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ABSTRACT

This document reports on a symposium that was held to begin to shape a national policy on delivery of services to children at risk and their families, and to develop guidelines for future collaborative efforts between representatives from the health and education professional communities. The symposium explored innovative ways to integrate and enhance the delivery of services. The symposium was opened with a keynote address by former U.S. Surgeon General, Dr. C. Everett Koop, which charged that existing service delivery systems do not function in ways that cherish and provide for children and their families. Symposium participants cited social changes impacting on service providers, such as the rise of poverty, homelessness, teenage parents, and substance abuse. Efforts toward collaborative service delivery were viewed as resulting in greater cooperation but falling short of creating the attitudinal and systemic changes necessary. Issues in service provision include determining which children and families should be the focus of future efforts, expanding and replicating successful integrated service delivery approaches, overcoming "turf" and attitudinal obstacles, and creating new professional training opportunities. Symposium participants proposed strategies such as coalition building, calling for a congressional hearing, identifying and promoting collaborative models that work, and articulating guidelines for collaborative professional practice. A list of conference participants, with addresses, is included. (JDD)

THE HEALTH/EDUCATION CONNECTION

Initiating Dialogue on Integrated Services to Children at Risk and Their Families

Symposium sponsored by
The American Association of Colleges for Teacher Education
The American Academy of Pediatrics and
The Maternal and Child Health Bureau, U.S. Department of Health and Human Services

Alexandria, Virginia
March 5-6, 1990

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Executive Summary

The Health/Education Symposium represents an important step in a collective effort to explore innovative ways to integrate and enhance the delivery of services to children at risk and their families. Sponsored jointly by the American Association of Colleges of Teacher Education, the American Academy for Pediatrics, and the Maternal and Child Health Bureau, the Symposium provided a forum for representatives from the health and education professional communities to begin to shape a national policy and to develop guidelines for future collaborative efforts.

In his keynote address, former U.S. Surgeon General, Dr. C. Everett Koop, charged that the existing service delivery systems do not function in ways that cherish and provide for children and their families and called upon Symposium participants to shape a national agenda that would make coordinated, family-centered, community-based services a reality. As Symposium participants reviewed changes taking place over the past decade in society and in their professional fields, it became apparent that the need for progressive action was imperative. The rise of poverty, homeless families, teen parents, and substance abuse has had devastating implications for both health and education service providers. Efforts toward collaborative service delivery, such as those mandated in P.L. 94-142, P.L. 99-457, and the recently passed P.L. 101-239 have resulted in greater cooperation, but still fall short of creating the attitudinal and systemic changes necessary to truly serve children in need. Other collaborative demonstration programs and projects have also been undertaken with some success, but as yet they benefit only a small number of children and families.

Many points of agreement and dissension emerged as participants discussed their ideals for integrated service delivery and possible strategies for action. The issues of coming to a working consensus over which children and families should be the focus of future efforts, of finding ways to expand and replicate what is already successfully being done to create integrated service delivery, of overcoming "turf" and attitudinal obstacles, and of creating new training opportunities for professionals in each field present formidable challenges.

Acutely aware of the barriers to successful collaboration, but determined to overcome them, Symposium participants proposed strategies designed to communicate nationally, institutionally, and at the grass-roots level what is already known and being done to create successful, integrated service delivery. Strategies would include activities such as coalition building, calling for a congressional hearing to focus on integrated service delivery, identifying and promoting collaborative models that work, articulating guidelines for collaborative professional practice, and disseminating a policy

analysis paper that addresses collaboration between the education and health communities. Symposium participants also disussed ways in which they could communicate their own activities to professional organizations by disseminating information about Symposium initiatives and resolutions. On a community level, grass roots efforts to integrate services could be encouraged by replicating the Symposium within home institutions and by providing technical assistance to high-risk communities. Finally, as participants requested the planning committee to develop the next steps in the initiative and to sponsor another symposium, they also affirmed their desire to continue their efforts as they returned to their home communities.

Purpose of the Symposium

As we move into the last decade of the twentieth century, our nation has yet to enact a national youth agenda that addresses the needs of children comprehensively. The existing service delivery systems do not function in ways that cherish and provide for children and their families . . . This symposium is a forum within which health and education leaders are being asked to shape the emerging national agenda for children and families. (Dr. C. Everett Koop, Symposium Challenge Paper)

During the summer and fall of 1989, the American Association of Colleges for Teacher Education (AACTE) launched a major initiative to increase professional dialogue on the coordination of human services to children and their families. Under the guidance of a planning committee, it was determined that the most manageable approach to the problem was to narrow the field initially to an exploration of ways in which the health and education communities could more collaboratively respond to the health-related needs of school-aged children and their families. Momentum for cross-disciplinary dialogue was further strengthened as the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau (U.S. Department of Health and Human Resources) became co-sponsors of the initiative. The Health/Education Symposium thus represents an important step in a collective effort to gather together representatives from the health and education professional communities to explore innovative efforts to integrate service delivery and to develop guidelines for future collaborative efforts. As a focus for the Symposium, three individual participants were commissioned to write papers delineating key issues confronting education and health service providers and the parents and children whom they serve. Prior to the Symposium, these papers were distributed to invited participants from various branches of the health and education fields including physicians, deans of colleges of education, medical school trainers, educators leading school reform efforts and special education programs, and leaders from the sponsoring organizations. Each of these participants then prepared short reaction papers for presentation, distribution, and discussion during the Symposium. The critical issues raised in Symposium papers, presentations, and dialogues are highlighted in the following sections.

A Changing Social Context: Implications for Service Provision

*There have been rapid changes in the fabric of the society that have signaled the need for changes in our **social institutions and professional practices.** Families need new kinds of support if they are to survive and flourish....(Dr. C. Everett Koop, Symposium Challenge Paper)*

As a sponsor of a major initiative to provide a comprehensive, family-centered community base of services to children with special health care needs during his tenure as Surgeon General, Dr. Koop expressed continued concerns with the challenges facing children and their families and the inability of present delivery systems to provide services within communities and neighborhoods which no longer function as systems of support to those families. Poverty is ever-present and larger numbers of families now have fewer resources for survival. Homelessness is reaching epidemic proportions and families have become the fastest growing segment of that population. Moreover, increasing violence and substance abuse threaten families at all socioeconomic levels.

Concurrently, the traditional family structure and roles have also changed and delivery systems are not organized in ways that are responsive to the needs of single parent families, aggregate families, and families with two working parents. The increasing number of teen pregnancies and a concurrent rise in infant mortality and morbidity rates means that medical facilities and schools are faced with an unprecedented number of children in critical need. Finally, despite the fact that communities are becoming more diverse, social institutions have been insensitive to cultural diversity and language barriers continue to impede accessibility to many families who need services.

The plight of individual children and families was keenly elaborated in one key issue paper which presented a series of vignettes detailing the social crises from the perspective of parents--many in poverty, and some only teenagers themselves--who pled passionately for help in dealing with a sexually abused/ emotionally disturbed daughter, an alcoholic son, a multi-handicapped child, a "crack baby", or an infant with AIDS. With the numerous and increasingly complex needs apparent in such children and families, the problems posed by these all-too-common cases defy solutions based on any traditional division between education and health services.

The same set of social problems were also echoed from a statistical and educational perspective: Over 12 million American children are being raised in poverty; 3.3 million children are living with teenage mothers; and over 2

million cases of child abuse and neglect are being reported every year. Predictably, these conditions have had a devastating impact on student success in the educational system. The overall dropout rate for all students is over 30 percent, for Hispanic students it is at least 40 percent, and for African-American students it rises to over 50 percent in urban areas. Moreover, no one can remain insulated or untouched by such findings--for in addition to humanitarian concern about wasted lives, there are also broad economic ramifications to consider: "The student dropout situation takes on a new sense of urgency when viewed beside the data on the shortage of youth and the increase in the elderly. . .our society must now ensure, for economic reasons, that everybody counts and that everybody is productive in the nation's economy. . .the school must reverse the spiral toward futility for many young people." And in the face of bleak statistics, the United States ranks only thirteenth of the sixteen leading industrialized nations in spending for elementary and secondary education.

Challenged by these grim findings and the pervasiveness of social problems, Symposium participants discussed their professional responsibilities and the population of concern. Although all agreed that every child in every family needs adequate medical and educational services, participants disagreed over whether their efforts should be directed toward changes that would affect all school-age children and their families, deal more specifically with children at-risk or with special needs, or focus more intensely on only those children with severe handicaps. A consensus on this issue was not reached, but one definition of the target population most in need of coordinated services was proposed to include:

1. Children with disabilities and handicapping conditions;
2. Children with chronic illnesses or conditions;
3. Children with health-related educational problems;
4. Children with health-related behavioral problems; and
5. Children at risk of developing the foregoing problems.

As a group, these children must have health promotion and preventative services, early identification services, diagnostic and evaluation services, treatment services, habilitation and rehabilitation services, dental services, nutrition services, and family/child education and counseling services.

Within any definition of the population of children and families requiring services, professions and institutions can no longer respond as isolated entities when faced with so many children who have so many needs. In the past, health and education have seen themselves as professions meeting very different needs joined

only by the fact that they were serving the same population. Now, these two systems, one primarily public and tax-supported and the other supported by a complex mix of public and private resources, struggle with a common set of problems and barriers as they seek to enhance the services provided to children and families. Health issues have become increasingly significant in the classroom and educational issues regularly arise in the examining room. Moreover, each system is finding itself addressing the same rapidly growing set of psychological and social issues in relative isolation from one another and from other community institutions.

With social change and social problems a constant, the challenge to health and education professionals becomes one of acknowledging common goals, of serving overlapping populations, and of organizing services to meet the complexities of the social environment as they emerge.

The Current Status of Service Provision: Foundation for Collaboration

In this country, health and education services are provided by a complex mix of public, private and voluntary agencies and organizations. We must develop new organizational relationships at the family and community levels among schools, physicians, public health agencies and social service organizations. In addition, federal and state systems must allocate necessary resources and establish conditions that facilitate the development of these new organizational relationships in local jurisdictions. (Dr. C. Everett Koop, Symposium Challenge Paper)

In general, the American health care system is a system in flux with its future direction unclear as fundamental changes take place in the organization and financing of health services. A central cause of these changes is the adoption of various measures to contain the enormous inflation in health care costs. Other trends are also cause for concern when considering the needs of children and families. Seventy percent of the health care dollar is spent in the last year of life and twenty percent in the first month of life, leaving only a very marginal ten percent to cover all of the years in between. Although technical advances have been made in recent years, it is questionable whether or not these advances are actually available on a broader scale than they were 10 or 20 years ago, and the basic medical services continue to be unavailable to an increasing uninsured or under-insured population.

There are many ways in which the pluralism and diversity of the American health care system has led to fragmentation of health services to children. Service to children with special needs is characterized by the predominant role of tertiary medical centers (i.e., academic medical centers, academic health science centers and children's hospitals) which focus on high-quality specialized medical care. While these centers provide vital services, they are relatively few in number and are usually located in large urban areas. Therefore, significant numbers of children must travel to such a center for follow-up care which creates additional stresses for already burdened families. In other cases, when the child is referred back to a community physician, the breakdown in the transfer of information too often results in problems such as inappropriate medical care, contradictory advice to parents, or duplication of painful and expensive procedures.

Conversely, secondary level care, provided by community physicians and other community health professions, has received little or no attention and lacks the necessary strong linkages with the large medical centers. Equally

unfortunate, the primary care of children by private sector pediatricians is frequently neglected. Every child should have a "medical home", but community pediatricians may be reluctant to assume the responsibility for providing primary care and coordination due to lack of education and preparation for that role, lack of strong linkages with tertiary medical centers, lack of reimbursement for primary care, and lack of mechanisms for coordination with other community service providers.

Also undergoing transition and critical review, the educational system has been inundated with proposals for educational reform during the past decade. The first attempts at reform can best be described as "reform through regulation" with the resolution to raise the achievement level of students through "tougher and longer doses of the old school formula". As it became apparent that such proposals were inadequate, outmoded, and in some cases counterproductive, the next wave shifted attention to teachers and teacher performance and accountability. This reform agenda called for teachers to account for the effectiveness of their profession, but still did not recognize them as professional decision-makers. The third and current wave is more complex and includes the concepts of restructuring schools as centers of inquiry, teacher empowerment, creating the conditions for professional practice, and establishing accountability for results at the local, state, and national level. Although the reform movement has slowed to some extent, the initiative to engage in collaborative service delivery between health and education professionals is timely and compatible with concerns in the national education agenda.

In an overall sense then, both the fields of health care and education are experiencing significant professional crises. The 'rising tide of mediocrity' that has been attributed to the public education system is matched by a growing sense of chaos and inequity in the health care system. Both professions are obsessed with cost containment and each is attempting to cope with increasingly complex human challenges within a demoralizing environment. But even amid these crises, some progress toward professional cooperative efforts to serve children with special needs has been made.

One example of an early effort to encourage cooperation between health and education professionals through specific legislative requirements was the special education experience of the last two decades. Under P.L. 94-142[1], the legislation mandated that the public education system create a new program to provide rehabilitation services for children who were educationally handicapped because of chronic illness or disability. This program was to be staffed by nonmedical educational and related services personnel or was to provide a wide spectrum of rehabilitation services by personnel who were employed and directed by the public education

system. Thus, P. L. 94-142 created a very necessary community-based program to provide educational services to a significant number of the nation's school-aged disabled children. Unfortunately, the legislation included no method to assure collaboration between the private and public medical care providers and the public education providers.

P. L. 99-457[2] was to a large degree designed from the P. L. 94-142 experience. It extended the services of P. L. 94-142 to provide for infants and small children who were "developmentally delayed" and charged states to develop early identification and treatment services for these children. Since many of these children need medical diagnostic and treatment care provided in a collaborative manner, it also charges the states to create systems of services that include the spectrum of services needed by these children and their families. To assure that these systems are created, the legislation mandates that each governor appoint a lead agency and state coordinating council composed of members to create an intra-agency, intra-professional council. Lastly, P. L. 99-457 recognizes that the child's family is ultimately responsible for the child's well being and so determines that any plans made by the program must recognize the needs of both the child and the family. Thus, as Dr. Koop stated, "For the first time in the federal education legislative process, states were challenged to make changes in existing service systems through a coordinated, well- managed early intervention process. Some of the most creative examples of collaboration between education and health professionals can be found in the extensive interagency planning process that is now occurring as states create service delivery systems in local jurisdictions for infants and toddlers with handicaps or at-risk for handicaps, and their families."

Despite the positive legislative efforts to foster coordination and collaboration, the reality of implementation often falls short of intended outcomes. For example, there is still a pressing need for more involvement of physicians and tertiary medical teams in the development of the Individual Education Program (IEP). A child's pediatrician frequently has little part in preparing recommendations for IEPs and does not participate in the conference. Additionally, if the child was seen in a tertiary medical center, the report of the medical center team may or may not be in the child's school record or used in development of the IEP. As a result, the health services that the child receives from his or her pediatrician and from a medical center team are not coordinated with the special education and "related services" that the child receives. Additionally, a substantial number of children with disabilities and handicapping conditions do not qualify for "related services" under the legislation.

Equally striking examples of poor communication and coordination were also noted: For

children with chronic illnesses who are regular education students, there is usually little or no communication between the child's physician, other health care providers, the school nurse, and other school personnel. Physicians fail to furnish school personnel with valuable information about the child's illness--its cause, treatment, complications and medications. Conversely, the school nurse and other school personnel all too rarely furnish the child's physician and other health care providers with valuable information such as observations about the child's illness in the school setting or general school progress. Part of the problem is that school nurses frequently have not functioned effectively as a liaison between the school and health care community. Thus, the limited communication between professionals in the separate disciplines is the norm rather than the exception and the true dynamic of P.L. 94-142 is rarely seen.

Concerns were also raised that P.L. 99-457 explicitly excluded medical services other than diagnostic or evaluation services from the definition of early intervention services for purposes of organization of the statewide system and did not explicitly require the coordination of health services and early intervention services. Therefore, as states organize their systems of early intervention services, it remains to be seen whether coordination of health and early intervention services will be effectively addressed.

In many ways, the concepts of P.L. 94-142 and P.L. 99-457 should become the basis for future reform. In fact, very comprehensive school reform, guided by the principles outlined in those pieces of legislation, would benefit all children, and would include, among other things, the elimination of labeling and classification of children, the development of a system for continuous progress reporting for each student, and the development of criterion or domain-referenced evaluation systems.

In addition, a number of exciting programs are now being implemented based on the premise that no single institution should be expected to take ownership of school failure, dropping-out, teen pregnancy, and youth unemployment. Examples of such collaborative endeavors, like the New Futures Project being carried out in five cities, provide an organization to bring together public schools, social service agencies, businesses, and local government and private groups with an interest in youth. The project espouses principles such as:

1. Establishing a broad "ownership" of the problems facing youth;
2. Establishing community membership among disadvantaged people;
3. Establishing an independent "lead" agency which serves as an organizational structure creating collaboration, coordination, and effective action among the various constituents;

4. Integrating the school and community; and
5. Establishing accountability for effectiveness.

Additional examples of collaboration were also cited by participants. The Commission on Interprofessional Education and Practice includes members from a wide diversity of professions ranging from education to social work, psychology, nursing, theology, medicine, law, and allied health services for the purpose of fostering interprofessional activities at the national level. Through the Child Health Plan, the Project Healthy Start/Medical Home demonstration project, and the Zero to Three Hawaii program, Hawaii is taking progressive steps to create a multi-disciplinary and multi-agency approach to service delivery.

Finally, efforts to achieve broader systemic change in the nature of service delivery systems are emerging as a result of P.L. 101-239[3], the Maternal and Child Health Services Block grant program. The purpose of the new P.L. 101-239 included the improvement of the health of all mothers and children and facilitation of the development of community-based systems of services. These efforts represent an innovative attempt to change the ways that health services were organized and were to be accomplished by the development of family centered, coordinated systems of care with the involvement of all relevant sectors of the service community. In the past, however, problems have arisen when professionals have not viewed parents as partners, when services were inadequate as children left hospitals and returned to home communities, and when families had to approach 20 to 30 agencies and professions in order to get all of the necessary services. Therefore, family-centered, community based, coordinated services represent the current focus of P.L. 101-239.

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[1]The Education for All Handicapped Children Act of 1975.

[2]The Education of the Handicapped Amendment of 1976.

[3]The Omnibus Budget Reconciliation Act of 1989 (Title V Amendment).

The Future of Integrated Health and Education Service Delivery: Explicating Ideals and Strategies for Action

These two professional groups must find ways to collaborate in the development of comprehensive service delivery systems at the community level. To accomplish this, we must share information about innovative efforts to modify service delivery in our respective professions and identify areas where we can work together and assume mutual responsibility. We must take action that responds to our common concerns and results in collaborative provision of services. . .In so doing, we will be working together to help create the kind of national youth agenda and resulting service delivery systems that make sense for both families and their children. (Dr. C. Everett Koop, Symposium Challenge Paper)

As Symposium participants reviewed the changes taking place over the past decade in society and within their own professions, and, as they examined the successes and shortcomings of previous collaborative undertakings, they also outlined their ideals of integrated service delivery and a wide range of possible ways to achieve those ideals. Dr. Koop summarized the components of an ideal system as one where:

1. Prevention is the norm;
2. Services are family-centered with parents playing active roles in meeting the needs of their children;
3. Access and ease of entry into the system are assured;
4. Family needs are addressed holistically and services are not fragmented; and
5. Excellent services and programs are provided in community-based settings with strong linkages to needed state and regional specialty services.

Acutely aware of the barriers to successful collaboration, but determined to take action, Symposium participants discussed the realities of how such systems could be created. Seven step required to build comprehensive systems were outlined:

1. Instituting a process for system development at the local-level;
2. Implementing a community plan based upon a needs assessment;
3. Establishing and maintaining organizational mechanisms at the local level to bring about collaboration among community service providers;
4. Establishing and maintaining an organizational mechanism for community-based case management;
5. Developing and implementing a statewide plan, based upon a needs assess-

ment, for building collaborative service delivery systems among all relevant state agencies;

6. Establishing and maintaining collaborative mechanisms by state agencies for the purpose of assisting communities in the process of system development; and
7. Enacting state legislation mandating and facilitating system development at both the state and local levels and providing funding for such system development.

In a similarly broad vein, it was also suggested that creating systems responsive to the needs of children and families would require "reconstituting" local government.

While generally endorsing the ideal described by Dr. Koop, Symposium participants were also very concerned that the growing numbers of children needing services, and the severity of their needs, warranted action which could result in more immediate changes. The two main avenues for change which were explored at greatest length were ways to facilitate change through communication and ways to initiate change through professional education and training.

Facilitating Collaboration Through Communication

Although expressing a variety of views on most topics, participants were fairly unanimous in their perception that examples of productive, collaborative efforts already exist and that these positive efforts should be expanded. The experiences of P.L. 101-239, P. L. 94-142 and P.L. 99-457, provide valuable insight into what has and has not worked. And, since a number of cities/states have planned, or planned and offered, programs to respond to client needs in a coordinated way, a systematic analysis of these programs would reveal what program components could be communicated and replicated. An analysis might pose questions such as: What are the project goals? What sort of organizational structures are used? What is the source of funds? Who receives funds? Who are care providers and how are they trained? To whom, and for what, are these structures accountable? What would be the best case scenario if these structures were successful? What new or innovative ideas for dealing with the same clients do these models utilize? And finally, what are the relative merits of partnership models as opposed to governmental or private initiatives? Part of the task facing Symposium participants might be to use such questions to define ways in which programs work.

Effective methods for communicating and replicating the essential features of successful programs are also needed. As such, a resource directory of "best practices" in collaborative service delivery might be developed. Such a directory would first identify practices related to health and education initiatives, but could also

be expanded to other human services professions. A set of principles specific enough to become guidelines for collaborative actions by the health and education communities could also be described. Finally, there is a need to articulate measurable criteria for assessing elusive constructs such as "comprehensive", "community-based", and "family-centered". In the absence of objective standards of measurement it will be difficult to evaluate change and monitor progress toward goals.

Communication efforts must also extend beyond the boundaries of the two professions since too few of the "educated" citizenry really understand that the future of all Americans is inextricably interlocked with the loss of human potential in undereducated or uneducated youth. Therefore, ways must be found to "educate the educated" so that no one remains comfortable without being a contributor to solutions. Likewise, a range of entities including business, government, religious organizations, social services, and mental health must endorse the commonality of the issues and their resources must be brought to bear on the problems.

Many Symposium participants also stressed funding as a high priority. It is crucial that communication efforts extend into political spheres since part of any plan for problem resolution has to include an approach for gaining influence over the allocation of public resources. On a concrete level, this requires a pragmatic political agenda that works toward the mandated coordination of "health dollars" and "education dollars" in order to achieve specific, well-articulated programmatic objectives.

Any communication of information must also be undertaken in a way that presents school/health linkages to professionals as a resource, rather than a burden. Large school districts are already confronting multiple problems and professional barriers are going up. Health and education collaboration will remain a low priority unless their connection to what are viewed as more pressing problems can be demonstrated. Additionally, some mechanisms of outreach are required since making people eligible for services does not mean they will know about or access services. Local leadership and community-based care givers will likely hold the key to successful outreach efforts.

As participants searched for strategies that they might engage in to communicate nationally, institutionally, and at the grass roots level what is already known and being done to create successful, integrated, service delivery, they proposed the following:

- Engaging in coalition building and making others aware of what can and should be done. Developing ways to interact with key individuals involved in the National Governor's Education initiatives and advocating that inte-

grated service delivery for children and families be a future national goal.

- Calling for a congressional hearing to focus on integrated service delivery for children and families.

- Identifying and promoting collaborative models that work. Using the "IEP/IFSP" experience as a model for broader service delivery, especially those dimensions that might foster interprofessional collaboration.

- Articulating the vision, including principles, beliefs, and realities to create a set of guidelines for collaborative professional practices.

- Developing and disseminating a policy analysis paper that addresses collaboration between the education and health communities.

- Drafting resolutions for the respective professional organizations that indicate the directions that Symposium participants are taking and that express an organizational commitment to collaborative service delivery.

- Disseminating information about Symposium initiatives in the newsletters of relevant professional organizations on a continuing basis.

- Making presentations or conducting mini-symposia on the emerging AACTE/AAP action agenda at annual meetings and conferences sponsored by professional organizations.

- Replicating the Symposium in home institutions.

- Supporting grass roots/community level efforts to integrate services for children and families, especially those efforts that involve parents and that result in "user-friendly" service systems for the disenfranchised as a "communities can" campaign.

- Providing technical assistance to involved communities and focusing intervention efforts on "high risk communities" by targeting locations rather than populations.

- Continuing the dialogue initiated at the Symposium in communities with front-line personnel.

Initiating Change Through Professional Education and Training

Several Symposium participants charged that the coordination of health and educational/early intervention services had long been hindered by "turf" issues and resistance on the part of professional personnel. Substantive, long-term change would ultimately depend on the extent to which the professions are able to design and implement fairly radical modifications in the training of educators and health care providers. As it now stands, the teacher preparation, human services, and health programs on large campuses seldom interact with one another resulting in autonomy and segmentation of programs. The need for dramatic change is especially critical at the apprenticeship level, where professional identities begin to be formed and change is often viewed as threatening. Those who prepare professionals must help to create more collaborative attitudes by providing opportunities for cross-disciplinary involvement.

Since physicians, especially pediatricians, largely control entry into the health care system, their participation in service delivery is of particular importance. Relatively few physicians receive the requisite education and training in community practice settings since pediatric residents obtain most of their training in tertiary medical centers. For that reason, among others, they do not feel that their programs have prepared them adequately for community pediatric practice and/or the care of children with special health care needs in community practice settings.

One solution considered was the development of post-graduate fellowship training opportunities to furnish pediatricians who are future academicians with training in a family-centered community-based coordinated service delivery system. Some progress is already being made in that area with the support of the Federal Maternal and Child Health Bureau. Another solution might be the development of continuing medical education (CME) programs for pediatricians interested in upgrading their knowledge and skills, as exemplified by the CME Physician's Involvement Project (PIP) in Hawaii. This could be pursued jointly with educators to encourage mutual exchange and growth. Other pre-service practica and internships could also be designed that place trainees in each other's settings. For example, all medical students at the University of Washington rotate through the Child Development Clinic. Teacher training programs in California include a practicum in a community organization.

On the education side, it is unfortunate that current practices in teacher education programs are generally not focused in ways that lead teachers and school administrators to see themselves as partners in the human service delivery system, nor are those individuals being enabled to know how to network services. To remedy this type of near-sightedness at the Murray State College of Education, a mix of faculty

came together in 1986 to ask the question, "What ought a graduate of our human service programs know and believe?" A consensus confirmed that an eclectic knowedge base was essential and that specialized knowledge and skills complement that base. The result of the dialogue was that the reconceptualization of many separate programs into integrated human service knowledge permitted faculty to move across programmatic and departmental lines and share talents and resources. And, as faculty shared ideas about common knowledge for services to people, they became more familiar and comfortable with the knowledge and special roles of others.

Although there was general agreement between Symposium participants that cross-disciplinary training could enhance collaborative efforts, other professional role and training questions raised more controversial discussion. For example, exactly who should be responsible to act as case managers for bringing multi-system resources to bear on the particular needs of multi-problem individuals? Should the role of human service educator or case manager be added to the existing roles and responsibilities of classroom teachers? But, as one participant cautioned, "If classroom teachers become human service educators, their job descriptions must be changed to provide the time and resources necessary to fulfill the new function. . .they can't teach six classes of 30 students a day and take on the new role of case manager for at-risk students." Alternately, should professional social workers, physicians and nurses be called upon to do case management? Or, is there really a need for a new type of human services professional who can relate to a broad range of human needs, who is well versed in health care needs and resources as well as education, and who can access and deliver resources for individuals and families? Conversely, would creating another type of professional case manager only add a level of complexity to a system already difficult for service seekers to negotiate?

Many of these difficult questions regarding the future roles of professionals in service delivery were not resolved by Symposium participants, but feasible activities to initiate change through professional education and training were proposed and included:

- Intensively examining training issues, including alternative preparation models, certification issues, barriers to change and interdisciplinary training experience in community as well as academic settings.

- Considering the AAP as a post graduate teacher of collaborative skills and exploring options for offering continuing education opportunities using extra-institutional settings.

Summary

Therefore, let us work together to enable all children to receive the kind of services they need and deserve. We have a lot of strengths to build upon and move forward. Using our knowledge and skills, and by collaborating, I know that we can make it happen--coordinated, family-centered services for children in their communities. (Dr. C. Everett Koop, Symposium Challenge Paper)

Through the Symposium, participants were able to take many preliminary steps toward fulfilling the challenges given by Dr. Koop. Although many crucial questions remained unresolved, and although issues gaining consensus were general and preliminary, the Symposium served as forum for an open exchange of innovative ideas. Through it, participants were able to examine the social context in which they must base their efforts, review the current status of service delivery including efforts at collaboration, and determine what particular strategies they might use to facilitate progressive changes in service delivery to children at risk and their families.

Moreover, Symposium participants felt that the forum provided them with a valuable opportunity to better understand one another's daily practices and the problems and professional issues being addressed in each field. It allowed each individual to meet with other "like-minded" professionals in order to receive positive reinforcement and to exchange fresh ideas.

However, much of the work still lies ahead for the symposium participants . The issues of coming to a working consensus over which children and families should be the focus of future efforts, of finding ways to expand and replicate what is already successfully being done to create integrated service delivery, of overcoming "turf" and attitudinal obstacles, and of creating new training opportunities for professionals in each field present formidable challenges. As participants requested the planning committee to develop the next steps in the initiative and to sponsor another symposium to be held in six to nine months, they also affirmed their desire to continue their efforts as they returned to their home communities.

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