Committee on Small Business. A member of the Senate Energy and Natural Resources Committee, Senator Weicker is a long-time proponent of decontrol and mandatory conservation, and is the Chairman of the Subcommittee on Energy Conservation and Supply. In recognition of significant contributions in health and education for disabled persons, ASAHP awarded its 1982 Distinguished Service Award to the Senator following his presentation.

Good evening and thank you very much for inviting me here tonight. Meeting the needs of disabled youngsters is, above all, a shared responsibility. Once we are past that hurdle, the rest follows naturally. For decades, the chief concern handicapped children and their families had was to make society as a whole recognize its responsibility to share the burden of their disabilities.

Meeting these needs was, until very recently, a lonely proposition. Disabled children were committed to institutions or, in some cases, left to fend for themselves. Or else the burden fell entirely upon the individual's family.

In Sunday's Washington Post, columnist George Will told the story of 75-year-old Mary Denny and her son John, who for the last 14 years has received nothing in the way of community services even though he frequently suffers as many as six seizures a day. Will rightly described John Denny as "part of the unfinished agenda of American Justice." Of Mary Denny, he wrote: "She is a marvel of courage who has been more self-reliant, longer, than any citizen should have to be." This from a columnist who considers himself conservative.

The fact is that this country is full of John and Mary Dennys. And there would be many more of them, if not for Public Law 94-142. In hearings leading up to that legislation, witness after witness detailed how local and state school policies relegated handicapped kids to the sidelines of life. More than one million were found to be shut out completely and less than 50 per cent were receiving what could be called a quality education. Standards varied widely from state to state.

Passage of the Education for All Handicapped Children Act promised handicapped kids a chance to move into the mainstream by way of a free, appropriate public education in a normal setting, with an individualized education plan. Last year, the General Accounting Office concluded that many school boards had not made good on that promise—and that it would take several more years for them to do so.

Instead of blowing the bugle to rally us all to redouble our efforts on this front, the Reagan Administration chose to sound the retreat. First, it tried to repeal Public Law 94-142 and consolidate special education funding into a block grant. When Congress, aided and abetted by handicapped advocates, balked at that, the Administration then threw its weight behind its proposal to cut the handicapped budget by 25 per cent. But, again, the coalition on behalf of the disabled held fast. And instead of a 25 per cent cut in the special ed budget, we ended up with a $70 million increase. That's nothing to crow about, to be sure, but it was a case of making the best of a bad situation.

The story was much the same for the rehabilitation and developmental disabilities programs: proposed consolidations were defeated and categorical funding maintained.

This is no time, however, to rest on our laurels. The Administration, which promised to come back "again and again" to achieve the budget cuts and policy shifts it wants, is proving true to its word. This year, it is recommending a rescission of 31 per cent in 94-142's state grant funds for the 82-83 school year. Ten special purpose programs would be consolidated into a single fund—among these the deaf-blind centers, programs for the severely handicapped, early childhood education and special ed personnel development. I would just note here your own release of earlier this week which underscored the manpower shortage in special education and rehabilitation. Cutting back on funds to develop personnel in these fields is no way to meet the needs of the handicapped.

Yet, it is proposed that in the rehab services budget, funding for training, service projects and independent living centers be consolidated into a so-called Special Purpose fund beginning in FY 83. And within the developmental disabilities program, funding for university affiliated facilities and special projects is to be transferred to an account entitled Social Services Discretionary Activities, along with child welfare research and child abuse projects. In all cases, smaller budgets are projected for the consolidated programs than they received categorically.

Now, the Administration claims, as it did last year, that these consolidations will lighten the administrative load and save enough money to keep services at current levels. Well, you know better than I that that is a bill of goods if ever there was one.

The National Association of State Directors of Special Education recently surveyed 24 states to assess the impact of proposed rescissions for special ed and Title I funding for institutionalized handicapped children in Fiscal year 82 and the proposed funding level for special ed in Fiscal 83. Their findings dramatically illustrate the disastrous cutbacks the Administration's budget would trigger.

The Association estimates that in New Jersey, for instance, about 4,000 handicapped students would receive fewer or no services and 453 teaching positions in kindergarten through 12th grade would be lost. The proposed cuts in federal funds would also wipe out the state's ability to assist local educational agencies by supporting residential costs, individualized transportation, extended school year programs, in-service training for regular classroom teachers, pre-school education, career and vocational training.

In Illinois, the cuts would mean the firing of 839 professionals and aides in the special ed program. Approximately 12,500 children aged 3 through 21 would not be served, and 29,000 others would have their level of services cut. In the Public Law 89-313 program for institutionalized disabled children, 86 professionals would lose their jobs, affecting 17,254 students.

Total staff cuts in Illinois of more than 1100 would primarily diminish services to the mildly retarded, the hearing disabled and speech handicapped, reducing services to 88,000 and possibly eliminating services to 26,000. So, we are not talking about a few children here and there. We are talking about thousands whose education will suffer, and with it, their hopes for the future. This year, as last, the budget debate is riddled with irony and paradox. On the one hand, the Administration preaches self-reliance and individual achievement, while on the other, it seeks to cut federal programs which promote independence and accomplishment on the part of the handicapped.

Then there is the irony of having Mrs. Reagan schedule a photo session with Easter Seal poster child, Mary Sacco, while the President is cutting the very programs that have helped Mary thus far. As Dr. Emil Rosenberg, head of the program for special needs in Mary's hometown of Milton, MA., points out: "All the things that have enabled Mary to grow physically and not to face life in a wheelchair were funded by federal monies. Future Marys are really at risk."

Easter Seals itself, as the Boston Globe's Ellen Goodman notes, receives anywhere from a fourth to a third of its funds from the government. Says Easter Seals director John Garrison: "I don't think it's within the capacity of the non-profit sector to pick up all the services."

Then there is the greatest irony of all: our bloated defense budget. Some of the best work on the paradoxes it presents has been done by the Children's Defense Fund. They have found that If the Department of Defense ceased sending routine, non-priority messages by teletype, it could save, according to GAO, $20 million each year. This much money could go a long way toward restoring programs for handicapped children.

If the Defense Department did away with the personal servants it provides to 300 senior officers at the Pentagon, the funds could be used to rehire 160 homemaking aides in Virginia who helped elderly, blind and otherwise disabled persons and families with handicapped children before they were laid off by budget cuts last year.

And if the Pentagon no longer furnished shots and other veterinary services for pets of military personnel, $1.4 million would be freed up to immunize 35,000 poor children who were dropped from the childhood immunization program last year.

Now I happen to believe that Congress is not going to go along with this Administration's attack on the handicapped budget any more than it did last year. In February, 59 Senators co-signed a letter I sent to the President urging full funding for 94-142 and opposing any change that would weaken the law. We reminded the President that at a recent press conference he had presented the dramatic example of a chronically ill child in Iowa who could be treated at home for $1,000 a month, instead of in a hospital for $6,000 per month in Medicaid. And we pointed out that many disabled Americans are in a similar situation.

We also reminded him that as a Presidential candidate in 1980 he called Public law 94-142 perhaps the greatest stride made to date toward a workable plan for the education of handicapped children.

In addition to the fifty-nine members of the Senate, a majority of the members of the Labor and Human Resources Committee has gone on record in support of full funding for special ed—and that's no mean feat this early in the game.

So I think we have reason to hope. However, 94-142 is seriously threatened by the proposed revision of its regulations, which is now in draft form. Not long ago I obtained a copy of a memo from Assistant Secretary for Special Education and Rehabilitation Services Jean Tufts to Secretary Bell. This memo, which outlines the proposed changes, is nothing less than a how-to pamphlet for sowing dissent in the ranks of the handicapped community. But it is being passed off as regulatory reform. The changes it proposes would cut off parental involvement, cut back on services, de-emphasize integration and do away with procedural safeguards. And it would do these things in a manner that would curry favor with some state and local officials at the expense of handicapped kids and their advocates.

One proposed change would eliminate the requirement that parents be given a copy of their child's individualized education program (IEP). Now, as you know, the IEP is in many respects the fulcrum of 94-142. It evaluates the child's level of educational performance, sets goals and outlines specific services to help the child reach those goals. It also establishes the extent to which the child can participate in regular classes and how long he or she will need special education. Parental participation has been a key factor in the IEP's effectiveness. Parents are by law equal partners in decisions affecting their children. To take parents out of the equation would be to strike at the heart of the program.

Elsewhere in the memo, other changes such as doing away with data collection and reporting requirements are described as non-controversial to professional groups like the Council of Chief State School Officers and the National Association of State Directors of Special Education but controversial to advocacy groups like the Children's Defense Fund. So the strategy of this Administration, when all else fails, is to divide and conquer. Nibble away at the law until there is nothing left.

We must not let that happen. Refuse to be taken in by repeal disguised as regulatory reform. Join forces with state and local officials and parent organizations to insure that this nation goes on meeting the needs of its handicapped children. The children are what is important. The programs deserve our vigilance because they give those children a chance. Let's not get things turned around. As your agenda reminds us, our focus must be the handicapped youngster and what will happen to him or her in this decade and the ones ahead. And that, my friends, is what makes our cause so strong. For as the Children's Defense Fund has noted: "We have so much more to fight for and with than Mr. Stockman. All he has is numbers that don't add up. We have the lives of millions of children who need our help if they are to grow up healthy, educated, uncrippled and with a family."

They need us, we need them and this nation needs them. Let's all do our best on their behalf.

Thank you.

STATE OF THE ART PAPERS

The following three papers present the state of the art in meeting the needs of youngsters with disabilities from the perspectives of education, health, and pediatric medicine. They were delivered to forum participants as a stimulus for further discussion.

Meeting the Needs of Children and Youth with Disabilities: The State of the Art in Education

Maynard C. Reynolds, Ph.D.

Maynard C. Reynolds is Professor, Department of Psychoeducational Studies, University of Minnesota, and Director of the National Support Systems Project (NSSP) for Dean's Grant Projects (DGPs). DGPs are grants given to Deans of Education to support efforts or development of improved preservice teacher preparation with emphasis on education for handicapped children. In 1981-82 there are 127 DGPs; over the past seven years there have been about 225 such projects in all parts of the nation. The National Support Systems Project provides technical assistance in various forms directly to projects, organizes regional and national conferences, develops publications in support of DGPs and, in various other ways, attempts to serve the needs of Dean's Grant Projects. Reynolds also serves as co-principal investigator for a special project to develop materials and systems for nation-wide inservice education of school psychologists. Both NSSP and the school psychology project are supported by the Division of Personnel Preparation, Special Education Programs, U.S. Department of Education.

The New Policies and Their Impact

It happened just 11 years ago. A small group of parents sued the chief school officer in the State of Pennsylvania for failure to admit their retarded children to the schools. They based their case on the equal protection clause of the Fourteenth Amendment to the U.S. Constitution. Settlement was reached when the State Secretary of Education entered into a consent agreement with the parents rather than to fight the case, and the court gave its approval. A number of particulars were included in that agreement: Henceforth public schools would (a) admit literally all retarded school-aged children and youth; (b) actively seek out or identify such children and assure their attendance; (c) provide programs that were "appropriate" or adapted to the unique needs of each retarded student; (d) work with parents to formulate educational plans and follow "due process" principles, including the right of parents to appeal to a higher authority and the courts, if necessary, any educational decision with which they disagreed; and (e) provide, when feasible, the appropriate programs for retarded students in regular classrooms in preference to placement in special classes, special schools, or residential institutions. This ordering of administrative arrangements, giving preference to regular classroom and regular school placement—embodies the concept of the "least restrictive environment" or, as it is popularly known, mainstreaming. The Pennsylvania suit, which became a judicial landmark, is known as *PARC* (Pennsylvania Association for Retarded Children) *v.* Commonwealth of Pennsylvania.

Shortly after the consent agreement was announced in Pennsylvania, the attorney for the San Diego (California) School District, who was well outside the official jurisdiction of the Pennsylvania district federal court which had accepted the agreement, reported that the case was "persuasive," and that the new principles included in the agreement were only "slightly off shore" for all school districts in the nation. He was correct. In 1972, the case of Mills. *vs.* Board of Education in Washington, DC, accepted and extended the PARC agreement to all handicapped children; and, in 1975, the Congress passed and President Ford signed Public Law 94-142, The Education for All Handicapped Children Act, which encompassed all the concepts and principles outlined in the PARC and Mills cases. Regulations for Public Law 94-142 were issued in 1977 and became effective as of October 1977.

Thus the judicial and legislative actions of the first half of the 1970s established the constitutional right to free, public, appropriate education for all handicapped children. Previously, state laws had made school attendance mandatory for children but the schools had no mandate to accept and teach all children. In fact, the schools had considerable discretion in what children they would accept, what kinds of educational programs they would provide, what children they would suspend or expel for whatever reasons, and what information they would pass on to parents. P. R. Dimond, in *The Hastings Law Journal* in 1973, characterized the change in public educational policy as "the quiet revolution."

Some dramatic changes have occurred in the operation of schools as the result of the new policy:

1. Many seriously handicapped children have been deinstitutionalized. In many states, enrollments in special schools, hospitals, and institutions for retarded, deaf, blind, and emotionally disturbed children have been halved or more. The education of these highly needful children is now the responsibility of local schools. A surprisingly large percentage of this formerly institutionalized population is able to live at home or in small-group homes and to attend neighborhood schools. The local school officials are responsible for making special arrangements for children who cannot benefit from local school attendance. The arrangements, however, must be made on an individual basis and reviewed regularly. The focus is on the needs of the individual rather than the convenience of the institution.

2. Many mildly and moderately handicapped students have been moved out of special day classes and

schools and returned to regular classrooms. In the past, few classroom teachers were prepared to work with such children. Hence states began retraining programs for teachers in service. However, teacher-education departments and colleges are under tremendous pressure to revise their programs to prepare their graduates to undertake new roles. The necessary training and retraining of teachers is accomplished only in part at this time.

3. The direct service activities of special education teachers are giving way to indirect services, for example, consulting with and supporting classroom teachers. Most special teachers are unprepared for these roles.

4. School psychologists, school social workers, speech-language pathologists, audiologists, physical therapists, occupational therapists and other specialists have been redeployed to serve exceptional students in decentralized settings. Many such specialized workers, in the past, were isolated from classrooms. (New conceptualizations of their functions are essential.)

5. Virtually all forms of school demissions (excuses, exclusions, suspensions, and expulsions) have been eliminated except when due process is observed fully and alternative methods of satisfying the right to education principle are adopted.

6. Parents of handicapped pupils must be formally involved in assessment, placement, and planning activities. Due process must be observed in all educational decisions. Special safeguards for the rights of parents are detailed in Public law 94-142. Nicholas Hobbs (1978) noted that for school personnel to start working with parents may be somewhat like rediscovering Niagara Falls.

7. Regular classroom teachers are required to participate in the planning and writing of explicit Individualized Educational Plans (IEPs) for handicapped students. Teachers have not been prepared for this task until recently, and even now the IEP requirement presents many difficulties. More than 4 million IEPs are now being written each year by the schools of the nation.

8. Most important, educational goals and programs for exceptional students must be determined on the basis of specific individual learning needs rather than gross categories of exceptionality.

It is truly notable that the schools of the nation have been given the responsibility to locate every handicapped child, arrange a multidisciplinary diagnostic study of each such child, work with parents in educational planning for the child, and furnish the least restrictive setting for that education. In many parts of the world most responsibility for persons with disabilities are carried by health or, perhaps, broad, family oriented agencies, It is interesting to speculate on why the primary responsibility here was assigned to the schools. Obviously, full understanding of a child with problems and the child's family depends upon the participation of health professionals as well as educators, social service personnel, and other specialists, but achieving the necessary coordination of services is still a problem.

It should be noted that Public Law 94-142 was based on the belief that the percentage of children with handicapping conditions in our nation runs about 10-12% of the total child population. The federal government pays to each state a bit over $200 for each identified handicapped child but not exceeding 12% of the state's total population of children. In fact, the percentage reported by states is nearer 10% than 12% at this time. Only about 3-4% of children can be judged to have distinct and chronic handicaps; thus the remainder - up to 12% at any one time - is made up mainly of children who display relatively mild and moderate - and often transient - handicaps, such as learning, speech, or behavior problems, or mild mental retardation. During the period from kindergarten through sixth grade, as many as 40% of children may manifest such problems at any one time or another and be of significant concern to their parents or teachers, but if they are given the right kind of help at the right time, most of the problems vanish. Note, therefore, that when one includes more than the chronic handicaps, the incidence rates for handicapping conditions go up markedly and vary greatly with the time intervals used for counting incidence: 12% on one day expands to 40% of the population over seven years.

The Changing Administrative Structures of Special Education

The administrative arrangements for special education in most schools of the nation well into the 1960s and, for many school systems, even into the 1970s, can be described in terms of a "two-box" structure. In this view, there were two kinds of classrooms (regular and special), two general classes of children (regular class children and special education children), and two sets of teachers (regular teachers and special education teachers). In effect, two separate school systems were operated, each with its own supervisory staff and funding system.

Under the "two-box" arrangement, if a child was obviously disabled in some significant way or showed difficulty in a regular classroom, he or she was referred by the teacher to a psychologist or other specialist for study. Should the child meet the standards for some category of handicap, he or she would be placed in a special class or special school. Most children who were "referred" eventually were taken away from normal environments and sent to special places. It was not unusual for a large elementary school operating under the "two-box" theory to have perhaps 24 regular "boxes" or classrooms and 3 or 4 special "boxes" that served retarded children, learning-disabled children, and perhaps others. In addition, there likely would be in the school system such itinerant workers as speech and hearing therapists, school psychologists, social workers, teachers of braille, and other specialists. They supplied part-time services. The average school system operated about seven or eight different kinds of special education boxes and employed an equal number of different kinds of special teachers.

The Original Continuum Model

A somewhat more complex administrative model for the organization of special education programs began to emerge in the 1960s. It is sometimes described as a cascade or continuum of administrative arrangements as opposed to two kinds of "boxes." However, this model was still oriented mainly to the *places* or *administrative structures* of special education. Some of its distinct features are shown in Fig. 1:

1. It proposed supports to regular classrooms as one means of meeting the special needs of handicapped children who are maintained there.

Fig. 1. The Special Education Cascade

Full-Time
Residential
School

Full-Time
Special Day School

Full-time Special Class

Regular Classroom plus Part-
time Special Class

The Regular Classroom plus
Resource Room help

The Regular Classroom with
Assistance by Itinerant Specialists

The Regular Classroom with Consultative
Assistance

The Regular Classroom

Move students this direction only as far as necessary

Return students as soon as feasible

Limited Educational Environments
Outside of the School

Special Treatment &
Detention Centers

Hospitals

"Home-bound" Instructors

2. It proposed that children *not* be classified and given special placements on a permanent basis but, rather, that they be moved to special stations only for as long as necessary, and that they be returned to regular classrooms as soon as feasible. No indelible labels need be involved thereby. The total number of children served over time in special settings greatly exceeds the number served at any given time.

3. It proposed that the boundary lines between special education and regular education be renegotiated and opened, so that students could pass back and forth easily, as dictated by their educational needs.

4. It proposed that regular and special education staff members become more interactive or collaborative in their daily work; for example, sharing responsibilities for students, rather than to remain isolated in their separate centers and classrooms.

5. It proposed that careful justification be required whenever a child was removed from the regular school environment, and especially when the removal took the child from both home and school environments for placement in a residential center.

A visitor to the schools today is likely to encounter something like this broad continuum or cascade of instructional arrangements, but it is not only children who are being moved about within the cascade arrangement; specialized personnel move also. (See Fig. 2.) As shown in Figure 2, staff members are coming down to the regular classroom base of the cascade to provide their services. There is a growing recognition that not all specialized instruction need go in special places and, in fact, that it is likely to be disadvantageous to confine children in special places or limited environments for long periods of time.

Fig. 2. The changing cascade: Fewer specialized places, more diverse "regular" places.

Removal of architectural variables

Braille and mobility instruction
for the blind

Classroom social structure becomes more "cooperative"

Recurring specialized diagnostic appraisal

Total communication for the deaf

Individualized contingency management systems

Effective management of acoustic environment

Individualized instructional management systems

Broad team approaches to planning

Regular classrooms, shops and laboratories with supportive services

Resource rooms

Special classes and schools

Move specialized instructional systems and staff toward the mainstream as rapidly as feasible

Under these new arrangements, regular classroom teachers increasingly find themselves joined with resource teachers, speech clinicians, school nurses, and other specialists in serving handicapped students. The classroom teachers cannot just refer such students to others, and thus, transfer responsibility for them. When a child is identified as handicapped or in need of special help, efforts must be made first to meet the child's needs in the regular classroom and school. Thus, consultation is required to work out how an accommodation to the child's needs might be made in the mainstream setting. Only if that approach proves to be totally unpromising may the child be displaced to a special setting, and then only on prescription - the IEP - and only for a limited period of time.

Emerging Problems

So far, I have been structuring the background for our consideration of a number of problems and issues that challenge both educators and health professionals. I shall discuss briefly only a few problems and then I shall describe briefly some important role changes that are indicated for the personnel who serve handicapped children.

1. *Communication*. Over the past two years I have had the opportunity to conduct, with Dr. Richard Nelson, a pediatrician at the Minnesota State Department of Health and head of the program for handicapped children, several short conferences for primary care physicians on the subject of health-school collaboration. We used the following case study as the springboard:

Erick, age 5, is observed by his kindergarten teacher to be immature in language and social abilities, somewhat awkward physically, and quite often distracted or inattentive when other children are "on task." The observations were made in November of the school year. One parent-teacher conference had been held in September. At that time, Erick's parents had not indicated any special concern, but the teacher had expressed the intention to observe Erick closely. Now another parent conference is in the offing, and Erick's progress calls for a report of "unsatisfactory." The teacher has told the school principal of a growing belief that Erick may have a significant problem. He may be in need of special education and related services. (Reynolds & Birch, 1982, p. 61)

Short as this case study is, it holds a number of questions that require communications between educators and health professionals.

1. What sequence of steps should be taken to pursue this situation and by whom? Should a special educator or school psychologist be consulted?
2. Does the school have a legal responsibility to identify Erick as a handicapped child, if indeed he is, and to write an IEP for him?
3. Assuming that Erick has not had a recent medical check-up, how should a thorough examination be secured for him? Who should pay for it? Should the physician be told of the teacher's concerns?
4. Who should be responsible for integrating all the information gathered on Erick and for consulting/planning with his parents?
5. How should the procedures differ if Erick is bilingual or a minority group child? (Reynolds & Birch, 1982, p. 61)

2. *Related Services*. Under Public Law 94-142 the schools are responsible for special education and *related services*. What are related services? The law lists "transportation. . .developmental, corrective and other support services." The language "other support services" holds much difficulty for school systems. There is no question that the phrase covers the services of audiologists and psychologists, but what about specialists who provide recreation, psychotherapy, parent counseling and medical services? In one midwestern community "equestrian therapy" (horseback riding lessons) became an issue. The provision of physical therapy, occupational therapy, and corrective physical education programs has increased rapidly in some places, not just in special schools but in mainstream settings, under the aegis of "related services." These services are initiated sometimes on the basis of diagnoses that are made without the participation of physicians. Sometimes perfunctory approvals may be given to such programs by physicians who may not have much background for this kind of program. Should the schools be the setting for a movement by some allied health professions to forge new degrees of independence in practice?

Judicial interpretations of the *related services* concept have tended to broaden rather than limit its application. Some observers feel that this broadening is not due entirely to Public Law 94-142, but also the expanded concept of the purposes of education that is associated with the enrollment of literally all children, including those with severe and profound handicaps. Obviously, such developments involve the schools in teaching children to walk, feed themselves, attend to their toileting needs, and other such basic behaviors in addition to teaching reading, writing, and arithmetic.

It was not too long ago that one of the de facto tests used to determine which handicapped children were eligible for admission to public schools was whether a child was toilet trained. When children were admitted to schools, it often was on condition that the parents provide the help the children needed to use the toilets. Should we interpret the term "other support services" to include such specific interventions as changing a child's soiled clothes? taking another child to the toilet? catheterizing a child with kidney problems? making sure a child's hearing aid is functioning properly?

Obviously, the area of "related services" is a potential source of problems for school curriculums and budgets. It raises many questions about the relations of health and educational responsibilities and even of relations within the family of health professions; it is sure to receive continuing attention.

3. *Money*. Our schools do not have sufficient funding to cover all the services now required of them and the situation is getting tougher every week. In addition, the funds for children with special needs tend to flow in many narrow streams, each with its own procedural requirements, time lines, and bureaucracy, so the structure of funding systems is also a problem. As mainstream teachers have assumed the responsibility for more children with special needs, a kind of backlash against the whole array of procedural requirements associated with funding is in the making.

It is unfortunate that Public Law 94-142 became effective at the time that the national economy had taken a downturn. Suddenly the schools were required to enroll thousands of children who, heretofore, had not been in the education system. There were but little increases in corresponding funding. In effect, the responsibility for the treatment of many handicapped children was transferred without the compensatory transfer of funds.

A particularly worrisome aspect of the current reduction of education budgets is that the agencies that should be cooperating to serve handicapped children and their families actually may be drawing apart. In one mid-size city funds and services amounting to a value of $500,000 per year were withdrawn recently by several health and United Fund agencies from a large public school operation for handicapped students. The argument was that because the schools face the legal imperatives, let them provide the money. That's a hard-nosed decision but a kind we may see more frequently when all agencies experience a decline in resources and ever-expanding demands for services. Unfortunately, that eventuality takes us exactly in the wrong direction. We should be creating more means of coordination across health, education and social service lines to assist handicapped persons and their families.

Interprofessional Communication. One of the most interesting and challenging problems we face today centers on interprofessional communication. It is often assumed that studies and plans for handicapped children are more valid if they are undertaken by several professions rather than one alone. Yet we often do strange things in these cooperative engagements. Certainly it is not uncommon these days for as many as four to eight different professional specialties to be represented in a school conference with parents to make plans for one child's educational program. In such situations, good communication is a rarity because, perhaps, we have not learned to work together.

In staff conferences I believe it is important to be clear about the nature of the decisions that must be made and then to discipline ourselves to seek only the information that is relevant to those decisions.

Teachers, for example, tend to function within the framework of a curriculum for teaching basic skills in language, arithmetic, social behavior, life maintenance, and career development, including, especially, the ability to make economically valued contributions to pupils' life situations. These are the cultural imperatives for schools, the areas in which children must learn basic skills in order to survive and to negotiate for a place for themselves in our complex culture. As progress is made in the imperatives, teachers move attention to electives in particular subject fields—the arts, recreation, and vocational skills. When teachers need help it usually is in making instructional decisions and in creating manageable and productive social situations for the groups of students in the classrooms. Teachers hope that health professionals will work with pupils and their parents to help develop healthy, energetic learners for the classrooms.

There is some tendency, when teachers discuss classroom difficulties with other professionals, for the teachers to be drawn to topics which are of first concern to them as teachers. For example, when a teacher discusses a learning problem with a psychologist, the latter may draw the teacher's attention to presumably underlying psychological or cognitive processes such as perception, memory, or attention. The speech language pathologist may draw the problem back to the psycholinguistic processes thought to be predispositional to problems in reading or spelling which were the concern of the teacher. Should a neurologist join the conversation, he or she might consider all education problems to be embedded in neurological dysfunctions. In such fashion, the teacher's instructional problem can be transformed into a series or order of presumed predispositional states which are not a part of her ordinary lesson planning. Teachers even may be advised to direct their instructional programs to the level of children's presumed predispositional deficiencies. For example, when a child has difficulty learning to read, the teacher may be urged to stress basic perceptual training or visual-motor sequencing or visual-motor coordination. In some places, even more drastic treatments are prescribed, such as special classes for "brain damaged" or "perceptually handicapped" children.

Unfortunately, many interpretations of educational problems in terms of their presumed dispositional states are based on a very thin knowledge base and are not useful. And it appears that when one teaches directly for such abilities, even if we make progress in the directly emphasized predispositional domains, there may be no transfer to the level of the curriculum where the teacher must function. For example, in a meta analysis of studies concerning psycholinguistic abilities, as measured by the Illinois Test of Psycholinguistic Abilities, Kavale (1981) concluded that training directed to these abilities is effective. Unfortunately, other researchers have found that training in psycholinguistic abilities does not improve academic performance (Arter & Jenkins, 1979).

The point of this excursion into some of the problems of interprofessional dialogue is to stress the importance of better communication across professional lines. Good and full communication will not occur to a large extent until we examine closely the logic and domains of decisions and the validity of the knowledge bases which relate to the diagnosis and treatment of children, and sort out very carefully how our decisions can be made efficiently. It has been suggested that in multi-professional discussions one profession must be given the focus of attention. Otherwise, each professional will focus on the diagnostic variables and classifications, decisions, and treatments which he or she knows best rather than to work cooperatively and effectively to answer given questions. It is very clear, of course, that teachers wish for their pupils to be healthy, energetic learners and this requires good help from health professionals. It is when we get to the more particular topics that our limited ability to communicate becomes obvious.

Implications for Professional Preparation

The new imperatives for the education of handicapped pupils were addressed to educators who were at best poorly prepared to respond effectively. Efforts are underway to correct that failing, but the task is a very large one.

The new policies themselves are the essential source of structure for the required efforts to improve the preparation of teachers. For example, it is clear that regular teachers need help on such unfamiliar topics as use of consultation, family life, managing diverse social structures, writing explicit individualized educational plans, and due process principles. Each is appearing in teacher-preparation programs as a new area of study. However, more emphasis is also needed by old topics such as teaching basic skills, classroom management, and individualized assessment.

Specialists—for example, social workers, nurses, and psychologists—who work in the schools also have experienced new demands. First is the call that they have experienced to come to classrooms and to carry out their duties in that mainstream environment. In the mainstreamed classroom they find themselves engaged in collaborative work with teachers in diagnostics, in consultation, and in direct intervention. It is their primary duty these days to help make that environment more powerful in dealing with human differences, and this mandates the change in work scene for many specialists.

It will take the work of a decade or more to make substantial progress in changing the roles of school personnel and revising the university programs that prepare the personnel. Teachers and other front-line educators feel directly the policy changes and the new legal imperatives. University personnel who conduct preparation programs for educators are a big step removed, and it is hard to get their attention to develop the necessary priorities for program change. Perhaps the same thing is true in some of the health-related professions as well. But ideas for the task are emerging; the detailed maps for changes in curricula are coming into the professional literature, and at least a few colleges are beginning to do a first-rate job in revising their preparation programs. At the top of the list of work to be done always is the awareness of the need to change, then comes the faculty-development work, the changes in curriculum at specific levels; and, finally, the major programmatic change.

One way that the training problems of educators has been dealt with is through the Dean's Grant Projects (DGPs). Since 1975, about 225 colleges and universities have received these grants - average amount per grant about $45,000 - from the Special Education Programs unit of the U.S. Dept. of Education. The purpose of the grants has been to help in the revisions of preparation programs for teachers and other educators, taking into account the new policies concerning education for handicapped students. Only deans of education have been eligible to receive the grants.

Many things have been learned in the process of seven years' work on DGPs. For example,

1) that deans can be effective programmatic leaders if they invest themselves deeply in projects;
2) that just "adding another course" is not the way to go in meeting important new thrusts in curriculum development; very often there are implications for many aspects of existing curricula;
3) that change in higher education programs is difficult and that it pays to be systematic about change processes;
4) that networks of institutions working on similar kinds of change can be very helpful, through exchanges of ideas, materials and supports of other kinds;
5) that often we do not have sufficient "life space" or academic space to do a thorough job of entry-level preparation.

In the process of working through 225 DGPs a very good set of ideas about curricular change has emerged and a number of outstanding examples of revised teacher preparation have been created. The field of teacher education now has a reasonably good leadership structure, a fair literature[1] on the new topics, a large number of committed professionals and general readiness to carry on to completion the important work in this field. The accrediting agencies, both national and state, are moving in parallel with the developing programs and now adds goading power for developments in all institutions that prepare teachers.

In education, the new policies relating to the education of handicapped children are being viewed as among the amost important ever established in education as a whole. Potentially, these policies affect not only handicapped children but all children: for how can you conduct a program adapted to the individual needs of only some children, or prepare explicit public plans for the education of only some pupils, or negotiate educational plans with only selected parents?

But Won't It All Go Away?

In 1981, President Reagan proposed to repeal Public Law 94-142 and to "block" the funds provided under the law with some other categorical support programs. Although his effort failed then, the same ideas are being forwarded again and the future is precarious. However, even if we lose Public Law 94-142 the many layers of law and judicial decisions at both state and federal levels will continue to uphold the same principles. Mandates for deinstitutionalization and the trimming down of enrollments in special schools have occurred faster than changes in training programs. In a sense, we are playing catch-up baseball with fundamental, hard changes in education. I believe that our moral development has been raised a degree as we have confronted the problems of handicapped children in the schools these past few years. Increasing numbers of school people have had to face up to the potentially catastrophic experience of rejection that some handicapped children and their families have experienced as they were turned away from regular schools. More and more educators realize, I think, that it is our duty to model in the schools the kind of inclusiveness now emerging in a deinstitutionalized society. We have no reason to expect concern with, decency toward, and genuine helpfulness for people who are different in our society if children have no experience with those sentiments during their school years.

Nor is it enough for educators to face these problems alone, just as it is not enough for teachers to meet as strangers their colleagues in nursing, physical therapy, occupational therapy, speech, psychology, audiology,

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[1] Persons wishing to know more about the developing literature in "mainstreamed education" are invited to write to the National Support Systems Project, 350 Elliott Hall, 75 East River Road, University of Minnesota, Minneapolis, MN 55455.

and medicine when they get into the schools. Universities supposedly are settings where communication across all disciplinary and professional boundaries is encouraged, but it is not so. Each of us tends to report to his or her own enclave. Sarason has said that all specialists tend to create environments that only specialists can manage. We as specialists create our specialized, very comfortable environments and socialize our clients, patients, or pupils to accommodate to those environments. But things are changing—radically—in the schools. We are being called into the mainstream environments—homes and regular schools—and asked to help make those environments more powerful resources for children. As Sarason (1978), again, has put it, mainstreaming is not just an education issue or problem; "it is a reflection of the nature of and changes in larger society, if only because the definitions of deviancy, atypicality or handicap arise out of societal norms" (p. 17). We—in education and in health—should do more of the necessary work together.

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Meeting the Needs of Children and Youth with Disabilities: The State of the Art in Allied Health

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Background

According to the National Commission on Allied Health Education,[1] allied health practitioners comprise more than one-third of all full-time hospital employees, between one-half and two-thirds of all full-time employees of Health Maintenance Organizations and other group practices, over three-fourths of all non-physicians employed in physicians' offices, over two-thirds of all employees of mental health facilities, over three-fourths of all laboratory employees, and over three-fourths of all practitioners in community health clinics and agencies. At least three-fifths of all providers of health-care services in the United States are members of the allied health professions. Appendix A describes the allied health work force.

With the advent of the Education for All Handicapped Children Act of 1975 (Public Law 94-142), mandating the provision of a free appropriate education for all handicapped children, increasing numbers of allied health practitioners found themselves delivering services in educational settings for the first time. Because many of these practitioners had not been prepared directly for these roles and responsibilities, new training needs were identified, and educational programs developed through both higher education institutions and professional organizations.

The extent and diversity of the allied health professions make it impossible to provide a detailed "State of the Art" discussion for each of the professions in allied health working to meet the needs of youngsters with disabilities. This paper, therefore, will be limited to: (a) summarizing the major allied health initiative for these youngsters (of which this Forum is a part), and (b) showing how three of the allied health professions are preparing their members to meet the needs of youngsters with handicaps in the schools.

The Allied Health Child Find and Advocacy Project[2]

In June 1980, the American Society of Allied Health Professions was awarded a three year grant from the U.S. Office of Special Education and Rehabilitative Services (OSERS) to involve allied health professionals in efforts to meet the education and education-related health needs of children with handicapping conditions.

The challenge of the Allied Health Child-Find and Advocacy Project has been to design curricula, instructional strategies, and advocacy models which encourage all allied health professionals to become proactive in advocating for the rights and needs of youngsters with disabilities and their families. The specific components of the Project have included workshops and conferences designed and conducted for three separate audiences, targeted for their unique potential in affecting change in the roles allied health professionals play in the implementation of PL 94-142. The activities include:

- Regional Workshops designed for a cadre of fifty experienced allied health professionals in each of the ten Department of Education Regions;
- Workshops for national allied health professional organizations as part of their annual conferences; and
- Invitational Conferences for chief administrators of schools and programs of allied health and education.

Through these activities, ASAHP has initiated a number of innovative activities and has generated much support in the coordination of training, service delivery, and advocacy for youngsters with handicapping conditions at both the regional and national levels.

The professions involved thus far have included:

- Audiology/Speech-Language Pathology
- Corrective Therapy
- Dental Assistance & Dental Hygiene
- Dietetics
- Health Education & Administration
- Medical Assistance
- Medical Technology
- Medical Record Administration

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[1] National Commission on Allied Health Education, The Future of Allied Health Education, San Francisco: Jossey-Bass Inc., Publishers, 1980.

[2] Information regarding the Allied Health Child-Find and Advocacy Project is adapted from ASAHP's Continuation Application for Grant No. G009001409.

- Mental Health Administration
- Rehabilitation Counseling
- Social Work
- Nutrition
- Occupational Therapy
- Physical Therapy
- Nursing
- Physician Assistance
- Recreational Therapy

During each of the Project's regional workshops and conferences, participants working in small groups have identified the roles and responsibilities all health professionals should assume—whether or not they interact directly or consistently with youngsters who have handicapping conditions. Five major responsibilities have emerged repeatedly—across working groups and across Regions. They include:

1. To communicate effectively with individuals with disabilities and their families; i.e., to adapt messages and listen actively to disabled youngsters and their families;
2. To understand state and federal legislation in order to assist families in solving problems related to the child/youth's condition;
3. To recognize, accept, and implement one's professional responsibilities in identifying, referring, and advocating for youngsters with disabilities and their families;
4. To help coordinate efforts of health, education and related services, and
5. To develop and/or modify educational standards to create *access* rather than barriers to disabled individuals who wish to enter the allied health, education, and medical fields.

While these roles and responsibilities have been identified specifically for allied health professionals, their relevancy for other professionals who provide services to disabled youngsters and their families (e.g., special educators, regular educators, physicians, nurses, school volunteers, etc.) are obvious, and would be well-worth considering as all groups develop and evaluate preservice and in-service education programs.

For the allied health professionals involved in the Project's activities (as well as for the resource persons and faculty), the overriding issue of providing efficient, cost-effective care in meeting the mandates of PL 94-142 has continually pointed to the need for *coordinated efforts* of health, education, and the related health services with an emphasis on developing adaptive programming for the life span of the youngster.

While some training programs in allied health address these roles and responsibilities, many do not. Leaders within the allied health professions generally recognize the lack of training their students receive to prepare them for meeting their responsibilities for handicapped youngsters. Further substantiation has come directly from Regional Workshop participants throughout the country. They concur with and reinforce ASAHP's underlying position: related health professionals working in clinical settings possess (a) special access to children and youth with handicapping conditions; and (b) little, if any, preparation for meeting their roles and responsibilities to assure these youngsters obtain their due educational rights.

Through this project, ASAHP is developing important alliances with medical and education personnel and organizations concerned with disabled youngsters, including the American Academy of Pediatrics, the American Association of Colleges for Teacher Education, the National Association of State Directors of Special Education and the member organizations of ASAHP. Communication, cooperation and collaboration among these and related organizations augur well in the promotion of this advocacy initiative as well as assuring delivery of needed services for these youngsters.

STATE OF THE ART—THREE ALLIED HEALTH SERVICES

While the first part of this paper has shared ASAHP's involvement with PL 94-142 through the Allied Health Child-Find and Advocacy Project, this section will focus on the current status and concern of three allied health services, namely occupational therapy, physical therapy, and speech-language pathology and audiology, specified in the regulations as "related services."

OCCUPATIONAL THERAPY

Traditionally, occupational therapists have served children in health care settings for many years. Providing service in educational settings is a later development in practice and is tied to the profession's goals of early intervention, service on interdisciplinary health care teams, provision of service from birth, and care in the most advantageous setting for the patient/client.

In 1978, number of school-based occupational therapists grew from 950 to 2500. To meet the training needs of the school-based therapist, the American Occupational Therapy Association (AOTA) designed a project, "Training Occupational Therapy Educational Management in Schools" (TOTEMS). Partially funded by the Bureau of Education for the Handicapped, the TOTEMS Project provides eight modules of competency-based advanced inservice training "to teach the occupational therapist better ways to initiate and manage occupational therapy programs as defined by the service delivery patterns and ethical practices of the occupational therapy profession and the rules and regulations of the school district that the therapist serves." A rich resource from TOTEMS is the four-volume training manual covering the content of the five pilot programs. The comprehensiveness of the four volumes is impressive and the adaptability of much of their content to other health professions and related services is significant.

Recognizing a further training need, the AOTA developed a subsequent project, "Faculty Development Workshops: Integrating Material to School Based Practice in Occupational Therapy Curricula," again, with partial support of the U.S. Department of Education's Special Education Program. The areas of practice and education at the basic entry level in occupational therapy have been enriched and strengthened by these two Projects and the materials produced by them.

In addition, continuing education programs on PL 94-142 and related content are offered for occupational therapy practitioners by a variety of sponsors, *e.g.*, state affiliates of the AOTA, school systems, ASAHP. The problems in providing adequate occupational therapy services in educational settings are shared with physical therapists: there simply are not enough therapists to fill all of the faculty positions in occupational and physical therapy educational programs. A second problem, also similar to physical therapy, concerns role identity. Most individuals enter occupational therapy with a desire to give direct service to patients/clients, while most of the service given to students in an educational setting is indirect. The occupational therapist in the school system accomplishes change in the pupil's status through the intervention of others: the teacher, the teacher's aide, the parents. This kind of change does not bring the same satisfaction to some occupational therapists as the direct care tendered in a health care setting where the therapist has control over the child's therapeutic program. Many training programs are not yet designed to prepare students to appreciate the career satisfactions that can be derived from serving as a consultant in providing the long-term, indirect care relevant to the education and lifetime career goals of the youngster with a disability.

PHYSICAL THERAPY

Among the physical therapy services provided in educational settings for disabled students are: evaluation; program planning; consultation to families and school personnel and/or community agencies; classroom or building modification; direct service to disabled students; construction management and use of adaptive equipment; assessment and provision of fire and safety procedures; assessment and management of transportation systems; collaborative activities as a member of an interdisciplinary team, including participation in the preparation of Individual Educational Programs; record keeping and reporting; budget planning and management; supervision of support personnel; and planning for inservice training programs for other health and education professionals, students and/or assistive personnel.

It is estimated that about 2700 physical therapists are currently employed in school settings. Data from a survey conducted by the American Physical Therapy Association (APTA) in 1981 indicated more than 60% of the respondents (N-612) were employed full-time in regular schools. This represents a significant change in employment settings for physical therapists. Traditionally, physical therapists employed in school settings functioned in special schools or classrooms for the orthopedically handicapped.

Most activities to prepare physical therapists for these new roles and responsibilities have been carried out at the state and local level by therapists already employed in school systems, by State Chapters of the American Physical Therapy Association, and/or by faculties of basic entry level or graduate educational programs. Although the need has been recognized, no organized national efforts exist to revise curricula to prepare physical therapy students for these functions. Continuing education programs have been offered to familiarize practitioners with PL 94-142 or to help them manage these newer roles and responsibilities. But, and this is a well recognized phenomenon, more needs to be done in curriculum revision; in raising awareness of many publics to the contributions physical therapists can make to disabled students in classrooms, and in helping current physical therapists gain knowledge and skills to function effectively in these environments.

Traditionally, physical therapists have delivered direct service to patients in medical/health care facilities. They have had considerable control over what they administered to patients and when. This has been true of many health care practitioners, including occupational therapists. In the past, school-based physical therapists dealt generally with students with blatant orthopedic and/or neurological problems. In today's "least restrictive environment" they will work with students with other problems, *e.g.*, developmental delays, fine and gross motor deficits, sensory disturbances, learning disabilities, clumsiness and awkwardness, and genetic abnormalities.

In addition to whatever expertise practitioners bring to the classroom setting, they need to bring special skills as coordinators, managers and consultants. Thus, faculties of educational programs must be equipped to prepare students for these new roles and functions in these new settings. Curriculum revisions must include more emphasis on interpersonal, management and communications skills. Students in physical therapy, as well as occupational therapy, must be prepared to achieve their patient's treatment goals and objectives through a new group of support personnel different from those found in a more traditional hospital or health care setting.

The supervisor/employer relationship is also different for both the physical and occupational therapist. Instead of supervision from another related health care professional, the overseer may be a special educator, school principal or similar educational administrator. Curricula should emphasize communication skills to help students work effectively with their educator colleagues. Management skills training must be given equal emphasis with development of professional skills. Sensitivity to the emotional and cognitive needs of the able-bodied child in the classroom with disabled children must be developed to greater depth. Further emphasis is needed on how to cope with varying learning styles and behavior problems.

Physical therapists in school systems face another problem due to their policy of delivering service on medical referral. The problem is twofold: not all school systems have physicians on the scene; not all school physicians know what physical therapists can contribute to disabled children in the classroom. Each State has a physical therapy practice act which binds physical therapists to medical referral. Currently the American Physical Therapy Association is studying the ethical and legal implications of its members engaged in autonomous practice. Occupational therapists can deliver their services on either medical or health status referrals so they do not face this particular problem.

In some states, school-based physical therapists, like other related-service providers in the schools, must complete additional preparation through continuing education. In others, it is required that they meet teacher certification requirements. It would appear to be more efficient and cost-effective to revise basic entry level curricula to include appropriate course work and field experiences to provide adequate preparation for service in these environments.

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Speech-language pathologists and audiologists have been important members of educational teams for many years, and are familiar with serving in roles as direct service providers, supervisors, coordinators, administrators, and as classroom or clinical teachers in training programs. Through the American Speech-Language-Hearing Association (ASHA), the members contributed significantly to the design and passage of PL 94-142.

While speech-language pathologists and audiologists are accustomed to working with teachers, teacher aides, special educators and educational administrators, the advent of PL 94-142 finds them serving as interdisciplinary team members with physical therapists, occupational therapists, social workers, psychologists, and physical educators. Thus, they too have a different and expanded role for students with communication disorders to ensure their I.E.P. goals are supplemented and complemented by other health practitioners. Speech-language pathologists and audiologists are finding it necessary to spend more time in team building and in using supportive personnel.

New patterns and areas of service delivery include the severely disabled (who are new in the classroom), the non-vocal, and the bilingual youngster. A significant change in the disorders found in the populations to be served emerged with the implementation of PL 94-142; from those with primarily articulation, voice, or stuttering disorders to those with developmental and dyslexia disorders. As a result, emphasis in educational curricula is on language rather than speech. Thus, acquisition of language as socialization, conceptualization, and writing processes is receiving much more attention, along with the importance of prenatal influences and family health histories.

There is an apparent need for entry-level curricula in Speech-Language Pathology and Audiology to stress newer roles; *e.g.*, less emphasis on consultant and management skills to greater emphasis on the new populations its graduates will be serving.

In 1982, ASHA conducted an impact study of 100 supervisors to obtain a profile of their members working in public schools.

> The data show that PL 94-142 has had an impact on speech-language pathology and audiology programs in schools. The mandate to provide appropriate education for all handicapped children has facilitated the move toward lower caseloads and increased employment.

Continuing education opportunities for specialists in communication disorders would probably be most effective and contributory if they were concentrated on improving knowledge, skills and attitudes toward the newer populations being seen in the classroom: the severely disabled, the nonvocal, the bilingual. Team building techniques are another area of concern which lend themselves to effective continuing education efforts.

Speech-language pathologists and audiologists appear to be strong in understanding school systems' advocacy roles and working collaboratively with educational personnel from a variety of job levels. It appears they need to transfer these skills and abilities to their newer arena which now includes other health practitioners.

SOME CONCLUSIONS BASED ON THE STATE OF THE ART IN ALLIED HEALTH

Roles and Functions

As noted for each of the professions discussed above, all the related-health professions need to be involved in a concerted effort to clarify the roles and functions of health professionals serving youngsters with handicapping conditions, define them, agree on them, promulgate them, and design curriculum offerings that develop the competencies needed to carry them out.

Allied health practitioners can make a significant difference in the lives of children and youth with disabilities and their families. They can contribute meaningfully to the satisfaction teachers, principals, and other education personnel derive from their jobs. Allied health professionals can help the educators develop realistic expectations regarding the performance of students with disabilities and modify educational settings to assure optimum learning environments. Further, they can help educators and parents become aware of assistive devices and techniques to use at home to complement and supplement what is taught in the classroom, and also to be aware of agencies, service groups and other organizations in the community which may be of assistance to them and to their students.

While individual disciplines have conducted research on the results of school-based activity, interdisciplinary research has not yet had the attention it needs to: 1) substantiate best approaches to program planning; 2) document cost-effective programs; and 3) differentiate the effectiveness of those factors in educational planning procedures (*e.g.*, the Individualized Education Program).

Allied health practitioners must take full responsibility for seeing that PL 94-142 and related legislative acts are fully financed and implemented at federal, state and local levels. As noted earlier, this means assumption of roles as advocates not just for the children they are serving, but for the school personnel and systems, for parents and for service programs. Allied health professionals must be political beings in the positive sense with a healthy respect for what can be accomplished by mobilization of an informed group to bring about desired action. Part of this political activity must include effective publicity and public relations so that there is appropriate understanding of the law, of the need to educate this special group of children, of the kinds of programs and resources needed to provide appropriate services, of the allied health practitioners' professional responsibilities for children with special needs, their families, and other interdisciplinary team members, and of the benefits to be derived from these efforts by the community and the larger society.

When necessary to assure adequate and appropriate services, the allied health practitioner must be ready and equipped to help change restrictive and outmoded behaviors, dictums, and laws. Further, the allied health practitioner must work in the present with a sensitivity, keenness, and an anticipation of the future. The children being served in the classroom today are the workers and contributers to the society of tomorrow. Their future needs for service, assistance, modifications, and support must be kept in mind when planning today's programs.

Educational Preparation

Much more needs to be done to help all practitioners who deliver services to disabled children to develop skills in management, team building, use of resources (human and financial), and in understanding the systems in which they are employed. Allied health practitioners must work with new populations, with new responsibilities, in new settings. "You cannot do today's job with yesterday's tools and remain in business tomorrow." Direct care for and/or daily control over the child to be served may not be appropriate to his/her educational needs. Allied health practitioners must develop and refine their consultation skills and accept the philosophy that effective management means getting things done through others.

More specifically, three kinds of educational change need attention: (1) revision of basic entry level curricula so students are taught competencies needed to function in school settings. This includes content taught in classrooms and provision of a clinical affiliation experience in a classroom setting; (2) development of an all-out effort to provide current allied health practitioners educational opportunities to update their knowledge, skills and attitudes so they can function effectively serving youngsters with disabilities in educational settings. In addition to workshops and inclusion of content in annual conferences of membership organizations, educational media such as interactive video tapes and audio-cassettes should be developed; (3) recruitment and preparation of faculty (classroom and clinical) must be given a higher priority of attention and action in allied health professional membership organizations and in ASAHP. Until we fill teaching openings, efforts to prepare practitioners for new settings, and to revise and update curricula will be thwarted.

The Future

What happens to PL 94-142 and related legislation is in our hands and others like us. Congress had to pass a law to give some of our children the right to learn, to be taught, to go to public school, to socialize with the able-bodied in a classroom setting. As allied health professionals, we have a vital role to play.

What we do in this arena to help youngsters with handicapping conditions achieve their due rights to a free education has great significance to our country, to our citizens and to ourselves. Let us all not only be committed to the goal, but equal to the task.

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Pediatrics and Developmental Disabilities: The State of the Art in Pediatrics

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Moving to Maine in 1978, Dr. Richardson has continued his work in child development and handicapping conditions as chairman of the Committee on the Handicapped ~~Child of~~ the Maine Chapter of the American ~~Academy~~ of Pediatrics and is co-instructor of the course New Directions in the Care of the Handicapped ~~Child~~ which is taught to pediatricians and their special education colleagues throughout the state. In addition to serving as a member of the Maine Planning and Advisory Council on Developmental Disabilities, he is consultant to the special education departments of 8 local school systems. Dr. Richardson is co-editor of the book Pediatric Education and the Needs of Exceptional Children *(University Park Press, 1980) as well as the author of several articles and chapters on general and developmental pediatric subjects.*

Pediatrics differs from most other medical specialties in its focus on the comprehensive and continuing health care of the people it serves rather than limiting its concerns to a particular organ system, set of diseases or method of care.[1] The goal of the American Academy of Pediatrics, membership in which now exceeds 20,000 pediatricians, is "The attainment by all children of the Americas of their full potential for physical, emotional and social health."[2]

The approaches toward the Academy's goal have changed dramatically over the past few decades. Prior accomplishments leading to improved nutrition and feeding practices, modern sanitation, wider use of routine immunization against infectious diseases, and appropriate use of antibiotics and other chemotherapeutic agents have led to a remarkable reduction of infant and child mortality.[2] For instance, mortality in the 1 to 4 year-old age-group has fallen from 987 per 100,000 population in 1920 to 70 per 100,000 in 1976; and accidents, not illness, currently account for almost half of all deaths in this age-group.[1]

In the past one or two decades, the emphasis has shifted from the treatment of life-threatening conditions to the promotion of physical, emotional and social health of the highest possible quality for each child. At the same time, as part of the enlightened awareness of the rights and needs of disabled people, pediatricians have demonstrated increasing interest and involvement with behavioral and developmental variations in children and, in cooperation will colleagues from a number of other disciplines, are making significant contributions on behalf of disabled children and youth. The nature of pediatricians' contributions, settings for service delivery, the status of current educational and research efforts, and some opportunities for cooperation between pediatrics, special education and related service disciplines will be reviewed.

THE PEDIATRIC CONTRIBUTION

Prevention of Disabilities. Before surveying the pediatricians' contributions to the identification, assessment and management of disabled children and youth, the fields' greatest contribution, that of prevention, will be summarized. Along with obstetric and family practice colleagues, pediatricians carry out most genetic counseling regarding inherited or congenital metabolic (e.g. phenylketonuria), chromosomal (e.g. Down syndrome), dengenerative (e.g. Tay-Sachs disease), and structural (e.g. spinal bifida) disabilities. Their efforts in immunization against rubella have greatly reduced the incidence of congenital rubella syndrome. In recent years, again with the support of obstetricians, pediatricians have counseled against the use of alcohol and smoking during pregnancy to avoid the resulting intrauterine growth retardation and developmental consequences. In addition, it has been pediatricians who have initiated and overseen newborn screening for phenylketonuria, glactosemia and hypothyroidism and have instituted the appropriate dietary or hormonal therapy which prevents subsequent retardation from these disorders.[3]

Most of the pediatricians' efforts in the perinatal period and throughout infancy and childhood are aimed at preventing or minimizing the severity of developmental disability. At the time of delivery, reduction of fetal anoxia, birth trauma, and neonatal infections have resulted from the appropriate use of fetal monitoring and Ceasarian sections.[4] Advances in the care of prematures, in addition to more effective prevention of premature delivery, have led to a marked improvement in recovery without disability following respiratory distress syndrome, newborn jaundice, hypoglycemia and sepsis. Efforts to promote bonding between the infant and both parents lead to improved language development[5] and reduction in child abuse.[6]

Beyond the neonatal period, the pediatrician is daily concerned with the prevention of disabilities. Without fanfare, it is primarily the pediatrician, along with family practitioners, who oversee the administration [illegible]cines against polio, whooping cough, diptheria [illegible] measles and mumps. The virtual elimination [illegible] diseases, particularly polio and measles with th[illegible]ing paralysis and brain-damaging enceph[illegible] has made a major impact on the incidence of de[illegible]mental disabilities.[7] In addition, pediatricians are [illegible] principal effective advocates of home and automo[illegible] safety for children, care daily for children with ear infections, and remain constantly alert to the risk of bacterial meningitis, preventing serious developmental sequellae with prompt and appropriate treatment.

Developmental Screening. The best opportunity for routine developmental screening of infants and pre-school children is during their health care visits. There are three principal impediments to the implementation of universal screening for developmental disabilities in primary health care settings. First is the adequacy of screening instruments. By far the best standardized and most widely used developmental screening instrument is the Denver Developmental Screening Test.[10] Nonetheless, specificity and sensitivity of the instrument, even in the hands of its developers,[11] [12] is not sufficient to meet the needs of most pediatric practitioners. False positive results are particularly costly in over-utilizing already limited referral resources. Other screening tests have been proposed, but none is adequately standardized to justify general use at the present time. The second impediment to screening is its cost in physician and staff time. Neither parents nor third parties (medicaid or insurance companies) are willing to pay for the 15 to 20 minutes which is the minimum required for adequate screening repeated several times during infancy and childhood.

The third impediment to universal developmental screening is the most important and is influenced the least by pediatricians. The problem of inadequate screening instruments and limited funding for screening would be quickly overcome if effective diagnostic and intervention programs were widely available. It is likely that once special educators and speech, occupational and physical therapists provide documentation of the effectiveness of their approaches, there will be appropriate referrals. It is frustrating for the pediatrician to read a special educator's admission that "Lack of objective support for the effectiveness of various educational strategies being used with young handicapped children is a serious problem."[13] It is also frustrating to have almost every child referred to an occupational therapist diagnosed as having sensory integration problems with a self-serving plan for sensory integration therapy recommended.

In spite of the failure of pediatricians to carry out standardized developmental screening on a broad scale for the reasons cited above, the entire process of routine well-baby/well-child care includes screens for developmental disabilities. The physical examination identifies chromosomal and other developmental syndromes, examination of the eyes and ears picks up early sensory deficits, and clinical observations and developmental history provide data on motor, language, cognitive and social development.[8]

Diagnosis and Assessment. The degree of pediatric involvement in the diagnosis and assessment of developmentally disabled children depends on the pediatrician's degree of interest and training in developmental pediatrics.[14] Even practicing pediatricians with no special interest in developmental disabilities carry out examinations that identify medical problems that might underlie or aggravate a child's difficulty. Hearing or vision defects, chronic illness, relevant deformities and active or progressive neurological diseases or seizures should be uncovered. Further assessment of the disability itself, however, is referred to other disciplines.

The practitioner with a special interest and further training in developmental pediatrics is in a position to carry out a much more extensive contribution to diagnosis and assessment. A comprehensive medical, family, social and developmental history, combined with a physical and neurological examination, can often elucidate factors that may have contributed to the child's disability. These may be pre-natal, peri-natal or post-natal and include chromosomal, genetic/metabolic, infectious, nutritional, hypoxic, traumatic, toxic and psycho-social factors. In addition to the search for contributing factors, a neuro-developmental assessment can add a valuable perspective to the assessments of other disciplines. Fine and gross motor function, language, both oral and written and receptive and expressive, and socio-emotional function including attention, attitude, motivation and interpersonal skills can be assessed.

The pediatrician's functional assessment of an identified child serves as a collation of the observations of others supported by clinical observations in each functional area. Data can be obtained from parents, teachers and other consultants, such as psychologists, speech and language clinicians, special educational diagnosticians, and occupational and physical therapists. An example of an observation protocol for assessment of the child, reflecting a wide range of functions, is the Pediatric Examination of Educational Readiness developed by Levine, et al.[15,16] The Pediatrician is often in the unique position of being able to bring together the many sources of information about the child's function and view the child in the context of the particular family and school setting.

In addition to pediatric practitioners with a special interest in developmental pediatrics, there are a growing number of full-time pediatric sub-specialists in the field, mostly affiliated with medical school adacemic departments. Their assessments may be more detailed, particularly within the area of their own training and expertise (e.g. learning disabilities, cerebral palsy, or mental retardation), but they are often further removed from the family and community than is the pediatrician in general practice.

Interdisciplinary Process. The pediatrician's contribution to the interdisciplinary process depends in large part on the degree of expertise in developmental pediatrics as discussed previously. At the community level, the pediatrician may be simply a contributor to the multidisciplinary assessment or may participate on an interdisciplinary team which formulates a complete diagnosis and outlines a plan. In either role, the pediatrician may be the case manager with responsibility for carrying out or overseeing the team's recommendations. This is often true for the handicapped infant or child under age three but is rarely the case for the school-aged child.[7]

In the academic setting, the pediatric faculty member who sub-specializes in developmental pediatrics has a number of interdisciplinary responsibilities in addition to participation on an interdisciplinary child development team for diagnosis and management of referred children. These might include interdisciplinary consultation in the newborn nursery, on the hospital inpatient services, and in speciality clinics serving children with birth defects, neuromuscular disorders, or genetic or metabolic problems. In addition, the developmental pediatrician may serve as a team member for teaching as well as service in pediatric neurology and child psychiatry clinics.

For both the practitioner and the academician the school is an important site for interdisciplinary contributions. Among New England pediatricians surveyed by Dworkin, et al.,[17] between 60% and 70% reported at least monthly interaction with a school nurse and a learning disability specialist and between 40% and 50% had monthly contact with psychologists, guidance counselors, classroom teachers and speech pathologists. The pediatrician's contributions in the school setting may include up-to-date information about medical problems or medication as well as the results of the diagnosis and functional assessment as described in the previous section.

Management. The pediatrician's management role for children with developmental disabilities usually involves a degree of coordination and oversight of other specialists' efforts on behalf of the child. On-going management of health maintenance is more crucial than for the non-disabled child as complicating medical problems arise more often. Coordination of surgical intervention for hearing or visual defects or congenital anomalies and use of appropriate medications for seizure control or hyperactivity are other examples of medical management. Many pediatricians who function as members of multidisciplinary or interdisciplinary diagnostic teams continue their involvement by monitoring the response to team recommendations for intervention. As the child grows, communication between the early intervention staff members and the pediatrician should continue regarding medical as well as developmental observations.

The pediatrician's most crucial management role, perhaps, is in providing support to the parents.[18,19] The initial informing of the parent about the child's handicap sets the stage for a positive relationship between parent and child. Pediatricians can guide the parents with understanding during their grief reaction to their being informed of their child's disability, can point out the child's strengths and can help parents develop realistic expectations, avoiding both over-protection and disappointment. As the results of on-going diagnosis and therapeutic interventions become known, the pediatrician can serve as an interpreter of findings and can discuss the implications of disabilities. Further, the frequent contacts with parents allows an opportunity to explore feelings and assess the adjustment of parents and siblings to the child's problems.[14] Other management roles for the pediatrician with the parents include genetic counseling and guidance in behavioral issues such as toilet-training or temper tantrums.

A final pediatric management role, particularly with the school-aged population, is as advocate for the specific child and family as well as for disabled children in general. The physician's position outside the school system as well as general level of professional respect lend weight to opinions favoring a program in the child's best interest. There is virtually always a team member from the school (classroom teacher, special educator, or therapist) with an appropriate recommendation, but conflicts of interest regarding staffing or funding sometimes lead to expedience over-ruling the team member's suggestion. The pediatrician's support of the educator's appropriate recommendation is often effective in directing the program back toward the child's best interests.

SETTINGS FOR PEDIATRIC SERVICES

The great majority of pediatricians (about 20,000 in all) are in general practice with most of the remaining 5,000 in pediatric sub-specialties (such as cardiology or neonatology), administration, research and/or teaching.[20] Pediatricians currently provide medical care to over two-thirds of all children in the United States, the remainder being provided by family or general practitioners. Most medical services to developmentally disabled children and youth are in primary care office settings, but other settings have become increasingly prominent in the past two decades.

Since the mid-1960's, federally supported Child Diagnostic Clinics have been staffed by a number of different disciplines usually including a pediatrician. These clinics usually have been administered by city, county or state health departments and generally meet to evaluate referred children on a weekly, by-weekly or monthly basis. The pediatrician serving on the team is often in general pediatric practice with a special interest in developmental disabilities. In some such clinics, the pediatrician is on the full-time staff of the sponsoring health department.

A wide variety of speciality clinics serving handicapped children are found in teaching hospitals affiliated with the approximately 120 U.S. medical schools. As mentioned earlier, these may include newborn intensive care follow-up clinics, birth defects clinics, genetic/metabolic clinics, school learning problems clinics and others. These clinics are frequently staffed by pediatricians on the full-time medical school faculty. Approximately 50 medical schools are the sites of university affiliated facilities for interdisciplinary training, research and service in the area of mental development. The great majority of these programs have developmental pediatrics sub-specialists on their staffs. Their case load and referral network depend on teaching and research interests as well as service needs.

The final setting for the provision of pediatric services is the school or residential institution. In some states, residential institutions for retarded persons are staffed by full-time pediatricians although the trend is to reduce the number of residents in such institutions by returning (or keeping) them in community facilities. Pediatric consultants to schools are usually either private practitioners or full-time health department or medical school staff members. School-based consultation affords the pediatrician the opportunity to observe the child in the learning environment as well as to meet more conveniently with involved educators and related service team members.

In spite of the many opportunities for pediatricians to contribute to the initial and on-going evaluation of children with developmental disabilities, there are several impediments currently to their fuller involvement on multi-disciplinary or interdisciplinary teams; particularly at the community level. First, the nature of pediatric practice is generally brief visits with a relatively large number of patients (twenty to thirty per day in the office). In visits lasting an average of about fifteen minutes, it is difficult to deal with the complex issues facing handicapped children and their parents except in a superficial way. Scheduling can be controlled, of course, and as more pediatricians work in group practices flexibility is possible, with one member of the group covering the routine illnesses and follow-ups while the other schedules longer appointments for the evaluation and management of developmentally disabled patients.

A second constraint, related to the first, is the difficulty of obtaining adequate compensation for time spent in the care of handicapped children. Although parents indicate a willingness to pay for extra time of the pediatrician in the management of behavioral or developmental problems,[21] often they are unable to pay the additional costs of a complex problem. Further, most private insurance companies provide no coverage for physician time spent although they readily pay for unnecessary laboratory and x-ray studies such as CAT scans. Medicaid for the indigent patient provides a set fee (usually low) for each visit, thereby encouraging many brief visits. Overhead costs in a pediatric office range from $30 to $60 per office hour so that the usual consultation fee ($35 to $50 per hour) may leave the physician with a loss. Only by scheduling consultations at particular times can this problem be overcome. Funding for the alternatives of health department or teaching hospital clinics is also in jeopardy.

A third constraint on general pediatric participation in developmental disabilities team consultation is a frequent lack of training in interdisciplinary diagnosis and management during medical school and residency. In 1979 a survey of residency programs[22] indicated that although the majority of programs offered training in developmental disabilities, most were elective and few were systematically organized. Dworkin and his colleagues[17] found that 50% of practicing pediatricians described medical school as having been of no value as a source of knowledge in developmental pediatrics and 20% indicated residency was of no value. In a larger survey of 7,000 recent graduates of pediatric residency programs,[21] over 50% stated that their residency experience was insufficient in the areas of psycho-social and behavioral problems and over 40% had similar dissatisfaction in the area of chronic cerebral dysfunctions. Remedial efforts in pediatric education at the medical student, resident, practitioner, and sub-specialist level are discussed in the following section.

PHYSICIAN EDUCATION

Increased emphasis on developmental disabilities in children and youth is evident at all levels of physician education,[22,23] with particular recent activity at the pediatric resident, developmental pediatrics fellowship and pediatric practitioner level. The four years of medical school generally offer from one to three months of pediatric experience for most medical students. Those planning on pediatrics as a career may have the opportunity of taking additional elective months in their fourth year. Fewer than 50% of medical school pediatric departments offered training in developmental or behavioral pediatrics to their students in 1979.[24]

Training in pediatrics after medical school requires a three-year residency program, the first of which (formerly called "internship") usually emphasizes the care of seriously ill hospitalized infants and children. The second and third years of residency offer more experience in ambulatory pediatric care often with one-month rotations, either required or elective, in developmental and/or behavioral pediatrics.[22] For pediatricians wishing to sub-specialize in developmental pediatrics, one to three year post-residency fellowship programs are offered at a number of sites, often as part of a university affiliated facility.[25] Pediatricians who intend to practice may take only one year of fellowship training whereas those intending to continue in academic careers and research take two to three years. Once in practice, a wide variety of continuing education opportunities exist from one to two day courses[26] to a one-month "mini-fellowship" or its equivalent.[14]

Medical Student Education in Developmental Disabilities. The content of the first two years of medical school focuses on the basic sciences such as anatomy, physiology, biochemistry, pathology, bacteriology and pharmacology. Developmental psychology deserves a place among these basic sciences, and behavioral and physical disorders (such as encopresis or dysmorphic syndrome) might be integrated into the pathology curriculum. Experience with normal children in public schools also offers an opportunity to teach the spectrum of cognitive, social and physical development between and within age groups.[27]

The third and fourth years of medical school are devoted to increasing exposure to and independent experience with clinical problems. This is the opportunity to teach all future physicians, regardless of their ultimate specialty, the development and behavioral functioning of each child they see. Each patient can be a brief developmental case-study. Senior students considering specialization in neurology, orthopedics, psychiatry, ophthalmology, otorhinolaryngology (ENT) and physical medicine and rehabilitation as well as pediatrics and family medicine should be encouraged to have elective experience with the interdisciplinary evaluation and management of handicapped children as this will make up a significant proportion of their ultimate practice.

Pediatric Resident Training in Developmental Disabilities. The first year of pediatric residency should offer the opportunity to review the resident's knowledge and interviewing skills in developmental and behavioral pediatrics. The core residency curriculum may be integrated into the entire three years but is more commonly taught as a "block rotation", full-time assignment to a developmental or behavioral pediatric service for a one-month period or longer. During the core rotation there should be an initial exposure to the evaluation and management of the major handicapping conditions e.g. mental retardation, learning and communication disorders, cerebral palsy and major psychopathological states. As wide a spectrum of clinical experience as possible is desirable; not only should the resident be involved in the management of children with different conditions but a range of ages should also be included. The attitudes, knowledge and clinical skills necessary to care for an infant with Down syndrome are totally different from those needed for the care of a teenager with the same condition.

The essential resources for resident training are the availability of interested residents and faculty, clinical opportunities, and supplementary learning opportunities such as lectures, seminars, readings, audiovisual programs and visits to schools, day-care settings and institutions. An available curriculum in developmental pediatrics emphasizing the developmental framework, attitudes, knowledge of handicapping conditions, screening, diagnosis, assessment, interdisciplinary planning, parent informing, management, community services and controversial issues has been implemented in eight residency programs this year and will be used in several additional sites next year.[22,28]

Sub-Speciality Training in Developmental Pediatrics. Fellowships in developmental pediatrics provide an extension of the knowledge and skills introduced during the residency years. They are characterized by extensive, in-depth clinical experience with a large number of developmentally disabled children with varying conditions and ages.[25] The setting is almost always an interdisciplinary diagnostic team with faculty from a number of different disciplines. The opportunity for longer term followup (two to three years) further extends the fellow's understanding of the natural history and varying management of each condition.[29]

Continuing Education for Pediatricians. Because of the intense life and death issues characteristic of the clinical experience of pediatric residents, it is often not until the pediatrician enters practice that the frequency and complexity of developmental problems is realized. For that reason pediatric departments and residency training programs are often relied on to provide continuing education for pediatric practitioners. The content of such teaching is not unique; review of the core residency curriculum with focus on recent advances and selected knowledge and skills from areas of the fellowship curriculum are offered. What is unique is the setting and delivery of such a curriculum.

Several formats have been developed. By far the most common is the one to two-day workshop or course.[26,30] Practitioners free themselves from practice responsibilities to devote full-time to such activities. The limitations, of course, are that only a moderate amount of information can be presented in such a short time, and even more importantly, the presentations are didactic and the learning mostly passive. There is effectiveness in this methodology, however, for two reasons: first, the interest level of practitioners and their sense of confidence in dealing with developmental conditions are raised, leading them to pursue further learning through selected reading. Secondly, they are encouraged to investigate children in their practice more thoroughly, thus allowing them to gain more clinical experience with developmental disorders. Supervision of such experience is often limited, but the brief exposure to the workshop faculty is often enough to create a consultation linkage which is used subsequently.

Another method of continuing education is for the practitioner to spend a scheduled period of time as a participant on an established interdisciplinary team. Usually a half day a week or two full days a month would be devoted to such a program. The curriculum in such a setting is rarely well-defined, but there is the opportunity to cover specific objectives sufficiently well to offer the program as a "mini-fellowship".[14] Improved skill in function as a member of an interdisciplinary team is the most valuable outcome of such a continuing education experience.

RESEARCH

Research in developmental disabilities is an approach to one of society's most challenging questions. How can intelligence and competence best be fostered in each person? Biological variations offer science unique opportunities to unravel normal processes. Further, as has been mentioned before, the clinical state of the art of developmental pediatrics, if not in its infancy, has certainly not passed beyond the toddler stage. A host of opportunities for original and substantiating research are available to developmental pediatricians and their colleagues from other disciplines.

An example of the importance of pursuing astute clinical observation is the rediscovery, about ten years ago, of the fetal alcohol syndrome.[31] Not only has the finding led to programs to prevent a major cause of developmental disability, but it has broadened awareness of substance abuse in general and its impact. Other major research issues concern the relationship between violence and child-rearing (e.g., exposure to T.V.), screening and assessment of developmental disabilities, dietary and drug influence on the learning process, and many others.

OPPORTUNITIES FOR INTERDISCIPLINARY COOPERATION

A review of the clinical contribution of pediatricians in the care of developmentally disabled children, as well as the current status of educational and research efforts in developmental pediatrics, has presented innumerable opportunities for collaboration between pediatricians and special educators or colleagues from the related service disciplines such as occupational, physical and speech therapy. In spite of such opportunities, a survey of major special education textbooks carried out in 1979[23] indicated very little said about collaboration between special educators and medical professionals; most centered only on specific medical problems of handicapped children. Similarly, a review of three major special education journals (The Journal of Special Education, Exceptional Children, and The American

Journal of Orthopsychiatry) from 1970 to 1979, revealed no articles specifically concerned with the collaboration (*e.g.* mutual training efforts) or communication (*e.g.* involvement in the team process) between physicians and special educators.[23]

The fact that such collaboration was seldom written about in the special education literature during the last ten years does not mean, of course, that it did not occur. Indeed recently, a course for master's level special education students taught by a special educator and a pediatrician has been described.[33] There are as well many opportunities for special educators and members of related service disciplines to teach medical students and pediatric residents, particularly in university affiliated facilities. Furthermore, over the past two years, a national continuing education course for pediatricians and other primary care physicians entitled "New Directions in Care for the Handicapped Child" has been taught in each state by an instructor team made up of a special educator and a pediatrician.[26] In Maine, the physicians attending the course are asked to invite special education colleagues (preferably the director of special education in the school system of the community in which they practice) to take the course with them. In this manner, a working relationship can be established as they participate together in the course.

Cooperation between pediatricians and special educators or others from related disciplines is even more frequent in multi-disciplinary or interdisciplinary diagnostic settings. The past infrequency of mutual training experiences has hampered the effective team participation of pediatricians with members of other disciplines. Impediments to effective interdisciplinary functioning include both excessive expectation of the value of the physician's contribution in some instances and defense of disciplinary territory with rejection of the pediatrician's suggestions in others. Developmentally disabled children will benefit from a resolution of these problems with more effective communication, understanding and role-definition among the disciplines.

There are several steps necessary to achieve effective interdisciplinary cooperation. Special educators and colleagues from other disciplines who wish to work more effectively with medical colleagues should seek a pediatrician in their community, agency or university with prior training, interest or experience in work with developmentally disabled children. Although there are notable exceptions, sub-specialty interest and training in the broad discipline of developmental pediatrics is limited to pediatricians. Consultations with neurologists or psychiatrists should be undertaken at the suggestion of or with the support of the pediatric member of the team.

Once a pediatric colleague is selected with whom to teach or work, establishment of an effective team-working relationship must be undertaken. Educators and members of related service disciplines are often surprised that pediatricians turn out to be neither arrogant in their omniscience nor totally ignorant of developmental and educational issues. The discovery of a pediatrician's humanness and limited but valuable contribution occurs through spending time together planning, learning, working, talking and even playing. As in any group work, issues of age, sex, race and authority must be confronted openly and sensitively.

CONCLUSIONS

The past two decades have seen rapid advances in pediatricians' involvement with and contribution to the care of developmentally disabled children and youth. Interdisciplinary efforts in prevention, screening, diagnosis, assessment and management of children with disabilities as well as joint educational and research efforts are occurring with greater frequency. The subspecialty of developmental pediatrics is receiving increased emphasis within medical and pediatric education and is becoming more clearly defined as a participant in interdisciplinary research. The future for productive alliances between health and educational disciplines appears bright, particularly if the past impediments to effective collaboration between pediatricians and their colleagues in special education and related service disciplines are confronted sensitively and overcome.

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A RESPONSE TO THE STATE OF THE ART

Two formal responses to the state of the art papers were presented. The first was delivered by Ethan Ellis, a consumer-advocate and the second by Jayn Wittenmeyer, a parent.

Meeting the Needs of Children and Young People With Disabilities: A Consumer View of the State of the Art

Ethan B. Ellis, M.A.

Trained as a vocational rehabilitation counselor, Ethan B. Ellis directed vocational services and managed a sheltered workshop at Bird S. Coler Hospital in New York City for five years. In the early sixties, he developed vocational and social studies curricula for high school dropouts at a prototype antipoverty program on the Lower East Side and later directed the State of New Jersey's technical assistance unit for OEO funded community organizations. In 1976, he joined the staff of the Office of Advocacy for the Developmentally Disabled at the New Jersey Department of the Public Advocate, and now serves as Deputy Director of that program. He also serves as President of the National Association of Protection and Advocacy Systems and current faculty workshop presenter for the American Society of Allied Health Professions' Allied Health Child-Find and Advocacy Project.

P.L. 94-142 and the changes in social policy which led to its enactment are causing basic and far-reaching changes in the way in which children with disabilities are educated, in the kind of health services they receive, and in the manner in which all of those services are delivered. It is fitting that those who prepare the professionals to deliver those services gather to discuss the impact of these changes on their curricula. It is fitting, and quite in keeping with the forces which brought about these changes in social policy, that such a discussion have input from the consumers those services are designed to benefit. The sponsors of this discussion are to be commended for seeking that input.

The widening bald spot on the top of my head and the gray in my beard belie my ability to provide that input directly. Its proper authors sit in fourth grade classrooms today, having entered school when P.L. 94-142 was first implemented in October, 1977. As he and she progress through the education and health service systems which that law made available to them and gain the wisdom to articulate their impact, I hope that you will consult with them more directly. In the meantime, let me try to act as their surrogate, extrapolating from my experience as one who grew up with a disability at an earlier time and as one who now serves as an advocate for them and their parents.

The papers presented by Hickey, Reynolds, and Richardson remind us once again of what sweeping changes P.L. 94-142 called for in the delivery of education and health services to children with disabilities. They also remind us of how unprepared the deliverers of those services were to provide them to the degree and in the new settings which the law rather suddenly required.

It is clear from what they write that each profession involved in those interwoven delivery systems has had to rethink its role in those systems. They make it equally clear that this redefinition of roles has just begun and will take some time to complete. They give us a glimpse of a complex process which begins at the work site, is filtered through informal discussions with colleagues, becomes formalized in the investigations of professional societies and academia, and finally results in modification of the curricula of classroom and experiential instruction. The multiplicity of feedback loops imbedded in that process are hard to trace, let alone calculate.

They also accurately portray the impact which the law's requirement for teamwork among professionals from different disciplines has had on each discipline's efforts to redefine its role. They describe how that teamwork has caused communication problems across disciplines. They touch upon the ways in which these communication problems are complicated by interdisciplinary rivalries and by the politics of traditional hierarchies within the service delivery systems which may no longer apply but which still leave their marks—or at least their scars. They describe several pilot programs which address these problems in the field and several efforts to fertilize the curricula in the classroom with the knowledge gained from them.

It is useful to the professional advocate to be reminded of the sweeping changes required by P.L. 94-142 and to be exposed to the complex processes by which these intertwined delivery systems of health and education are attempting to accommodate themselves to those changes. We ordinarly see only the delays and dysfunctions in the delivery systems themselves. We are seldom exposed to the processes which cause them or the steps being taken to address them. To us, they appear as personal failures on the part of the individual educator or health professional or as dumb recalcitrance by an impenetrable system.

This knowledge is useful, however, only if it assists us in understanding how to make those systems work more effectively and in diverting the energy which might be wasted in anger at the persons involved. It should not stand as an excuse to lessen our demands for the services which the children we represent need now or to deflect us from pushing the educators of professionals to effect the changes in the training and retraining required to improve those service delivery systems and make them more responsive more quickly.

By and large, I found the problems identified in these presentations valid and interesting. They checked out against my experiences with the educators and health professionals who share them. I found my interest drawn and held by the solutions the authors proposed for them.

This seduction suddenly stopped when I realized that none of the identified problems dealt with the relationship between the professional and the child with the disability, him- or herself. While a discussion of changing interdisciplinary roles and the communication problems which may result from them is legitimate in this forum, it is not the only relationship which P.L. 94-142 and the consumer movement by persons with disabilities has changed and will continue to change into the foreseeable future.

It is my thesis that the introduction of great numbers of children with disabilities into America's classrooms requires that the educators who teach them and the health professionals who provide them with therapies reexamine the impact which they can and should have on the lives of these children. Let me expand on that thought for the balance of this paper.

There are only a few basic themes which run through the course of every human life, beginning in infancy and being played and replayed in different keys throughout each person's lifetime. One of those basic themes may be stated as the question: "How much *control* can I exert over my physical and social environments and *how* can I exert it?" Each of us has asked this question since we were in our cribs and we continue to ask it now no matter what our ages. It gets asked more often in infancy and childhood and the answers received then tend to limit the contexts in which it will be asked later, tend to set limits on the asker's perception of his or her own ability to control those twin environments and thus, on his or her potential.

Infants and children with disabilities ask that same question, although their ability to control either their physical or social environment may be severely circumscribed by their disabilities. In the past, society showed little concern as to how their question was answered since it was primarily concerned with their maintenance, not with their abilities or potential. Potential and abilities have limited, if any, meaning for a person who is to be kept in a dependent state.

The movement for independence for persons with disabilities has legitimated that question for such persons. P.L. 94-142 has specifically legitimated that question for children with disabilities.

Because that question is asked most often in childhood, the educators who teach children with disabilities and the physicians and other health professionals who treat their disabilities have an inordinately large role in shaping the answers to it. Since the question is seldom asked directly or consciously, educators and health professionals may be unaware that it is being asked at all or that they are answering it.

From what I can tell, there is very little in their professional training which specifically prepares them to answer it, to structure their experiences so that their answers will become more cogent as that experience accumulates, or to make them aware that their most important interaction with the disabled child and his or her family is about the business of answering that question.

Because the question is so crucial to the therapeutic and educational relationship, let me restate it, identify some of the critical junctures at which it is asked, and then examine some of the consequences of recognizing how critical it is.

The question: "How much *control* can I exert over my physical and social environments and *how* can I exert it?"

It is generally first asked on behalf of the child by its parents when they first learn of his or her disability. It is often phrased in terms of limits. "What will my child be able to do?", meaning what won't my child be able to do? The question is most often asked of physicians initially when they bring the news of a newly discovered disability, but the question is also repeated in different forms to most of the health professionals and educators who see the parents during the child's early years.

Unfortunately, the question in that form is as unanswerable as it is legitimate. Few if any can predict the limitations that a disability will have on the life of a youngster at the point of disability or for quite some time thereafter. It is a question that the child will spend a lifetime answering and any answer given then can only limit the parents' perception of the child's potential and therefore limit their willingness to allow him or her to explore that potential fully.

At the same time, that child with a disability, let us call him John, has begun to collect his own answers to the question. The answers all children get are mixed and full of contradictions. The answers which John gets are more mixed than most. His attempts to control his physical and social environments trip over his physical or mental limitations. John imitates what others do to control their environments and the imitation often fails.

It is in this state of honest but still unselfconscious confusion that John is led into the therapeutic setting and the classroom. These twin environments, the classroom and the gym occupational therapy room/speech therapy room are theoretically just what he's been looking for, places where he can test the current limits of his control over his physical and social environment and systematically expand his control over both.

All too often they are not. They are places where he is put through a series of physical and mental manipulations which are designed to help him reach his objective but he doesn't know it. Nobody bothers to tell him. As a result, what happens in those rooms remain for John a series of mechanical manipulations. He may see the benefit of them in retrospect. While they are going on, he is likely to remain a passive participant in them.

I suggest that the professionals who use these rooms must redefine them as places where the child with a disability learns how much control he exerts over his physical and social environment and must redefine their roles in terms of their responsibility to assist that child in learning the limits of his current control and in learning how to expand that control. To do that, they must also redefine what goes on in that room in terms of learning and expanding that control. Most importantly, they must make those redefinitions in terms that are meaningful to the child, in terms which assure him that he and the teacher/therapist are engaged in a search for the answer to the same question—his question.

There is a cogent reason for suggesting this redefinition which grows directly out of the nature of disability but one which may not be apparent at first glance. Aside from a curiosity about their minds and bodies which intensifies from time to time as they develop, nonhandicapped children take their minds and bodies more or less for granted. The child with a disability does not. He rather consistently questions how and whether they will be allies in his attempt to control his environment. As he grows older and they fail him in public situations, that questioning takes on social as well as personal meaning and intensifies.

This suggests that therapeutic and educational processes must not only assist the child with a disability in learning to use his mind and body to control his environment, they must also assist him in understanding how those tools work in terms that he can understand. I am surprised by how little we teach children with disabilities both about those disabilities and about how the rest of their human apparatus works when I consider how fiercely they will contend with that apparatus as they grow up.

There are some advantages to the redefinitions I am recommending which accrue to the child with a disability, his teachers and therapists, and his parents. If implemented, they would engage the child with a disability as an active participant in educational and therapeutic processes which make sense to him in terms of his own needs. By giving him an active role in his own development and by defining that development in terms of expanded control over his environment, they better prepare him to live more independently as an adult.

These redefinitions unify the separate skills and approaches of the various professionals who treat that child by setting a commonly defined goal for their efforts. Hopefully, this will provide a focus for their interaction and simplify their communication with one another. It also may provide a framework in which to redefine their own roles more effectively.

In redefining the educational and therapeutic processes as a means by which a child with a disability learns and expands his control over his environment, parents are given a role which is more intelligible to them. They can more easily evaluate specific educational and therapeutic objectives in terms of that goal and thus participate more effectively in setting and achieving those objectives.

In suggesting this redefinition of the educational and therapeutic process in terms of the child with a disability and his need to control his environment, I have borrowed from many schools of thought. In order to avoid injustice to any of them, I have dressed up those borrowings in language ordinarily foreign to them. It is also not the language commonly spoken by either educators or health professionals. I have done this self-consciously in the hopes that you will look afresh at the ideas the language contains . . . and carry them to conclusions far beyond those set forth here.

Meeting the Needs of Children and Youth with Disabilities: A Parent's View of the State of the Art

Jayn Wittenmyer

An active advocate for persons with disabilities, Jayn Wittenmyer serves as Executive Director for the Wisconsin Council on Developmental Disabilities. Her primary interest is obtaining services for handicapped persons through the political and administrative arena. A former teacher, Jayn Wittenmyer is parent to three daughters, one of whom is handicapped. It is because of her interest in securing meaningful services for her daughter that Jayn became involved in the volunteer work of the Association for Retarded Citizens. She has had local, state and national involvement in the volunteer movement.

Jayn also serves as a faculty workshop presenter for the American Society of Allied Health Professions' Allied Health Child-Find and Advocacy Project.

Introduction

My paper could be titled "To Be or Not To Be," as the past nineteen years have been a series of successes (to be) and struggles (not to be) as our daughter Amy has made her way through the medical, allied health and educational systems.

During my years as Amy's case manager, and as an advocate at the local, state and national levels for other people who are disabled, I have become more and more aware of one missing piece of the system puzzle. In the State of the Art papers from your notable colleagues, it was evident also. That piece relates to *pre-service* training — education for professionals before they are in the community and working with persons who are disabled and their families.

Before I react specifically to the three state of the art presentations, I would like to share with you a short story.

Last week I received a frantic call from a foster parent caring for a child who is severely retarded and has a congential heart defect. The previous week the child started having breathing problems and the foster parents rushed her to the hospital. At the hospital, oxygen was administered and within a couple of days the child responded and was sent home. The doctor told the foster parents that if this should reoccur, the child should not be brought to the hospital but should be left to die. The foster parents talked to the nurse and were told they could do nothing. They talked to their case worker and again were told they could do nothing. They talked to a friend who was a judge and again were told that if the doctor told them not to bring the child to the hospital, they must comply. The call to me was a last resort.

Needless to say I think there can be another course for the foster parents and the child they have in their custody.

I am sure this story raises many questions in your mind. Some are simple, such as—how much information do the foster parents have about the medical/health condition of the child? What is the medical prognosis and what is appropriate health care? Is there another doctor in the town where these folks live?

Other questions are more complex: What is society's responsibility to a child with serious medical problems? What are the moral and ethical rights of the child? Who gets to play God?

My use of this 1982 story as the start of my reaction to the medical, allied health and education papers is one way of saying, "Yes, we've come a long way because of P.L. 94-142 and other significant state and federal legislation, but we haven't really arrived." One major reason—we cannot legislate a change in attitude.

Reaction in Pediatric Medicine

Surprisingly, I agree with most of Dr. Richardson's analysis of the pediatricians' contributions, and, in particular, his reflections on the impediments to multidisciplinary teams and the limitations in physician education.

My remarks reflect across the physician population because most parents with a child who is handicapped must relate to a variety of physicians. Our first contact, and usually the bearer of "bad" news, is the obstetrician or family practitioner—that is, unless he "passes the buck" to the pediatrician or specialist.

Our range of contact with physicians for Amy has included her pediatrician, who went into adolescent medicine as his "kids" became teenagers; an ophthalmologist, for her severe near-sightedness; an orthopedist, due to Amy's developing scoliosis and lordosis which required a Milwaukee brace for two years; her dentist for continuous preventive care complicated by several medications; and currently we have added a cardiologist due to the increasing severity of Amy's congential heart condition.

As I've analyzed my feelings about the medical profession, I find what I guess is only natural—that I bear some resentment toward the person who must tell me something negative about someone I love very much. In spite of my initial and sometimes continuing negative feelings, I must say that Amy has had some great, caring physicians over the past nineteen and a half years. She also has had some whose bedside manner left something to be desired.

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As Dr. Richardson noted, in physician education, very little pre-training time is spent on developmental and behavioral functioning of children.

My recommendations for physician education are: (1) to increase training for all medical students in the following areas: (a) relating to *children* with developmental problems, (b) working with *parents* of children and adults with handicapping conditions, (c) working with *siblings* of children with disabilities; (2) to raise the level of understanding between physicians and related professionals, particularly allied health and education; (3) to continue research at all levels on the prevention of handicapping conditions, and (4) to continue to update pre-training and inservice training to include the latest programs, resources and medical techniques for working with persons with handicaps and their families.

Reaction in Allied Health

Here, again, I agree with the analysis on Allied Health as presented by Ms. Hickey. The five major areas of responsibilities that have emerged from the Regional Workshops of the Allied Health Child-Find and Advocacy Project could be incorporated into pre-training curricula and/or continuing education for allied health professionals. I have thoroughly enjoyed the opportunity to participate in the Project and have gained much insight and knowledge from the broad array of professionals who have attended.

Our family experience with allied professionals has been varied also, as Amy has related to psychologists, nurses, social workers, occupational and physical therapists, adaptive physical education personnel, X-ray and laboratory technicians, and others. These experiences have produced both good and bad effects. Luckily, through continued communication among myself, Amy, her two sisters, and her father, we have been able to weather the storm.

My recommendation for the allied health pre-training curricula is to incorporate the findings and summaries from the Regional Workshops of the Child-Find and Advocacy Project.

Specifically, the allied health pre-training should include:

1. Assistance in communicating effectively with children and youth who are disabled and with their families.
2. Encouragement to recognize, accept and implement professional responsibilities in identifying, referring and advocating for youngsters who are disabled and for their families.
3. Assistance in understanding efforts of other professionals in health, education and related service fields.
4. Assistance in understanding state and federal legislation in order to assist families.
5. Encouragement to develop and/or modify educational standards to create access rather than barriers to persons who are disabled and wish to enter the health, education or related fields.

Reaction in Education

Dr. Reynolds' paper on the State of the Art in Education was particularly interesting to me as I have spent the last twelve years working to assure that Amy has an appropriate education. Nine of those years were spent convincing the school system that she could learn in the same building as her younger sister Adriene. I wasn't able to get her in the same building with her older sister Andrea.

We moved from a rural area of Indiana to Wisconsin to provide Amy with what we perceived to be better educational services. In our area of Indiana, Amy wasn't allowed in a school building. In Madison, children who were moderately to severely retarded were allowed into city schools, even though the children were segregated. However, when we enrolled Amy, we found that all is not always greener on the other side of the street. As Dr. Reynolds stated in the beginning of his presentation, "a small group of parents" in Madison got together and started working with the school administration. I appeared so frequently before the school board that the Superintendent asked who I was in hopes that I was one of his teachers and could fire me.

Mandatory special education legislation was passed in Wisconsin the year before P.L. 94-142, and as stated by Dr. Reynolds, many children with handicapping conditions have been provided educational opportunities many of us parents thought we would never see.

In addition to a special education teacher, Amy has worked with language development specialists, a mobility specialist, pre-vocational and vocational counselors, daily living coordinators, and numerous others. The Individual Educational Plan (IEP) with the multidisciplinary team (M-team) can work. What makes the process work? The key link is a parent who acts as advocate and case manager and who consistently makes sure that the educational and medical needs of a son or daughter are being met. One thing I learned from working with professionals over the years is that we all are able to learn if we all learn to listen and communicate.

Summary

I shifted into my summary section with that last phrase and I think it bears repeating. The most important point you as trainers of professionals can teach to your students, no matter what area of the human services field they are entering, is to LISTEN. The one complaint I hear the most from parents, family members and persons with handicapping conditions is that the professional didn't listen, didn't appear to hear what I said, didn't pay any attention to what I want for my child.

Second, encourage more information in pre-training curriculum about handicapping conditions and available resources.

Next, encourage and support discussions about how to talk to parents, siblings, children and adults who are disabled and other family members.

Fourth, encourage cross-discipline knowledge and communication.

Last, support and encourage research and continued learning of new techniques in working with children with handicaps. Medical research has done a tremendous job of developing life-saving techniques. We have trauma centers with highly technical staff who get to the scene of an accident quickly. Two specific examples come to mind: the teenager in a car accident with severe head injuries or the two-year old who falls in the backyard swimming pool. We know how to revive or sustain life. However, we have not done adequate research into the social and personal resources these children and their families need. The number of individuals in these two categories is increasing at alarming rates, and the allied health or educational professionals are not prepared for the kinds of problems these persons and their families are experiencing.

In conclusion, let me say that with early identification, coordination among professions, communication and cooperation with parents, dollars for resources and research to continue learning and prevention, we could make this a better world for our children and our children's children.

COOPERATIVE PROGRAM INITIATIVES

The following summarizes three concurrent sessions presented to Forum participants as case studies of collaborative efforts. Summaries of additional collaborative efforts follow.

The Role of Interinstitutional Relationships in Responding to the Needs of America's Handicapped: A Model

Keith D. Blayney, Ph.D.
Janice Hawkins, M.A.

Dr. Keith D. Blayney is Dean of and Mrs. Janice Hawkins is a faculty member in the School of Community and Allied Health, University of Alabama in Birmingham, Birmingham, Alabama.

Administrators, teachers, parents and others responsible for the provision of services to handicapped students recognize the need for inter-agency communication and cooperation. If services are to be integrated into an effective continuum, an effort must be begun to organize and promote programs throughout the states to serve a wide spectrum of handicapped individuals. In the absence of base funding to provide stability for this continuum of services, the quality and degree of programming is attainable only through agency cooperation.

One example that best characterizes what is possible through interinstitutional cooperation is the relationship shared by the School of Community and Allied Health (SCAH), University of Alabama in Birmingham (UAB), and the Alabama Institute for Deaf and Blind (AIDB).

SCAH's first major involvement on behalf of the handicapped came as a direct result of a multi-year grant funded by the Bureau of Health Professions in 1976. The purpose of the project was to integrate hearing and visually impaired students into some of its programs. For the first time allied health programs, traditionally closed to the majority of handicapped students, were offered as potential training opportunities for the sensory impaired. The objective of the grant was to identify problems and obstacles which might thwart enrollment and to identify solutions whereby sensory impaired students could function in these programs. During the term of the project, 23 students were enrolled in the technical and clinical phases of allied health programs at SCAH. Of that number, 21 were considered to have severe to moderate visual or hearing problems. Ten of these 23 students ultimately graduated from the programs and are presently employed in their respective fields. Five students are in the process of completing their clinical training and will graduate within the next year. Eight students dropped from the program due to health problems, personal problems, academic problems, or a transfer to other institutions.

Of the ten graduates, six had hearing losses, four had visual impairments. These ten graduates finished in eight different programs. Eight students received Associate Degrees and two have received Master's Degrees. The five students presently enrolled in technical clinical training are exploring three additional areas of study. Thus, data collection on the total fifteen students relates to eleven different allied health programs. It should be noted that *ALL* the students who completed the programs are working in their respective fields.

Lessons learned from this experience include the following:

1. Reliable and well informed referral sources are imperative.
2. Counseling and career exploration with the prospective student should take place as early as possible. This can best be accomplished through professional services offered by personnel trained in rehabilitation counseling and through on-site clinical experience.
3. The Allied Health Program Directors teaching handicapped students need support and encouragement at all levels, but particularly at the administrative level. Also, interaction with successful handicapped persons is valuable as the Program Directors experience attitudinal changes regarding the ability of handicapped persons.
4. No student, whether handicapped or not, can do *everything* well. The handicapped student should be given the *opportunity* to try rather than automatically excluded due to the often false assumption that he or she cannot succeed in training.
5. The identification of as many resources as possible for faculty and students on the local and national level must be accomplished.
6. Occasionally, handicapped students may require additional time for course completion.
7. Students who are successful in mainstreamed environments, for the most part, demonstrate functional independence, good personal skills, resourcefulness, initiative and persistence.

In the process of grant development and in the recruitment of students, a cooperative relationship was established between the School of Community and Allied Health and the Alabama Institute for Deaf and Blind (AIDB).

The AIDB is located in Talladega, Alabama, approximately 50 miles from Birmingham, and is one of the world's most comprehensive facilities serving the deaf, blind and deaf-blind multihandicapped from birth through age 65. The nature of the Institute is such that considerable attention is focused on the health aspects of the various populations served. A number of interinstitutional relationships exist between the Institute and the UAB Medical Center. Perhaps the oldest relationship is with the School of Optometry.

Through this arrangement, examination services as well as low-vision services and training are offered to students and blind employees of the Institute. This program has served to benefit both student interns at the School of Optometry and the students and blind employees of the Institute through service delivery.

Initial interinstitutional efforts with the School of Community and Allied Health included the delivery of staff development programs by faculty of SCAH for the purpose of upgrading AIDB houseparents. The goal of this staff development program was to provide intensive training in areas which would better equip houseparents to perform their jobs. To accomplish this goal, SCAH faculty taught a variety of courses, including an orientation to occupational therapy (OT), physical therapy (PT), and family relationships. The program culminated in the awarding of certificates of completion to the houseparents by the School of Community and Allied Health.

The next phase of SCAH/AIDB involvement was a comprehensive evaluation of AIDB programs by SCAH's OT and PT faculties, followed by an indepth evaluation by SCAH's Nutritional Sciences Department. The working relationship between the School of Community and Allied Health, UAB, and the Alabama Institute for Deaf and Blind holds great promise for each partner in this collaborative process. For SCAH, student interns have the benefit of training with a student population that is unique. For the Institute, the ability to expand services for its unique populations is desirable and, in fact, necessary.

The role of interinstitutional relationships in meeting the needs of the handicapped in future years will deserve increased attention. Due to funding constraints, coupled with a need to reduce unnecessary duplication while expanding resources, it is felt that Alabama's interinstitutional consortia offers a viable and valuable example which could be replicated at comparable institutions located throughout the United States.

Institutions such as the Alabama Institute for Deaf and Blind recognize all too clearly that they must avail themselves of a "critical mass" of resources, such as those which exist at SCAH, in order to assure comprehensive and continuous availability of services required in serving handicapped students. Shared relationships prove to be mutually satisfactory and mutually beneficial; hence, the watchword of the future will be the ability to "capitalize through collaboration."

Multiclinic: An Interdisciplinary Team Approach

Clyde R. Willis, Ph.D.

Dr. Clyde R. Willis is Director for the Center on Human Services at Western Michigan University in Kalamazoo, Michigan.

Clinical diagnosis of children and youth with multiple handicaps has been improved significantly through interdisciplinary activities. While many service programs have contributed to this trend, our clinical education and training programs failed to keep pace. Academic programs, lumbering under policies that tend to resist change, are frequently protective of disciplinary boundaries; in many, team approaches are not popular and often rejected as part of a clinical student's basic curriculum. To adequately meet the needs of children and youth with handicapping conditions or chronic illnesses, our academic programs must emphasize more strongly the special training needed for team care. Innovative approaches to clinical teaching must be explored.

One such approach is Western Michigan University's MULTICLINIC. This interdisciplinary diagnostic clinic for multiply handicapped individuals was initiated more than a decade ago on the campus in Kalamazoo. This presentation will summarize the development of the MULTICLINIC and will attempt to analyze some of the possible reasons for its success.

Western Michigan University has a long and distinguished history as an institution with outstanding clinical programs. Its speech, language and hearing program and its occupational therapy program were among the first of their kind in the Country. Both have international reputations. In addition, Western's programs in blind rehabilitation, reading disabilities and psychology are exceptional. New programs for physician assistants, music therapists, and special educators also enjoy a strong clinical reputation. It may also be important to point out that Western has no medical school.

In 1972, a handful of faculty from some of these programs met to discuss ways that cross-disciplinary clinical teaching might be improved at Western. Team-taught courses and other strategies had been tried in the past. All met with the same fate: disinterest, nonsupport and elimination. A new approach would have to be faculty-supported, cost-effective and clinically effective. The decision was made to utilize television. MULTICLINIC was born.

Each month a client with multiple handicaps was selected from the clinical pools of the various programs. The faculty, all volunteers, would meet at lunch to discuss the case and to plan a two-hour diagnostic evaluation that would be televised. Emphasis would be placed on those clinical activities most important to the students who would be watching. Following the television production, faculty would be available to students for a discussion of the clinical proceedings and to answer questions.

The experiment was an immediate success. Students were impressed by the observation of not only their own faculty, but of faculty from other health and human service clinical programs; the administration was impressed by the fact that the activity had been initiated by the faculty at virtually no additional cost to the institution; clients and their parents reacted favorably to the comprehensive, interdisciplinary evaluation.

Most important, perhaps, was the reaction of the participating faculty. Not only did they feel some ownership of the program, but their participation became a refreshing variation in their routine, provided them with an opportunity to interact with clinical faculty from other departments and yielded a teaching videotape that would be useful in their respective classrooms. Later, they would find that participation would have advantages with respect to tenure and promotion reviews, presentations at professional meetings and research endeavors.

In 1981, ten years after the initial production, the MULTICLINIC was awarded Second Prize in the International Rehabilitation Film Festival held at the United Nations in honor of the International Year of the Disabled. Presentations on the MULTICLINIC have been made to the Council on Exceptional Children, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, the American Association of Physician Assistants, the American Society of Allied Health Professions, the American Association of Educational Broadcasters, the Council on Social Work Education, the Health Education Media Association and several other organizations.

Why has it worked? There are no clear answers, but several possibilities come to mind. First, *the MULTICLINIC originated with the faculty and is maintained by the faculty.* Although administrative responsibility has been assigned to the Center for Human Services in the College of Health and Human Services at Western, the MULTICLINIC preceded both and remains virtually autonomous. It has an executive committee comprised of faculty who elect their own chairperson and establish their own policies. Second, *the MULTICLINIC is cost effective.* The faculty who participate do so on a volunteer basis. The pay-off comes in the form of recognition, interaction with other clinicians and access to outstanding clinical material rather than monetary compensation. Since no one is assigned to the MULTICLINIC, those who participate do so willingly and enthusiastically. Also, the videotaped productions provide a bank of *valuable instructional material.* Finally, *the MUL-*

TICLINIC has been accepted by the community as a service by the University. As such, it has increased the interaction among and support by the community agencies and institutions, a condition strongly endorsed by the University administration.

Students from the clinical programs continue to represent the most significant outcome. As a result of the MULTICLINIC they have been able to observe outstanding clinical work and the team approach in action. As clinicians, they will be much better prepared to respond to the complexities of the multiply handicapped. A small step, perhaps, but one that heads us all in the right direction.

For more information on the MULTICLINIC, write Dr. Clyde R. Willis, Director, Center for Human Services, Western Michigan University, Kalamazoo, MI 49008.

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Roles and Responsibilities of Allied Health Professionals in Providing Services to Individuals with Disabilities and Their Families

Carolyn M. Del Polito, Ph.D.
Anthony S. Bashir, Ph.D.

Dr. Carolyn M. Del Polito is the Director for ASAHP's Advocacy Initiative for Persons with Disabilities and coordinator of the Forum. Dr. Anthony S. Bashir is Chief Speech-Language Pathologist at Boston's Children's Hospital. Dr. Bashir also has participated as a faculty member for the Society's Advocacy Workshops.

A m[illegible]vity of the Advocacy Initiative for Disabled P[illegible] has been the implementation of regional workshops, designed for cadres of experienced related health professionals in each of the Department of Education regions. Participants for each of the six Workshops[1] were identified by their professional organizations as leaders within their professions and targeted for their unique potential in affecting change both within and outside their work environments. In addition to the significant professional and personal alliances and advocacy initiatives developed during the workshops, a major outcome was the identification of specific roles and responsibilities all health professionals should assume—whether or not they interact directly or consistently with youngsters who have disabling conditions. Importantly, the roles and responsibilities reported below emerged repeatedly across working groups and across regions.[2]

The roles and responsibilities required by allied health professionals to meet the needs of persons with disabilities and their families may appear extensive; however, they are not unlike the roles and responsibilities needed for serving any client. The emphasis and implementation of these roles and responsibilities will vary from time to time, determined primarily by the context of one's professional practice, personal motivation and environmental and organizational constraints.

Clearly, the competencies suggested by this list of roles and responsibilities are important for all related health professionals and should not be perceived as limited to those professions which treat children and youth for their handicapping conditions. As indicated earlier, as professionals in the health-care system, all related health professionals will be expected to possess such competence and, therefore, need to be prepared.

1. Roles and Responsibilities Related to Legal and Regulatory Issues
   - To understand State and Federal legislation in order to assist families in solving problems related to the child/youth's condition; that is:
     1. To facilitate the provision of appropriate services for the youngster with a handicapping condition;
     2. To facilitate parents' understanding of case management procedures for the child/youth;
     3. To facilitate identification of an appropriate case manager for the youngster;
     4. To recognize and provide accurate information to parents;
     5. To assist parents in understanding their legal rights;
     6. To assist parents in defining and accepting their roles and rights; and
     7. To promote self-advocacy skills among youngsters and parents.
2. Roles and Responsibilities Related to Societal and Professional Attitudes
   1. To recognize and accept the needs and rights of disabled youngsters.
   2. To recognize the need to be sensitive to and understand the influence of cultural differences in the identification, referral, and treatment processes.
   3. To recognize the prevalent forms of prejudice, stereotyping, and tokenism, and understand how myths and stereotypes contribute to the devaluation of people with disabling conditions.
3. Roles and Responsibilities Related to Professional Practice—General
   - To provide effective and competent services for which one is trained; that is:
     1. To recognize the indicators of handicapping conditions for severe, mild-moderate, and high-risk children and youth;
     2. To provide appropriate screening programs so as to identify children and youth with possible disabilities and make appropriate referral for assessments;
     3. To provide appropriate assessments of individuals with disabilities; and
     4. To participate in the planning, design, and

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[1] Regional workshops were conducted in California, Minnesota, Maryland, Vermont, Tennessee, and Colorado.

[2] Individuals participating in the workshops have represented the professions of Audiology/Speech-Language Pathology, Corrective Therapy, Dental Assistance & Dental Hygiene, Dietetics, Health Education & Administration, Medical Assistance, Medical Technology, Medical Record Administration, Rehabilitation Counseling, Social Work, Nutrition, Occupational Therapy, Physical Therapy, Nursing, Physician Assistance, Psychology, and Recreational Therapy.

implementation of programs for individuals with disabilities as appropriate to one's professional concern and practice.

- To understand, implement, and promote methods for identifying appropriate referral sources.
- To maintain accurate records of assessments, treatments, and progress.
- To maintain and use current technologies to share information about clients and their conditions (e.g., computer networks).
- To understand the effects of current treatments on the future performance of the client and to communicate this understanding to parents and clients.
- To educate one's self, parents, colleagues, employers, and communities about the needs and rights of individuals with disabilities and their families and the roles the various professionals perform in providing services.
- To disseminate accurate information to the public concerning:
  1. the nature of disabling conditions;
  2. the needs and rights of individuals with disabilities;
  3. the roles health, education, and medical professionals assume in the rehabilitation of individuals with disabilities; and
  4. the qualifications for providing services.
- To promote excellence in the quality of service delivery among one's own and others' professions (e.g., eliminate time constraints and scheduling barriers, develop peer review systems).
- To recognize the need for and participate in activities that will ensure continued professional growth and competency, that is:
  1. To participate actively in one's professional organization;
  2. To advocate for the needs of individuals with disabilities and their families within one's profession;
  3. To participate in various activities that will facilitate continued growth of professional knowledge; and
  4. To promote appropriate interdisciplinary training of allied health professionals so as to meet the needs of and ensure the rights of individuals with disabilities.

Roles and Responsibilities Related to Professional Practice—Coordination

- To help coordinate efforts of health, education, and related services; that is:
  1. To understand other health, education, and related services professionals' roles;
  2. To work cooperatively with other professionals concerned with the services provided for children and youth;
  3. To be sensitive to and actively participate in coordinated and adaptive health-care planning for the life span of the youngsters;
  4. To promote interdisciplinary pre-service teaming opportunities (e.g., shared curricula and field experiences);
  5. To promote and, as appropriate, conduct research pertinent to clinical practice;
  6. To read and publish in the journals of other disciplines;
  7. To help develop effective alliances between various professional organizations and existing parent and consumer coalitions to promote the needs and rights of youngsters with disabilities; and
  8. To advocate for funding from appropriate local, state, and federal agencies to train health professionals.
- To help develop and provide cost-effective programs and services.
- To identify and help implement creative approaches to funding programs for persons with disabilities (including community and business resources and consultants);
- To improve existing approaches to the delivery of health and education services through research and dissemination.

5. Roles and Responsibilities Related to Professional Practice—Advocacy

- To promote advocacy initiatives on behalf of youngsters with disabilities with other professionals.
- To promote and advocate for prevention of disabling conditions (e.g., pre-natal care; genetic counseling, etc.).
- To understand and be able to explain the dimensions and limitations of personal and professional advocacy and its intimate relationship with appropriate identification and referral procedures.
- To assist in consumer/client and parent involvement in advocacy efforts.
- To exert pressure for enforcement of existing laws at local, state, and federal levels.
- To promote regulation, legislation, and litigation on behalf of youngsters with disabilities and their families.
- To understand the political process and the implications of advocacy within one's work setting, community, state, and professional organization.
- To help establish and maintain geographical networks to promote access to services in underserved areas (e.g., transportation networks, rural service delivery networks, etc.).
- To help develop and/or modify educational standards to create access rather than barriers to individuals with disabilities who wish to enter the health, education, and medical professions.

6. Roles and Responsibilities Related to Communication

- To communicate effectively with individuals with disabilities and their families; that is:
  1. To convey information clearly and listen actively to individuals with disabilities and their families;
  2. To adapt messages according to the needs of the individual with a disability and his/her family; and
  3. To be sensitive to and adapt to the verbal and nonverbal cues which indicate concerns or problems related to the handicapping condi-

tion, whether expressed by parents, siblings, or the individual with a disability.

- To facilitate and effect appropriate interprofessional communication.
- To facilitate and effect appropriate inter- and intra-agency communication.
- To facilitate and effect appropriate communication between university/college training programs in health, special education, and regular education.
- To facilitate and effect appropriate communication with and between various state and/or federal agencies and governing bodies.

INTERDISCIPLINARY INITIATIVES

The following groups have begun interdisciplinary efforts in the service of youngsters with disabilities. They have listed their initiatives with the American Society of Allied Health Professions and information on their programs was shared with Forum participants. A brief summary of the program, participating groups, and contact persons follow. For more detailed information, please contact the person(s) listed for a particular program.

Program Title	Description	Sponsoring Unit/Contact
Child Development Clinic	Interdisciplinary model for training professionals in human services	James Madison University and the Virginia Department of Health & Bureau of Maternal & Child Health Contact: Dr. A. Jerry Benson, Child Development Clinic, James Madison Univ., Harrisonburg, VA 22807 703-433-6484
Children's Center	Interdisciplinary and discipline-specific training to students within the allied health professions and other related fields	Louisiana State U. Medical Center and School of Allied Health Professions Contact: Patsy Poche, Children's Center, LA State U. Medical Center, 1100 Florida Ave., Building 119, New Orleans, LA 70119 504-948-6881
Cooperative agreement for undergraduates in special education	A major in education for the visually impaired, multiply-handicapped and a minor in speech and hearing science to supplement a generic special education major	Vanderbilt Univ. and Trevecca Nazarene College Contact: Thomas Rosbrough/ Ralph G. Leverett, Trevecca College, Nashville, TN 37203 615-248-1200
COUNTERPOINT newspaper, cable link, handcrafted books, electronic networking	Newspaper: an interface among special education, regular education, and related disciplines concerned with education and special education; Linking allied health professionals with cable television; Featuring information on allied health on SPECIAL NET	Counterpoint Communications Company Contact: Judy Smith, Counterpoint Communications Co., 3705 South George Mason Drive, Suite C-4, Falls Church, VA 22041 703-931-4432
Masters Degree in Special Ed. for Therapists Working in Education Settings	Training a new educational specialist for the public school who can train school personnel to perform the specialized function of the therapist.	George Peabody College of Vanderbilt Univ. Contact: James R. Lent, Vanderbilt University, George Peabody College, Dept. of Special Ed., Box 328, Nashville, TN 37203 615-322-8265
Parent Training Program	Enabling parents to play an informed and active role in obtaining public education and related public educational services for their handicapped children	Southwestern Ohio Coalition, Parent Information Center Contact: Joanne Queenan, Southwestern Ohio Coalition for Handicapped Children, 3025 Burnet Ave., Cincinnati, Ohio 45219 513-861-2400

Project C.H.I.L.D.	Coordinated help for infants with lags in development	Michigan Dept. of Mental Health, Developmental Disabilities Grants Unit and Kalamazoo County Community Mental Health Board Contact: Clyde Willis, Western-Michigan University, Center for Human Services, Kalamazoo, MI 49008 616-383-4941
Role of Interinstitutional Relationships in Responding to the Needs of America's Handicapped: A Model	Cooperative interinstitutional relation between the School of Community and Allied Health and the Alabama Institute for Deaf and Blind	School of Community and Allied Health, Univ. of Alabama in Birmingham Contact: Keith D. Blayney, School of Community and Allied Health, U. of Alabama in Birmingham, University Station, Birmingham, AL 35294 205-934-3527
Special Child Clinic Program	Increasing participation of medical and health community in evaluation and program planning for handicapped youth served by Special Education	Kansas Crippled Children's Program; Kansas State Departments of Education, Health and Environment Contact: Joan Watson/Elizabeth Husband, Box 1308, Emporia, KS 66801 316-343-6978
Special PT/OT Project	Develop and implement a state-wide plan for the effective integration of therapists into school settings	U. of NC, Chapel Hill and State Dept. of Public Instruction, Div. of Exceptional Children Contact: Dianne Lindsey, PT/OT Special project, 267-A Trailer #11, Craige Trailer Park, Univ. of NC, Chapel Hill, NC 27514
Speech-Language Pathology	Related findings and recommendations of speech-language pathology with other professional disciplines, schools and parents.	Speech and Hearing Clinic, Minot State College Contact: David K. Williams, Minot State College, Speech and Hearing Clinic, Box 46, Minot, ND 58701 701-857-3030
Service Coordination for Pre-School Handicapped Children	Techniques developed for local coordination of services, a needs assessment, and action plan for coordinating services for pre-school handicapped children.	Georgetown University Hospital Contact: Phyllis Magrab, Director, Child Development Center, Georgetown University Hospital, 3800 Reservoi Rd., N.W., Washington, D.C. 20008 202-625-7676

FORUM: ISSUES AND RECOMMENDATIONS

With the materials presented thus far in this document forming the background for small group working sessions, the 125 administrators present at the forum responded to the following questions:

FOCUS: In what ways can allied health and education training programs coordinate their efforts in preparing their respective students to meet the demands and challenges of both new and existing work environments related to youngsters with disabilities and their families?

Discussion Questions:

- Why is cooperation needed/desirable; *i.e.*, What's wrong with the current situation?
- Where are the critical junctures where cooperative efforts are needed?
- What appear to be the obstacles for cooperation?
- What resources are available?
  - — What expertise does each individual bring to the conference?
  - — What resources does each conferee have at his/her disposal?
  - — What expertise is available from the institution/community (*e.g.*, Rehabilitation Counselors, Parent Coalitions, School Nurses, Social Agencies, etc.)?
  - — Other professional networks/resources?
  - — Other personal networks/resources?
- What strategies can be utilized to overcome the identified obstacles?
- How should these interventions be prioritized at the local level? State level? National level?

Within the small-group working sessions, the chief administrators in allied health and education identified the need for new and refocused leadership in building and implementing collaborative models for cooperation — among professions, among academic programs, and among institutions and agencies. Specifically, the administrators outlined the *major barriers* to interprofessional and interagency alliances as well as the *policy recommendations* which follow.

Barriers to Coordination

A. *Communication problems* between and among professional groups, academic units, educators, service providers, consumers, and advocates: including:
   1. Philosophical differences (e.g., discipline based vs. systemic approaches); and
   2. Complexity of institutions and institutional types.

B. *Parochialism in professional training programs;* including:
   1. Traditional missions and roles of various training programs and faculty;
   2. Emphasis on skill acquisition vs. philosophical and problem-solving approaches;
   3. Absences of common clinical settings for training; isolation of service delivery sites;
   4. Maintenance of traditional territorial specialization; and
   5. Fragmentation of service delivery and responsibility.

C. *Low priority given to interdisciplinary activity in academic institutions;* including:
   1. Little recognition among many programs/institutions that a problem related to coordination among health and education training programs actually exists;
   2. History of separateness between health and education, both physically and philosophically;
   3. Few university mechanisms available which facilitate or reward interdisciplinary activity; in fact, many interfere (e.g., negative impact of joint appointments for faculty tenure decisions and program accountability (FTE's);
   4. Credentialing and licensure procedures which mandate specialization and, therefore, weaken inter-professional activities;
   5. Competition for time and space in already overpacked curricula for students and faculty; and
   6. Perceptions of limited resources.

D. *Financial constraints*, including:
   1. Lack of funding for training and service delivery, producing competition among the training and service delivery institutions for available resources;
   2. Funding and control of related services by agencies separate from education agencies (e.g., occupational therapists funded by a State Health Department); and
   3. Influence of third-party payment eligibility for practice and health care delivery intervention.

E. *Parochialism in service delivery* (i.e., no one accepts responsibility for the whole person), including:
   1. Perceived fragmentation of responsibility for the provision of services—among agencies and among professionals;
   2. Limited incentives for interdisciplinary approaches;
   3. "Turf" disputes;
   4. Limited appreciation of each professional's expertise or contribution in the management of the youngster;

5. Conflicts in agreeing on who will make management decisions and coordinate the youngster's program;
6. Failure to prioritize service needs; and
7. Difficulty in recognizing each others' perspective relative to the child's (e.g., a physical therapist can explain what he/she is doing for the child but may not recognize or address the classroom teacher's needs in managing the same child).

F. Leadership issues, including:
   1. Absence of a shared philosophy among leaders within and across professional groups; and
   2. Absence of effective coalitions within the groups to influence policy and administrative decision making.

G. Governmental and regulatory issues, including:
   1. Differences between the social/political realities of academia as compared to the social/political realities of service delivery practice;
   2. Influence of accreditation regulations of professional societies on inter-agency collaboration and cooperation among professionals;
   3. Influence of tenure and promotional regulations and institutional rewards systems for cooperation and interdisciplinary programs for preparing professionals; and
   4. Influence of the disjuntive and incremental development of policy and regulations governing resources and services for a comprehensive policy for persons with handicapping conditions.

Policy Recommendations

As key innovators within the health care and educational systems, chief administrators in allied health and teacher education have much to contribute to the design and implementation of local, state, and national initiatives for youngsters with disabilities, their families, and their service providers. The policy recommendations emerging from the Forum's problem-solving sessions and the preamble, repeated here, clearly illustrate the collective vision maintained by the 125 participants. This vision encourages, guides, and supports new collaborative initiatives and models for personnel training programs.

Preamble

We believe the goal of education is to prepare each individual to function effectively and productively as a self-sufficient and contributing member of the society. Provision of an appropriate education becomes a key principle upon which educational programs are developed. It is important, therefore, to:

1. Provide a comprehensive and coordinated system of services to children and youth with handicapping conditions;
2. Coordinate and share responsibilities among the allied health, regular education, and special education professions for planning and delivering services;
3. Develop new coalitions among local, state and federal agencies, the private sector, colleges and universities, and professional organizations for developing education and health care delivery programs which are based upon a strong, comprehensive policy and are supported by adequate resources (financial, personnel, etc.) for meeting the needs of persons with handicapping conditions;
4. Disseminate successful and cost-effective models of service delivery to service agencies, educational institutions, and the public;
5. Develop new and stronger alliances among governmental agencies, advocacy groups, families, clients, educators, and the allied health professions for implementing effective models and other successful practices;
6. Increase the awareness of the various publics as well as members of the education and related health services professions to the needs of children and youth with handicapping conditions; and
7. Encourage and facilitate university systems to (a) examine critically the roles and responsibilities of education and health care providers for meeting the needs of youngsters with disabilities, and (b) develop appropriate curricula for personnel preparation programs to address the expanding roles and responsibilities.

A. *National Recommendations*

1. Promote a national priority for education and health alliances for children and youth with disabilities.
2. Establish a coalition among national associations and disciplines to (a) identify and utilize functional models of training and service delivery, and (b) promote alliances among the disciplines, professional associations, and federal agencies.
3. Advocate for the maintenance of strong federal legislation on behalf of individuals with disabilities and their families. A uniform policy for all states is essential if persons with handicapping conditions are to have adequate educational and health care services.
4. Advocate for the provision of adequate funding for implementing federal legislation and regulations.

More specific recommendations include:

5. Through ASAHP's Interdisciplinary Task Force, with representatives from national professional associations concerned with meeting the needs and rights of youngsters with disabilities, (e.g. American Society of Allied Health Professions, American Association of Colleges for Teacher Education, Council for Exceptional Children and other appropriate allied health, education, and medical professional organizations, as well as parent and consumer organizations), the following agenda items should be pursued:
   (a) Encourage professional associations to adopt policies and/or endorse positions supporting interdisciplinary education, train-

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ing, and service delivery for persons with disabilities.

(b) Assist interested individuals (at local and state levels) in instituting specific efforts for interdisciplinary training (pre-service and in-service).

(c) Identify and disseminate information on effective interdisciplinary models and programs via existing avenues (e.g., national and state association journals, newsletters, meetings, ASAHP's expertise exchange, etc.).

(d) Promote administrative support for interdepartmental cooperative efforts in educating allied health and education professionals (e.g., invite ASAHP, AACTE, CEC, and perhaps others to write a joint letter to appropriate chief administrators in allied health and teacher education training programs, emphasizing the importance of such interdepartmental cooperative training efforts; OSERS Deans Grant's resarch and models should be consulted as well).

(e) Develop and disseminate a brochure illustrating interdisciplinary management of services (rather than a particular profession's isolated contribution). The design and dissemination of the brochure should involve all appropriate professions.

(f) Promote the recruitment of individuals with handicapping conditions into the various professions.

(g) Promote research on efficient, cost-effective approaches to training and delivery of services.

(h) Promote the need for each profession to develop and/or maintain a comprehensive plan to raise consciousness among members of the professions about the needs and rights of individuals with disabilities.

(i) Promote compatible theoretical bases among the professions—or at least an understanding of [illegible] professions' theoretical bases.

(j) Promote an app[illegible]ation (recognition of and respe[illegible] an understanding of the competencies and roles of other disciplines through training institutions, state agencies, and professional organizations.

(k) Obtain sanctions and commitments from gate-keepers in educational administration and professional associations in working toward the goals identified in the Forum.

B. *State Recommendations*

1. Work with state legislators to formulate strong, state-supported policies to assist youngsters with disabilities (ages 0-21) and their families.
2. Promote the establishment of formal agreements among those responsible for providing services to children and youth with handicapping conditions, including local education agencies, state agencies, regional boards, reimbursement agencies, and academic institutions to ensure coordinated, comprehensive, and appropriate plans for (a) the delivery of education and related health care services, and (b) preparing service providers.
3. Encourage states to gather, analyze, and disseminate data, including needs assessment information, for training and service delivery needs.
4. Encourage institutions to design appropriate curricula to prepare administrators of health and education programs for managing and coordinating comprehensive systems of service delivery.
5. Encourage states to establish certification requirements (or similar standards) which mandate adequate and appropriate preparation requirements for all persons serving children and youth in schools; i.e., regular teachers, special education personnel, and allied health personnel.

More specifically:

6. Encourage interdisciplinary and comprehensive planning among agencies providing education and related health services by convening a meeting of the agencies' key administrators at both state and local levels.

C. *Local Recommendations* (Note: Many of the National and State Recommendations also are appropriate for implementation at the local level.)

1. Encourage collaboration and develop new coalitions within academia (both between and among disciplines and institutions) and across systems (between and among public sector, private sector, academia, parent and consumer groups, employers, and legislative and regulatory bodies).
2. Encourage and promote formal agreements among the providers of services, local education agencies, and public and private agencies to ensure appropriate services for education, health care, and other life needs for children and youth with disabilities.
3. Promote the delivery of education and health-related services which are based according to locally coordinated and comprehensive plans.
4. Promote and develop appropriate conditions for professional practice for all health and education personnel.
5. Revise curricula to reflect the expanding roles and responsibilities of health and education professionals to meet the needs of youngsters with disabilities and their families, that is, curricula should be revised to include:
   a. Content and instructional strategies to produce health and education professionals who can interface with one another to serve the youngsters with whom they mutually interact.
   b. Core curricula across disciplines, including greater emphasis on: (1) communication and decision-making skills, (2) ethics; (3) laws and regulations; (4) individual rights;

and (5) organizational and community resources.

c. Strategies to facilitate interaction among faculty, students, clients, and professions for program decision-making, planning, and implementation.

d. Shared training and practice opportunities among disciplines.

e. New content areas (e.g., psychology of human sexuality, interpersonal and small group communication, organizational/systems change strategies, etc.)

f. New technologies to demonstrate interdisciplinary activity.

6. Encourage and promote acceptance of a shared philosophical approach for service delivery and training among the professions (e.g., a philosophy which centers upon needs of the client).

7. Facilitate and develop new organizational arrangements within and among academic institutions and programs to:

   a. Include clinical faculty on academic curriculum committees;

   b. Include consumers, advocates, and employers in program planning;

   c. Facilitate faculty exchanges; i.e., academic, clinical, and school-based faculty;

   d. Formalize information sharing between disciplines and institutions;

   e. Provide continuing education opportunities for health and education professionals to meet their expanding roles and responsibilities; and

   f. Design an action plan which would include:

      - a needs assessment;
      - review of existing curricula;
      - review of clinical practice and field sites and placement;
      - review of philosophy and mission statements of professional programs to reflect current needs for *appropriate* practice;
      - review of local resources; and
      - develop collaborative initiatives among the health and education professions.

CLOSING REMARKS

The following comments were delivered by Dean Corrigan, President of the American Association of Colleges for Teacher Education and by Dean Fitz, President of the American Society of Allied Health Professions at the closing of the Forum.

Summary Comments: A Perspective From Education

Dean C. Corrigan, Ed.D.

Dean C. Corrigan is serving currently as Professor and Dean of the College of Education, Texas A&M University. Being an active leader in the education field, he holds the position of President of the American Association of Colleges for Teacher Education.

A distinguished speaker and prolific writer, Dr. Corrigan has presented at many national and state educational functions and has authored over 70 articles dealing with a variety of educational issues. He has received recognition awards including the Distinguished Teacher Award from the National Association of Teacher Educators and the Educator of the Year Award from the Maryland Association of Teacher Educators, as well as scholastic awards from Columbia University.

The most vivid truth that emerges from the deliberations at this conference is that the time to stand and fight for the rights of the handicapped is now. We must not fold at each gust of discontent. The rights of minorities are always hard to achieve but the future of this country rests on the response we make to those in need. We have raised the expectations of the handicapped in all of the agencies represented at this meeting. We must not dash their hopes again.

The times call for leadership and the situation calls for collaboration across a variety of educational sites.

A new kind of leader will be needed in colleges of education to respond positively and promptly to the challenge of preparing educators for non-school settings. The new leaders will need to know how to work effectively not only within the setting of their own institutions, but with diverse groups in unconventional educational settings emerging in many places for people of all ages.

Versatility, imagination, a sense of social purpose, a futures orientation, clear theoretical frameworks, instructional and administrative ingenuity will all be necessary professional strengths of the new leaders for the expanded education profession. But the most important characteristic of the new educational leaders will be the ability to develop collaborative relationships which link organizational units with similar educational purposes.

The name of the game for leadership today is collaboration. Modern society puts a premium on organization, on system, on cooperation between units having common purpose or overlapping interests. It is a day of "calculated interdependence," of "involvement," of "planned togetherness." Life today is made possible by cooperation, by arranging interlocking complexities, by consciously making things more complicated. And the reason is simple. The complexity of modern society requires a pooling of knowledge and a sharing of resources to achieve mutual goals.

Academic leaders can no longer preside over their institutions in splendid isolation. Constructive relationships must be established with the federal government; with private educational institutions, with public agencies in such fields as health, environment, welfare, housing, community planning, libraries, television, the performing arts, business, industry and other settings which have up to now stood on the edges of the formal teaching, learning and social services processes. Colleges of education and allied health are now called upon to educate researchers, teachers, counselors and administrators and other education specialists for the federal government, regional educational laboratories, research and development centers, television councils, special programs to help the aging, the poor and the handicapped in community action centers and social service agencies, industrial establishments like Xerox, IBM, and Time-Life, and other agencies developing curricular materials and instructional systems. These are just some new interlocking complexities with which education and social service leaders must cope, and for which their educational preparation and previous experience has probably not prepared them. The new era then is one of "going steady." Educational leaders no longer walk alone.

In order to respond to this new era, new designs for programs to prepare education and social service professionals must be developed. As demonstrated in the alternative models presented at this conference, a central feature of these new designs is collaboration among agencies operating at different phases of the educational spectrum. The fact that education in the schools, social agencies, and other non-school settings, and the university and its colleges are interrelated and interacting components of *one* educational delivery system for the "learning society" must be recognized and reflected in plans for the future. Elementary and secondary schools and colleges are now part of a complex of continuing education for a large majority of America's people. Colleges can become obsolete, or they can become the training and research arm of this new, expanding education delivery system.

The time is right to seize the initiative in broadening the parameters of the education profession in the 1980's by developing collaborative unified programs with colleagues in the allied health professions and across all of the settings which employ educators.

Let's build this new coalition and put the full force of the professions to work for persons with handicaps in every community service setting in every part of this country.

Summary Comments: A Perspective From Allied Health

Polly A. Fitz, M.A.

Polly A. Fitz, Dean of University of Connecticut's School of Allied Health Professions and President of ASAHP, is also an Advisory Council Member for the Allied Health Child-Find and Advocacy Project, which is sponsoring ASAHP's 1982 Conference for the Chief Administrators of Allied Health and Education. Along with participating as a synthesizer for this conference, and chairing the National Forum on Allied Health Accreditation, Ms. Fitz also provided leadership for a number of ASAHP and other professional organizations' Councils and Committees. With wide experiences in education and administration, her background includes teaching and consultancies in Dietetics and Allied Health Education generally.

Many of the humanistic changes in health and education come from the consumers and/or the parents. Therefore, I believe it is important to focus initially on the parents and the persons with disabilities. Let us reflect on the comments of Jane Wittenmeyer and Ethan Ellis.

Listen to the parent. It is important that we talk face to face. It is important that we provide more information and meaningful experiences in pre-training curricula so that practitioners know how to talk to and listen to persons with disabling conditions. Further, the cross discipline knowledge and knowledge of cross discipline programs are most important. This knowledge will help to bridge gaps between practitioners and services. Lastly, it is important to further the cause of research so that there always will be hope and a future.

Ethan Ellis helped us to be sensitized to the person with a disability. His advice becomes an important goal to us: To build relationships between the allied health educator and the teacher. It is also important that we build toward independence, toward an understanding of how mind and body impact on the individual's life, so that persons don't separate mind and body.

As I participated and listened in many of the groups, I saw people beginning to worry about cost and financial concerns — and then move to discussion of resources — the quality of the product — the quality of the service. I saw people beginning to talk about control — who has responsibility for what, and who should be designated — and who has the appropriate title? As they moved through the conference, participants felt a release. People began to talk about mutual collaboration, the provision of services, and the generation of new ideas.

Another observation: people began to talk about communication. What were the channels? Who communicated to whom? How it was done in written terms? How it was done in terms of legal responsibilities? Gradually, through the conference, I saw developing in the group a move from communication to relationships... how can we join together . . . not only to channel our words and actions, but rather to change those words and actions into ideas and meaningful programs.

My last observation is that I saw the many conference participants high in the area of creativity. They brought this characteristic as a wonderful resource to their groups. And gradually, through the sharing and idea generation in those groups, they began to move toward renewal. . . a most precious commodity in terms of the future for PL 94-142.

I believe all of these moves from cost to resources, control to release, communication to relationships, creativity to renewal are the moves to both a pro-active stance and a coalition between allied health education and service. I believe that we now have the alliance between two important sectors: education and health.

I am humbled by the persons I have met in this conference and that are present in this room. I also reflect the pride of the Board of Directors of the American Society of Allied Health Professions in both the project and the project director, Carolyn Del Polito.

The challenges of the conference are many. The two foremost are the need for strong legislation and the necessary funds. Additionally,

- — We need to have our states address certification issues and the beginnings of formal agreements between the providers of services;
- — the American Society of Allied Health Professions is charged with developing a joint committee of allied health professionals and educators. Such a joint committee will utilize existing coalitions, and will use the expertise exchange established by the new initiatives of the American Society of Allied Health Professions. A joint committee will provide for initiating change at the local level throughout individual committee members;
- — We need to develop a brochure that is child-centered; one that can emphasize the interdisciplinary aspect of service delivery;
- — Deans and other administrators need to be alerted to coordinating efforts between ASAHP and AACTE;
- — We need to establish target groups at the local level. Deans of education and allied health must form alliances within their own universities. Furthermore, these universities must form alliances with school systems and parents, and with reimbursement sectors;

- Deans must take the responsibility to assist in the creation of an environment that will sensitize faculties to their roles and responsibilities for persons with disabilities. Our curricula, the majors and minors, must be examined with a needs analysis of the community as a basis for re-designs. Focus will be on team efforts and the coordination of clinical experiences. A role of staying healthy will be an important aspect of our curricula;
- We need to recruit persons with disabilities into the allied health professions and thus increase representation. This will assist us in formulating future goals;
- We need to provide for in-service and pre-service programs;
- We must all work toward a unified policy for all states.

The new coalitions consisting of allied health professionals, educators, special educators, university administrators and faculties can emphasize and begin planning for this future. This will be the new alliance. Through this we must work on adequate funding, formal agreements, certification, merging of departments, requisite activities, and leadership.

To promote the national alliance between education and allied health we need to first, develop the networks, coalitions and alliances at the state and national level. It will be across-systems and expanding beyond ourselves to the consumer. Members of these groups must re-examine educational philosophy, health discipline philosophy and training. Second, they must develop alliances with the leadership in education, so that the policy makers can promote the study of methods and techniques to further advance the curricula. Third, political action must follow, so that people who are making policy recommendations will know of our intent and the necessary goals and future directions. The role of ASAHP in promoting and participating in the initiative is to further the alliance between education and allied health and to work with the national and state perspective. Fourth, we must get the sanction and approval from higher education leadership. We need to get action for the programs initiated from both departments and practitioners. Getting our act together will enable us to influence policy. Fifth, the social scientist support networks need to be tapped, so that follow-up is our most important action.

We need to begin with ourselves and our respective spheres of influence. After all, leadership is nothing more than being out front and being a risk taker. In meetings we must raise awareness, put forth proposals, be ready with priorities, and now is the time for such action. . . let's not lose the value of 94-142 or the transition to a holistic idea!

I accept the charge to the American Society of Allied Health Professions to form the joint committee to keep this initiative alive, as we continually re-examine our priorities. I look for advice from the advisory committee. We have many opportunities in our regional symposia and local projects through the Kellogg initiative. We can foster legislative initiatives as a priority of our members. I'd like to end with a quote from Lowell Weicker from one of his recent TV shows regarding the institutionalization of the handicapped. I quote:

"There is a broad spectrum of opportunity, but it is most important to go in the direction of maximum opportunity."

I believe that that is the statement to carry us forward.

FOLLOW-UP ACTIVITIES

To implement the Forum's national, state, and local policy recommendations, participants urged the American Society of Allied Health Professions (ASAHP) to continue its leadership role, expanding on the work accomplished thus far, and establish an Interdisciplinary Task Force to (a) review the Forum's outcomes and (b) identify next steps to promote and implement the Forum's recommendations on behalf of youngsters with disabilities and their families. ASAHP's Board of Directors approved the establishment of such a Task Force and identified members and organizations for participation. A meeting of the Task Force was held January 27-28, 1983 in Washington, D.C. Members include representatives from the following:

- American Society of Allied Health Professions (ASAHP)
- American Academy of Pediatrics (AAP)
- American Association of Colleges for Teacher Education (AACTE)
- American Association of Community and Junior Colleges (AACJC)
- American Association of School Administrators (AASA)
- Council for Exceptional Children (CEC)
- National Association for Protection and Advocacy (NAPA)
- National Association of State Directors of Special Education (NASDSE)
- National Council on Developmental Disabilities (NCDD)
- Parent Coalitions
- University Affiliated Facilities (UAF)
- Education in Allied Health
- Education in Medicine
- Education in Special Education

In its deliberations, the Task Force focused on the critical issues in the *design of quality personnel preparation programs, resources,* and *data needs,* and identified *future directions* to meet the service delivery demands of the 1980s. Importantly, Task Force members reitterated and emphasized the need for interdisciplinary training and collaboration among allied health, regular education, and special education with the CHILD as the focus for all provision of services.

As Task Force members poignantly reviewed, professionals in health and education are unaware of one another's roles and responsibilities in providing services to youngsters with handicapping conditions. Collaborative, interdisciplinary training programs which address the concerns identified during the Forum do exist; however, dissemination of effective practices and widespread implementation do not exist. Task Force members cited the critical need to:

1. Identify, document, and disseminate current model programs and practices;
2. Promote research to obtain the quantitative and qualitative data required to support "quality" training programs; and
3. Encourage and promote collaboration among *all* existing training programs preparing service providers in allied health, regular education, and special education.

The following summarizes, in outline form, the Task Force's deliberations on:

I. Critical Issues in Personnel Preparation
II. Criteria for Quality Training Programs
III. Data Needs
IV. Available Resources
V. Desired Outcomes and Future Directions.

I. CRITICAL ISSUES. The following issues were identified as critical for meeting the needs of youngsters with handicaps as they impact the design of quality training programs in allied health, regular education, and special education.

A. With the passage of Public law 94-142—the Education for all Handicapped Children Act—health and education services for youngsters with handicapping conditions have changed radically. Educational approaches and systems similarly have changed, impacting the youngsters, their families, their teachers, and their classmates. These changes in services require professionals in special education, related services, and regular education to assume new and expanding responsibilities, demanding further changes in training programs—both pre-service and in-service preparation programs.

B. The focus of all provision of services should be on THE CHILD. Professionals serving the child should recognize and accept the responsibility to ADVOCATE for the entire child; that is, to advocate for full, total care adapted to the life-long needs of the youngster.

C. Allied health must help to ensure appropriate, total care for the child. While many youngsters with handicapping conditions are in clinical settings, the majority of these youngsters are in the schools—some receiving duplication of services; some receiving inappropriate services; others receiving no services. The schools need allied health to assist in identification, referral, and advocacy of appropriate services.

D. Professionals in health and education are unaware of one anothers' roles and responsibilities in providing services to youngsters with handicapping conditions.

- Related services professionals (e.g., PTs and OTs) meet for the first time over the *body* of the youngster with a handicap.
- Related services professionals and educators meet for the first time over the *mind* of the youngster with a handicap.

Exposure to others' roles is not included/available in training programs, with the ground rules worked out in the mainstream. According to Task Force member, Ethan Ellis, "It's a national crime."

E. Attitudes of health and education professionals working with persons with disabilities are more discriminatory than other persons not so involved. Health professionals, particularly, tend to perceive the youngster only in relation to the disability; not as a whole person. Outcome: generalizations and stereotypes, providing model behavior for peers and others.

F. Service providers are operating under current PL 94-142 regulations. The Education Department's Special Education Program has received numerous comments regarding the proposed revisions of PL 94-142. The outcomes of the ED/SEP analysis will impact *all* groups: youngsters, their families, and their education and health service providers.

G. Budgetary cutbacks at federal and state levels reinforce the low priority given to training: need cooperation and collaboration in training programs; need cohesion in provision of services.

H. Advocates, whether in allied health, education, or medicine (pediatrics), generally are not in positions of power to affect over-riding changes in training programs.

I. States tend to view the State Education Plan as a compliance document for ED/SEP, rather than as a method for identifying needs, particularly in related services.

J. Redesigning personnel preparation programs to meet the needs of youngsters with disabilities and chronic illnesses is a timely issue (e.g., an issue for Maternal and Child Health, Surgeon General, and ED/SEP); however, we need to identify training priorities, evaluate effectiveness of current programs, and target funds appropriately.

II. CRITERIA FOR QUALITY TRAINING PROGRAMS. These criteria were considered essential for *all* training programs preparing service providers (allied health, regular education, and special education providers) for their expanding roles and responsibilities for youngsters with handicaps and their families.

A. *Program Design:*

- *Functionally-based:* focused on the needs of the child and family.
- *Interdisciplinary:* pre-service, practicum, and in-service programs designed collaboratively by allied health, regular education, and special education.
- *Community-based:* designed collaboratively with local education and social service

agencies, higher education institutions, clients, and families.

B. *Curriculum Content:*
- The education, related health, and psychosocial needs of the youngsters with handicapping conditions and their families.
- Attitudes: toward persons with disabilities, toward other professionals, and toward collaboration in the delivery of health and education services.
- Role definition and delineation; complimentary and individual professional reponsibilities and practices for youngsters with disabilities and their families.
- Interdisciplinary team and case management responsibilities in planning for the life-span of the youngster.
- Governance, monitary, and informal control systems of local and state education and social service agencies.
- Advocacy responsibilities and rights as professionals in health and education.
- *Realistic* practicum experiences, with competent, model faculty and practicum supervisors.

C. *Trainee Population:*
- Special Educators
- Regular Educators
  - Elementary
  - Secondary
  - Vocational
- Allied Health Professionals
  - Occupational Therapists
  - Physical Therapists
  - Audiologists and Speech-Language Pathologists
  - Rehabilitation Counselors
  - Nutritionists and Dietitians
  - Corrective Therapists
  - Social Workers
  - Physician Assistants
  - School and Clinical Psychologists
  - Recreational Therapists
  - Child-Life Specialists

  (NOTE: All related health professionals should be aware of their advocacy responsibilities as professionals in the health care system.)
- Medical Professionals
  - Nurses (school, clinical, and community-based nurses)
  - Pediatricians
  - Family Practice Physicians

III. DATA NEEDS. Members identified specific limitations in our current knowledge base which need to be addressed to design "quality" training programs responsive to the needs of youngsters with handicaps and their families. Quantitative and qualitative data are needed to determine:

A. *Functional* needs of youngsters with handicaping conditions and their families to identify:
- Protocol/Clinical Practices
- Appropriate/necessary services
- Appropriate providers of services
- Credentialling needs
- Duplication and limitations of services

(Example: For Functional Need X, the youngster may require the Services of Provider A *and* B or C independently.)

B. Types and "effectiveness" of interdisciplinary and profession-specific (a) training programs, (b) practice, and (c) service delivery.

C. Supply and demand data for health and education services.

D. Definitions and delineations of "related services," "education," and "medical" services.

E. Competencies and skills required of health and education professionals to determine need for and impact on all levels and forms of training: technical schools, community and junior colleges, four-year programs, and graduate and post graduate programs.

F. Financial implications of service delivery mechanisms for local and state education and social service agencies.

Once identified, these data need to be shared with all appropriate programs and agencies concerned with training, research, and delivery of services for youngsters with handicapping conditions.

IV. *AVAILABLE RESOURCES.* The resources identified by Task Force members included (a) sources for model, quality training programs; and (b) leading organizations, agencies, and persons who should be involved in helping to effect change in the design of personnel preparation programs in allied health, regular education, and special education.

A. *Model Interdisciplinary Practice and Training Programs:*
- University Affiliated Facility (UAF) Programs:

  (1) Interdisciplinary Council of UAFs.

  (2) Community Development; training programs.

  Contact: American Association of University Affiliated Programs (AAUAP).
- State Crippled Children's Offices
- Special Education Training and Resource Centers (SETRC) in New York State.
- National Association of State Directors of Special Education's (NASDSE), ED/SEP Forum Contract with state agencies; and the West Virginia Interagency Collaboration Model.
- Interagency Collaboration Studies in twelve states funded by Maternal and Child Health (MCH), in some cases in coordination with ED/SEP.
- Pre-school Project with State Directors of Maternal and Child Health.
- Interdisciplinary pre-service training program for pre-school youngsters with handi-

caps for allied health professionals (Louisiana State University Medical Center).

- American Society of Allied Health Professions' (ASAHP) Clearinghouse on collaborative training programs in allied health and education.
- University of Minnesota Model for interagency collaboration using an innovative financial plan.
- Colorado Interagency collaboration in health and education with focus on local communities. Contact: Council for Exceptional Children (CEC).
- Consortium planning among all agencies providing services to youngsters with handicapping conditions in six states: New Jersey, Colorado, California, Missouri, South Carolina, and Iowa. Contact: American Academy of Pediatrics (AAP).

B. *Leading Organizations, Agencies, and Individuals*

- American Society of Allied Health Professions (ASAHP). Contact: Carolyn Del Polito.
  - — Delineation of roles and responsibilities for allied health professionals in serving youngsters with handicapping conditions.
  - — Network of leaders in allied health and education concerned with interdisciplinary training and service delivery.
- National Association of State Directors of Special Education (NASDSE). Contact: Beverly Osteen.
  - — Special Net—computerized national network of persons concerned with special education issues at local and state levels.
- U.S. Education Department, Special Education Program, Division of Personnel Preparation (Ed/SEP/DPP). Contact: Herman Saettler.
  - — Discretionary Grant Program.
  - — Comprehensive System of Personnel Development (CSPD) Section of States' Plans.
  - — Reports on Direction Services activities.
- National Association of Developmental Disabilities Councils (NADDC) and 54 State Council affiliates. Contact: Susan Ames-Zierman.
  - — Training programs for developmental disabilities professionals and Council members.
  - — Developmental Disabilities Electronic Mail Network.
- American Association of Colleges for Teacher Education (AACTE). Contact: Diane Merchant.
  - — Conference for Deans' Grant Directors, February 20-21, 1983, focusing on maintaining linkages for quality personnel preparation programs.
  - — Resource materials on collaborative training programs in regular and special education.
- Council for Exceptional Children (CEC). Contact: Alan Abeson.
  - — New, proposed standards for special educators, as developed by CEC, include intra- and interpersonal coordination of services which are responsive to the needs of exceptional children.
  - — Re-training project funded by ED/SEP.
- American Association of Community and Junior Colleges (AACJC). Contact: Connie Sutton.
  - — Assists in working with community colleges to design appropriate training programs for (a) paraprofessionals, and (b) bridging two-year programs with four-year programs in allied health and education.
- U.S. Department of Health and Human Services, Maternal and Child Health (HHS/MCH). Contact: Merle McPhearson.
  - — Funding a number of interagency collaboration studies (see IV A.).
  - — National Public Policy Conference on Chronically Ill Children (Vanderbilt Study), Spring, 1983.
  - — Report on the Surgeon General's Invitational Workshop on Children with Handicaps and their Families, Spring, 1983.
- All other organizations listed on Task Force to work with ASAHP in follow-up and dissemination activities.

C. *Additional Resources*

- Direction Services (OSERS).
- New Jersey Training Project with rehabilitation counselors by persons with disabilities. Contact: Ethan Ellis.
- Educational Resources Information Center (ERIC) Network.
- Early Childhood Programs. Contact: U.S. Department of Health and Human Services, Maternal and Child Health.

V. OUTCOMES AND FUTURE DIRECTIONS. Members identified (a) specific outcomes for a national effort in designing quality personnel preparation programs in allied health, regular education, and special education, and (b) specific, limited activities to be conducted during the remaining three months of the Allied Health Child-Find and Advocacy Project by the American Society of Allied Health Professions (ASAHP).

A. *National Effort*

- Promote *policy statements* by professional organizations which identify:
  - (1) Professionals' rights and responsibilities as explicit extensions of PL 94-142 and Section 504 of the Rehabilitation Act (i.e., what constitutes appropriate professional responsibility); and

    (2) Clear description of professional advocacy role (i.e., what constitutes appropriate advocacy).
- Design and obtain funding for demonstration efforts in interdisciplinary personnel preparation designed in compliance with the Task Force recommendations herein. Capitalize on national alliance concept by identifying alliance teams and coordinators at ASAHP/AACTE member institutions.
- Design, promote, and support coordinated training and service delivery with local and state education and social service institutions and agencies. Emphasize continually the functional needs of the client.
- Design, promote, and support public commitment activities among all appropriate constituencies for effective, coordinated training and service delivery for youngsters with handicaps and their families.

B. *ASAHP Effort*

- Develop a *Policy Statement* reflecting ASAHP's commitment to interdisciplinary training programs and service delivery in allied health, regular education, and special education.
- Develop a *Position Paper* to support and expand ASAHP's policy statement on professional training and practice for meeting the needs of youngsters with handicaps and their families. The Position Paper should emphasize the professional, economic, and practical implications of interdisciplinary training and service delivery in health and education.
- Disseminate ASAHP's Policy Statement and accompanying Position Paper to all appropriate local, state, and national professional organizations, agencies, and higher education institutions for acceptance, support, and use with their constituencies.

  For example, allied health and education trainers will be able to use the documents for designing and supporting new programs, as well as for use with students in class discussions.
- Plan a keynote panel program for ASAHP's annual meeting, showcasing model interdisciplinary training programs. Invite Task Force members to participate.
- Coordinate data collection and dissemination of interdisciplinary personnel preparation programs through the Society's Center for Continuing Education.

As evidenced throughout these proceedings, efficient, cost-effective, quality care for persons with disabilities and chronic illnesses is jeopardized by the lack of coordination of health and education services. For personnel preparation programs, the implications are clear: while many times difficult to initiate and maintain, interdisciplinary, collaborative training approaches (preservice, practicum, and in-service) must be embraced and promoted by professional organizations, credentialling bodies, and most importantly, by those educating our providers of services in the 1980s.

APPENDIX A

About the Allied Health Professions

As knowledge and technology in the health fields have grown, so have the numbers and types of professions required to deliver effective health services. In a lifetime, the average American is likely to benefit from the special competencies of health professionals in over 150 different occupations. Each of these occupations is essential in combatting disease and disability and saving lives.

The allied health professions include about 140 of these occupations and over half the health workforce. The concept of "allied health" developed about 15 years ago as a way of promoting teamwork and collaboration. With so many different health professions, teamwork would be discouraged if all were educated in isolation. Colleges and divisions of allied health professions were established in postsecondary education institutions across the country to create an environment where those who will one day work together can study together and develop the mutual appreciation which is necessary for efficient and effective health care.

The allied health professions are extremely varied in the level of education they require (from short-term training through the doctorate) and in the services they provide. Examples of such services are:

- *emergency services* (e.g., emergency medical technicians, emergency/disaster specialists, physician assistants);
- *reception and screening* (e.g., medical or dental secretaries, medical office assistants);
- *initial evaluation and diagnosis* (e.g., physician assistants, dental hygienists, mental health technologists, medical social workers);
- *continued assessment as part of treatment* (e.g., physical therapists, occupational therapists, respiratory therapists, speech-language pathologists, audiologists, dietitians);
- *testing* (e.g., medical laboratory personnel, radiologic technologists, ultrasound technical specialists, nuclear medicine personnel, cardiology equipment personnel);
- *acute care therapy* (e.g., operating room technicians, obstetrical assistants, surgeon's assistants);
- *long-term care therapy* (e.g., occupational, physical and other therapists; personnel in mental health, social services, counseling, speech-language pathology, audiology, nutrition);
- *medical instrumentation* (e.g., radiation and respiratory therapists, dialysis technicians, cardiopulmonary technicians, ophthalmic dispensers, dental laboratory technicians);
- *community health promotion and protection* (e.g., nutritionists, dental hygienists, population and family planning specialists, health educators, school health educators, medical librarians, health writers);
- *control and elimination of hazards in an institutional or industrial setting* (e.g., audiologists, health physicists, health care facilities housekeepers, industrial hygienists); and
- *research and development* (e.g., biomedical engineers, biostatisticians, epidemiologists, toxicologists, public health scientists, and researchers in every occupational category).

ABOUT ASAHP

The American Society of Allied Health Professions (ASAHP) is a national nonprofit scientific and professional organization formed to serve the needs of allied health educators, practitioners, professional institutions and organizations, and others interested in improving health care and health-care education. ASAHP has as its ultimate goal the best possible training and utilization of all allied health professionals. As a means to that goal, the Society provides a vital forum in which allied health educators and practitioners—their educational and clinical institutions and their professional associations—can address and act on mutual concerns.

Established in 1967, ASAHP now serves 118 educational institutions, 23 national professional organizations, and over 1,300 individual members.

The Society's role in serving the interests of these constituent groups is twofold. First, it provides a forum for sharing concerns and solutions that relate to significant, mutually relevant allied health issues. Second, ASAHP serves as the vanguard of the allied health movement—an organization which forcefully and effectively represents positions of overreaching allied health significance to government, other major health-education and health-care system elements, and the public.

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