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ABSTRACT

The study documents effective state and local policies in providing related services to handicapped children as required by PL 94-142, the Education for All Handicapped Children Act. The areas reviewed include those state policies which clarify education agencies' responsibilities, and those which increase the resources available for related services by securing other state agencies' cooperation. The volume also examines local policies which (1) obtain resources from other human service agencies, (2) pool resources to increase the availability of services, and (3) seek to develop new programs for specific population groups such as emotionally disturbed students. Examples are given of policy implementation including state or local actions in the following localities: Michigan; Washington; California; Connecticut; Maine; Anne Arundel County, Maryland; Upper Peninsula in Michigan; Capitol Area Region, Maine; Weld County, Colorado; Independence, Missouri; and Montgomery County, Maryland. Unresolved issues concerned with related services are identified including the limits (if any) to the responsibilities of education agencies, how education agencies can meet their financial obligations to provide related services, and how to share resources with local agencies to provide related services. (DB)

VOLUME 2

EFFECTIVE POLICIES IN THE PROVISION OF RELATED SERVICES

by
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A Report of

The Handicapped Public Policy Analysis Project

(Contract #300-82-0829)

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Preface

The Education for All Handicapped Children Act, Public Law 94-142, was enacted in 1975. The statute requires that a "free appropriate public education" be available to all handicapped children (age 3 through 21) in the United States, regardless of the severity of their handicap unless services to children aged 3-5 or 18-21 would be inconsistent with state legislation. The law also mandates that State Education Agencies (SEAs) and Local Education Agencies (LEAs) develop special education and related services to meet these children's unique needs. In tandem with Section 504 of the Rehabilitation Act, as amended, this law has had, and continues to have, a profound impact on, not only handicapped children and their families, but also the entire public education system.

Implementation of P.L. 94-142 has proven difficult in many respects. While the law mandated major new responsibilities to state and local education agencies, it did not provide detailed federal guidance nor full financing to carry out these responsibilities. As a result, state and local education agencies have had to develop a wide range of new policies to implement the law. In so doing, they have confronted problems and controversies ranging from the consequences of shrinking human service resources and the debate over the rights of handicapped persons, to professional disagreements about the most effective settings in which to educate handicapped children.

Recognizing the importance of providing states with technical assistance to implement P.L. 94-142, Special Education Programs (SEP) of the U.S. Department of Education (formerly the Office of Special Education), awarded a contract to the Center for the Study of Social Policy (CSSP) to (1) identify effective policies used by state and local education agencies that serve handicapped children; and (2) disseminate information about these strategies to federal, state, and local decision-makers.

In conducting this project, the Center analyzed state and local policies in five areas of implementation:

- Interagency collaboration;
- Provision of related services;
- Provision of services to handicapped students in out-of-district placements;
- Implementation of the least restrictive environment mandate; and
- State monitoring and compliance activities.

The project design proceeded from a broad overview of policies and implementation strategies developed by states and local districts, through successive stages of data collection. A telephone survey was conducted in all 50 states; follow-up site visits were made to 18 states; and over 400 LEAs recommended as having effective policies were surveyed, with approximately 60 follow-up telephone interviews and field visits to some 35 LEAs.

From these data collection efforts, the project has produced four reports:

Volume 1: Effective State Policies to Promote Interagency Collaboration. The first volume sets forth a perspective on interagency collaboration which applies not only to this volume of the report, but to the other three volumes as well. This volume also reviews the use of state interagency committees, interagency agreements, and other collaborative efforts designed to (1) define responsibilities for services to children in residential facilities; (2) promote local interagency collaboration; (3) assign service delivery and financial responsibilities among state agencies; and (4) share information across agencies.

Volume 2: Effective Policies in the Provision of Related Services. This report documents effective state and local policies in providing related services to handicapped children. The areas reviewed here include those state policies which clarify education agencies' responsibilities, and those which increase the resources available for related services by securing other state agencies' cooperation. This volume also examines local policies which (1) obtain resources from other human service agencies, (2) pool resources to increase the availability of services, and (3) seek to develop new programs for specific population groups such as emotionally disturbed students.

Volume 3: Policies Which Address Out-of-District Placements and Assure Education in the Least Restrictive Environment. This volume examines two important policy areas: the provision of services to children in out-of-district placements and the implementation of the least restrictive environment mandate. State policies are analyzed which help SEAs influence local placement decisions, as well as others which transfer responsibility back to the LEAs for institutionalized handicapped students. This volume also examines local policies which utilize the resources of other human service agencies to implement the LRE mandate. These policies include those through which LEAs develop new programs to enable students to remain in local public schools; others that reflect LEA procedures to allow greater control over placement decisions, and still others that seek to change attitudes about integrating handicapped and non-handicapped students.

Volume 4: Effective State Monitoring Policies. The final volume examines two policy areas. The first focuses on SEA policies that seek to evaluate program quality as well as perform compliance monitoring. The second examines alternative strategies used by SEAs to effectively monitor education programs administered by other state human service agencies.

Support for this work was provided by Special Education Programs, the U.S. Department of Education, under Contract #300-80-0829. Full responsibility for the accuracy of its findings and conclusions rests with the Center for the Study of Social Policy. However, many thanks are due to the officials of state and local education agencies and other human service agencies who gave their time to discuss their programs and provide the information upon which the projects' reports are based. In addition, staff of the Center would like to extend particular thanks to several people whose efforts contributed to these reports. Ray Smiches, the study's initial contract officer at the U.S. Department of Education, helped define the scope of the study and contributed to its work throughout. David Rostetter and Jaddis Franklin, the subsequent contract officers, made numerous improvements in the style and content of the reports. Dr. Kenneth Olsen and Ethel Bright from the Mid-South Regional Resource Center, the University of Kentucky, generously shared their own work, assisted in the Center's data collection efforts, and worked collaboratively in the preparation of the related services volume. Dick Galloway and Beverly Osteen of the National Association of State Directors of Special Education also assisted Center staff in all phases of the project's work.

VOLUME 2

EFFECTIVE POLICIES IN THE PROVISION OF RELATED SERVICES

EXECUTIVE SUMMARY

Ever since the passage of the Education of All Handicapped Children Act (P.L. 94-142), the related services mandate has been one of the most controversial aspects of special education programs. While educators agree that, in order to achieve full educational opportunities, many children with handicapping conditions require a wide range of services, the exact parameters of those services and the responsibility for financing them have been much debated.

This report examines the policies which state and local education agencies have used to implement the related services mandate. It views related services from a policy perspective and gives particular attention to the inter-governmental and interagency aspects of providing related services.

I. THE RELATED SERVICES MANDATE AND ITS IMPACT

P.L. 94-142 required that local education agencies (LEAs) assure the provision of related services: those components of an educational program which, while not primarily educational in nature, are deemed essential to enable handicapped children to benefit from special education. In doing so, the federal law transformed related services from optional services to be provided at a school district's discretion, to an entitlement.

The scope of this new entitlement is broad. The law defines related services to include "transportation, and such developmental, corrective, and other support services...as may be required to assist a handicapped child to benefit from special education." While more specificity has been provided by subsequent regulations, the ambiguity that remains has generated disagreement in areas ranging from the practical to the theoretical. State education officials, in particular, question whether education systems should be solely responsible for all of these services and have urged greater collaboration with other human service agencies. Local education agencies question their own capacities to pay for expanded related service programs. Despite problems, however, the related services mandate has increased in importance as an expanded number of handicapped children have been served by local districts, and as other, non-educational resources to serve these children (health, mental health, and social service dollars, for example) have decreased as the result of federal, state, and local budget cuts.

To accomplish their related services mandate, state and local education agencies have had to assume major, though different, responsibilities. This report looks at each in turn.

II. EFFECTIVE STATE POLICIES IN THE PROVISION OF RELATED SERVICES

SEAs have undertaken two major tasks in connection with related services. The first has been an attempt to clarify

education agencies' responsibilities for these services. SEAs have adopted several strategies in order to do this, as described below.

While many SEAs recognize the need to make the related services mandate more specific, most have been reluctant to develop written policies that go beyond federal statutes and regulations because they fear that any such "clarification" may raise compliance issues and jeopardize federal funding. Thus, most SEA policy statements do little more than duplicate federal policies. However, some SEAs have taken unusual approaches to setting limits on related services responsibility.

- Staff of Michigan's Department of Education developed a classification system to both target the provision of services and define "first dollar" responsibilities. In order to limit the SEA's responsibilities and distinguish its tasks from those of other human service agencies, SEA staff differentiated three kinds of services handicapped children need -- education, rehabilitation, and life support -- and agreed to assume responsibility for education alone. While of conceptual interest, this system has not been translated into policy because it has not been approved by other state agencies or the relevant federal agency.

- In an attempt to clarify its responsibilities, Washington State's Office of the Superintendent of Public Instruction differentiated its provision of services by population. The State Division of Developmental Disabilities and local disability centers were assigned responsibility for handicapped children aged 0 to 2, while comparable responsibility for developmentally disabled children and other handicapped children aged 3 to 5 remained with the education agency. This agreement was put into place to avoid service duplication and increase cost-effectiveness.

The second major task undertaken by SEAs is their attempt to secure other state agencies' cooperation in expanding the availability of related services for local districts. A review of these efforts suggests that success in these endeavors is based on the SEA's fiscal capacity, bureaucratic clout, and staff skills, as well as on the flexibility of the state's traditional patterns for allocating responsibility among agencies. Generally, these endeavors have taken three forms: (1) increasing access to another service system's resources; (2) negotiating to secure third party financing; and (3) joint funding and cooperative programming arrangements with other human service agencies. Despite the different nature of each of these strategies, they share important characteristics. Each maintains and improves services by sharing financial responsibility, offering participants positive fiscal incentives, recognizing the importance of professional working relationships, and interweaving state and local interests.

These common factors appear in the following examples of education agencies that have secured other agencies' cooperation.

- California's Departments of Education and Mental Health developed a strategy to allow LEAs greater access to local mental health services. These two departments entered into a joint agreement to ensure that local mental health agencies would use their funds to pay for local related service costs for emotionally disturbed children. Essentially, this agreement helped to both change the pattern of service delivery and prioritize services for handicapped children. It defines the services for which education and mental health respectively

agree to accept responsibility, details the process by which emotionally disturbed children are referred from one agency to another, and promotes the use of mental health dollars to finance related services at no cost to parents when such services have been indicated.

- Connecticut's Department of Education developed a system of third party financing to help LEAs pay for health-related services. The SEA hopes to save state and local education dollars by claiming private insurance and Medicaid reimbursements for costs incurred by local school districts for medically related services. Important factors which have helped the SEA undertake this initiative are: SEA staff understood the nature of these other funding sources; the Governor's Office and the State Offices of Policy and Management strongly supported the effort; federal policy clearance was given; and participating agencies expressed willingness to change their systems. This system is to be pilot-tested in the 1983-84 school year.

In other states, such as Oklahoma, Michigan, and Maine, SEA efforts focused on joint funding and cooperative program arrangements that addressed both programmatic and fiscal concerns.

- Oklahoma's Cooperative School/Rehabilitation Work Study Program is the joint effort of the Special Education Section (SES) of the State Department of Education and the Division of Children, Youth, and Rehabilitative Services of the State Department of Human Services (DHS). These agencies recognized that neither had adequate resources to serve handicapped secondary school students. The Cooperative School/Work Study Program had two goals: establishing a comprehensive and coordinated effort to identify and serve all physically, mentally, and emotionally handicapped youth enrolled in participating secondary schools, and bridging the gap between school and employment. The program is based on an interagency agreement that facilitates linkages between the SES and DHS and, as its title suggests, includes both a work study program and various kinds of services for students who, while not in this program, can benefit from assessment, counseling,

and placement services. As a result of this program, service delivery has improved and savings have been realized.

- The Special Education Division of Michigan's Department of Education undertook a joint effort with two other agencies, the State Division of Rehabilitation Services and the Vocational Education Division, to improve education and related services for handicapped secondary students. Their agreement stressed the importance of technical assistance in translating interagency cooperation into improved local programming, and specified each agency's respective roles and responsibilities in secondary programming as well as a process to expand vocational programming to handicapped students. Unlike Oklahoma's agreement, this agreement does not mandate that participating agencies conform to a single program statewide. Instead, it identifies each agency's functions, suggests generic levels of vocational programming, and gives local districts considerable discretion in program design.

- The goal of Maine's interagency effort was to increase joint funding and the collaborative delivery of related services through its Interdepartmental Coordinating Committee for Pre-School Handicapped Children (ICCPHC). The goal of this committee is to help to develop regionally-based coordination efforts by "emphasizing and promoting the active role of other public and private local service agencies and parents in coordinating, planning, and service acquisition." Rather than devising any state level interagency mechanism, as Michigan and Oklahoma did, Maine's Committee -- recognizing the high degree of local autonomy -- allows local agencies to develop joint service arrangements. ICCPHC secured funding from a number of sources to set up nine pilot projects. These projects, in turn, established local coordinating committees to develop interagency funding arrangements. To date, these projects have increased public and private agencies' service coordination and stimulated the development of new services and programs funded by non-education monies.

III. EFFECTIVE LOCAL POLICIES IN THE PROVISION OF RELATED SERVICES

In contrast to state education agencies, local education agencies (LEAs) have a different responsibility under P.L.

94-142. They must assure that handicapped children have access to those related services that would allow them to benefit from an education program. LEAs have chosen to fulfill this mandate by either providing all related services directly or obtaining services from other agencies. Specific activities that reflect these tasks include obtaining resources free of charge from another human service agency, pooling resources to increase the availability of related services, and developing new programs for special student populations.

- Only a few districts have succeeded in providing related services at no cost to the district. One such example occurs in Anne Arundel County, Maryland, where the local education agency secured occupational and physical therapy from the County Health Department. Because these services were part of the school health system, the LEA was not charged for them. This arrangement predated P.L. 94-142 and was the consequence of strong interagency ties. After the federal law's passage, services needed to be expanded. Unlike other counties, the county Health Department expanded its OT and PT agreements at no cost to the LEA.

A larger number of LEAs, particularly those that are smaller and less populated, have pooled resources to increase the availability of related services. Such arrangements occur in Michigan, Maine, and Colorado, where several factors have contributed to their success: all of these efforts took place in rural areas where the lack of services exacerbated the need for interagency collaboration in order to either expand or provide similar levels of services in the face of budget cutbacks; local participants had developed strong informal

relationships; and the regional, inter-district organization through which each pooled resources did not diminish each district's sense of "ownership."

- Several Intermediate School Districts (ISDs) in Michigan's Upper Peninsula formed a Special Education Staff Resource Pool to increase the availability of related service specialists. This low cost alternative has enabled school districts to recruit staff who had specific related service skills and already were located in the region. By relying on this expertise, these rural districts have been able to increase the quality of their education and related service programs at relatively low cost.

- Eight school districts in Maine's Capitol Area Region formed a contractual services "pool" from which they established region-wide contracts with related service providers and purchased related services for children with severe or rare handicaps. As a result of this "pool," handicapped children's access to related services has increased, district costs have been lowered, and a well-organized service delivery network has evolved that facilitates the efficient allocation of resources.

- In Colorado's Weld County, a group of public and private agencies began a cooperative screening program for children (from birth to age five) who were suspected of being developmentally delayed. The goal of this program was to prevent or reduce future handicapping conditions by identifying these children before they reached school age. As a result of this program, more at-risk children have been screened, service duplication has been reduced, county schools have been given information that facilitates their planning future programs and budgets, and agencies that suffered budget reductions have been able to maintain their previous service levels.

Other LEAs have chosen a third approach to related services, developing new comprehensive programs that integrate education and related services for special populations. These programs blend a range of services without being overly con-

cerned about whether a specific service is "educational" or "related". Two local programs have been developed, one each in Missouri and Maryland, which received state funding to provide services to emotionally disturbed children.

- Independence, Missouri's LEA joined with a local community mental health center to interest the State Departments of Education and Mental Health in investigating whether the related service needs of seriously emotionally disturbed children were being met. In response to this investigation, the LEA and the Mental Health Agency established the New Direction program which provided services for children between 8 and 15 with behavioral disorders whose needs could not be met by the school districts' special education program. As a result of this comprehensive program, several children have been de-institutionalized into it, and a small number have been reintegrated into the regular school program.

- The Maryland Department of Health and Mental Hygiene and the Montgomery County Public School jointly fund and operate the Regional Institute for Children and Adolescents (RICA) to provide residential and/or day treatment and education to emotionally disturbed students aged 6 through 20. RICA operates as an interdisciplinary program of clinical, educational, and residential teams and reflects the following beliefs: handicapped students with multiple problems can be well served only if a range of community specialists and organizations are involved; students should be kept as close to home as possible; and residential services provided in, rather than outside, the county can be cost-effective.

IV. CONCLUSION

Beyond the general agreement that related services are an essential component of any special education program, education agencies have yet to resolve a number of major issues. For example, no consensus exists about the limits (if any) to the responsibilities of education agencies, an especially

delicate topic in a time of decreased budgets, and a controversial one as well that has become the concern of the courts. An important issue on which progress has been made is how education agencies can meet their financial obligations to provide related services. Many SEAs have developed mutually beneficial arrangements with other human service agencies at the state-level to jointly provide related services to handicapped students. SEAs also have used education monies as matching funds for other state agencies, thereby increasing federal dollars for handicapped students. LEAs have focussed on yet another problem: how to share resources with other local agencies to provide related services. As noted in this report, an increasing number of LEAs have worked out effective arrangements with other local agencies to jointly provide and finance related services.

INTRODUCTION

The mandate to provide related services as an integral part of handicapped students' education is one of the most controversial provisions of P.L. 94-142. Even after five years of implementation, many of the policy problems posed by the related services mandate remain unresolved and continue to be a source of debate at all levels of educational programming and policy development. Yet, despite this situation, the general premise underlying the provision of related services is rarely questioned. Educators and other professionals, parents, and advocates all agree that, in order to achieve equal educational opportunities, many children with handicapping conditions require a wider range of services than those traditionally associated with "education."

However, putting into place this range of services has been difficult. In fact, attempts to carry out the related services mandate result as often in frustration and conflict as in successful and expanded programs. For instance, parents and school administrators disagree about the extent of services that should be provided to children with handicapping conditions. Local districts claim that their budgets cannot withstand the costs. State education agencies encounter seemingly intractable barriers when collaborating with other human service agencies to finance and deliver related services.

In addition to these administrative and financial issues, the related services mandate raises even more fundamental

questions about the role of the education system in general, and special education in particular. Even after stripping away the many operational difficulties surrounding related services, key questions remain: What are the parameters of education? To what extent are schools responsible for handicapped students' full development? What roles should special education programs play in the intergovernmental financing and service delivery of programs for handicapped children? Because P.L. 94-142 raised these questions, but gave no definitive solutions, state and local education agencies were left largely on their own to formulate answers.

Consistent with the mission of the Handicapped Public Policy Analysis Project, this volume looks at related services from a policy perspective and focuses on the broad strategies both state education agencies (SEAs) and local education agencies (LEAs) have adopted to provide related services. Particular attention is paid here to the intergovernmental and interagency aspects of the related services mandate.

This volume is divided into three sections. The first section reviews the federal mandate and the context in which this mandate has been implemented. An understanding of the context in which school districts attempt to provide related services is essential to analyze the strategic approaches SEAs and LEAs have adopted. Section II analyzes the effective state policies identified in the course of this study. This section identifies some generic strategies for providing related services and documents specific SEA efforts which seem

particularly successful in making services available to handicapped children. Section III examines policies which local school districts have developed in order to provide related services more effectively. Detailed descriptions of most of these state and local policies are included in the appendices.

I. THE RELATED SERVICES MANDATE AND ITS IMPACT

The concept of related services did not begin with P.L. 94-142. Local school districts traditionally have provided services which, while not primarily educational in nature, are important components of educational programs. These services have been offered to both handicapped and non-handicapped students, and include in-school services such as school nursing and guidance counseling, as well as out-of-school services such as transportation.

However, the concept of related services assumed greater prominence in connection with special education programs, because, for students with handicapping conditions, these services came to be seen as, not "add-ons," but components of an educational program which were essential to a child's ability to learn. The precedent to thus expand the range of services offered specifically to children with handicapping conditions was established in those states that in the late 1960's and early 1970's pioneered special education legislation.

With the passage of P.L. 94-142, the provision of related services was made mandatory in all states, thereby transforming related services into an entitlement. The Act's statement of purpose requires states "to assure that all handicapped children have available to them a free appropriate public education which emphasizes special education and related services designed to meet their unique needs..."[1]

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[1] 20 USC 1401, Sec. 3 (c)

Related services were to be "provided at public expense, under public supervision and direction, and without charge" and "in conformity with the individual education program."[2]

The law broadly defines these services to include "transportation, and such developmental, corrective, and other support services...as may be required to assist a handicapped child to benefit from special education."[3] However, the federal statute does not define whether a specific service, in a specific circumstance, is allowable, thus leaving SEAs and LEAs with the task of developing their own policies within a broadly defined federal framework. Some aspects of the related services mandate have been clarified by the regulations issued after P.L. 94-142's passage, and subsequent policy interpretations released by Special Education Programs in the U.S. Department of Education have attempted to establish still further criteria for determining when a service is or is not "related."

By its nature, the related services mandate introduced two important new elements into almost all school districts' special education programs. First, under the language of the law, few services could be excluded from the definition of "related" if they helped a child benefit from special education. Thus, the scope of the mandate broadened considerably the range of services for which schools were to assume

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[2]20 USC 1401, Sec. 4 (a)(18)

[3]20 USC 1401, Sec. 4 (a)(17)

responsibility. Many of the services cited in the regulations were completely new to school districts, particularly those districts that were smaller, less wealthy, and/or rural. Even larger districts that had offered a wide range of programs to allow a child to benefit from special education now found themselves expected to pay for intensive services such as residential care, occupational and physical therapy, and a range of mental health services.

Second, by vesting the public education system with such broad responsibilities, P.L. 94-142 implicitly reduced other agencies' responsibilities for related services. The language of the law makes related services an integral part of handicapped children's "entitlement" to a "free appropriate public education." If any child with handicapping conditions needs a specific related service so as to benefit from a special education program, the local education agency has to make the service available. Similarly, state education agencies are responsible for both assuring that related services are provided to all handicapped children who need them and supervising their provision. While P.L. 94-142 stopped short of saying that the SEA or LEA must pay for all related services, the force of the law was clear: lacking other public funding sources, the education agency must pay for these services.

Thus, in effect, P.L. 94-142 provided financial incentives for many human service agencies to reduce services to clients. In contrast to special education, most other state

and local human service agencies do not operate under an entitlement mandate. These service systems -- such as mental health agencies, developmental disability agencies, and vocational rehabilitation agencies -- have greater discretion over whom they will serve and the scope and intensity of their services. For the most part, they can adjust their provision of services to the availability of resources. For example, a state mental health agency is not required by law to furnish services to all state residents who need these services. If appropriated funds are sufficient to pay for services to only one-third of the identified target population, the agency can focus all its resources on this number. Other human service agencies, which in the past provided services that now overlap with those of special education programs, have comparable "discretionary" mandates.

By shifting to special education the responsibility to pay for those services defined as "related," P.L. 94-142 made it possible for human service agencies to reallocate their own resources to other services and target populations. These agencies for the most part maintained that they were doing their best with limited resources. However, state and local education agencies often had a different opinion of these actions: namely that the human service agencies were abdicating their responsibilities for handicapped children's related services.

This differing view of responsibilities might not have had the dramatic repercussions of the past five years if other

factors had not come into play. Developments, both within and outside of special education, have had an impact on the related services mandate and made even more difficult the already enormous tasks confronting LEAs and SEAs. With hindsight, two factors seem particularly important: the increased number of handicapped children seeking special education from local districts; and the shrinking resource base available, across all programs, to serve vulnerable population groups, including children with handicapping conditions.

This first factor, the increased number of handicapped children seeking special education from local districts, resulted partly from P.L. 94-142's requirement that all handicapped children receive a free appropriate public education. In addition, many children who previously had attended institutions, private schools, and other out-of-district facilities returned to their home districts because of the Act's "least restrictive environment" provisions. Because these children often had quite severe handicaps, the decision to return them to local public school classrooms often necessitated providing new related services to allow them to benefit from the local schools educational programs.

The pressure for local schools to serve more -- and more severely handicapped -- children was reinforced further by trends outside special education. For example, the deinstitutionalization movement, which began in the late 1960's and gathered momentum throughout the 1970's, eventually affected

the demand for related services for handicapped children and youth. Many of these state-based deinstitutionalization efforts were strengthened by federal legislation such as the Developmental Disabilities Act and the Juvenile Justice and Delinquency Prevention Act. When retarded children, emotionally disturbed children, and juvenile offenders left residential care facilities pursuant to these new laws, the responsibility for providing them with "community-based" services fell most directly on local public schools. Whereas school districts previously could have claimed an inability to serve these children and youth, both P.L. 94-142 and state special education statutes made it clear that LEAs had to not only meet these students' educational needs, but also provide other services that would allow a child to both benefit from the education program and remain in the least restrictive environment.

At the same time that local schools were providing an increased number of handicapped children with special education and related services, a second factor became important: resources -- other than educational resources -- to serve these children were being reduced. FY 1982 and FY 1983 federal budget reductions took a toll on state and local agencies whose budgets already had been cut in the late 1970's. Due to the impact of not only these federal cuts, but also state and local cutbacks, the categorical human service funding streams that had sustained state and local service systems for the handicapped suffered reductions. Con-

sequently, many state and local human service agencies focused on the related services mandate as a way to either replace lost funds or reduce costs. Thus, even though federal appropriations for Part B of P.L. 94-142 were not decreased (and, in fact, were slightly increased in FY's 1981, 1982, and 1983),[4] the total pool of resources for handicapped children was reduced appreciably. Faced with these wholesale budget reductions, in conjunction with their "first dollar" responsibility, LEAs and SEAs feared they soon would be paying total costs for all handicapped children's services.

This situation differed greatly from any in the past. Whereas LEAs and SEAs previously had sought, at their discretion, to expand service availability by developing joint programs with human service agencies, this activity now became essential if best use was to be made of available resources. The very nature of the new mandate created the need for new and more effective relationships with other agencies. While administrators and teachers may formerly have had contact with other service systems through their "front line" direct service personnel, few were familiar with the legislation, funding patterns, policy processes, and financial incentives that determined which human services were or were not provided. Many school districts felt they were losing control of their resources: administrators could not fully determine, as

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[4]Federal appropriations for Part B of EHA were $874.5 million in FY 1981; $931 million in FY 1982; and $970 million in FY 1983.

they had in the past, the amount of resources devoted to related service efforts. Parents, advocates, and, in some cases, the courts, proved effective in influencing or determining districts' decisions.

Faced with this new situation, SEAs and LEAs began to address the policy problems generated by the related services mandate, often in ways that recognize interagency and intergovernmental dimensions. While many of these policies are only recently developed, dimensions of them already seem to have helped SEAs and LEAs meet their responsibilities under the federal law and also have led toward improved services to handicapped children. This report next considers those policies by first examining state-level policies and strategies in Section II, and then reviewing local-level policies in Section III.

II. EFFECTIVE STATE POLICIES IN THE PROVISION OF RELATED SERVICES

State education agencies have grappled with two major tasks in trying to ensure that all handicapped children in the state receive the necessary related services.

First, they have attempted to clarify education agencies' responsibilities for related services. In the absence of definitive federal policies, states have had to guide LEAs on such questions as: When is a service "related" to an educational program, and when is it not? Should a "related" service be defined by the nature of the program activity, the type of professional providing it, or the outcomes produced for children? What is an LEA's financial liability for specific services, and is this liability limited in any way? In effect, states have had to decide whether or not to develop policies that give the federal mandate on related services more specificity and operational utility.

Secondly, SEAs have had to increase the resources available to LEAs statewide for related services, recognizing that many LEAs had neither the resources to provide related services to all children who needed them, nor the capacity to develop these resources on their own. In particular, SEAs have taken the lead in working out the state-level interagency arrangements that are designed to expand the availability of local services.

To carry out these tasks, SEAs have established different types of policies and set in motion a wide range of

strategies, each adapted to the particular circumstances of that state. This section looks at these policies and strategies in more detail, with the goal of identifying common elements that can be of use to a large number of SEAs.

A. Policies Which Clarify Education Agencies' Responsibilities for Providing Related Services

Few states have developed written policies which go beyond federal statutes and regulations and establish criteria for defining related services. The major impediment to such policies seems to have been the states' concern that any "clarification" of federal policy would raise compliance issues, thereby possibly jeopardizing federal funding. Thus, in their formal, written policies, SEAs have operated within the framework of federal policy, attempting to resolve any ambiguities in the related services mandate through implementation rather than policy.

The degree to which states have adhered to federal definitions of related services can be seen in Appendix A which shows, state-by-state, SEA 1982 definitions of related services. As can be seen, most states had not modified federal definitions. Those that had, made only slight adaptations, usually to achieve consistency with previously existing state laws and/or to add one or two services which traditionally had been provided in that state.

While most SEA policy statements either duplicated or only slightly adapted federal policy, a few made efforts to clarify education agencies' responsibility for related

services. For example, staff of the Michigan Department of Education directly addressed the conceptual problem of distinguishing "educationally-related" services from other services. While not adopted as Departmental policy, this policy approach illustrates some of the potential benefits, as well as limitations, of such a clarification.

> Staff of the Michigan Department of Education developed a framework intended to categorize the different types of services that might be required by a handicapped child. This approach distinguished three developmental goals -- education, rehabilitation, and life support -- and defined them as follows: Education is "instruction related to the teaching of new skills;" rehabilitation is "the act of restoring a useful function that was lost through accident, illness or injury;" and life support is "services needed to maintain life or health which a handicapped person may not be able to secure for him or herself." The definition of life support includes activities such as medical treatment and services, nursing home care and personal care, and other custodial services which provide food or shelter. Under this framework, education agencies would take responsibility only for education services, not for rehabilitation or life support services.[5]
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> Several examples illustrate possible applications of this framework:
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> - Assume a youngster with permanent nerve damage in her lower limbs, with no prognosis that she will ever be able to walk. Since the child cannot benefit from any attempts to develop her lower limbs, physical therapy would not serve an educational function and, thus, could be provided by, not the school district, but, rather, a local private agency who would view the service as one aspect of this child's life support program.

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[5]Jan M. Baxter, "Requirements for Ancillary and Related Services for Handicapped Persons Under P.L. 94-142," Special Education Services Area, Michigan Department of Education.

- In contrast, assume a three-year old child with cerebral palsy who needs special training of the hands and arms to strengthen muscles needed for writing. Because the goal of therapy would be to develop pre-academic skills, the LEA would provide an occupational therapist.

- Finally, consider the case of an aphasic child who has suffered severe injuries as the result of a car accident. While this child might participate in a school's special education program, the school would not provide speech therapy because the service is considered rehabilitative, designed to help the child regain previous language skills. Under this policy approach, the parent would be expected to cover costs through either private insurance or by applying to another state agency.

Essentially, the goal of this policy approach is to limit school districts' financial liability. Implemented at the state level, this policy would help the state education department distinguish its role from those of other human service agencies. Such a policy could be used as, not a hard-and-fast rule to decide if a service is "related" or not, but a guideline to determine "first-dollar" responsibilities.

Michigan has not translated this approach into state policy for several reasons. While the framework might prove useful in negotiating agreements among state agencies, it is unclear whether it would be approved by Special Education Programs at the federal level. State officials are concerned that the approach could raise compliance issues if it is interpreted to mean that a child would not receive a necessary related service. Another barrier to statewide use of this policy framework has been uncertainty about its acceptability by other agencies. By its nature, redefining related service

responsibilities requires the active participation of relevant agencies. Any unilateral edict from the SEA cannot change longstanding patterns of service financing and delivery. Thus, other agencies must accept the new conceptual framework and agree to change their own practices accordingly.

Michigan's consideration of this approach illustrates yet another important point: without compatible federal policy or legislation, a state is limited in its ability to redefine related services. Ultimately, redefining related services necessitates restructuring the responsibilities of a complex network of state and federal human services. Because federal statutes often determine the "rules of the game" for state agencies, it probably is futile for any SEA to unilaterally assign responsibility for "life support" or "rehabilitative" services to another state agency if these classifications are not recognized by those federal laws and regulations that govern, for example, Medicaid, Vocational Rehabilitation, and Developmental Disability programs. The absence of compatible federal activity also helps explain why the approach outlined here -- one that is conceptually bold -- has not been formally implemented. The lesson here to be learned may be that full clarification of related service responsibilities will occur only when corresponding state and federal efforts redefine the mandate in ways that actively involve both education agencies and other human service systems.

A second approach to clarifying the education agency's responsibilities for related services is dividing service

responsibility for populations of handicapped children among state agencies. This approach sidesteps the difficult conceptual problem of distinguishing among types of services. Instead, it makes a simple decision: while the education agency assumes service responsibility for one target population, a second agency accepts responsibility for another population. In theory, this division of labor allows SEAs and LEAs to concentrate their resources on those groups of children for whom education is the primary goal. Other state agencies direct their resources to groups of handicapped children whose primary need is for services other than education.

While this approach has been used infrequently, policies enacted in the State of Washington illustrate how such a division of responsibility can facilitate handicapped children's access to education and related services.

> In 1981, the Washington State Office of the Superintendent of Public Instruction (OSPI) entered into an agreement with the Division of Developmental Disabilities of the Department of Social and Health Services to divide responsibility between the two agencies for handicapped children ages 0 to 21. The main purpose of the agreement was to clarify responsibilities for special education and related services for children aged 0-5 and 18-21. This clarification became necessary because two networks of statewide services had developed to deal with these young and older developmentally disabled children: one run by the local education agencies, and the other administered by the local public and private agencies funded by the Division of Developmental Disabilities.
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> An agreement between the two state agencies, reached after one year of negotiations, assigns responsibility for serving handicapped children aged 0 to 2 to local developmental disability centers. Comparable responsibility for developmentally disabled children

and other handicapped children aged 3 to 5 remains with the education system. (While education and related services to this latter group remain optional under state law, most LEAs have such programs.) OSPI retains responsibility for Child Find activities.

This agreement does not mean that education agencies will no longer serve children aged 0 to 2. Nor does it mean that developmental disability agencies will never serve children aged 3 to 5. Rather, the intent is to clarify the primary responsibility for developing financing arrangements and service delivery systems for children in these age-groups. Within the age-groups for which they have lead responsibility, both agencies are authorized to set priorities for the children they serve and determine service delivery arrangements.[6]

The Washington state policy was motivated by two factors: a desire to avoid duplicating services and a conviction that dividing responsibilies could make services more cost-effective. Officials of both state agencies also recognized that, at a time when both agencies faced the possibility of reduced funds, their agreement represented a more efficient use of resources and thus, in effect, an expansion of resources. For example, OSPI administrators observed that by limiting LEA responsibility for children 0-2 under this agreement, there was a greater chance that LEAs could maintain the level of support provided to children aged 3-5.

The Washington state agreement illustrates that new state policies pertaining to related services can affect

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[6]For more information on Washington's policy, contact Dr. Judy Schrag, Assistant Superintendent, Office of the Superintendent of Public Instruction, Division of Special Services, Old Capitol Building, Olympia, Washington 98504.

statewide delivery systems rather quickly, if the policies are both well conceived and in the financial interest of all participants. Since the agreement's enactment, local agency responsibilities have been realigned as intended. The agreement also has led to an overall increase in services to a large number of pre-school handicapped children. The population of children aged 0 to 2 served by Developmental Disability programs statewide grew from less than 200 before the agreement to more than 700 in February 1982. Similarly, OSPI believes that services to children aged 3 to 5 have increased.[7]

The policy approach taken by Washington state is not only an innovative way to clarify agency responsibilities, but, based on evidence available to date, a method of increasing access to necessary services. While this approach retains the concept of primary responsibility by holding one state agency accountable for services to a particular group of children, it also distributes overall accountability for handicapped children between these service systems. This approach thus stands in contrast to those of other states which, as discussed in the next section, have attempted to divide financial responsibility for education and related services, rather than service responsibility for certain groups of children.

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[7]This increase partly reflects the Division of Developmental Disabilities' decision to change their service eligibility criteria to serve a wider range of children than would have been served prior to the agreement.

B. Increasing the Resources Available for Related Services Statewide

SEAs have increasingly taken the initiative in securing other state agencies' cooperation to expand the availability of related services for handicapped children. In doing so, SEAs have tried to establish clear and explicit policies that guarantee that other agencies' resources -- e.g., dollars and service programs -- are made available to either local school districts or handicapped children directly.

The extent to which an SEA can be successful in obtaining cooperation and/or sharing resources with other state agencies depends on factors such as: the fiscal capacity of that agency; the traditional pattern of service within the state; the relative bureaucratic clout of each agency; and the skill of the staff participating from both agencies. But while each SEA is likely to take a slightly different approach to establishing related services policies, many states have found success with certain general strategies. Particularly effective examples of these strategies are analyzed below.

The first of these strategies can be described as an SEA's attempt to obtain another service system's resources for use by LEAs. It was this strategy that was pursued by so many SEAs through the interagency agreements that proliferated after P.L. 94-142's implementation.[8] In the best of these

[8]For an extended discussion of the use of interagency agreements and other methods for establishing interagency cooperation, see Volume 1: Effective State Policies to Promote Interagency Collaboration, prepared by the Handicapped Public Policy Analysis Project.

agreements, state agencies made explicit, often for the first time, the degree of responsibility each was willing to assume in serving children with handicapping conditions. More typically, however, these agreements yielded little specificity about the amount of services that would be provided. They thus represented little more than an expression of good intentions, with both agencies remaining cautious about making any policy commitments that would drain resources away from the services they were already providing.

As SEA officials began recognizing the weaknesses of these "first round" interagency agreements, some states began to develop a "second wave." These later agreements represented a more genuine and better informed attempt to both change the pattern of service delivery and establish a priority for handicapped children within other human service systems. These agreements often addressed the key issue -- availability of dollars -- with a directness that had been lacking in previous agreements. In addition, the agreements went further in identifying the type of service commitment made by each agency.

The agreement between the California Department of Education and the California Department of Mental Health provides an example of this type of interagency agreement.

> The California Departments of Education and Mental Health entered into a joint agreement to ensure that local mental health agencies would use their funds to pay for local related service costs for emotionally disturbed students. This joint agreement, which was revised yearly between 1979 and 1982, defines the services for which education and mental health

agencies respectively agree to accept responsibility. It also details the process by which emotionally disturbed children are referred from one agency to the other.

Most importantly, this agreement clearly states that mental health dollars under California's Short-Doyle state law are to be used to finance related services at no cost to parents when such services are indicated in a child's IEP. In order to comply with P.L. 94-142, the Department of Mental Health encouraged local mental health programs to consider waivers of individual fees in order to provide services at no cost to parents. These waivers would be considered valid by the State Mental Health Department if there was an interagency agreement, memorandum of understanding, or a contractual agreement between the LEA and the local mental health program. Even though a blanket waiver of the Uniform Method for Determining Ability to Pay (UMDAP, the State Mental Health Department's policy on client fees) has not yet been officially approved by the Health and Welfare Agency (the parent agency of the Department of Mental Health), many local mental health centers are waiving fees according to the intent of the federal law and the interagency agreement.

Both Departments had important reasons for entering into this agreement. The Department of Education had received reports from LEAs that fewer local mental health dollars were being used to provide services to seriously emotionally disturbed children enrolled in special education classes since California defined psychotherapy as a related service in 1980. At the same time, the Mental Health Department found dramatic reductions in the number of children referred by schools to their local agencies. The mental health agencies feared that schools were developing competitive programs that might reduce the need for separate mental health programs. Thus the agreement was of mutual benefit to both agencies. Mental Health received greater numbers of referrals, and education agencies were relieved of part of the burden of financing and providing related services.

As a result of the agreement, the State Mental Health Department now recognizes handicapped children as a legitimate responsibility for local mental health agencies. At the local level, mental health staff have devised creative ways to provide resources,

often in-kind, to handicapped children at no charge to parents.[9]

Through their agreement, California's SEA and Department of Mental Health have done more than just promote an abstract sense of "cooperation" among their local counterparts. By committing mental health dollars to children in special education programs, they have opened the doors for local education and mental health agencies to jointly develop programs that increase the availability of related services to seriously emotionally disturbed children. Although California's agreement technically will not be in full force until the Health and Welfare Agency approves the blanket waiver allowing local mental health centers to serve handicapped children at no cost to parents, local mental health agencies have been providing an expanded range of services to children with handicapping conditions, at no cost to the LEAs or to parents, even in the absence of the waiver.

Like the successful agreements found in other states, California's required both considerable sophistication among state agency staffs as well as a consensus about service goals. An examination of successful agreements supports the view that effective interagency ties result when state agency staffs know each other's programs well and can draw on personal relationships, often established through previous work. In many states, the biggest contribution of the first round of

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[9]For more information on California's agreement, contact Dr. Winnie Bachman, California Department of Education, 721 Capitol Mall, Sixth Floor, Sacramento, California 95814.

interagency agreements may have been that they brought agency staffs together. For example, initial mental health/special education agreements in California, although programmatically weak, laid the groundwork for the later, more effective, agreements by identifying substantive issues and providing opportunities for staff from the two agencies to work together for the first time.

Obviously, state agreements such as California's do not, by themselves, insure either improved delivery of related services or greater access to services. Their effectiveness is ultimately dependent on the activities of local school districts and local human service agency offices. Thus, an important factor in this context is the degree to which SEAs encourage and assist local districts in following-through on the opportunities created by state-level agreements. However, a clear and forceful state-level agreement that specifically mentions financial commitments is a good first step for the more concrete local level negotiation which must take place.

The concept of an SEA obtaining financial commitments from another human service agency can be carried further through a strategy best described as <u>third party financing of related services</u>. As part of this approach, an SEA seeks to utilize non-educational entitlements as funding sources to pick up the costs of services previously paid by education agencies. This differs from the previous example in which the SEA established a priority for handicapped children, but LEAs still had to negotiate new funding arrangements at the local

level. Under this approach, the SEA directly facilitates the attainment of funds for the payment of related services.

The utility of this approach for education agencies is obvious: it saves dollars. The potential opposition of other funding sources to this approach is equally clear: agencies which can control how their funds are spent will often not want to use them to replace what is viewed as a first dollar payor (that is, special education dollars as mandated by P.L. 94-142).

An example of this approach is provided by Connecticut's policy claiming Medicaid reimbursement for the cost of medically-related services in local school districts.

> The Connecticut Department of Education, working with the State Department of Income Maintenance (DIM), has developed a third party billing system that allows local school districts to claim private insurance and Medicaid reimbursement for school-provided health-related services. The goal of this plan is for payment sources, other than local school districts and the state education agency, to assume responsibility for the cost of certain health-related services.
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> The effort to establish a statewide billing system grew out of work performed by a southern Connecticut Regional Educational Service Center (RESC). Because the RESC believed that third party reimbursement was an underutilized source of financial support for special education and related services, the RESC commissioned a feasibility study to estimate the degree to which costs currently assumed by the local school districts in that region potentially could be financed through the state's Medicaid program. Two types of costs were analyzed: (1) those resulting from LEAs' provision of direct services, and (2) services provided by hospitals, under orders of the LEA, to handicapped children.
>
> Because the RESC's findings were favorable, the SEA commissioned a statewide study and this corroborated the earlier findings: substantial savings would be realized if Medicaid reimbursement to school districts for health related services could be arranged.

Following the SEA's and DIM's acceptance of the feasibility study, the two state agencies developed an enabling agreement which was signed in July, 1981. This committed both departments to developing a billing system that allowed local schools to claim Medicaid reimbursement. In addition to these two state agencies, the Governor's Office and the state Office of Policy and Management were involved in the agreement and approved further development. The federal Health Care Financing Administration (HCFA) also gave policy clearances which enabled DIM to proceed with developing the system.

In preparation for pilot testing the new system in academic year 1983-84, the SEA and DIM signed a second implementation agreement in August, 1983. This defined the specific operational roles and responsibilities for DIM, the SEA, and the participating LEAs. Once the pilot begins, a centralized billing system for the 14 LEAs participating in the pilot project will be administered by a RESC.

While schools will not actually determine eligibility for Medicaid (this remains DIM's responsibility), all health services provided by schools and included in the Medicaid state plan will be eligible for reimbursement. The two state agencies will act to determine the liability on the part of third party sources and advise LEAs accordingly.[10]

The Department of Education's agreement with Medicaid promises to yield significant cost savings to local districts, because local education dollars for medical services will be replaced by state/federal Medicaid dollars. For the state government as a whole, the new arrangement is expected to lead to lesser cost savings. That is, while cost savings will be achieved in the Department of Education's budget, these will be almost entirely offset by the rise in the state's share of Medicaid costs. In order to mitigate the budgetary impact of

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[10]For more information on Connecticut's third party billing system, see Appendix B or contact Ms. Elizabeth Guldager, Bureau of School and Program Development, Connecticut Department of Education, P.O. Box 2219, Hartford, Connecticut 06145.

the first year changes on DIM's budget, a special appropriation of $2.2 million has been made to DIM. Thus, neither DIM's budget nor the state budget as a whole will be affected negatively.

Connecticut's use of third party liability illustrates steps that an SEA needs to take to tap into a major non-educational funding source. First, an SEA must understand in detail the nature of the other funding source, including its eligibility requirements, utilization rules, and the availability of funds. In Connecticut, a consultant was hired to provide this expertise, but SEA staff rapidly developed knowledge about the Medicaid system as well so that they could deal confidently with the Department of Income Maintenance.

Second, involving a higher level of state government is probably necessary for any large scale transfer of funds or cost sharing among funding sources. In Connecticut, the Governor's Office and the State's Office of Policy and Management played important roles in developing this plan. In most states, the state budget office's involvement will be crucial to re-allocating state agency resources.

Third, when considering alternative funding sources, it often is necessary to secure federal policy clearance. Federal inter-agency agreements between the Department of Education and other federal human service agencies can be useful here. One reason for Connecticut's success in securing Medicaid financing was that both the federal Health Care Financing Administration (HCFA), in the Department of Health

and Human Services, and Special Education Programs (SEP) in the Department of Education had been promoting the use of Medicaid to finance school-based health services. The federal agreement between these two agencies clearly encourages school districts and state Medicaid agencies to work together.

Finally, major re-directing of financing as seen in Connecticut demands that participating agencies change their current systems, often in significant ways. For example, developing a new Medicaid billing system for Connecticut's school districts has required a significant commitment of time and energy from both the SEA and LEAs throughout the state. Similarly, DIM's willingness to extend Medicaid certification to schools has involved significant changes in that Department's procedures.

Connecticut's experience is particularly noteworthy because reductions in human service budgets have left few federal or state funding sources that, like Medicaid, could be expanded. Because the potential for extensive payment from private third party payment sources remains undefined, Medicaid may be the only major funding source which promises education agencies a significant and immediate financial offset. Not all attempts to tap Medicaid need be as ambitious as Connecticut's. LEAs in several states have arranged for Medicaid financing of school-based services on a local basis only. While less comprehensive than Connecticut's policies, these efforts have been effective on a smaller scale.

Connecticut's use of Medicaid is primarily a fiscal arrangement. It allows LEAs to stretch -- in effect, increase -- their budgets for related services. Other interagency arrangements which try to expand related services for children simultaneously address programmatic and fiscal issues. Examples of these agreements are described below.

When SEAs establish joint funding and cooperative programming arrangements with other human service agencies, they are usually creating entirely new types of programs. In so doing, they often achieve the type of integral blend of education and related services which seems to have been the intent of P.L. 94-142; that is, programs in which the educational and service components are planned, developed, financed, and implemented together from the start in order to best meet the needs of handicapped children. While such efforts are not usually viewed as "related service" efforts per se, they, in fact, accomplish the goal of making necessary services more accessible to handicapped children.

State agency efforts to promote or create such programs are usually undertaken on behalf of children with handicapping conditions who, because they require a rich mix of related services, have been unserved or inappropriately served in the past. For example, pre-school handicapped children have been the focus of a number of these efforts. More recently, many SEAs have attempted to target services to older handicapped children and promote services to seriously emotionally disturbed children.

The following three examples illustrate the way joint state agency efforts can create comprehensive education and related service packages. These programs include the Oklahoma Cooperative School/Rehabilitation Work Study Program, that is described next. This description is followed by two others: Michigan's Rehabilitation/Special Education/Vocational Education Program and Maine's Early Childhood Development program.

The Oklahoma Cooperative School/Rehabilitation Work Study Program was developed jointly by the Special Education Section (SES) the State Department of Education and the Division of Children, Youth and Rehabilitative Services of the State Department of Human Services (DHS). Begun in 1961 in Oklahoma City as a pilot program, it has grown into a statewide comprehensive and coordinated effort to identify and serve all physically, mentally, and emotionally handicapped youth enrolled in the participating secondary high schools. This special program is available to all secondary schools in Oklahoma that have an established special education program. During FY 1983, there were 60 participating high schools.

The Cooperative Program developed from the conviction that no agency has all the resources necessary to meet the needs of handicapped youth. However, by linking the services of special education and vocational rehabilitation, Oklahoma SES and DHS officials believed they could provide coordinated services that would bridge the gap between school and employment. An interagency agreement was designed to facilitate the linking together of these agencies: for each local program, the agreement is signed by the LEA and a representative from the two state agencies.

The program has several components: (1) a work-study program, in which special education students identified in local high schools receive academic credit for part-time vocational training, on-the-job training, and/or work experience coordinated with classroom instruction; and (2) services for students not in the work study program, but who can benefit from assessment, counseling, and placement services by a vocational rehabilitation (VR) counselor.

To implement the program, LEAs hire a teacher-coordinator with special education dollars. This person is assigned field responsibilities related to vocational rehabilitation services and works under the supervision of VR. A VR counselor, paid for by the Vocational Rehabilitation Division, works in a team with the teacher coordinator. The Division also pays for medical and psychological diagnosis when this is not available through the LEA; vocational evaluation of employment potential for students; vocational counseling; on-the-job training fees for students; and other vocational guidance services for which they may be eligible and which can not be provided through the LEA. (See Appendix C for a more detailed description.)

While this program was started well before P.L. 94-142, it nevertheless embodies the goal of providing related services as set forth by the federal law. Rather than attempting to draw fine distinctions between an "education" component and a "service" component, the program recognizes that because neither of the two agencies has the resources to adequately serve secondary-school age students, they had to combine resources. The Oklahoma program also illustrates the benefits to be gained from sustained interagency effort: since its inception as a pilot project in 1961, there has been a steady increase statewide in the number of special education students receiving vocational education and finding employment.

While the primary motivation for developing this program was improving service delivery, financial incentives obviously were a powerful factor. Oklahoma officials believe the program has yielded substantial cost savings because it has eliminated duplication between the two service systems. In addition, the Division of Children, Youth, and Rehabilita-

tive Services originally claimed local special education dollars as matching funds for federal financial participation in the Vocational Rehabilitation program. While this arrangement is no longer necessary, by all accounts this fiscal "glue" helped maintain an unusual degree of interagency cooperation over the years.

Like Oklahoma, Michigan has developed a program to improve education and related services for handicapped secondary-level students that involves three agencies. Its history illustrates several additional facets of interagency attempts to utilize all existing resources to provide related services.

> In 1980, the Special Education Division of Michigan's Department of Education undertook an intensive joint effort with another division of the Department -- the Vocational-Technical Education Service -- and with the Michigan Rehabilitation Services. Their goal was to develop state policies that would facilitate and stimulate improved secondary level vocational services. This collaborative effort was motivated by a shared conviction that secondary level special education students were neither being prepared effectively for work nor developing skills commensurate with their potential.
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> Working together, a staff from each of the three agencies produced a state-level interagency agreement that not only demonstrated a commitment to joint programming on the part of their respective agencies but also provided a detailed guide from which local districts could build their own delivery systems for secondary age students with handicapping conditions.
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> The agreement outlined the roles and responsibilities of each agency in secondary programming and a process to expand local vocational programs for handicapped students. By resolving the major policy issues among the three state agencies, this agreement cleared the way for the development of local programs.

Unlike the Oklahoma program, the Michigan agreement does not attempt to make the service delivery practices of the three participating agencies conform to a single program model statewide. Instead, it identifies the functions each agency is mandated to perform, suggests generic levels of vocational programming, and then gives considerable discretion in program design to local districts.

Since school year 1982-83, Michigan Rehabilitation Services has been able to use local special education resources contributed to these cooperative programs as match for federal Vocational Rehabilitation (VR) funds. This arrangement enables LEAs to multiply their own funds, which has been a boon for less wealthy, rural LEAs. In addition, it saves state funds previously used to match VR dollars. As of September, 1983, approximately ten million dollars in federal funds had been generated through this arrangement. (See Appendix D for a more detailed description.)

Because the Michigan program was developed amidst budget cutbacks and shrinking state resources, the agreement-drafting process was often delayed. At several junctures, each of the three participating state agencies questioned whether it could afford the level of staff time required for the cooperative program-building effort. Yet, at each point, the agencies affirmed their willingness to proceed. Their sustained involvement was, in itself, a clear message to their local counterparts that developing local programs was not only important, but a priority. The several years of work at the state level have proven worthwhile. By 1983, over 30 local districts had established programs pursuant to the state interagency delivery system, serving over 10,000 secondary age handicapped students.

The contrasts between Oklahoma and Michigan's cooperative programs are instructive. Although both aim at

the same target population, the Michigan program demonstrates the greater difficulty involved in achieving interagency coordination in a state where government is both larger and more complex. During the course of developing its program, the Michigan agreement drafting team encountered far more bureaucratic resistance from direct service and middle management staff than was experienced in Oklahoma. Indeed, the Michigan team spent much time and effort familiarizing each agency with the other's programs and policies and melding apparently disparate, and often conflicting, policies. Yet, the close working relationships that consequently developed among the professional staffs contributed much to the program's success.

One similarity between the programs is also important. Both the Oklahoma and Michigan programs demonstrate the importance of technical assistance if state-level interagency cooperation is to be translated into improved local programming. In Oklahoma, this technical assistance was often informal and occurred over many years as the Cooperative Program model was disseminated to an increasing number of districts. In Michigan, technical assistance was a key task pursued deliberately by the staff assigned to the interagency effort. Through joint appearances at workshops and in-service training sessions, the Michigan staff have kept a focus on the importance of vocational programming using all agencies' resources.

Another interagency effort designed to increase joint funding and collaborative delivery of related services is Maine's statewide approach to serving pre-school handicapped children.

In 1979, Maine established an Inter-departmental Coordinating Committee for Pre-school Handicapped Children (ICCPHC), a product of a special study commissioned by the state legislature. This study had documented the fragmentation in the planning and delivery of currently available services, and the resulting exclusion from needed services of many families and children.

The Commissioners of the three state agencies with responsibility for services for young handicapped children -- the Departments of Educational and Cultural Affairs, Human Services, and Mental Health and Mental Retardation -- determined that while the state could not effectively coordinate local service planning and provision, it could facilitate the development of regionally-based coordination efforts. ICCPHC thus was given the specific task of "emphasizing and promoting the active role of other public and private local service agencies and parents in coordinating, planning, and service acquisition."

To carry out this mission, ICCPHC used Pre-School Incentive grants, state implementation grants, and state appropriated funds to set up nine pilot projects which cover most of the state's populated areas. These projects, in turn, have established local coordinating committees whose role is to develop interagency funding arrangements for related services to young children. The state dollars received by the pilot projects can only be used to generate local funds or develop new services; the projects are prohibited from using their grant funds to purchase services whose costs can be borne by a local provider. Since 1980, the projects have been funded totally through state appropriations, as the SEA has been able to convince the legislature to support the local committees in full.

The pilot projects funded by ICCPHC seem to have validated this approach. They have increased the level of coordination among existing public and private services and stimulated the development of

new programs and services funded, in many cases, by non-education monies.[11]

Maine approached the task of increasing related service resources statewide somewhat differently than the other examples mentioned above. Education officials in Maine wanted to stimulate local education agencies to develop joint service arrangements for pre-school handicapped children rather than attempt to work out interagency mechanisms at the state level. Since state officials knew they could not directly affect local programming (there is considerable local autonomy in Maine), they chose instead to set up regional structures that could promote joint ventures in local school districts. Maine officials believe this approach has been more effective than if they had simply developed state-level linkages among agencies.

Oklahoma, Michigan, and Maine's programs, along with the others described in this section, illustrate approaches states have taken to increase the availability and scope of related services and spread the financial burden for providing these services. Although these approaches differ in significant ways, they illustrate several characteristics, described below, that are common to state policies that successfully develop and/or promote comprehensive education and related service programs among multiple agencies.

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[11] For more information on Maine's ICCPHC, contact Ms. Chris Bartlett, Division of Special Education, Department of Education and Cultural Affairs, Statehouse Station 23, Augusta, Maine 04333.

• Maintaining and improving services by sharing financial responsibility. Each of the efforts described in this section was undertaken with the premise that agencies serving handicapped children prior to the passage of P.L. 94-142 should not reduce their financial or service commitments after this legislation was passed. In addition, the collaborating agencies were committed to not only working together, but achieving improved levels of service for handicapped children throughout their respective states. Implicit in these commitments was the desire to share financial responsibility equitably at the state and local levels. Absent from these discussions were the prolonged debates in which some other states have become mired, e.g., seemingly unresolvable disputes regarding the boundaries between education and other services and the service responsibilities of one agency versus another.

• Offering fiscal incentives to participants. The financial arrangements described in this section vary widely, but each offers fiscal incentives to participants. In some instances, the incentives are obvious. For example, budget projections for Connecticut's third party billing system indicated that local school districts would save significant amounts of money when this system was successfully implemented; with this type of financial forecast, LEAs are more than willing to make the initial investment of time and resources to develop the system. Similarly, the Michigan and Oklahoma programs offered their respective state Vocational

Rehabilitation programs an incentive to participate because special education funds earmarked for the cooperative programs could be used to meet federal matching requirements.

Incentives are less obvious, but still present, in other interagency arrangements. For example, the California Mental Health agreement allows local mental health agencies to use their dollars to provide related services to emotionally disturbed children, but this was in part motivated by a desire to sustain existing mental health funding levels. Such funding had been jeopardized by the SEA's decision that psychotherapy was a related service, thereby raising the possibility that LEAs would provide this service themselves. The agreement changed this situation. Similarly subtle incentives were evident in the early years of the Michigan agreement where the three participating agencies decided that there was greater fiscal benefit in working together than in pursuing separate programs. As budget constraints tightened, the benefits of cooperative efforts increased, outweighing any advantages that may have resulted from each agency going on its own.

- Recognizing the importance of professional working relationships. Almost without exception, the working relationships among professionals from different agencies were crucial to the success of the related service efforts described here. Programs became effective only when professionals agreed on, and worked toward, common goals. In some instances, it was the strong interpersonal ties among agency

staff that overcame bureaucratic criteria and made these arrangements work. But even without such personal ties, the ability of professionals of different disciplines to communicate well with each other, to symphathize with and trust each other's perspectives, and to cease to defend professional turf, is essential for the development of comprehensive cooperative programs.

• Interweaving state and local interests. The importance of interweaving state and local interests often is ignored by federal policymakers but is particularly important in interagency efforts undertaken to develop related service programs. Except in the California example cited above, all of the state policies just described evolved either from local efforts or in close conjunction with local efforts. Many state and local administrators and policymakers, who describe themselves as still "feeling their way" in developing interagency relationships, recognize that state policy benefits when it closely reflects local practice. Conversely, they also recognize that local efforts are facilitated whenever they are implemented within the context of sound state policy, as evidenced by the Oklahoma Cooperative Work Study Program and the Maine Early Childhood Development Program.

III. EFFECTIVE LOCAL POLICIES IN THE PROVISION OF RELATED SERVICES

Local education agencies' responsibilities for related services differ from those of state agencies. Local agencies face one large task: assuring that all handicapped children have access to the related services they need to benefit from an educational program. The services must be available when needed, in the quantity needed, and with requisite quality. A local district also must ensure that services are provided in a cost efficient manner.

LEAs can either provide all related services directly or try to obtain services from other agencies, either through contracts or free of charge. The data in Tables 2 and 3, taken from a survey of LEAs, reveal that the majority of responding districts elected to provide services directly rather than contract out for them. For larger school districts especially, direct provision of some services approaches 100%. Predictably, these services are those most frequently associated with "traditional" educational responsibilities. Services that are less "traditional" and the least likely to have been a part of a school district's activities prior to the state and federal requirements for special education programmming are those for which school systems most frequently contract out. These services include diagnosis, occupational and physical therapy services, and audiological and psychological treatment services.

TABLE 2

Methods of Providing Related Services
By Type of Service Among LEA's with
Enrollment of Less Than 10,000 Students

SERVICE	SERVICE PROVIDED BY:			
	(1) Staff Employed By District (%)	(2) Staff Employed by An Intermediate Educational Unit (%)	(3) Another Agency Through Purchase Arrangement or Contract (%)	(4) Another Agency At No Cost To LEA (%)
SPEECH AND LANGUAGE				
Testing/Assessment	78	26	13	9
Therapy	76	28	10	4
AUDIOLOGY				
Testing/Assessment	34	18	45	18
Therapy	30	32	34	11
PSYCHOLOGICAL SERVICES				
Testing/Assessment	81	25	22	10
Psychological Services	68	4	21	17
SOCIAL WORK	48	30	8	24
PHYSICAL THERAPY				
Testing/Assessment	20	8	46	9
Therapy	25	30	43	10
OCCUPATIONAL THERAPY				
Testing/Assessment	23	26	46	12
Therapy	26	26	48	11
MEDICAL				
Diagnosis/Evaluation	17	8	65	33
Catheterization	92	8	0	0
Administration of Medication	88	19	0	0
RECREATIONAL THERAPY	62	14	14	14

NOTE: Rows do not equal 100% because LEA's often provide services in more than one way.

SOURCE: Center for the Stuy of Social Policy, Survey of Selected Local School Districts to Identify Exemplary Policies Related to Implementation of P.L .94-142 and Section 504 of the Rehabilitation Act, 1982.

TABLE 3

Methods of Providing Related Services
By Type of Service Among LEA's with
Enrollments Over 10,000 Students

SERVICE	SERVICE PROVIDED BY:			
	(1) Staff Employed By District (%)	(2) Staff Employed by An Intermediate Educational Unit (%)	(3) Another Agency Through Purchase Arrangement or Contract (%)	(4) Another Agency At No Cost To LEA (%)
SPEECH AND LANGUAGE				
Testing/Assessment	87	16	16	8
Therapy	89	11	13	5
AUDIOLOGY				
Testing/Assessment	64	13	31	5
Therapy	75	13	19	3
PSYCHOLOGICAL SERVICES				
Testing/Assessment	85	18	18	10
Psychological Services	84	16	16	13
SOCIAL WORK	81	15	4	7
PHYSICAL THERAPY				
Testing/Assessment	73	8	27	14
Therapy	71	11	21	16
OCCUPATIONAL THERAPY				
Testing/Assessment	74	9	20	17
Therapy	77	9	20	17
MEDICAL				
Diagnosis/Evaulation	21	7	66	41
Catherization	80	10	0	10
Administration of Medication	79	16	0	11
RECREATIONAL THERAPY	67	7	13	33

NOTE: Rows do not equal 100% because LEA's often provide services in more than one way.

SOURCE: Center for the Stuy of Social Policy, Survey of Selected Local School Districts to Identify Exemplary Policies Related to Implementation of P.L .94-142 and Section 504 of the Rehabilitation Act, 1982.

Presumably, districts prefer to provide services directly for two reasons: it is easier for them to do so, and direct staff hiring offers stronger administrative control. Contracting for services, or even obtaining free services from another agency, entails the risk that the nature and scope of the services provided will not meet the school district's specifications. However, with decreasing school budgets, more local districts are accepting the risks involved in collaborating with other agencies so as to reduce costs and improve programs. Rather than trying to build full program capacity into a school staff -- and duplicating another community agency's capacity in the process -- LEAs now are more willing to join their own programmatic strengths with another agency's, thereby creating a comprehensive program.

Providing related services in conjunction with outside agencies and existing funding sources requires that school districts develop new policies, and education administrators new skills. To integrate school services with those of other agencies is not always easy. At a policy level, it requires not only an understanding of how best to organize educational resources, but a vision of how to organize and finance the full range of services, educational and non-educational, needed by children with handicapping conditions. At the operational levels, interagency ventures almost always entail new management practices and become especially difficult when separate audit trails are required for each agency's funds.

It is important to note that school districts are not the only ones to have initiated collaborative programming and financing arrangements. Other human service agencies facing reduced budgets also are looking for more cost-effective ways to provide services. These agencies now often approach LEAs or SEAs with proposals for uniting services and sharing costs.

Whether initiated by education or other human service agencies, several general approaches have proven successful in assuring the provision of a full range of related services:

- Obtaining resources free of charge from another human services agency;
- Pooling resources among neighboring districts or within one district to increase the availability of related services; and
- Developing new programs which provide education and related services for specific population groups.

Each of these strategies is described in turn below.

A. Obtaining Resources Free of Charge from Another Human Service Agency

The barriers to obtaining resources free of charge from another human service agency have already been mentioned in conjunction with state level policies. Despite these barriers, a few districts have been successful in providing related services at no cost to the district. An example is cited below: an arrangement through which occupational therapy (OT) and physical therapy (PT) are made available to handicapped children in Anne Arundel County, Maryland.

> In Anne Arundel County, Maryland, the local education agency secures occupational and physical therapy as

part of school health services from the County Health Department at no cost to the LEA. The arrangement began in the mid-1950's when the Health Department first procured the services of a physical therapist to serve children attending its Crippled Children's Clinics, most of whom were also attending public schools. When the LEA subsequently built a school to include several classrooms designed especially for handicapped students, the LEA worked with the local Health Officer to review plans for these students. The physical and occupational therapy rooms were constructed as recommended, and OT and PT personnel were assigned from the Health Department, in 1957, to work with the children.

When P.L. 94-142 necessitated an expansion in services of both OT and PT services, in contrast to other Maryland counties, the LEA in Anne Arundel increased the number of teachers in special education, while the health department expanded its OT and PT services. An interagency agreement was drawn up to formalize this arrangement, but since there have been no problems in service provision, neither the school district nor the Health Department has seen the need to ratify it.

In recent years as resources have diminished, the Health Department has not cut back its services. Instead, the OT and PT practitioners have intensified their instructions to teachers and other educational personnel in OT and PT related activities, thereby increasing the amount of services children receive by allowing non-health personnel participation. OT and PT supervisors employed by the Anne Arundel County Health Department often describe themselves as trainers, attempting to enhance the methods by which teacher-aides and parents assist the child, thus reducing the need for direct OT and PT services.

Neither the health department nor the LEA expects that this arrangement for OT and PT services will continue indefinitely. In most Maryland counties, LEAs have the responsibility for the cost of both OT and PT. However, both the Director of Special Education and the Health Officer in Anne Arundel County make clear that any new arrangements would be a joint decision between the two agencies. Neither would attempt to shift costs to the other without careful planning and preparation.[12]

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[12]For more information, contact Mary Madeleine, Director, Special Education, Anne Arundel County Public Schools, 2644 Riva Road, Annapolis, Maryland 21401.

This example illustrates a recurring pattern in many states. Frequently, whenever public and private agencies provide related services at no cost to the LEA, these arrangements have predated P.L. 94-142. They result from strong agency ties developed over many years and reflect established service patterns inherent in local delivery systems. These patterns seem particularly likely to evolve in those communities where practitioners strongly believe in sharing the responsibility of a community service system, rather than being preoccupied with each agency's self-interest.

This belief in sharing responsibilities is evident in Anne Arundel and explains much of the health department's continued willingness to pay for OT and PT services. Personal ties have also played a role over the years. The Director of the Health Department and the Superintendent of Schools had established a long-standing and productive working relationship out of which developed, among other services, this collaborative arrangement involving OT and PT services.

B. Pooling Resources to Increase the Availability of Related Services

Many LEAs, particularly those that are smaller and less populated, must cope with the difficulty of providing high cost, specialized services in geographic areas where these services are rare. Some of the most innovative local policies, as evidenced by the three approaches described below, have developed in this kind of situation. The first example, a resource pool developed in the remote Upper

Peninsula area of Michigan, involves several school districts collaborating to provide technical assistance on special education and related services.

> Several Intermediate School Districts (ISDs) in the remote Upper Peninsula region of Michigan formed a Special Education Staff Resource Pool to increase the availability of related service specialists. Recognizing that some districts often had particular expertise unavailable in neighboring districts, the special education directors created a resource pool from which each could draw to answer particular needs. This pool was seen as a low-cost means of obtaining technical assistance.
>
> Most frequently, the services so obtained involve workshops and consultations about particular special education and related service needs rather than direct intervention.
>
> As a result of the Resource Pool, school districts report that they have been able to obtain persons with specific related service skills without either paying exorbitant consulting fees or hiring full time permanent staff. By relying on expertise that is already available in the region, these rural districts have been able to increase the quality of their education and related service programs at relatively low cost. (See Appendix E for a more detailed description.)

Maine offers another example of a cooperative effort to gain access to services among school districts in a rural area.

> Eight school districts in Maine's Capitol Area Region have formed a contractual services "pool" from which they purchase related services for children with severe or rare handicaps.
>
> This idea developed because small districts found that bringing even one child back from a private residential setting to a district-based program required either access to services that were unavailable or funds that could not be squeezed from individual school budgets. Confronted with these limited resources, eight special education directors

established region-wide contracts with related service providers and a "pool" to be used for services that no one district could afford.

The region-wide contracts negotiated with related service providers throughout the area are based on uniform rates, and, because they are developed jointly by all districts, hold prices for services at uniform levels. Providers agree in these contracts to bill third party payment sources first; the districts pay for services only when no other funds are available.

The resulting regional system of related services has had several effects. It has increased handicapped children's access to services by making related services readily available to all parts of the region; it has lowered costs to the district by tapping other funding sources and holding providers' rates constant; finally, it has created a well-organized service delivery network which allows districts and providers to allocate resources efficiently. (See Appendix F for a more detailed description.)

Colorado's Weld County offers a third illustration of cooperative efforts to increase access to related services.

A group of public and private agencies in Weld County, Colorado, began a cooperative screening program for children (from birth to age five) who were suspected of being developmentally delayed. The object of the program was to identify high risk children and refer them to appropriate services within the community before they reached school age in order to prevent or reduce future handicapping conditions. The interagency project was intended to be a more efficient use of resources, since duplication in screening services could be reduced.

As a result of the project, agencies that have suffered budget cuts have been able to maintain their previous level of services. Because county school districts are able to use information from the screening clinic in their planning activities, they can plan programs and project budgets for handicapped children when they enter school. Most importantly, many more at-risk children are being screened in far less time, and many more young children are receiving services at earlier ages, long before they enter school. (See Appendix G for a more detailed description.)

These three examples illustrate the different kinds of "pooling" approaches taken to assure access to related services in rural areas. While the Upper Peninsula's "pool" was for resource specialists, Maine's Capitol Area Region formed a pool of related service providers and Colorado's Weld County established a common "pool" of screening professionals. Each sought to expand related services to areas where the number of handicapped children was relatively small by combining resources with neighboring districts. The rural nature of these areas made interagency collaboration a necessary step if services were to either expand or remain constant in the face of budget reductions.

Several factors that contributed to the effectiveness of these three efforts are noteworthy. First, there were strong informal relationships among local participants in all three areas. Not only did special education staff from multiple districts work together, as in the Upper Peninsula region, but private providers joined the efforts in Maine and in Colorado. Second, the regional inter-district organization of the resource pools did not diminish the sense of "ownership" of any participating district. LEAs shared in the planning and operation of these efforts equally, thus none felt a loss of control over the basic decisions involving utilization of related services. Consequently, these three programs have operated smoothly and effectively, without competition or significant disputes among LEAs or other human service providers.

Finally, in the Upper Peninsula region of Michigan and the Capitol Area Region of Maine, seed funding from state and federal resources was critical to each project's success. Michigan's Resource Pool initially was developed as part of a Title IV federal grant. Maine's Regional Team was supported originally by a Title IV-C federal grant. Without these seed grants, both would have had much more difficulty initiating their programs.

C. Developing New Programs for Special Student Populations

A third approach to the task of assuring access to related services is illustrated by those LEAs that have developed new, comprehensive programs that integrate education and related services for specific populations. Typically, such programs are designed to serve (1) seriously emotionally disturbed children, (2) very young handicapped children, or (3) handicapped youth at the secondary school level. The multi-dimensional needs of these children almost demand that LEAs integrate educational and non-educational "related" services in a new way.

The concept of an "integrated education and related service program" is somewhat abstract; simply put, it is a program that blends a range of services in the interest of meeting the needs of children without being overly concerned about whether a specific service is an "educational" or a "related" service.

Two local programs are described below, both of which

provide services to severely emotionally disturbed children.

In the late 1970's the School District of Independence, Missouri became convinced that adequate services were not being provided to the district's seriously emotionally disturbed children. The LEA sought to enter into a joint venture with the local community mental health center which was a private non-profit agency. Together, the LEA and the mental health agency explored several funding possibilities, finally receiving an interagency coordination grant under P.L. 94-142 discretionary funds. After a year of planning, the two agencies approached the state Departments of Education and Mental Health, performed a feasibility study to determine if seriously emotionally disturbed children could be served within the school district, and received seed money with which to develop a program.

In 1981, the New Direction program was established as a cooperative program between the LEA and the mental health agency. Services are provided to those children between the ages of 8 and 15 with behavior disorders whose needs cannot be met by the school district's special education program. The New Direction program is comprehensive: the instructional programming is supported by daily individual and group sessions with a recreational therapist and a psychologist. The Center is financed jointly by the LEA, the SEA, and the local mental health agency.

As a result of this program, several children have been de-institutionalized to New Direction, thereby being placed in a less restrictive environment than previously available. From 1981-83, a limited number of children were reintegrated into the regular school program. (See Appendix H for a more detailed description.)

A similar pattern of joint planning, funding, and program development for seriously emotionally disturbed children is found in the RICA program in Montgomery County, Maryland.

The Maryland Department of Health and Mental Hygiene and the Montgomery County Public Schools jointly fund and operate the Regional Institute for Children and Adolescents (RICA) which provides residential and/or

day treatment and education to emotionally disturbed students aged 6 through 20.

RICA was developed in the mid-1970's. This program reflected the two agencies' recognition of the need for a new type of program that would offer a combined program of education and clinical treatment for troubled adolescents who did not fit neatly into then currently available care settings.

RICA's planning period lasted eight years and involved close coordination between the LEA and the Maryland Department of Health and Mental Health. Despite difficulties encountered in developing this program, the two agencies continued working together because both believed that (1) handicapped students with multiple problems can be well served only if a range of community specialists and organizations are involved, (2) keeping students close to home was a desirable policy, and (3) cost savings could be achieved by providing residential services in the county rather than by sending children out of state to other hospital centers or private facilities. Both agencies agreed that RICA would be cost efficient if students could be rehabilitated more quickly and, thus, more quickly returned to less costly settings.

The Maryland Department of Health and Mental Hygiene provides the bulk of the funding for RICA -- $3.8 million in FY 1983, of which almost $1 million is used to contract with the LEA to provide the program's educational component. In addition, Montgomery County Public Schools donated the land for the facility and uses approximately $600,000 of its own funds to enhance the educational program.

RICA operates as an interdisciplinary program made up of clinical, educational, and residential teams. The Medical Director, School Principal and Directors of the Clinical and Residential programs report directly to the Chief Executive Officer. (See Appendix I for a more detailed description.)

The New Direction program and RICA were established because administrators recognized that emotionally disturbed students needed a blend of clinical treatment and an education program. One without the other would be inadequate. Furthermore, administrators recognized that clinical treatment should

be so well integrated into the educational program that each would complement the other. Both LEAs recognized that this type of new program was essential if emotionally disturbed students were to be returned to the regular education system from their previous placements in out-of-state facilities or in-state residential centers.

Once these LEAs recognized the need for a new program, they sought, and were granted, state funds without which they would never have been able to begin operation. New Direction received planning money and operating funds from the Missouri SEA while RICA received the bulk of its funding from the Maryland Department of Health and Mental Hygiene. These state monies were vital to both LEAs' efforts to establish entirely new programs. Both LEAs feel that their programs will be cost effective after the initial start-up period when other revenues can be realized and students are either returned to the district or are placed in less costly programs than those outside the district.

In setting up these new programs, both districts experienced a long and difficult developmental period during which the financial security of their enterprises remained in doubt. Start-up costs were high, and various problems were encountered in obtaining state agency approval and funding. However, in neither case were local participants overly discouraged by the early setbacks, nor did the cooperative arrangements between the LEA and the mental health agency

falter. In both instances, the recognition of potential gain for emotionally disturbed students was sufficient to overcome the difficulties in developing the programs.

IV. CONCLUSION

Beyond the general agreement that related services are an essential component of any special education program, considerable controversy remains regarding the provision of related services. In the absence of strong federal guidelines the courts have come to play a major role in determining education agencies' responsibilities for providing various services to handicapped children. Even the U.S. Supreme Court addressed this question recently in its first case based on P.L. 94-142 -- the now famous Rowley case. However, the numerous judicial decisions involving questions of school districts' responsibility for providing and financing related services have been somewhat equivocal; i.e., rulings have favored both limiting and increasing school district liability.

As education and other human service agency budgets continue to be squeezed over the coming years, it is likely that the courts will be forced to make even more judgements regarding this issue. Financial resources are a critical factor in school districts' capacity to provide the necessary related services to their handicapped populations. While the federal law establishes the related services mandate as an entitlement, insufficient funds are provided to cover these services, forcing state and local budgets to produce the necessary monies.

Although few education agencies can boast that they have resolved their financial problems in providing related

services, some have succeeded in doing so thorugh arrangments with other public and private agencies that also provide services to handicapped children. These SEAs and LEAs have recognized that they cannot afford to provide all necessary related services themselves, and, therefore, have entered into arrangements with other service agencies whereby each shares costs. One of the prime motivations for interagency arrangements to provide related services has been the desire to reduce duplication among service agencies. This has in many cases resulted in more efficient use of resources so that service levels can be maintained, or even expanded, despite fiscal cutbacks.

At the same time that education agencies have reacted to fiscal incentives, they also have realized many handicapped students need the special expertise other agencies provide. Increasingly, school districts are coming to believe that perhaps schools cannot be all things to all students, and that assistance from outside agencies is advantageous and even necessary for handicapped pupils to benefit fully from their education.

Information collected from states and localities during the course of the project, including those joint efforts with other agencies to provide related services described in this report, lead to several observations about the current state-of-the-art of interagency ventures to enhance related services for handicapped students. On the one hand, education agencies are breaking new ground in several areas with innovative ways

payment source of eligible handicapped students, only a few states have successfully established policies for doing so statewide. In addition to the Connecticut Department of Education, the Louisiana Department of Education has enabled an education agency to utilize Medicaid funds for mentally retarded students in institutions (see Volume 4 for a description of this arrangement). Oklahoma was perhaps the first state to use education funds to draw down increased federal Vocational Rehabilitation funds and then use those for handicapped students. Several other states have initiated similar arrangements in the past few years, Michigan and Colorado among them. The utility of these policies lies in the fact that, at no cost to other state agencies, SEAs can draw on federal funds that have not traditionally been used for education purposes, thereby increasing their resources with which to provide related services to handicapped students.

While SEAs are just beginning to successfully share other state agency resources and increase federal funds for related services, they have with few exceptions remained fairly ineffective at the task of clarifying responsibilities for particular related services among agencies. In general, SEAs have not perceived it to be their function to precisely define what related services education agencies will pay for and what services other agencies will provide. In part, this may reflect their reluctance to make it appear that they are abdicating their own responsibility to provide education and related services to all handicapped children. Furthermore, it

of sharing programmatic and financial responsibilities among other human service agencies. At the same time, however, there are areas where education agencies have not been particularly successful in resolving some of the policy challenges faced with regard to the provision of related services.

For state education agencies, two general trends are emerging as effective ways to expand the related service resources available statewide. One is simply the development of mutually beneficial arrangements with other human service agencies at the state-level to jointly provide related services to handicapped students. For other state agencies, this has been often recognized as a positive step because it helps increase the agency's caseload and therefore qualifies the agency for more funds, as in the case of the Department of Mental Health in California. State education agencies and other state human service agencies are now beginning to take advantage of such mutual benefits by developing ways to share both the costs and caseloads of handicapped students who need particular related services.

The second innovative way SEAs are beginning to expand related services resources statewide is to use education dollars as matching money for other state agencies and thereby increase federal dollars for handicapped students. Such arrangements are just now being developed in several states, targeted on two federal funding sources: Medicaid and Vocational Rehabilitation funds. Although many local education agencies are beginning to use Medicaid as a third party

is extremely difficult to specify, by type of services, responsibilities among agencies since the services are defined in terms of an individual student's needs. As a result, states have generally remained silent on questions of who is responsible for what services, which, by default, has left these questions up to local agencies. The one exception to this general pattern is the area of institutionalized students where several states have worked out satisfactory service and financial arrangements with other state agencies operating such facilities (see Volume 4).

For local education agencies, sharing resources with other agencies is more common than among state agencies. Although still not general practice, a number of LEAs have worked out effective arrangements with other local agencies to jointly provide and finance related services. Weld County, Colorado, Independence, Missouri, and Montgomery County, Maryland, are among the more innovative of such ventures, but other school districts have similarly established joint service programs on behalf of handicapped students. In most cases, these efforts are targeted to special population groups such as emotionally disturbed students or pre-school youngsters since these children are most likely to need the direct services of another agency.

While these are several examples of joint efforts in which two or more agencies share the costs of a related service, it is much more rare to find school districts that have leveraged other local funds to pay the entire costs of a

certain related service. Anne Arundel County, Maryland, is he only example we found of this, where the County Department of Health has for some time provided all physical and occupational therapy to handicapped students in schools.

Perhaps the most innovative trend emerging among local education agencies, and one which is only now beginning to be attempted in a very few districts, is an effort to collaborate with private service providers in order to expand related services to handicapped children. This arrangement, which may be best suited to rural areas, is demonstrated by Maine's Capitol Area Region's contract with a group of private service providers. For the consortium of LEAs, the contract establishes uniform rates which gives them greater control over their budgets and providers -- and for lower rates than they would be able to negotiate independently. For the providers, most of whom are physicians, the contract virtually guarantees them a certain level of service. And perhaps most importantly, such an arrangement establishes for handicapped students an organized network of private related service providers, a group which traditionally operates without any connection to the school district.

It is likely that diminishing state and local budgets over the next few years will make joint efforts more attractive to education and other human service agencies and private providers. The examples of effective policies documented in this report and the emerging trends they portray may be of use

to other agencies who may likewise attempt to enter into arrangements with other service systems in order to more effectively provide needed related services to handicapped children.

LIST OF APPENDICES

APPENDIX A

COMPARISON OF FEDERAL DEFINITIONS OF RELATED SERVICES WITH THE DEFINITION FOUND IN SELECTED STATES' RULES, REGULATIONS, OR STATUTES

EXPLANATION OF TABLE

The table in this Appendix indicates how a selected group of states identify related services in their special education rules, regulations, or statutes.

The information on the table should be interpreted as follows:

- A (-) indicates that the service is mentioned specifically in the state's rules, regulations, or statute, but that no description is provided;
- The term "same def." indicates that the service is not only mentioned specifically, but that the state's rules, regulations, or statute adopt the federal definition as well;
- Comments provided on a state's definitions indicate how that definition of a service differs from the federal definition.

Note that information on each state is spread across two pages.

APPENDIX A

COMPARISON OF FEDERAL DEFINITIONS OF RELATED SERVICES WITH THE DEFINITION FOUND IN SELECTED STATES' RULES, REGULATIONS, OR STATUTES

STATE	AUDIOLOGY	SPEECH PATHOLOGY	PSYCHOLOGY SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	RECREATION	EARLY IDENT./ ASSESSMENT	COUNSELING SERVICES	MEDICAL/ DIAGNOSTIC EVALUATION
TEXAS	Same Def.	I.d. and instruct, diagnose, refer	No mention of consulting and planning	Eval.; prog. planning and implem. of physical or corrective conditions	Eval.; consult., and/or direct services	Recreation therapy to change behavior and promote growth and development	No mention other than "evaluation	Fuller Def.	-
WYOMING	-	-	-	-	-	No mention	Educational and psychol. assessment	-	No mention
NEW JERSEY	-	-	-	-	-	-	-	-	-
NORTH CAROL	Same def.	Same def.	(See p. 2)	(See p. 3)	Same def.	Same def.	Same def.	Same def.	Same def.
DELAWARE		-		-	-		-	Special counseling services	-
WISCONSIN	-	-	In school	-	-	-	-	-	-
UTAH	-	-	-	-	-	-	-	-	-

STATE	SCHOOL HEALTH SERVICES	SOCIAL WORK SERVICES IN SCHOOL	PARENT COUNSELING AND TRAINING	TRANSPORTATION	ADDITIONAL SERVICES					SOURCE
TEXAS (cont.)	Screening, referral, monitoring medications, consult. and emerg. care training	Same def.	No mention	"Special" transp. only	Art, music and dance therapy	Corrective therapy	Vision training (use of low vision and visual perception)	Orient. and mobility training	Provision of adaptive equipment	Policies and Administrative Procedures for the Ed. of Handicapped Students (Section 35.72 (63) April 1980
WYOMING (cont.)	No mention	-	No mention	-	itinerant instruction	Room and board and tuition	(See [illegible])			State Plan [illegible] 93) under [illegible] Ed. [illegible] Handicapped [illegible] amended by [illegible] 94-142 [illegible] 1, 1980
NEW JERSEY (cont.)	No mention	No mention	-	No mention	Vocational services	Social services	Psychiatric servi			N.J. Adm. Code, Title 6, Ed. (p.10) August 11, 1978
NORTH CAROLINA (cont.)	Same def.	Same def.	Same def.	Same def.						Rules Governing Programs and Services for Children w/Special Needs 9/10/80. (p.8)
DELAWARE (cont.)				"Special transport. only"	"developmental, corrective supportive services					Admin. Manual for Programs for Exceptional Children, Oct. 77/Revised 9/80
WISCONSIN (cont.)		-								Rules Implementing Subchapter IV of Chapter 115 February 1978
UTAH (cont.)		-	-	-						Rules and Regs. for Programs for the Handicapped [illegible] 17, 1980

STATE	AUDIOLOGY	SPEECH PATHOLOGY	PSYCHOLOGICAL SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	RECREATION	EARLY IDENTIFICATION/ ASSESSMENT	COUNSELING SERVICES	MEDICAL/ DIAGNOSTIC EVALUATION
GEORGIA	No mention under R.S. but def. is same except for no mention of amplification aids	No mention under R.S. but def. = same exc. no mention of prevention	Same def. but no mention of planning school programs and consulting w/other staff and parents	No mention under R.S. but defined (see p. 3b)	No mention under R.S. but def. is same exc. for no mention of prevention	Same def. plus more	Same def.	-	-
ILLINOIS	**	includes referral, follow-up, clinical program	includes prevention and rehab.	(see p. 3b)	(see p. 3b)				
COLORADO	provision of therapy must be in accord with diag. and recom. of an MD - see p. 3b								
MASSACHUSETTS		-	-	-	-				-
MARYLAND	-	-	-	-	-	-	-	-	-
NEW Y	-	-	-	-	-			-	Same def.
(O)	Same def.	Same def.	Same def.	-	Same def.	-		-	-

**According to NASDSE report, February 1979 Illinois definition is "identical to tion 12/a/3".

STATE	SCHOOL HEALTH SERVICES	SOCIAL WORK SERVICES IN SCHOOL	PARENT COUNSELING AND TRAINING	TRANSPORTATION	ADDITIONAL SERVICES					SOURCE
GEORGIA (cont.)	Same def.	Same def.		-						Georgia Special Ed. State Program Plan FY 81-83 (p. A-31)
ILLINOIS (cont.)		Includes prevention and rehab.			Individual or small group instructional services for students whose educational needs can be met through part-time instruction by a special education teacher.*					Rules and Regulations to Govern the Admin. and Operation of Special Education 1976
COLORADO (cont.)				No mention of special equipment or transport within a school bldg.						Rules for the Admin. of the Handicapped Children's Educational Act 10/76
MASSACHUSETTS (cont.)	Nursing services		-	-	Voc. Ed.	Peripatology	Special equipment (see p. 25)			Regulations 766 Massachusetts Department of Education 9/7
MARYLAND (cont.)	-	-	-	Transport. & reimbursement						Programs for Handicapped Children Bylaw 13.04.01 (p.5) 5/19/78
NEW YORK (cont.)										New York Ed. Law 4401 Article 89 9/80
OHIO (cont.)	-		-	-	Student reader services	Guide service (blind)	Attendant service (crippled,	Orient and mobility service (blind)	Adaptive P.E./ Voc. Sp. Ed.	Rules for the Ed. of Handicapped Children- Effective 7/1/82

*also, reader services brailllists and typists.

STATE	AUDIOLOGY	SPEECH PATHOLOGY	PSYCHOLOGY SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	RECREATION	EARLY IDENT./ ASSESSMENT	COUNSELING SERVICES	MEDICAL/ DIAGNOSTIC EVALUATION
CALIFORNIA	includes home training programs	-	-	- (see p. 3a)	-	Same def.	-	-	-
OKLAHOMA	-	-	-	-	-	-	-	-	-
LOUISIANA	Same def.	Same def.	Same def.	Slightly diff. (see p.3a)	Same def. plus more (see p.3a)	Same def.	-	Same def.	-
CONNECTICUT	-	-	-	-	-	No mention	No mention	-	-
VIRGINIA	no mention of prevention	- not defined	same def.	same def.	same def.	same def.	same def.	same def.	same def.
WASHINGTON	does not provide habilitative services	"communication disorders services (same)	-	(same)	i.d. of status & needs, counseling, but no mention of direct provision	-	-	-	-
MICHIGAN	Audiol. Eval.	speech and language eval.	Eval.	-	-				-

ATE	SCHOOL HEALTH SERVICES	SOCIAL WORK SERVICES IN SCHOOL	PARENT COUNSELING AND TRAINING	TRANSPORTATION	ADDITIONAL SERVICES					SOURCE
LIFORNIA ont.)	school nursing servi[illegible]	asically [illegible]	-	-	visually handicapped services/ adaptive P.E.	Orient. and mobility/ driver training	supplemental services 1) indiv. and small group instruction 2) note-taking & interp. 3) transcribing, reader services. Career Prep/Occup. Training			California State Plan for Part B of the Educ. of the Handicapped Act as Amended by P.L. 94-142 (p. 65) 11/21/80
LAHOMA ont.)	-		-	see p. 3a	Recreation/ Therapeutic					Oklahoma Dept. of Ed. Policie and Procedures Manual for Sp. Ed. 1981 (p. 28)
ISIANA ont.)	Same def.	Same def.	Same def.	Broader def. (see p.2a)						Act 754 Regulations, Louisian Department of Education (p. 458) 1978
NECTIC T ont.)	-	-	-	-	"language servi[illegible]"	transla-tion				Connecticut State Department of Ed. Regs. Concerning Children Requiring Sp. Ed. 9/80
GINIA ont.)	same def.	same def.	same def.	same def.	artistic and cultural programs	art, music and dance therapy				Regs. and Admin. Requirements for the Operation of Sp. Ed. Programs in Va. 6/23/78
HINGTON nt.)	-		-	-	orienta-tion and mobility services	"classified staff services" - to provide for handicapped student's safety and/or personal care; interpreter services, braille services				8/19/80
HIGAN nt.)		-		-	psychia-tric eval.	educ. eval.	recrea-tional, music, work or other therapy	mobil. & orient services	see p.2a	Michigan Sp. Ed. Rules 8/13/80

STATE	AUDIOLOGY	SPEECH PATHOLOGY	PSYCHOLOGY SERVICES	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	RECREATION	EARLY IDENT./ ASSESSMENT	COUNSELING SERVICES	MEDICAL/ DIAGNOSTIC EVALUATION
MINNESOTA	-	-	-		-			-	treat- ment also
PENNSYLVANIA									
NEW HAMPSHIRE	same def.	same def.	same def.	same def.	same def.	same def.	same def.	same def.	same def.
RHODE ISLAND	-	-	-	Provide assesment and services		-	-	-	-
MAINE						Not reimbursable			
IOWA									
FLORIDA									

STATE	SCHOOL HEALTH SERVICES	SOCIAL WORK SERVICES IN SCHOOL	PARENT COUNSELING AND TRAINING	TRANSPORTATION	ADDITIONAL SERVICES					SOURCE
MINNESOTA (cont.)	-	-	-	-	psycho-therapy					
PENNSYLVANIA (cont.)				-	readers, helpers, guides, aids	appliances and special school books				Public School Code of 1949 - Exceptional Children (p. 150)
NEW HAMPSHIRE (cont.)	same def.	same def.	same def.	same def.	orient. and mobility services	low vision services	inter-preting services			Special Ed. in N.H.: A P.L. 89-313 Training Program for Parents, School Administrations, Sp. Ed. Eval/Placement Team Members 8/24/81
RHODE ISLAND (cont.)	-	-	-	seat belts and hydraulic lifts	special individualized assistance in mathematics and remedial reading		mobility training			Education for Handicapped Children - Regs. of R.I. Board of Regents for Ed. Effective 10/1/77 Amended 6/26/80
MAINE (cont.)	not reimbursable		not reim-bursable	only "special" transp.						Maine's Spec. Education Regs. 7/81
IOWA (cont.)				-						
FLORIDA (cont.)										

APPENDIX B

THIRD-PARTY BILLING SYSTEM

CONNECTICUT DEPARTMENT OF EDUCATION

THIRD PARTY BILLING SYSTEM FOR HEALTH RELATED SERVICES

CONNECTICUT

SUMMARY

The Connecticut Department of Education, working with the State Medicaid program, has developed a third party billing system which allows local school districts to claim private insurance and Medicaid reimbursement for health related services for handicapped students provided through the schools. This system is part of an attempt to have third party payment sources assume responsibility for the cost of health related services, rather than having local school districts and the state agency pay all such costs.

The system has been under development for over two years and will be pilot tested in the 1983-84 school year. Its implications for financing special education and related services in Connecticut are significant. The new system is expected to save as much as $1 million in the first year, just among the fourteen districts participating in the pilot project. If the system is extended statewide as planned, administrators estimate even more substantial cost savings to local districts and to the state budget as a whole. Connecticut's billing system is seen by the state education agency (SEA) staff as the first step toward a financing system that will allow for a more equitable distribution of responsibility among the major payment sources for health care for handicapped children. Ultimately, they hope that it will

distribute fiscal responsibility for services equitably among private insurers, public payment sources for health care such as Medicaid, and local and state education agencies.

NATURE OF POPULATION SERVED

All school children who are receiving special education and related services and who meet the present state Medicaid income guidelines are potentially eligible to have services paid for under the new billing system. Students with health impairments or other handicapping conditions who use health services and are entitled to benefits from third party sources are the primary beneficiaries of this system. Just in the 14 districts pilot testing the system, it is estimated that there are 10,500 potentially eligible children.

OBJECTIVES OF THE POLICY

The overall goal in establishing this system is to insure that health services are provided, as required by Public Law 94-142 and Connecticut state law, and that available health resources for payment of care are fully used before local school districts must pay the costs. Specifically the objectives of this effort are to:

- Establish a third party billing system that can be administered by school districts, that recognizes school districts as providers of health care, and that is compatible and comprehensive in billing all health payment resources;
- Bill third party private insurers, thus ensuring that all entitlements which families of handicapped children may have for payment through the private sector are utilized;
- Bill the State Medicaid Program as appropriate; and

- Have local school districts pay the cost of health related services when no other payment source is available.

DEVELOPMENT OF THE POLICY

The effort to establish a statewide billing system grew from the work of a regional educational service center (RESC) in southern Connecticut. The RESC director believed that third party reimbursement was an untapped source of support for special education and related services. He thus commissioned a feasibility study to estimate the cost of implementing such a system within the RESC's service region. This study focussed only on Medicaid, analyzing the costs that potentially could be paid by the Medicaid program for (1) direc EA service costs, and (2) services provided by hospitals to handicapped children, but under order of the LEA. The findings of the study were impressive: it was estimated that just within the one RESC, savings would be considerable. Seeing th local study, SEA officials decided to explore the potential for savings on a statewide basis. The SEA provided a contract for a statewide feasibility study which not only looked at the potential for Medicaid reimbursement, but also examined the services available from the Connecticut Department of Health to determine if these could supplement local school districts' health services.

The conclusion of the statewide study was that the system was indeed feasible. It estimated statewide savings of as much as $12,000,000 annually and recommended that the state proceed to develop the necessary agreements between the

Department of Income Maintenance (DIM), which maintained authority over the Medicaid program in Connecticut, and the State Education Agency. Following acceptance of the feasibility study, the two state agencies began developing an enabling agreement which was signed on July 2, 1981. Although only a two-page document, this agreement represented a major step and committed both Departments to the development of the new billing system. For this commitment was especially significant for DIM, since Medicaid financing of new services and the development of the necessary Medicaid systems were that agency's responsibility.

Three factors seem to have been particularly important to DIM's willingness to enter into the agreement with the SEA. The first was a lawsuit by the Easter Seal Society which complained that DIM had not reimbursed the Society for services provided to Medicaid eligible handicapped children. While not strong on its legal merits, this suit brought political pressure to bear on DIM. There was a desire at the state administrative level to develop a system that would simultaneously contribute to the resolution of this suit and prevent such suits in the future.

Second, the involvement of the Governor's office at a critical point seems to have eliminated many barriers to cooperation between the State Education Agency and the Department of Income Maintenance. When the Governor's office saw the feasibility study performed by the SEA, it was attracted by the cost savings that would potentially develop

from the new billing system. As a result, the Governor's staff gave their support and have continued to be involved in all stages of the process. This has tended to reduce any difficulties that might have arisen between the two state agencies.

Third, and perhaps the most significant factor contributing to the development of the system, was the approval which DIM received from the federal Health Care Financing Administration (HCFA) on the principles behind the billing system. HCFA's policy clearly contributed to the development of the system. In an exchange of letters in 1981, DIM requested HCFA to clarify federal guidelines on the payment of Medicaid to school districts. In its reply, HCFA indicated that the policy issues here were complex, and, on the basis of the information it had, it could not give a full answer to Connecticut's question. However, HCFA referred to the federal interagency agreement between the Office of Special Education (now SEP) and HCFA and indicated that the intent of this agreement was "to insure that handicapped children received all services available to them and that all payment sources were used as appropriate." Further, HCFA stated that if all third party payment sources were tapped, a school could legitimately bill the Medicaid program for the health care costs for eligible handicapped children. This represented an important clarification of the issue of "last dollar responsibility" because it meant that school districts operating under P.L. 94-142 were not necessarily the first dollar payors.

Instead both private insurers and Medicaid could be billed for eligible costs before the school district had a responsibility to pay for these costs.

Once DIM staff had HCFA's go-ahead, they became willing to enter into an agreement and begin developing the billing system. The agreement went into effect in July, 1981, and called for a year of developmental activity and further analysis of the feasibility of this system. The SEA was charged with the lead responsibility for developing the system, although the agreement committed DIM to take all action that was necessary to uphold its end of the agreement. Subsequently, the third party billing system and necessary policy structures were established and a second, implementation agreement was developed which specified roles, responsibilities, and functions related to putting the new policies in place.

There were at least four important factors affecting the development of the new billing system which contributed to continued progress in implementation. One of the most important was that the Medicaid agency had already developed a Medicaid management information system (MMIS). This system, through which all Medicaid payments are billed and eventually paid by the state agency, has resulted in more rapid payments, and a more efficient and cost effective method of handling Medicaid claims than was the case before the system became operative. DIM had a strong interest in insuring that the system developed by the SEA fit within the MMIS, and thus, DIM

staff participated actively in developing the system under which local school districts would become eligible providers of care.

The second factor was a policy exception on the issue of "prior approval" for Medicaid reimbursement. The Connecticut Medicaid Program usually requires prior approval on most health care services, i.e., providers must receive approval in advance from DIM before services are given if they expect to claim Medicaid reimbursement. This could have represented a major barrier to implementation of the system, because school districts would have been held up for weeks in seeking prior approval before a handicapped child could receive services. Through a policy ruling, the Department of Income Maintenance decided that prior approval would not be necessary on medical services provided to handicapped children through the schools. It agreed to accept the prescription for Medicaid services contained in the IEP as a sufficient basis for prior approval, if the related service component of the IEP is signed-off on by a licensed physician. (The physician can be either an employee of the local school district or the handicapped child's own physician.) The elimination of the prior approval requirement means that schools, with only a physician's signature, can proceed immediately to provide or contract for services for a handicapped child.

Third, as part of its responsibilities under the inter-agency agreement, the SEA prepared estimates of the additional costs that would be necessary to implement the system. These

estimates showed that local school districts would save as much as $1 million under the pilot project and additional amounts when the system was implemented statewide. The SEA was also expected to incur savings during the pilot stage and further cost reductions following implementation of a statewide system. The DIM was shown to have its costs increased, but only approximately 50% of these would be state costs. (The remainder would be federal funds, as the Connecticut State Medicaid matching formula is approximately 50/50.) (The first year additional DIM costs were to be met by a special appropriation of $2.2 million to DIM's budget.) Although estimates, these projections of cost savings and cost reductions to the state and local education agencies were sufficiently impressive to encourage all involved in the project to continue with it.

IMPLEMENTATION OF THE POLICY

After providing medical care, local school districts will send invoices for such care to an SEA-supported central billing service which will be administered by a RESC. The RESC will compile the claims for all districts and present the actual bill to the Department of Income Maintenance or to any other third party payor.

The entire system will be computerized to enable quick access to the health care records of all eligible children, and to check the child's eligibility for any third party payment source. That is, if the child is eligible for private

insurance, the private insurer will be regarded as first dollar payor and is billed accordingly. If the child is eligible for Medicaid, Medicaid is billed using all the necessary forms and procedures for the MMIS system. Finally, if the child has no other source of payment available to him or her, the school district is responsible for the cost.

The other RESCs in Connecticut will assist in implementation by providing technical assistance and training to local districts as they move forward with implementing the system.

ANTICIPATED EFFECTS OF THE POLICY

Connecticut officials expect three main effects from the new system:

- First, it should ensure that a wider range of funding sources, including public entitlement funds and private insurance funds, are used to pay for related services costs;
- Second, it will save education dollars, both local and state, which currently go to pay for health services; and
- Third, ultimately, it should result in more comprehensive availability of health services for handicapped children in local school programs.

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APPENDIX C

THE COOPERATIVE SCHOOL/REHABILITATION
WORK-STUDY PROGRAM

OKLAHOMA DEPARTMENT OF EDUCATION

THE COOPERATIVE SCHOOL/REHABILITATION WORK-STUDY PROGRAM

OKLAHOMA

SUMMARY

The Cooperative School/Rehabilitation Work-Study Program is a joint effort of the Special Education Section (SES) of the Oklahoma Department of Education and the Division of Vocational Rehabilitation (VR) of the State Department of Human Services.

The program is designed to provide vocational training, on-the-job training (OJT), work experience, and job placement services to handicapped youth in high school throughout the state. The two state agencies share responsibilities for assisting local school districts to develop and generate work-study programs. Through this program, VR assigns rehabilitation counselors in high schools to coordinate job training and placement activities for handicapped students. The LEA contributes a teacher-coordinator to the program who instructs and supervises students enrolled in the vocational or OJT program. The work-study program now operates in over 60 high schools throughout the state, with a program enrollment of over 2,000 students. In the past, LEA funds have been used by VR as match for federal funds.

TARGET POPULATION AND OBJECTIVES

The work-study program was originally designed to serve mentally retarded students in secondary schools. Since its inception, however, the program has expanded and now serves

any physically, mentally, or emotionally handicapped youth enrolled in a high school who is assessed as being able to benefit from the program.

The overall objective of the work-study program, as stated in the interagency agreements which are used to establish local programs, is:

> "...to help each individual realize full potential in order to function completely as a contributing member of society, as well as to understand, accept, and compensate for limitations."*

Specifically, the state program attempts to promote local programs that will:

1) Improve basic skills of handicapped youth and render these skills workable in a practical way;

2) Increase awareness by handicapped students of the functional aspects of family and community life;

3) Increase the productive capacity and employment prospects of handicapped students;

4) Increase the number of employed disabled persons throughout the state; and

5) Reduce the drop-out rate among handicapped students.**

DEVELOPMENT OF THE PROGRAM

The origin of the Cooperative School/Rehabilitation Work-Study Program was a pilot program that began in 1961 in

*Agreement for the Coopeative School/Rehabilitation Work-Study Program, Special Education Section, Oklahoma State Department of Education, p. 3.

**Ibid., p. 3.

Oklahoma City. This program sought to broaden the vocational experiences of high school age handicapped youth by creating part-time work-study opportunities in local businesses. The school district was the lead agency for the program, but VR provided job placement and job development services, with support from a federal grant from the federal Rehabilitation Services Administration. The program served primarily educable mentally retarded students, and began with 40 in the first year.

The success of the pilot program in securing employment opportunities for handicapped youth led to a steady expansion of these programs throughout the state in the 1960's and 1970's. A key factor in VR's willingness and ability to continue expansion of these programs was the use of local school district funds as VR's "match" for claiming federal dollars. LEA funds could be used for this purpose when the teacher-coordinator assigned to the program by the district was placed under VR's supervision and given functions described as "of a vocational rehabilitation services nature." Local school district funds, in effect, became the 20% share necessary to attract 80% of program costs from the federal government. The financial benefit this arrangement provided to VR served as an incentive for that agency's participation in the program. For this reason, as the program expanded, LEAs were required to agree to this arrangement if they wanted to launch a work-study program. (This matching is no longer used, because VR is able to meet the federal matching requirement in other ways.)

The program model became well-developed and proved its effectiveness in preparing students for employment, and the two state agencies developed a formal interagency agreement, spelling out the financial and service commitments which each would make to the program. The agreement is unusual in that it is intended to be a three-part agreement; that is, for every local program, VR, SES, and the participating LEA sign the agreement. This ensures that the goals of the program, the degree of the state agencies' participation, and the LEA's responsibilities remain uniform throughout the state.

As the program developed, the curriculum was also standardized. A committee composed of staff from local programs developed a curriculum over a two year period and this was eventually adopted as part of the state's curriculum guides. This standardization occurred at a critical juncture of the program's development. Significantly, like most of the program's development, it grew from the "bottom-up," rather than emerging from outside of the program.

SES and VR plan to have work-study programs in all areas of the state eventually. This is part of an increased emphasis on vocational programming and job development for handicapped youth.

Implementation

The cooperative program is guided by uniform policies which apply to all participating schools, although specific program activities can vary greatly from school to school.

Students are enrolled in the program following joint assessment by special education and vocational rehabilitation staff. An IEP and an IWRP are developed and pursued jointly by special education personnel and the rehabilitation counselor.

The program has two parts: (1) a work study component, and (2) the "Co-op Other" component. In the work-study program, special education students identified in local high schools receive academic credit for part-time vocational training, on-the-job training, and/or work experience coordinated with classroom instruction. The students spend a part of the day in the classroom and earn school credit, and the balance of the day in vocational training, on-the-job training, or competitive employment where they also earn school credit for these activities.

The second part of the program provides vocational services to handicapped students who are not engaged in the work-study activities but who are also enrolled in the high school. These students are identified as the "Co-op Other", and they are usually referred to the rehabilitation counselor during their final year in high school for determination of eligibility and provision of services. Ideally, school officials believe that "Co-op Other" students should be referred to the rehabilitation counselor in the 10th grade, because most of these students can go on to additional, post-high school training. By picking up a student in the 10th grade the vocational rehabilitation counselor can work with the parents and the student on individual responsibilities,

i.e., financial obligations and maintaining "C" average grades. Also, the counselor can work with the student's teachers to insure appropriate courses are taken for post-high school education and training. (Too often, "Co-op Other" students fail to take proper prerequisite courses for their chosen college major. When picked up as seniors nothing can be done, and this is often a substantial reason for college failure during their first three years.)

To administer the cooperative program, the LEA and the Vocational Rehabilitation Agency have agreed on a division of responsibility. The LEA agrees, among other tasks, to:

- Employ the teacher coordinator and assign him/her to provide services such as the following:

  -Instruct and supervise students in vocational training, on-the-job training, and employment skills;

  -Make initial home visits with the rehabilitation counselor;

  -Participate in developing the IEP;

  -Develop greater community awareness of the employment needs of the handicapped;

  -Make job placements and assist with follow-up.

- Identify and place special students in the "regular" special education program or in the work-study program, according to the students' needs as identified in the IEP, and with the concurrence of the rehabilitation counselor.

VR has the following responsibilities:

- Assign a rehabilitation counselor to each cooperative program, with duties to include:

-Accept referrals of physically, mentally, and emotionally handicapped students enrolled in the local high school;

-Determine eligibility for rehabilitation services;

-Develop an Individual Written Rehabilitation Program for the student in conjunction with the IEP, and authorize payment for all rehabilitation services;

-Supervise the teacher-coordinator and pay job related travel expenses during the hours assigned to work in the field;

-Make home visits with the teacher-coordinator;

-Orient other school personnel and students to the cooperative program;

-Provide post-secondary training and/or other services if indicated. This includes insuring that no work-study student's rehabilitation file is closed prior to graduation without consultation with the parent and teacher-coordinator.

- Pay for all vocational rehabilitation services needed by a student, when these services are not available through the local school and are not provided to non-vocational rehabilitation clients enrolled in the school. (This latter policy is essential in order to qualify these services for federal matching funds.)

Prior to budget reductions in FY 1983, a summer program had been provided to hire teacher-coordinators for the summer months in order to supervise students and survey the community for additional employment opportunities -- thereby further bridging the gap for these students from one school term to the next. The teacher coordinators were paid by special funds for the handicapped from Vocational and Technical Education and from Vocational Rehabilitation funds. While this part of the summer program has been temporarily discontinued, a summer

workshop is still provided by the Special Education Division for in-service training for the teachers, VR counselors, and administrators who work in the work-study phase of the program. This improves communication among these agencies and helps develop a closer working relationship among the staff as they deal with mutual problems during the conference.

EFFECTS OF THE PROGRAM

The impact of the Cooperative Work-Study Program over the years has been considerable, and its effects have been wide-ranging.

1. Most importantly, it has improved the vocational and employment opportunities for thousands of handicapped children in Oklahoma. Since its inception, the rate of placement and continued employment for students served by the program has been high. A total of 4,653 clients are served by the program: 1,526 work-study students, 579 other handicapped high school students, and 2,548 "co-op other" and work-study graduates. While the program was originally developed primarily for EMH students, it has expanded to include TMH, ED, hearing impaired, orthopedically impaired, and multi-handicapped students.

2. The work-study program has integrated the services of local school districts and VR, resulting in greater cost-efficiency of services for all participating agencies, as well as greater accessibility of services for handicapped youth. At least part of this success today may be due to the fact that the Director of Special Education and the VR Program Development Supervisor both helped develop the original project over twenty years ago. The integration of school and rehabilitation services has been notoriously difficult across the country; Oklahoma has not only accomplished it but demonstrated its continuing utility over a period of years.

3. The policy effort which surrounded the Cooperative Work-Study Program has contributed

to greater emphasis, statewide, on vocational training for handicapped students. For example, Central State University in Oklahoma added to their curriculum a class pertaining to the fundamental elements of the Cooperative School/ Rehabilitation Work-Study Program.

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APPENDIX D

THE MICHIGAN INTERAGENCY DELIVERY SYSTEM FOR VOCATIONAL EDUCATION AND RELATED SERVICES FOR THE HANDICAPPED

MICHIGAN DEPARTMENT OF EDUCATION

THE MICHIGAN INTERAGENCY DELIVERY SYSTEM FOR VOCATIONAL EDUCATION AND RELATED SERVICES FOR THE HANDICAPPED

MICHIGAN

SUMMARY

The Michigan Interagency Delivery System for Vocational Education and Related Services represents a strong effort, among three state agency divisions, to increase the availability of vocational education opportunities for handicapped children throughout the state. Using an interagency agreement process at the state level, Special Education Services Area (SESA), Michigan Rehabilitation Services (MRS), and Vocational-Technical Education Service (VTES) developed a model delivery system which could be used by local school districts and local MRS offices to help build comprehensive programs of vocational education and related services. Approximately 30 local programs have been developed or strengthened as a result of the state agreement. Michigan's effort thus serves as an example of state leadership giving impetus to expanded educational, vocational, and related services programs at the local level.

TARGET POPULATION

The Interagency Delivery System was developed to serve secondary school age special education students who are (1) eligible for Michigan Rehabilitation Services, and (2) assessed as able to benefit from one of the vocational education alternatives provided by the program.

OBJECTIVES

The overall goal of the interagency effort, according to the interagency document developed by the three agencies, was to provide:

> "....the services needed by handicapped youth in order that each individual will have the opportunity to develop to his or her maximum potential and to live as fully and independently as possible".[1]

Specifically, SESA, VTES, and MRS hoped to:

1. Better define the responsibilities of each of the three agencies for vocational education and employment-related services to handicapped youth;
2. Reduce duplication and overlap among the services of the three agencies, particularly in light of scarce resources for all three agencies.
3. Encourage cooperative programming at the local level, using a generic program model, in order to improve handicapped youths' access to and preparation for employment.

DEVELOPMENT OF THE POLICY

The origin of the Michigan Interagency Delivery System was in a program begun by MRS in the 1960's and early 1970's. Initially, MRS just hired a special counselor to work with handicapped youth, but by 1972, the vocational education and special education programs have become involved in this

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[1] "Michigan Interagency Delivery System for Vocational Education and Related Services for the Handicapped," by Michigan Rehabilitation Services, Special Education Services Area, and Vocational-Technical Education Services, published by the Michigan Department of Education, p. 27.

effort. Staff of the three agencies realized that the three programs were often pursuing the same goals, "knocking on the same doors," yet frequently duplicating each others' services. Agency staff became increasingly convinced that services would be more efficient if they were well-coordinated, and if the roles of each agency with regard to the others could be clarified. An initial agreement was developed among the three agencies in 1972-73. However, its scope was limited and it did not address financial issues.

Michigan's efforts at the state level to better integrate special education, vocational education, and vocational rehabilitation services were reinforced by parallel federal efforts occuring during the same time period. Representatives of the Bureau of Education for the Handicapped (now Special Education Programs), Vocational Education, and the Rehabilitation Services Administration (then in DHEW), issued a federal memo of understanding, setting forth the goal of interagency cooperation and urging states to devise their own programmatic efforts. Michigan's work, which by that time included specific ideas for interagency services delivery, was presented to the three federal agencies in Washington as one possible model and as an example that state level cooperation was not only possible but was likely to improve services. This new federal interest, combined with on-going concern in Michigan about vocational issues, led in 1979 to a revised agreement among the three Michigan agencies.

However, Michigan SEA and MRS staff realized that

interagency agreements are only a first step toward cooperative and effective interagency programming. Such agreements, they felt, have little impact unless they are followed by coordinated and sustained program development. "Any three fools can sign an agreement," as one staff person asserted; the more difficult task is to develop a delivery system which actually results in improved services for handicapped students. This became the next goal of the three agencies.

The Interagency Delivery System was developed by a committee composed of representatives from each of the three agencies. Committee members were both personally and professionally committed to the goal of interagency programming, and this commitment turned out to be crucial to developng the delivery system. Even when other demands on their agencies threatened the priority of the interagency effort, the committee members were able to sustain attention on it. The committee was responsible for all aspects of the state level cooperative effort, including: (1) obtaining agency resource commmitments for the cooperative effort; (2) clarifying or changing agency policies which acted as barriers to cooperative service delivery; (3) designing the local delivery model; (4) encouraging local program development through workshops, training sessions, or on-site consultation; and (5) providing technical assistance as local programs ran into difficulties or needed further state policy changes.

IMPLEMENTATION

The major step in implementing the interagency delivery system was publication of a document entitled, Michigan Interagency Delivery System for Vocational Education and Related Services. Developed by the interagency committee, and distributed widely in 1980 by the three agencies, this document set forth the delivery system which the state agencies were recommending to their local counterparts.

This interagency document was unusually detailed and comprehensive. It included:

- A copy of the most recent agreement between SESA, MRS, and VTES, which outlined the commitments each of these agencies made to the delivery system.
- A description of the structure, mandate, eligibility criteria, referral procedures, and services of each of the three agencies, as a reference for local agencies;
- An outline of a generic delivery system model, identifying, by task, which agency had (a) primary responsibility, (b) limited responsibility, or (c) no responsibility. For example, this model outlined procedures for joint development of IEPs and IWRPs, utilizing expertise from all agencies. Local agencies were free to adapt this generic delivery model to their own resources and programs;
- Recommendations for a process of achieving local collaborative programming including models of local interagency agreements;
- Descriptions of the four vocational training options and the related services available to special education students, including:

  -Regular vocational education
  -Adapted vocational education
  -Special Education/Vocational Education, and
  -Individualized Vocational Training

  The service delivery and financial responsibilities of each of the three agencies were detailed for these alternatives.

This document was the basis for in-service training of local agency staff interested in improving vocational programming and rehabilitation services. (The state interagency committee representatives developed other in-service training materials and conducted most of the training themselves.)

After local school districts, intermediate districts, or MRS field offices decided to implement the program model, state staff provided technical assistance as requested. The process usually involved local design of a program; consultation with staff of each state agency in order to identify barriers to implementation; and joint work by state and local staff to remove these barriers, either through change in state policy or through alteration of local procedures.

Implementation of the interagency delivery system has not been free of problems. SEA staff cite several issues which were particularly difficult, as well as several factors which were crucial for continued implementation of the effort:

- The development of the interagency effort was endangered at several points because the three staff persons assigned to it (from SESA, MRS, and VTES) were on the verge of being reassigned to other agency priorities. This was in part due to agency funding cuts and resource constraints, which meant that all three state agencies had trouble just accomplishing their basic functions with little staff time to spare for new interagency ventures. However, reassignment of state staff would have eliminated technical assistance to local districts and -- in the view of the SEA and MRS staff involved -- slowed the development of local programs. This problem was reduced in the 1982-83 school year when the state agencies, and particularly SESA, renewed their commitment of staff time to this effort.

- Except for the federal interagency agreement developed in the late 1970's, federal policy did not mandate cooperative interagency ventures at the state level. Thus, state staff involved in the cooperative delivery model had to spend much of their time justifying it as a priority effort.

- Some provisions of P.L. 94-142 created barriers to interagency programming. State staff particularly cite the difficulty they encountered in working with the due process orientation of P.L. 94-142. Since neither MRS or VTES had these requirements, local staff in these agencies initially thought local special education personnel were "hiding behind" the due process requirements as a way of not fully cooperating in joint programs. Once local staff understood each others' mandates, however, and realized that they shared program goals, such difficulties were overcome.

- A similar difficulty in local program development emerged on the issue of confidentiality of information. Some local school districts were unwilling to share student information with MRS. This problem, too, was able to be resolved as local agency staff developed closer working relationships, and after the State Attorney General's office indicated that MRS could be considered an education agency.

The factors which enabled the cooperative effort to persist, despite these difficulties, were (1) the strong personal and professional commitments of the three staff assigned to the effort who were successful in keeping their agencies committed to interagency programming; (2) the interest of local school districts and MRS offices in improving vocational training for secondary students; (3) the strength of the interagency delivery model document which, once published, provided reference materials and guidelines for anyone interested in vocational education/special education/rehabilitation programming; and (4) the ability of MRS to use local special education expenditures to match

federal funds. This latter factor has been particularly important in encouraging districts to develop collaborative programs. LEA expenditures for staff and space which are used for the purposes of vocational rehabilitation (and which are under the control of an MRS supervisor) can be matched with federal vocational rehabilitation funds at a ratio of 20%/80%. By the summer of 1983, thirteen districts were using this matching arrangement, which accounted for over $2,000,000 of rehabilitation dollars. Rural districts have found this arrangement especially attractive because of its "multiplier" effect on their limited local dollars.

EFFECTS

There have been three major benefits from the Michigan interagency delivery system.

1. More than 30 local programs have been developed, using the state agency agreement as a basis and adapting it to local circumstances. In the 1982-83 school year, it is estimated that these programs served approximately 10,000 secondary school handicapped students.

2. Working relationships among the three state agencies are closer and more productive. In addition to cooperating on this effort, the agencies now review and respond to each others' state plans to identify ways in which collaborative policies and programming could be strengthened. Staff from the three agencies attend each agency's state conferences to make presentations updating the collaborative program, answer field staff questions, and increase their own information-bases related to the other agencies.

3. The interagency effort has led to other activities to improve vocational opportunities for the secondary age students. As an example:

staff of VTES and MRS are now developing expanded guidelines for a post-secondary delivery system for handicapped young adults.

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APPENDIX E

SPECIAL EDUCATION STAFF RESOURCE POOL

UPPER PENINSULA, MICHIGAN

SPECIAL EDUCATION STAFF RESOURCE POOL

UPPER PENINSULA, MICHIGAN

SUMMARY

The Special Education Staff Resource Pool is a semi-formal agreement of intermediate school districts in the Upper Peninsula of Michigan. As a result of this agreement, a list of available special education and related service staff members, with their specified areas of expertise, is distributed to school districts in the Upper Peninsula of Michigan. The intent of this agreement is to increase awareness about the availability of expertise in all school districts, without significantly increasing costs.

TARGET POPULATION AND OBJECTIVES

The Resource Pool is intended to serve all handicapped children in member districts. The objective of the program, as noted above, is to increase the expertise available in small school districts, without increasing costs.

DEVELOPMENT OF THE PROGRAM

The Resource Pool initially was developed as part of a Title IV federal grant that called for each school district to exchange staff members at no cost and in equal amounts. This directive soon became a problem because larger school districts, with broader ranges of staff expertise, were constantly receiving requests for services, whereas smaller school districts experienced no such drain on their resources. Because of this disparity, the directors agreed to limit each school district to a maximum of twelve days of service. While minimizing the losses, this action

did not alleviate the problem of unequal requests for services. Eventually, it was decided that all school districts would pay a rate equivalent to the daily salary of the selected staff member.

Yet another problem soon became apparent. When the system was first initiated, it became clear that it was cluttered with the name of every staff person in every Intermediate School District. The directors found it too difficult to search for someone with specific skills. They thus agreed to limit their listing in the Resource Pool to persons with unique skills.

IMPLEMENTATION

Each school district completes a simple one-page form pertaining to those staff members having specific skills and/or areas of expertise which might be appropriate and available to other Upper Peninsula Intermediate School Districts (ISDs). Typically, school districts include staff who can assist with diagnosis, in-service workshops, third party assessments, consultation, etc. This information is compiled by the Delta Schoolcraft Special Education Director and sent to all Upper Peninsula Intermediate School Districts.

When an ISD identifies a need for a staff member from another district, a letter is written to the director of the school district, requesting the services of that person. At the bottom of the letter a space is provided for the Special Education Director's signature, affirming concurrence with the request. The requesting ISD then reimburses all travel, meals and phone costs for the staff member. The services most frequently re-

quested are workshops and consultations rather than direct services, although direct assessments sometimes are provided.

System maintenance requires minimal effort because Upper Peninsula Special Education Directors meet frequently and the Resource Pool is an on-going agenda item. In addition, each director takes responsibility for maintaining his or her portion of the Resource Pool , as there is no grant financing to maintain the system.

EFFECTS OF THE PROGRAM

One of the school districts participating in the Resource Pool, the Delta-Schoolcraft District, reports that they have been able to access persons with specific skills for dealing with hearing & visually impaired students without either paying exorbitant consulting fees or hiring permanent staff members. In addition, by utilizing personnel employed by the other school systems, LEAs report that there is little need to orient these staff personnel to school regulations or procedures. Finally, these staff already are familiar with both the LEA's operating styles and other contextual factors of the Upper Peninsula that may appear foreign to outsiders.

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APPENDIX F

REGIONAL COMPREHENSIVE SUPPORT SERVICES TEAM

MAINE CAPITOL AREA REGION

THE REGIONAL COMPREHENSIVE SUPPORT SERVICES TEAM

CAPITOL AREA REGION, MAINE

SUMMARY

Maine's Capitol Area Regional Directors of Special Education encompasses eight school districts, with a total enrollment of approximately 12,000 students. These eight LEAs developed a resource pool to help finance the related services that were necessary to allow students to remain in their own home districts. For such small districts as these, the financial and service implications of bringing back even one child from a private residential setting to a district-based program were enormous. Frequently, the necessary services and resources were both unavailable in the area and could not be funded through individual school budgets.

Confronted with these problems and aware that the limited funds available through P.L. 94-142 could disappear at any time, the eight districts' Special Education Directors developed a resource pool that was both broad and stable over time. This pool, called the Regional Comprehensive Support Services Team, was constituted by region-wide contracts with related service providers.

Title IV-C funds for innovative programming initially were used to create this pool. Any of the participating districts could draw from this pool to obtain unbudgeted diagnostic and/or ongoing support services for low incidence handicapped children or children with complex problems. This discretionary grant also

was used to hire a half-time administrative coordinator. Upon the expiration of the three-year grant in the spring of 1982, participating districts picked up the costs of the funding pool and the administrative coordinator, contributing shares in proportion to their total enrollments. In addition to reducing the unit cost of several services, both school district personnel and related service providers credit the regional contracts and, thus, the Support Services Team, with significantly improving the quality of services available to handicapped children in the area.

TARGET POPULATION

The eight districts participating in the Capitol Area Comprehensive Support Services project have a total enrollment of about 12,000 students; individual district enrollments range from 715 to 3,609 students. These eight districts serve 42 separate towns and cover portions of three counties. Project referrals generally come through one of the Special Education Directors, following consultation with the child's teacher, parents, and school principal to determine the need for diagnostic or supportive services otherwise unavailable in the district.

The project's first priority is children with low incidence and/or complex handicapping conditions who could not otherwise be appropriately served in a small district. In addition, all of the districts have their own programs for handicapped children, and many individually have contracted with the same service providers who are members of the regional program.

OBJECTIVES

The Comprehensive Support Services Team continues to pursue the objectives that the Special Education Directors originally identified. The Directors agreed that these objectives needed to be met if the districts were to be successful in bringing children back into local programs:

- Expand the range and quality of services available to handicapped children;
- Maximize the use of scarce professional resources;
- Reduce the cost of services;
- Decrease the amount of time between referral and service provision; and
- Develop an interdisciplinary evaluation and service capacity.

DEVELOPMENT OF THE POLICY

The development of the regional interdisciplinary service team has been central to the eight districts' efforts at implementing P.L. 94-142. Although some of the participating districts had worked with other outside agencies, these efforts had been confined to individual children.

In fact, at the time P.L. 94-142 was passed, only three of the districts had Special Education Directors. Soon after the passage of P.L. 94-142, these three directors began meeting to discuss the implications of the law for the area's districts. They were particularly concerned about the service needs of severely handicapped children who formerly were placed outside their own districts but who would now be under their jurisdiction. This small group of Special Education Directors also agreed

that it was important to include in their discussions representatives from those other districts that had no designated Special Education Director.

As a result of these larger monthly meetings, the district representatives recognized, first, that they shared the common problem of how to implement the federal law, and second, that they were somewhat interdependent. Members understood that one district's incapacity to serve a child might only become a neighboring district's financial and service burden. These early meetings also identified the "good people" in the area -- that is, those individuals in private practice who had both demonstrated an understanding of and been responsive to the needs of handicapped children. These providers were identified as potential candidates for the resource pool. Since their initiation, these meetings have facilitated the creation of a support network for the participating agencies as well as providing overall direction for the project. These meetings operate informally, without a chairperson, and are held monthly after school hours.

Although the Capitol Area Special Education Directors have initiated a range of programs, (including two district-based programs for severe and moderately retarded students, a series of summer programs for handicapped children, and inservice training programs,) the Comprehensive Support Services Project is the only special education program that is regionally administered. As they began to address the education and service needs of children currently placed out-of-district, the directors realized that they had no idea what these students' specific service needs

would be. Thus, they decided that, while they needed to establish formal arrangements with existing service providers, it was essential that these be available as needed and in the manner they were needed, at least until they had had an opportunity to work directly with these children.

Before the group began negotiating contractual service agreements, each committee member was asked to describe how a particular member of the new regional multiservice team would provide a particular related service. Members therefore developed a "job description" for that provider, specifying how the service provider was to work with the teacher, the child's family, and other school personnel to insure that the service would be of maximum benefit to the child in a classroom setting.

IMPLEMENTATION

The steps needed to establish and utilize the region-wide contracts are as follows: After the appropriate providers are identified, the private provider and the regional program sign a contract. This contract stipulates uniform rates so that costs are held constant for all member districts. In addition, these contracts specify that the provider will bill possible third party payment sources, such as private insurance or Medicaid, before billing the school system.

The Regional Comprehensive Support Services Team became operational in 1979. Currently, the interdisciplinary team's specialized services include the following:

- Psychiatric and Psychological Services

  Kennebec Valley General Health Center
  Crisis and Counseling (a nonprofit agency providing psychological counseling)

- Speech Pathology

  Private group practice

- Audiology

  Kennebec Valley Medical Center, Gardiner Division

- Physical Therapy

  Private group practice

- Occupational Therapy

  Private practitioner

- Pediatrics

  M.D./private practice

- Neurology

  Pediatric neurologist

  Neurologist

- Vocational Education Evaluation (available on a consultation basis)

  Opthalmology

  Nutrition

  Dentistry

EFFECTS OF THE POLICY

The Capital Area's regionalized approach to providing related services has produced several positive results. Most significantly, after the State IV-C grant was terminated at the end of its three year period in the spring of 1982, the member districts have picked up the full program costs. Each of the

eight local superintendents has been able to extract commitments from a total of 42 school committees to assume a proportionate share of the program's costs based on each school's total enrollment for the school year 1983-84. Specific outcomes of the program to date include the following:

1. Assured access for handicapped children to a network of primary and supportive services. The contracts developed with service providers have helped ensure that specialized services are available throughout the eight-district region. This access to services has been particularly important for smaller districts with limited financial resources. Along with making services more widely available, the project has increased the scope of available services.

2. Improved quality of diagnostic and support services. Participants in the Capitol Area project maintain that the regional multidisciplinary team has improved the quality of services available to handicapped children in several ways:

- The quality of purchased services has improved significantly. The regional approach to purchasing related services has yielded a level of quality which the Special Education Directors feel would have been unobtainable had they negotiated separate contracts, each for only a small amount of service. For example, each of the contracts stipulates that services are to be delivered at the school site. This stipulation ensures that service providers can observe the child in the school setting and, thereby, develop a service plan integrally related to the school setting. Both Special Education Directors and the individual providers feel that this on-site service delivery has helped improve the quality of evaluative and therapeutic services.

- The quality of evaluation also has been improved, as the result of interdisciplinary team members' ongoing consultations about the efficacy of various evaluation techniques.

- The quality of communication between classroom teachers and diagnostic specialists has improved. This improved communication has been facilitated by the emphasis on the school-based provision of contracted services. Equally important, however, has been the fact that the providers' diagnostic and periodic progress reports now are written specifically with the classroom setting and teacher in mind. At the same time, the directors, acting regionally, have been successful in working with specialized service providers to increase readability and utility of their diagnostic reports.

- Specialists are used more appropriately as a result of the regional project. One of the primary roles of the Project Coordinator has been to insure that members of the interdisciplinary team are used appropriately. Although the establishment of the regional team has increased the availability of service overall, both professional and financial resources are still scarce. Thus, The coordinator continues to work closely with specialists to try to maximize the use of their skills.

3. Cost Savings. The improved quality of diagnostic and supportive services has been achieved at a lower cost. The eight Special Education Directors recognized that their single regional contract with service providers put them in a stronger position to negotiate cost than if each district individually approached a provider. The decrease in unit costs for the 1980-81 school year ranged from 15 to 30 % for each of the purchased services. In the aggregate, the eight school districts can guarantee a significant portion of the total business available in the area to both private agencies and individual practitioners. Thus private providers can afford to keep their rates low. Further, the fact that they can jointly hire a full-time specialist rather than purchase this service has led to reduced costs. The provision requiring providers to first use any third party payment sources has also held costs down.

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APPENDIX G

INTERAGENCY EARLY CHILDHOOD AND PRESCHOOL
SCREENING PROGRAM

WELD COUNTY, COLORADO

INTERAGENCY EARLY CHILDHOOD AND PRESCHOOL SCREENING PROGRAM

WELD COUNTY, COLORADO

SUMMARY

At the beginning of the 1981-82 school year, a group of Weld County, Colorado, public and private agencies began a cooperative screening program for children, from birth to 5 years of age, who were suspected of being developmentally delayed, and, consequently at-risk. The object of the program was to identify these high risk children before they reached school age and refer them to appropriate services within the community.

Prior to 1981, several community agencies had conducted some pre-school screening programs and child-find activities. Several of these agencies had contracted out for those aspects of the screening process for which they lacked the appropriate specialists. The interagency project was developed to reduce the duplicative screening efforts and was considered to more efficiently use available resources. Each of nine participating public and private agencies contributes one or more professionals one day per month to participate in the comprehensive screening program. Perhaps the most important consequence of this project is that interagency communication has been enhanced and duplication of services has been reduced. Due to this interagency effort, agencies, whose staffs have been reduced due to budget cuts, have been able to maintain their previous level of services. The county school districts, in addition, use information from the screening clinic to plan programs and project budgets for handicapped children upon their entrance into school. Most impor-

tantly, many more at-risk children are being screened in far less time and more young children are receiving services long before they even begin school.

TARGET POPULATION

Eligibility criteria to participate in the joint screening program are quite broad: For instance, any child between the ages of birth and five years, referred by professionals or parents because of concern with some aspect of the child's development, is eligible. Typically, these eligible clients include children with developmental disabilities, and, in many cases, with developmental delays that later disappear.

Premature babies often are referred to the program in order to ensure that their development proceeds without problems. Young children with learning or language difficulties also participate. In summary, the program will screen any child from birth to 5 years of age who resides in Weld County, is referred by a parent or professional, and is suspected to be at-risk because of developmental problems. While participating families need not be taxpayers, they must be county residents. There is no limit to the number of times a child can participate in the screening and there is no fee for the service.

OBJECTIVES

All agencies involved in the interagency screening program are committed to identifying as early as possible those children who are at-risk in order to prevent or reduce the severity of their handicapping conditions. The screening program is viewed

primarily as a prevention strategy. Members believe that both early problem identification and close tracking of certain vulnerable young children will decrease the number of children who will need either special education or intensive services later on.

In summary, program objectives include the following:

- Identify young children who are at-risk;
- Recommend appropriate services for these children;
- Provide parents with information on how to promote their child's optimal growth;
- Minimize screening duplication among community agencies; and
- Reduce the amount of time needed to provide comprehensive screening.

DEVELOPMENT OF THE PROGRAM

Weld County is a large, mostly rural, county in northeastern Colorado. Prior to the creation of the interagency screening program, most public health and social services were provided through county level agencies which are governed by an elected Board of County Commissioners. Agencies that provide services include the County Department of Health; the Handicapped Children's Program, which uses federal Maternal and Child Health Funds (Title IV) and state funds to purchase adaptive equipment for handicapped children; the county Department of Mental Health; the county Department of Human Resources; and the county Department of Social Services.

The county also has 14 school districts, two of which, located in Greeley and Windsor, have separate special education

divisions. The remaining twelve districts belong to a county-wide educational cooperative, the Board of Cooperative Education Services (BOCES), and share common special education resources. Weld County also operat s a Headstart program.

Besides these public agencies, numerous private agencies additionally have served young handicapped children. For example, the Weld County Community Center Board, a private non-profit agency licensed under the State Department of Institutions, provides services to 100 developmentally disabled persons age 0-5 and over 21, as well as a few clients age 5-21 for whom an LEA chooses to purchase services. The agency's funding includes monies from the United Way, Title XX, P.L. 89-313, and state and local government sources. Other private agencies serving this population are the University of Northern Colorado; the Northern Colorado Medical Center which provides physical and occupational therapy; and the Rehabilitative and Visiting Nurses Association, which provides in-house services to physically disabled adults and children. Finally, the Northeast Health Care Program, a non-profit agency, provides health care services to low income families.

Several of these community agencies have been responsible for identifying young handicapped children. According to P.L. 94-142, the LEAs must participate in Child Find activities, the local Community Board is mandated to identify handicapped children; and the Health Department is required to both find and serve young handicapped children. Thus, prior to the creation of the screening program, each of the agencies separately devoted a

portion of its resources toward fulfilling the same mandate. Recognition of the need for a coordinated screening and referral program began to emerge as early as 1977. Through their Child Find activities, agencies found that there were still numerous handicapped children who had not yet been identified. School districts, the Community Center, and other agencies found themselves duplicating some of each other's services such as home visits while also having to purchase from each other specialized services such an audiological exams. Each agency had distinctive in-take screening procedures, so cross-agency information was not necessarily comparable. Additionally, the county has a high mobility rate, both within the county and across its borders. For example, the city of Greely has a 30% student turnover rate each year. Thus, agencies realized they needed a mechanism to track highly mobile children who may wind up being served, if at all, by different agencies in different parts of the county.

As a result of decreasing budgets in 1980, the agencies even more strongly recognized their need to consolidate their screening efforts. Thus, in effect, shrinking budgets proved the impetus for establishing an interagency preschool task force. Agencies realized that combined resources would expand the scope of services available to children without necessitating a larger staff. In fact, in some cases, individual agencies could compensate for staff cut-backs by joining forces with other agencies.

These factors led the Interagency Child Consortium, a group of representatives from the above local agencies, along with members of a parent group, a day care center, and the community col-

lege to apply to the State Developmental Disabilities Council for a grant to establish a uniform referral center in 1977. However, the grant was not awarded. Nothing further was undertaken until 1980 when the Child Find coordinator from the Community Center Board suggested that local agencies should revive the idea of coordinating early childhood screening. This time, however, it was suggested that instead of relying on state funds, each agency would contribute in-kind resources.

This coordinator, obtaining approval from her Director, and confident that other agency directors would also approve the idea, called a meeting of the Interagency Children's Consortium. This Consortium was made up of staff members from each of the agencies who worked directly with children. Prior to this, the Consortium had played the fairly passive role of sharing information; this was its first active initiative.

The development of this interagency effort was entirely a local matter and did not include any state-level involvement. At the meeting, the concept of interagency collaboration for preschool screening was discussed. Participants decided to use as a model a program developed by the SEA in Colorado (Project ECHO) in which local public and private agencies from one county jointly screen, diagnose and treat infants and preschool children from another county.

Participants also discussed what information and professionals were needed for this effort, the instruments to be used, and the ways results could be made most useful to member agencies. To this end participants developed generic criterion-referenced

forms that were taken from several formal screening instruments. These forms enable staff members to explore many facets of a child's behavior without being wedded to one particular test.

Each of the Consortium staff representatives then obtained approval from their agency director to both participate in this joint endeavor and contribute professional staff time. While no formal contracts or agreements were ever signed, each agency has fulfilled its commitment. No instances have occurred where an agency staff person did not perform his or her functions at the screening clinic.

The agencies also decided on a plan based on agency contributions. The Weld County Community Center agreed to provide a psychologist and a full-time program coordinator; the County Health Department and the Northeast Health Care program each put in a public health nurse; the Rehabilitative and Visiting Nurses Association agreed to provide an OT, a PT, and an RN; the University of Northern Colorado's Speech Clinic contributed graduate students to provide speech and language testing; and Weld County General Hospital added another PT and OT. In addition, the County Health Department's Coordinator of the Handicapped Children Program, an RN, comes to the screening and helps parents fill out applications if adaptive equipment is needed and if the family is eligible. The local Headstart program also agreed to contribute a Spanish translator, while a local nursing home donated the space for the clinic, which includes a sound room for audiological exams. The agencies also agreed that each of the staff persons would bring his/her own equipment to use at the

screening since there is no other funding for the program.

These in-kind donations resulted from a process of self-examination; that is, each agency determined what professional expertise it possessed that might be of benefit to the screening program. At least one of the agencies, the University, was at first somewhat reluctant to participate because its main source of income was audiological exams, for which it recieved $25/hour. Since that time, however, its staff have become eager participants, a change at least partially due to the increased number of referrals for follow-up service it receives from the screening clinic.

Three groups noticeably absent from this program are the County Departments of Mental Health and Social Services and private physicians. The County Department of Mental Health chose not to be involved because the program does not perform psychological testing. Thus, no IQ test or psychological diagnostic tests are used. The interdisciplinary staff believe that these tests only serve to label very young children and, because of their ages, are often inaccurate; however, if a child exhibits obvious emotional problems at the clinic or in a home visit, the child and/or family may be referred to the mental health agency for play therapy or for parenting classes.

The County Department of Social Services also has chosen not to participate in the program to date. Although they were invited to participate because almost half of the referrals involve children who fall under the agency's jurisdiction -- i.e., children in foster homes, wards of the court, or available for adopt-

ion -- the social services agency did not see an appropriate role for itself. The screening team is responding to this absence by both filing its reports with the Social Services Director and providing in-service instruction to Department staff.

The third group choosing not to participate is private physicians. However, a prominent pediatrician, also a member of a local school board, is trying to recruit resident doctors from the county hospital.

Contrary to most interagency efforts, this screening program resulted from the efforts of personnel at the staff worker level. Only after staff were on board was approval obtained from agency directors. One of the agency directors reported that the key to this effort's success was "to hire good staff people and get out of their way", because it was at the staff level where the program would succeed or fail. Staff persons are the ones who already know each other, who can get excited about a new program, who will spend the necessary planning time, and who will ultimately make the program work.

IMPLEMENTATION

Physicians, community agencies, and parents may at any time refer children to the clinic through the Program Coordinator. At one point, the team experimented with local newspaper advertising, but became so overwhelmed with referrals, most of which were for non-handicapped children who only needed vaccinations, that they decided against this strategy to obtain referrals.

Upon receipt of a referral, the Program Coordinator contacts the parents to explain the purpose of the screening and the procedures involved. Parents then are asked to sign an imformation release form that grants each participating agency access to the results.

At this screening appointment, the child is seen by professionals for direct observation and testing in the following areas:

- hearing
- vision
- physical health
- general cognitive development
- fine and gross motor abilities
- receptive and expressive language
- neuro-motor evaluation
- family environment

Approximately 12-16 children are screened at each of the monthly clinics. Following both the morning and afternoon sessions, staff discuss recommendations for each child, compare notes, and reach agreement on what services if any, the child may need. Several factors are taken into account in recommending these services: the type of delays the child exhibits, the family's available resourse and various agencies ability to meet the child's needs. The recommendations are made to parents only as suggestions based on one day's observations. Parents are cautioned about screening - i.e., that test results may vary from day to day with young children and long term projections are

highly unreliable. Frequently, further testing is recommended.

Following the individual staffings, the Program Ccoordinator, in a report, summarizes the screening findings and recommendations. A copy is sent to the parents, the referring agency, and the local school district.

Because pre-school is not mandatory in Colorado, the team can recommend placement with an agency that charges a fee. Because fees are usually based on a sliding scale, the burden for low income parents is minimized.

EFFECTS OF THE PROGRAM

The interagency screening program has had several positive effects on both participating children and agencies.

- An increased number of children have been found to be at-risk and are receiving services prior to entering school. As a result of this screening program, more children have been identified as handicapped and are receiving some services. Whereas only about 30-40 preschool children were screened in the school year 1980-81 before the clinic was established, approximately 110 children had been screened in the school year 1981-82. Consequently, more children with developmental deficiences are being located and more referrals for intervention are being made, primarily because many more children can be screened through the interagency clinic. The number of physician referrals also has increased because the clinic, being representative of so many agencies, is respected as a neutral, objective entity without any vested interest in one particular agency or program.

- Children are being screened in a shorter time. The interagency effort has made the screening process more efficient. Whereas one agency could spend several weeks to screen a child who may have required appointments with different professionals, the interagency clinic completes this screen in one day. The program's success in shortening this process results from its ability to bring different professionals to the child, instead of making the child (and parents) visit several professionals in different places on different days.

- Children are receiving services that more appropriately address their particular needs. Because of this interagency staffing, children are more likely to obtain the services they require. Each clinic staff person knows the range of services available within his/her own agency. The cumulative range is far wider than that offered by any single agency. It is therefore more likely that a given child who participates in this program will receive services that more appropriately address his/her unique needs.

- The interagency screening effort allows at-risk children to be tracked during their pre-school years without being labeled "handicapped". Many of these children have developmental delays which may or may not become handicapping conditions. In either case, keeping track of the child through his/her early years is an important step in minimizing future problems. The interagency screening provides a central entry point through which a child's progress can be noted.

Participating agencies also directly accrue benefits which ultimately result in improved services for children:

- Duplication of screening and services has been reduced. Prior to the existence of the interagency clinic, several agencies conducted their own screening. By consolidating their professional and equipment resources, these agencies now can maintain their prior level of screening resources with fewer staff and reduce service duplication. Almost informally, and as a direct result of staffings following the screening, agencies have begun to focus their individual efforts on service gaps. A general attitude has evolved that Agency X can provide services A, B, and C best while Agency Y provides services D and E better. As a result of this process, agencies have carved out for themselves somewhat mutually exclusive functions so they all do not provide the same services.

- School districts are better able to plan for their school age handicapped population. Computerized records of each child's screening results are distributed to the local school district. This record provides the LEA with information one to five years sooner than they otherwise would receive regarding both the likely number of handicapped children who will enter first grade and the general type of services needed. The school district can thus better

plan and budget for its elementary special education programs.

- Participating agencies have developed greater awareness of and respect for each other thereby improving relationhips outside the screening clinic. Agencies involved in the screening program now understand each other's tasks; they feel more free to call other agency staff to talk about mutual concerns; and their respect for each other has grown. The resulting improvement in communication has spilled over into other areas. For example, members of the screening team now talk to each other about adult clients who may need other agency services.

- Participting agencies also ensure that there is no competition for money; i.e., that no private agency would feel that the screening takes business away from them. Participants are careful to ensure that each agency gets a fair share of the referrals when a follow-up service is recommended. To date, no problems have been reported; agencies readily agree on recommendations. Rather than experiencing a reduction in the need for their services, most of the participating agencies have increased their service caseloads, a result of the larger number of children the clinic identifies.

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APPENDIX H

NEW DIRECTION

INDEPENDENCE, MISSOURI

NEW DIRECTION: A DAY SCHOOL PROGRAM FOR EMOTIONALLY DISTURBED CHILDREN

School District of Independence, Missouri

SUMMARY

In collaboration with Comprehensive Mental Health Services, a private nonprofit community mental health agency, the School District of Independence, Missouri, established a comprehensive program to serve severely emotionally disturbed children. The program, which began serving children in February, 1981, was designed to return children who had been placed in private residential and day settings to regular classroom settings as soon as possible. Entitled New Direction, the program represents a collaborative effort in which the administration, program planning and development, program operation, and funding are conducted jointly by the LEA and the private mental health agency. This program grew out of the two agencies' shared conviction that a collaborative effort was the most effective way to serve these children whose educational needs were intertwined with and inseparable from their therapeutic needs.

TARGET POPULATION

New Direction was developed for children between the ages of 8 and 15 who are emotionally disturbed and who reside in the Independence School District or from surrounding school districts in Northeast Jackson County. Most of the students currently in the program had been placed in private day or residential schools or inappropriately placed in classrooms for behavi lly disordered children.

OBJECTIVES

New Direction's primary goal is to assist children in developing the behavioral skills that will enable them to return to a less restrictive educational setting that can be provided in their home school district. As a collaborative approach to serving this population, New Direction has established the following sub-objectives:

- Make family therapy an integral component of the program;
- Share program costs with as many sources of revenue as possible; and
- Blend professional roles.

DEVELOPMENT OF THE PROGRAM

While Missouri state law makes the SEA responsible for serving the severely handicapped, historically this law has not been applied to seriously emotionally disturbed children. Although the State Department of Mental Health and the State Department of Education developed an interagency agreement to provide services to emotionally disturbed students, the directors of both agencies agreed that such interagency activities must be developed at the local level. The state agreement thus functioned as a general statement, and did not address specific guidelines for local cooperative arrangements.

Officials in Independence were concerned that emotionally disturbed adolescents, in particular, were being inadequately served. Most of the seriously emotionally disturbed children in the Jackson County area, for example, were being served in a

private psychiatric day facility, 40 miles from Independence. This facility is one of 12 centers statewide. Because of travel problems, the educational programs in these facilities did not allow for extensive parental involvement nor were they able to integrate education and treatment programs with services in the home community.

To remedy this situation, the Independence LEA approached the SEA with a request for P.L. 94-142 discretionary funds. The LEA wanted to hire an interagency coordinator to develop alternative services for seriously emotionally disturbed youth. An interagency grant was made in August of 1979. One year later, the state Director of Special Education and an Assistant Director of the Department of Mental Health suggested the need for a study to answer the question: "How feasible is it to serve emotionally disturbed students in the catchment area of the Jackson County Mental Health Center?"

This study found that there were no area day treatment or residential programs for behaviorally disordered or emotionally disturbed children. Based on these and other findings, the Independence School District submitted to the SEA and the Department of Mental Health a proposal for establishing a new joint program. The proposal was funded in the summer of 1981, with a one-semester planning period to precede full operation in January 1982.

During the planning phase, representatives from the LEA and the County Mental Health Center met to define new program parameters. A steering committee was formed to establish the program's

budget and set operating guidelines. Members of this steering committee included the Executive Director of the Mental Health Center, the Director of Special Education in Independence, the Assistant Superintendent in Independence, and two program administrators from the LEA.

The steering committee agreed that the Mental Health Center and the LEA would jointly hire all staff for the program. From the beginning, the steering committee decided there was to be one program and that everyone would work for New Direction, not for only the mental health agency or only the education agency. For the first year of operation, they hired one psychologist, a half-time recreational therapist, one psychiatrist, two teachers, and one secretary. The committee was able to increase several of these positions in subsequent years.

Financial arrangements were also made during this planning phase. The mental health agency was identified as the fiscal agent, and contributions were made by each agency. The mental health agency made in-kind contributions of $120,000. The LEA's contribution, partly in-kind, was $70,000 and the SEA's contribution was $58,000. The total beginning program budget was thus $248,000. All participating LEAs in the county outside of Independence were to be charged a standard tuition fee.

One of the initial hurdles that had to be overcome during the planning phase was negotiation over the two entirely different approaches to providing services by the education agency and the mental health agency. Mental health personnel found it hard to understand that in education everyone had to be served,

even if funds had to be reduced. The provision of flat funding rates on a per-child basis without regard to level of services needed was equally difficult for mental health administrators to grasp. On the other hand, educators had difficulty understanding the mental health concept which, in its simplest terms, amounts to the adage, "If you can't provide quality services, don't provide any." In short, mental health staff viewed education as a "factory" with the goal of mass production without real regard for individuals. Educators viewed mental health services as esoteric and highly expensive per individual. These differences led to initial confusion in establising New Direction's budget, yet members came to better understand each other's budgeting processes as they came to understand the principles by which each operated.

IMPLEMENTATION

Following acceptance into the program, a child is normally placed for the full 6-hour day in one of the program's two classrooms. These classrooms are located in a former elementary school building in Independence which also houses the district's Alternative School. Each classroom is staffed by a teacher and an aide. Each child sees the full-time recreational therapist daily and has an individual session with a psychologist once a week where the focus is on the specific behaviors which are preventing the child from achieving in the regular classroom. The psychologist also conducts group sessions with the students and meets with each family on a weekly basis. A psychiatrist is

on duty at the school one morning per week.

The program has an elaborate referral process that screens out children for whom the program may be inappropriate. First, students must have been placed in other less restrictive special education settings before New Direction is considered. This allows program staff to be more sure that each student has already tried less restrictive settings and indeed seems to require the more intense services available in New Direction. Following a review of the student's psychological evaluation, achievement test data, and further diagnostic work, a pre-IEP conference is held to determine whether New Direction is the most appropriate placement. This conference brings together New Direction staff, the referring teacher and/or Special Education Director, and the student's parents. Only after this group agrees is a formal IEP meeting scheduled.

New Direction's curriculum consists of standard materials from regular junior high and senior high classes. On-going contact with faculty and curriculum supervisors is maintained by the staff. Behavior and classroom management are based on a point system for junior high students and a monetary system for senior high students. Suspension from school is used only as a last resort.

The staff hold regular informal conferences and prepare daily reports for parents. Monthly and annual reviews also are conducted for each child.

EFFECTS OF THE PROGRAM

Both the mental health agency and the LEA agree that New Direction has provided a service for emotionally disturbed students where none had existed previously. They cite several areas where the program has achieved its goals:

1. Increased parent involvement. Before New Direction, the Independence LEA did not have the authority to require that parents become involved in the educational program for emotionally disturbed children. Now, because the mental health component is supported by a private agency, mental health center staff are able to make parental involvement mandatory. Parental participation in the therapy component is seen as critical to the success of each child's program.

2. Total integration of education and mental health services. New Direction has been able to integrate these two services by setting up one administrative mechanism and by designing the program so that both sets of professionals interact daily on behalf of individual children.

3. Successful reintegration into regular classes. Approximately four students were returned to regular classrooms during the first two years of the program's operation. It is expected that this rate will increase in the program's third and fourth years.

There is one area where New Direction has not yet achieved its objective: cost savings. Because of initial expensive start-up costs, the program lost $12,000 during its first year. Per diem reimbursement was $28 per student in 1981, while actual per

diem costs were $48 per individual. This difference was made up with mental health agency funds and SEA discretionary funds. Administrators believe, however, that 90% of the funds will come from LEA tuition fees in the years ahead. The mental health agency also sees increased use of third party payors in the future which will reduce their burden further.

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APPENDIX I

THE REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS

MONTGOMERY COUNTY, MARYLAND

REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS

MONTGOMERY COUNTY, MARYLAND

SUMMARY

The Maryland Department of Health and Mental Hygiene (DHMH) and Montgomery County Public Schools (MCPS) jointly fund and operate the Regional Institute for Children and Adolescents (RICA). This program provides residential and day treatment services, along with special education, to emotionally disturbed students age 6 through 20. The Maryland Department of Health and Mental Hygiene provides the bulk of the funding: $3.8 million out of a total budget of $4.4 million in FY 1983. Approximately one million dollars of this is used to contract with the LEA who is responsible for the program's educational component. In addition, Montgomery County Public Schools allocates approximately $600,000 of its own funds to the education of these students as well as donating the land for the facility. The State Department of Budget and Fiscal Planning devised this funding arrangement so that the LEA would pay a portion of the costs of a public residential treatment center where previously counties were not required to pay any of these costs.

RICA'S educational service takes the form of a certified special education program that is under the direction of a principal. The therapeutic component is interwoven with the educational service and is under the supervision of a clinical psychiatrist. Both the school principal and the clinical teams work directly with the RICA Chief Executive Officer.

TARGET POPULATION

180 students in grades 1-12 who have been diagnosed as severely emotionally disturbed attended RICA in 1982-83. Eighteen of these 180 students attended RICA from neighboring counties. Students must be placed in RICA through the LEA's Admission, Review, and Dismissal Committee (ARDs) or through a joint placement with the courts. Of the total number of students in 1981-82, 26% were court-ordered and 40% were involved with the Department of Juvenile Services.

Students are placed at RICA because they have been unable to succeed in regular schools' special education classes. Students have average or above intellectual functioning. Many exhibit depression, withdrawal, conflicts with authority figures, low self-esteem, aggressive and runaway behavior, substance abuse, schizophrenic or autistic behavior, and/or unreasonable anxieties. Some 38% of RICA admissions in 1981-82 had required psychiatric hospitalization and 88% had received out-patient therapy prior to admission.

OBJECTIVES

RICA's education and clinical treatment program is designed to enable such emotionally disturbed adolescents to return to either regular schools or vocational settings. Four specific objectives guided RICA's development:

- Both the Department of Health and Mental Hygiene and the LEA were committed to minimizing institutional placements and maximizing use of community-based services. Because many Montgomery County students formerly were being served in either state hospitals or private residential facilities in other geographical locations, DHMH and MCPS sought an alternative

that would allow students to be placed in their home communities. Both agencies believed that some students who were residing in residential settings could live with their parents, if an appropriate day program were available. DHMH and MCPS agreed that RICA should bring community specialists and organizations together to collaborate on efforts to return children and youth to less restrictive settings.

- DHMH and MCPS believe that handicapped students have multiple problems that demand a wide range of services which different agencies offer. Both believe that emotionally disturbed students are virtually uneducable without effective intervention by skilled mental health clinicians since these students cannot concentrate on learning until their inappropriate behavior is changed. A child's emotional development therefore is seen as essential to his/her intellectual growth. Thus, the collaboration of both agency staff was seen as a critical component of any effort to maximize a student's potential.

- Both agencies recognized the need for a year-round program for these students. MCPS knew that many emotionally disturbed students regress when, as in the summer months, they do not participate in continued educational and treatment programs. Since no suitable summer programs were then available, RICA was designed to meet that need.

- From a financial perspective, both DHMH and MCPS recognized a potential savings by providing this population with residential services in the county rather than sending them out of state to other state hospital centers or private facilities. Both agencies agreed that RICA would be cost efficient if it would allow students to be rehabilitated more quickly, thereby returning them to less costly settings in less time than would pass if they were sent out of state.

The State Department of Health and Mental Hygiene sought to link local level mental health and education services by encouraging local agencies to feel a sense of ownership and responsibility in the program. Because local agencies often regard a state-operated facility as alien, the intent was to make RICA a truly local interagency program. Unfortunately, this goal was not entirely realized, as the county health department which was

originally going to run RICA's mental health component, chose not to participate. They did not wish to conform to the state's prospective salary schedule which, through the state merit program, was 30% below their own county schedule.

DEVELOPMENT OF THE PROGRAM

The initial impetus for RICA originated in the early 1970's with the Maryland General Assembly. Alarmed at the rising costs of placing students outside their district, and reacting to reports that appropriate services were not being provided in many of these facilities, the Assembly formed a commission, made up of numerous department heads, to study the financial and qualitative issues involved in sending students out-of-district and out-of-state. This commission recommended that ways be found to bring these students back home.

At the same time, DHMH noted both a rise in the number of emotionally disturbed children in the county and the existence of two RICA-type models that seemed effective: one in Catonsville which served young children and the other in Prince George's County. In 1971, DHMH recognized that Montgomery County needed a residential facility for emotionally disturbed adolescents. At DHMH's instigation, a committee was formed to look into the possibility of such a facility in Montgomery County.

The original committee, consisting of representatives from DHMH, MCPS, the county health department and other community representatives, met for six years, working out the details of the project. The SEA was not involved. Several problems arose

which prevented the committee from quickly reaching any agreement. For example, they had difficulty agreeing on the precise target population: i.e., the ages of the students to be served and the level of handicap. DHMH initially wanted to serve disturbed students with some retardation, while MCPS wanted to admit only those students with emotional problems who had at least average intelligence. They resolved this problem by agreeing to use functional capacity as an eligibility criterion rather than IQ. The committee also discussed the problem of reconciling the two agencies' policies regarding confidentiality of information. For example, MCPS has to make all of its records available to parents while DHMH is not so required. The MCPS policy, which mandates confidentiality of information, but which allows access to parents, prevailed. Another problem discussed resulted from different building codes. Before improvements were finally negotiated, MCPS refused to open the facility because it would not meet their building safety codes.

Upon completion of the preliminary negotiations, each agency submitted its budget for approval. The original DHMH budget submitted to the State Department of Budget and Fiscal Planning did not contain funds for RICA's educational component. At that time, there was considerable discussion about differentiating educational from health and custodial budget items. The Budget Office rejected the original DHMH budget because it did not contain any education funds. DHMH staff went back to the drawing boards and resubmitted a new budget which did earmark funds for education.

Prior to this action, counties were not required to pay any portion of the costs associated with placements in public residential treatment facilities. They were only required to pay a portion of those costs incurred in private facilities. By earmarking a substantial sum from DHMH's budget to be used for the educational component of RICA, the state budget office was able to strike a deal with Montgomery County which provided that county funds were to be used in a public facility -- RICA. In essence, this action set a precedent for treating public facilities as private ones, with respect to the requirement of county contributions. The budget analyst saw this arrangement as a bargaining tool that would be advantageous to both DHMH and the county education agency. It would also help encourage counties in other parts of the state to contribute funds to public residential centers.

Montgomery County and the Maryland Department of Health and Mental Hygiene agreed to share in the financing of RICA with the understanding that the latter would bear the majority of the costs. The entire operating budget for RICA is $4.5 million for school year 1982-83. This total budget is comprised of several sources.

DHMH contributes $3.3 million to cover all clinical, residential and building maintenance costs, and gives Montgomery County Public Schools $911,999 to pay for the bulk of the educational costs. MCPS supplements this sum with $592,857 of its own money. Neighboring counties also contribute a sum representing the tuition costs for their students attending RICA.

To determine the amount of money DHMH would grant to RICA for educational purposes, the state teacher/pupil ratio requirements for special education and the Montgomery County salary schedule level were used. For example, if 15 teachers were required for 180 students, DHMH would agree to pay MCPS an amount equivalent to 15 times the average teacher salary.

Because this amount covered only the minimum required staffing ratio, MCPS chose to supplement it with county funds, which, in 1982-83, equaled $592,857. This amount was determined by subtracting the state contribution from a budget of what the county considers it needs to operate the program effectively. In addition, the county deeded 14.6 acres of county land to the state in 1978 for construction of RICA. MCPS also provides speech and language therapy as an in-kind contribution from its own budget.

Drafters of the agreement worked out a system whereby DHMH sends a check quarterly to MCPS for its portion of the funds. The county money is kept in a separate budget within the county. RICA's principal and the county Special Education Director must go through the county budget process each year to receive RICA's funds. Their budget must be approved by the County Department of Education, the Superintendent, the Board of Education, and finally the County Commissioners.

After years of planning and several budget resubmissions, the Department of Health and Mental Hygiene and MCPS signed an agreement of understanding in 1980 which assigned service responsibilities and funding requirements for the operation of RICA.

IMPLEMENTATION

RICA's administrative structure was designed to integrate clinical, residential and educational services. A chief executive officer, jointly selected, maintains overall responsibility. Instead of mandating that the chief executive officer be a mental health official, and therefore a doctor, both agencies agreed to steer the program away from a strictly medical model and hire an overall administrator as chief executive officer. RICA clinical and residential staff support the educational program through their direct participation in the educational program, crisis support, behavior monitoring, and liaison with residential counselors. Education staff, likewise, participate in therapy meetings and a "level system" in which students progress through a series of levels, steadily achieving increasingly appropriate behavior and gaining expanded responsibilities and privileges. This "level system" is one component of an overall treatment approach and behavior management system used at RICA to help students function successfully in the least restrictive environment possible.

Each of the staff persons at RICA is a member of a treatment team responsible for a number of students. This team is made up of a primary therapist, an educational advocate who serves as the homeroom teacher, a residential advocate, a creative services therapist, and any special subject teachers involved with a particular student. Each team meets weekly to review progress and problems that surface during the week. Every two months, the team sets new goals for the individual student and reevaluates

the individual education plan (IEP) and the individual treatment plan (ITP). To integrate these two documents as much as possible, RICA has made it a policy to ensure that both documents share social-emotional goals and are developed jointly by education, clinical and residential staff.

After breakfast in the residential cottages, small groups of students meet with residential counselors on the unit for a brief goal-setting meeting. A Daily Interaction Sheet is developed and used to monitor on-going behavior. The students then take this sheet to their homeroom teacher who reviews it with them so as to acknowledge and discuss any problems that occurred the prior night. The students then attend six 50-minute class periods for the remainder of the day, including at least one therapy period per week. Each teacher signs the behavioral sheet, notes any problems, or makes relevant comments for the subsequent teachers. At the end of the day, the sheet is returned to the residence where it is discussed in small group sessions.

According to RICA's agreement, an interagency board advises RICA's administrator on matters concerning potential conflicts between RICA and other community facilities or agencies. Members of the board include representatives from the following agencies:

- Maryland Department of Health and Mental Hygiene
- Maryland Department of Education
- Montgomery County Government
- County Department of Social Services
- County Department of Juvenile Services

- Montgomery County Public Schools
- Court Diagnostic Team

Although their recommendations are advisory in nature, the board has helped establish procedures that involve RICA and other agencies. RICA staff members also strive to maintain good relationships with the courts since the courts have referred some of their students to RICA. One staff member meets twice monthly with those county judges who handle juvenile cases. This relationship has developed over the past two years so that judges are aware of and respect the RICA program and can therefore make appropriate referrals. In addition, RICA performs, at no charge, out-patient assessments for the courts, including psychiatric evaluations.

RICA also maintains a Citizens Advisory Board, appointed by the Governor and made up of concerned parents, citizens, professionals in the local social work and psychological communities, and, currently, a state legislator. This committee, which reports directly to the governor, is actively involved in the budget process and serves an important public relations function.

EFFECTS OF THE PROGRAM

In 1981-1982, its second year of operation, RICA graduated 16 students and returned 21 students to the public school system. The students who graduated from RICA either went on to college or began working. None were hospitalized; some continued private therapy on an out-patient basis. Of the 21 students who were returned to regular school, sometimes with resource room supports, all but four were able to remain in regular school.

From a financial perspective, RICA has not resulted in clear-cut budget savings. The 1981-82 average annual cost per residential student was $27,518, including both educational services and clinical treatment. While this figure may be lower than some out-of-state placements, it is far higher than many placements. However, for Montgomery County Public Schools, the cost is far less than if they had sent students out-of-district. Because their portion of the budget is relatively small, Montgomery County's costs are only $3,294 per student, less than the costs of educating a student in the regular public school system. DHMH is paying $5,067 per student for education and $18,544 per student for treatment. Because of this financial structure in which the State Department of Health and Mental Hygiene contributes 86% of the total operating budget, Montgomery County Public Schools has been able to offer this extensive program to seriously emotionally disturbed students at very little cost.

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