Special Education: Examining the impact of poverty on the quality of life of families of children with disabilities

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Abstract

Today, school personnel are facing many challenges in their efforts to serve diverse families and children with disabilities. Inadequate human and fiscal capacity, attitudinal and cultural barriers are among the many hurdles that must be surmounted for successful provision of related services. Decisions about who is educated versus who is habilitated or treated are often tied to classification systems that do not provide the necessary support for families and children with disabilities. The process by which parents become more autonomous as consumers of services for children with disabilities is complex. Educators cannot be a vehicle for parents until they are able to have a better understanding of the system within which these families exist and function.

This article examined the impact of poverty including cultural amnesia on the quality of life of families of children with disabilities. Additionally, the presentation will highlight (1) who are children with disabilities? (2) Family unit and cultural system, (3) impact of poverty stressors in life, identification, and assessment procedures for children with disabilities, (4) incidence of disabilities, international classification, and criteria for classification systems, and (5) conceptual professional collaboration model for related services.

"*Empty pockets never held anyone back; only empty heads and empty hearts can do that"*[1]

Introduction

Today, school personnel are facing many challenges in their efforts to serve diverse families and children with disabilities. Inadequate human and fiscal capacity, attitudinal and cultural barriers are among the many hurdles that must be surmounted for successful provision of related services. Decisions about who is educated versus who is habilitated or treated are often tied to classification systems that do not provide the necessary support for families and children with disabilities. The process by which parents become autonomous as consumers of services for children with disabilities is complex. Educators cannot be a vehicle for parents until they are able to have a better understanding of the system within which these families exist and function.

As of 1997, there were more than a fifth of children in America that lived in families with cash flow incomes way below the poverty level.[2] There have been a significant amount of

current demographic studies that have found a growing relationship between poverty and risk for disability.[3] There has been a significant increase in the rate of childhood disability over the past fourteen years[4]. The impact of the home, school, and family factors (e.g., income, parent education, language background, and cultural diversity) are found in many educational systems across the country. All of these factors contribute to teacher qualifications, student achievement, and class size. It is becoming increasingly evident that poverty has a compounding impact on the educational achievement of all children, including those with disabilities. Poverty is not a secondary topic in the field of special education, service delivery, and disability policy however, it is a challenge for educational systems to obtain results of productivity, accountability, independence, equal opportunity for all and diversity. Additionally, inclusion is complicated by a variety of complex factors associated with poverty as discussed in this article.

What is poverty?

Definition

The word poverty has been defined in several ways. In the current discussion poverty is defined as follows: a family, and every individual in it, is considered poor when the family's total income is less than the income threshold set by the US Census Bureau.[2] In the light of the above definition we conceptualize poverty as lack of opportunity, exposure, racial inequality, and constant struggle with social problems (e.g., educational failure, teen pregnancy, single parenting, incarceration, unemployment, inadequate housing, homelessness, substance abuse, AIDS etc.) that exist all over the world. We argue that with poverty, individuals become victims of the aforementioned risk factors, and that poverty can occur at any age, regardless of race, or gender. Money is not all,

money is not everything to educational success, but money can enhance the quality of life for all individuals in order to meet the demands and challenges in today's schools. In the United States, we waste time, money, and effort focusing on what we do not have instead of breaking the barriers in communities across the country for what we do have.

Prevalence

The greatest numbers of families struggling with poverty live in central cities, in rural agricultural areas and in the southeastern United States.[5] Nearly one in every four rural children are poor. One out of every two female-headed families with children lives in poverty compared to one in 12 headed by married couples.[6] In 1998, the poverty rate was 12.75; about 34.5 million Americans lived in poverty and a total of 15.1% of all American families with children were living in poverty. The poverty rate for children below the age of eighteen years old was 18.9% (13.5 million children) in 1998. Among children with disabilities aged three to twenty one years of age, in the US, 28% are living in poor families.[5] By contrast, among the children without disabilities, in the same age range; approximately 16% are living in poverty.[3] The rising numbers of children with disabilities in poverty is of special concern. Poverty is such a critical issue for children and families with disabilities. Poverty affects children and their families across the country from all types of diverse ethnic groups. Children born in conditions of poverty are at risk for developmental concerns.[7,8,9] Current data indicate that one in four children are born into poverty and the literature states that children who live in poverty are more likely to suffer from serious health risks and inadequate health care.[10] Children and families with disabilities are struggling to succeed. The real-life stressors for day to day survival place significant social, emotional, and psychological hardship on these

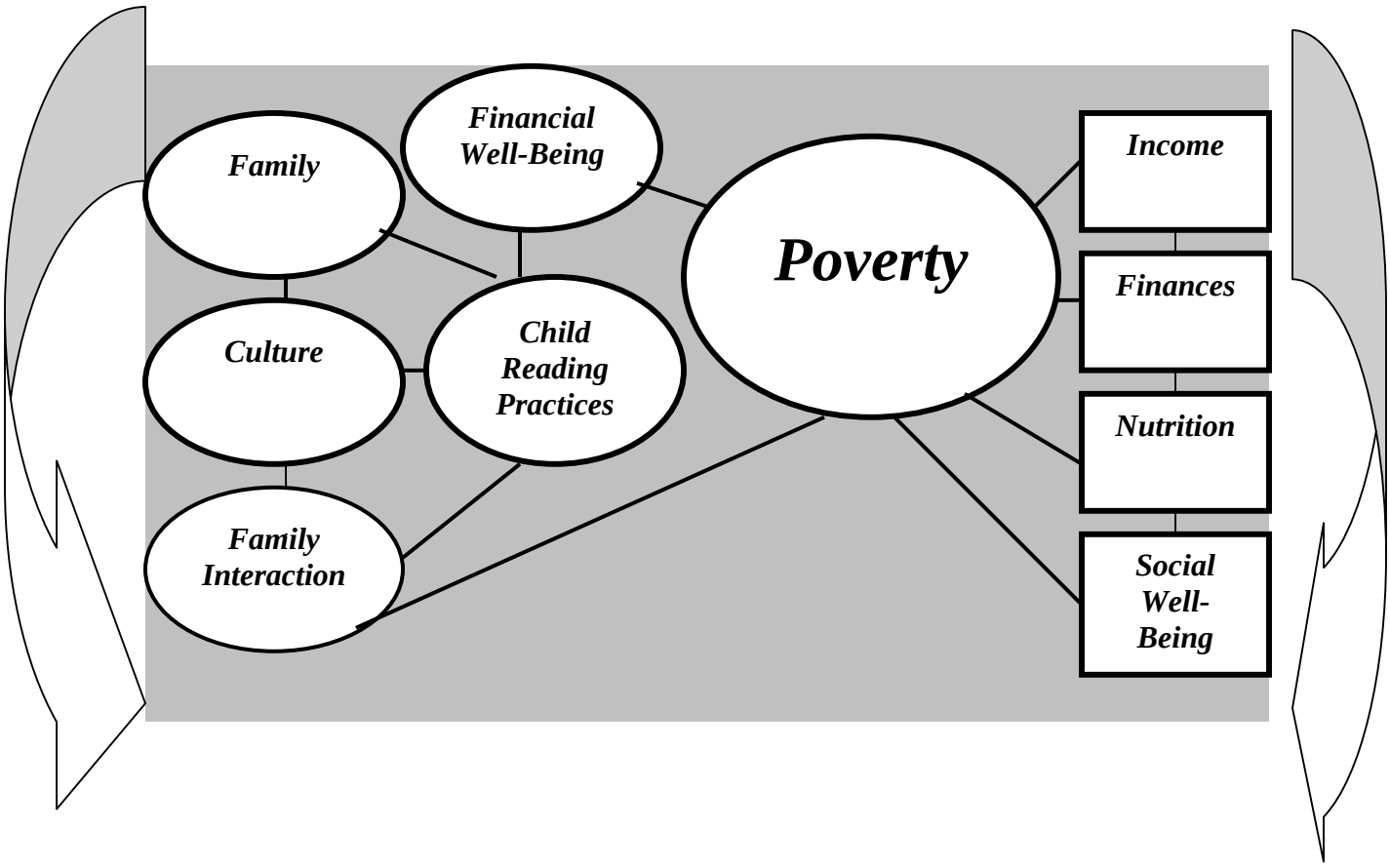
families.[11] In 1999, 33% of births were to unmarried parents, 26% were of white births, 68% black births, 42% Hispanic births, 58% Native American births, and 5% Asian births.[11] This percentage is up overall from 26% in 1990. Today, due to a large increase in the number of mothers who have never been married, the number of births to divorced and unmarried women is almost the same. For every racial and ethnic group, the child who is being raised by a single mother is two to three times as likely to be raised in poverty.[11]

Real Life Stressors Associated with Poverty for Families and Children with Disabilities

- ✓ **Infant and Child Mortality**
- ✓ **Low birth weight**
- ✓ **Child Abuse and Neglect**
- ✓ **Inner City vs. Southern Poor**
- ✓ **Lack of Social Service System**
- ✓ **Poverty Entrenchment**
- ✓ **Employment Problems**
- ✓ **Lack of Education**
- ✓ **Lack of Health Care**
- ✓ **Lack of Housing**
- ✓ **Poor Nutrition**
- ✓ **Substance Abuse**
- ✓ **Drugs**
- ✓ **Mental Health**
- ✓ **Violence**
- ✓ **Alcohol Abuse**
- ✓ **Barriers to services (e.g., transportation)**
- ✓ **Long Term Health Problems**
- ✓ **Inability to speak English**
- ✓ **Poverty**
- ✓ **Depression**
- ✓ **Race and Gender**
- ✓ **Single parents**
- ✓ **Teen parents**
- ✓ **Incarceration**

Due to poverty how will families continue to thrive? All of these are some of the real life stressors that children with disabilities and their families deal with on a day to day basis. There is a growing relationship between poverty and the risk for a disability that have been researched over the past ten years.[3]

Impact of Poverty on the Quality of Life of Children with Disabilities and Families



About one third of our black and Hispanic children are being raised in poverty while ten percent of non-Hispanic whites live in poverty.[3] Alarmingly, while the largest numbers of poor children are white, the highest percentage of poor children are black and Hispanic.[3] Also, of the 14 million children age range birth to 18 living in poverty in 2000, 9 million were white and 5 million were black.[3] Four million Hispanics were living in poverty, but were included in both white and black totals. Regardless of race, the children in married couple families are much less likely to be poor (about 8 percent) while 29% of white children and 52% of black and Hispanic children who live with a single mother are likely to be poor.[3] The nation is truly at risk. It is important to stress that many children have been at risk of not achieving their full potential from the day of their birth, if not in utero. All of the real life stressors listed are related to poverty, and all poor children, regardless of their race and ethnicity are all at risk. What can we do as a nation? The United States is supposed to be the richest nation in per capita wealth; we had the highest discrepancy relative to youth poverty rates of any of the advanced industrial democratic states. In 2000, 16.9% of all children in the United States were poor, while only 9.7% of people over age 65 and only 11.8% of all Americans lived in poverty.[3] The second poorest age group in the United States in 2000, after 18 to 24 year olds at 17.3% was our youngest citizens at 16.9%. Globally, individuals with disability continue to experience low standards of living and suffer immeasurably from continuous discrimination and racial inequality. The United Nations, in an attempt to address this situation has consistently promoted the full equality of individuals with disabilities and their participation in the social, economic, and political life of their respective countries. The United Nations'

apprehension on this issue is entrenched in the organization's founding principles that are based on human rights, fundamental freedoms, and the equality of all human beings. Despite the efforts of the United Nations, it is deplorable to note that about eighty percent of individuals with disabilities still live in poor countries that are less equipped to address their needs.

Percentages of Children in Poverty in 17 Developed Countries

Country	Percentage of Children in Poverty
United States	**22%**
Australia	**14%**
Canada	**14%**
Ireland	**12%**
Israel	**11%**
United Kingdom	**10%**
Italy	**10%**
Germany	**7%**
France	**7%**
Netherlands	**6%**
Norway	**5%**
Luxembourg	**4%**
Belgium	**4%**
Denmark	**3%**
Switzerland	**3%**
Sweden	**3%**
Finland	**3%**

Poverty alone can cause low academic achievement. Poverty, along with cultural and linguistical differences, tends to lower academic achievement and result in high dropout rates. Families of children with disabilities trying to survive from day to day have difficulty planning for the future of what a good education might bring; they simply do not see academic achievement as a priority, given the necessities of their daily

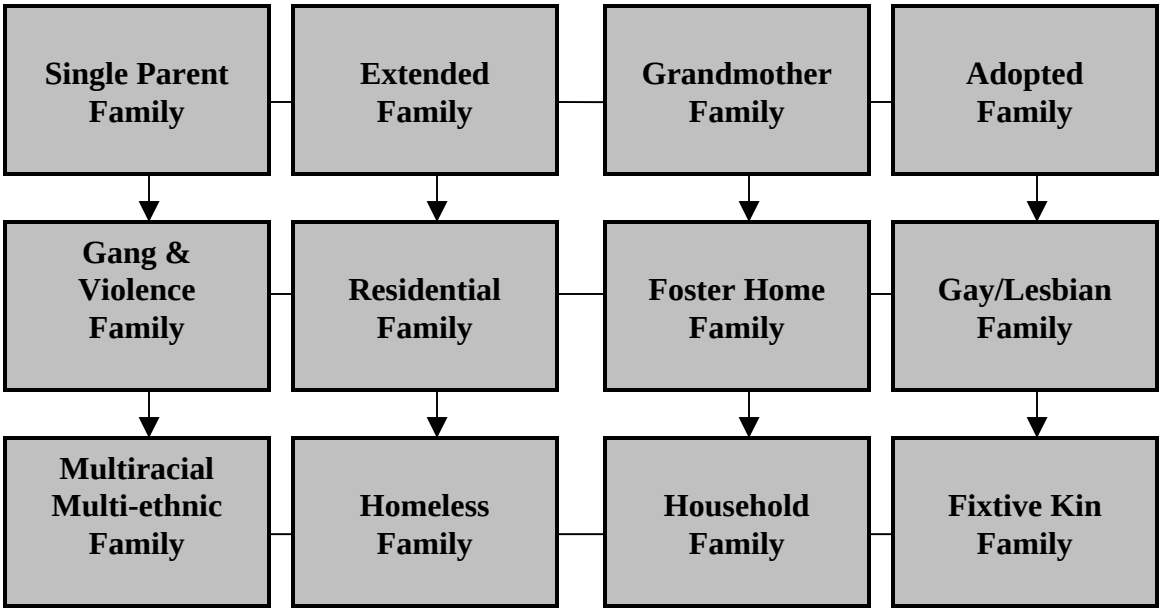
existence.[11] To blame individuals and individual families for their poverty is unrealistic. No one wants to be poor. No parent wants their children to be hungry.

Family Composition

Definition

Over the span of over a couple of decades, the makeup of the family has shifted tremendously. Many teachers used to work primarily with students who came from traditional families. Those families were simply made up of both a mother and a father. Today, teachers deal with students who come from a variety of different types of families.

Types of Family Compositions in Today's Society:



The family composition unit today has changed in many ways. We can no longer relate to family unit consisting of only a mother and a father. The family composition at the present has a large impact on the home and family factors (e.g., income, parent education, language background, culture, religious beliefs, community of residence, child rearing

practices). A family and every individual within its family composition are considered poor when the family's total income is less than the income threshold by the US Census Bureau. In general, the figure listed above defines family as anyone of those units. There continues to be a debate concerning what does a family actually entail. A single adult heading the household is considered a family.[12] Various family researchers have argued the fact that there is not a single common definition of family rather there are multiple definitions for the makeup of family.[13,14,15] There are numerous research reports that speak to how families relate to having a child with a disability, however there is paucity of information in the research literature regarding the cultural perspectives of families.[16, 17, 18] Educating children from diverse family backgrounds and communities is becoming more and more common in today's schools.[11] The family traditions, values, social and cultural experiences are imperative considerations for teachers and various other professionals working together to improve the lives of children with disabilities.[11, 19, 20, 21] Poverty puts an enormous restraint on the family to be able to afford a nutritionally safe and adequate diet. An insufficient diet impacts the health and well being of the entire family composition which leads to risk for respiratory, neurological, cognitive problems (e.g., cerebral palsy, visual and motor coordination problems, mental retardation, and learning disability).[3] Due to the family members' health and financial constraints, the family is unable to afford health services from dentists, psychologists, physicians, or prescription drugs. Therefore, this leads to a lack of access to efficient medical care and other services.

What is family quality of life?

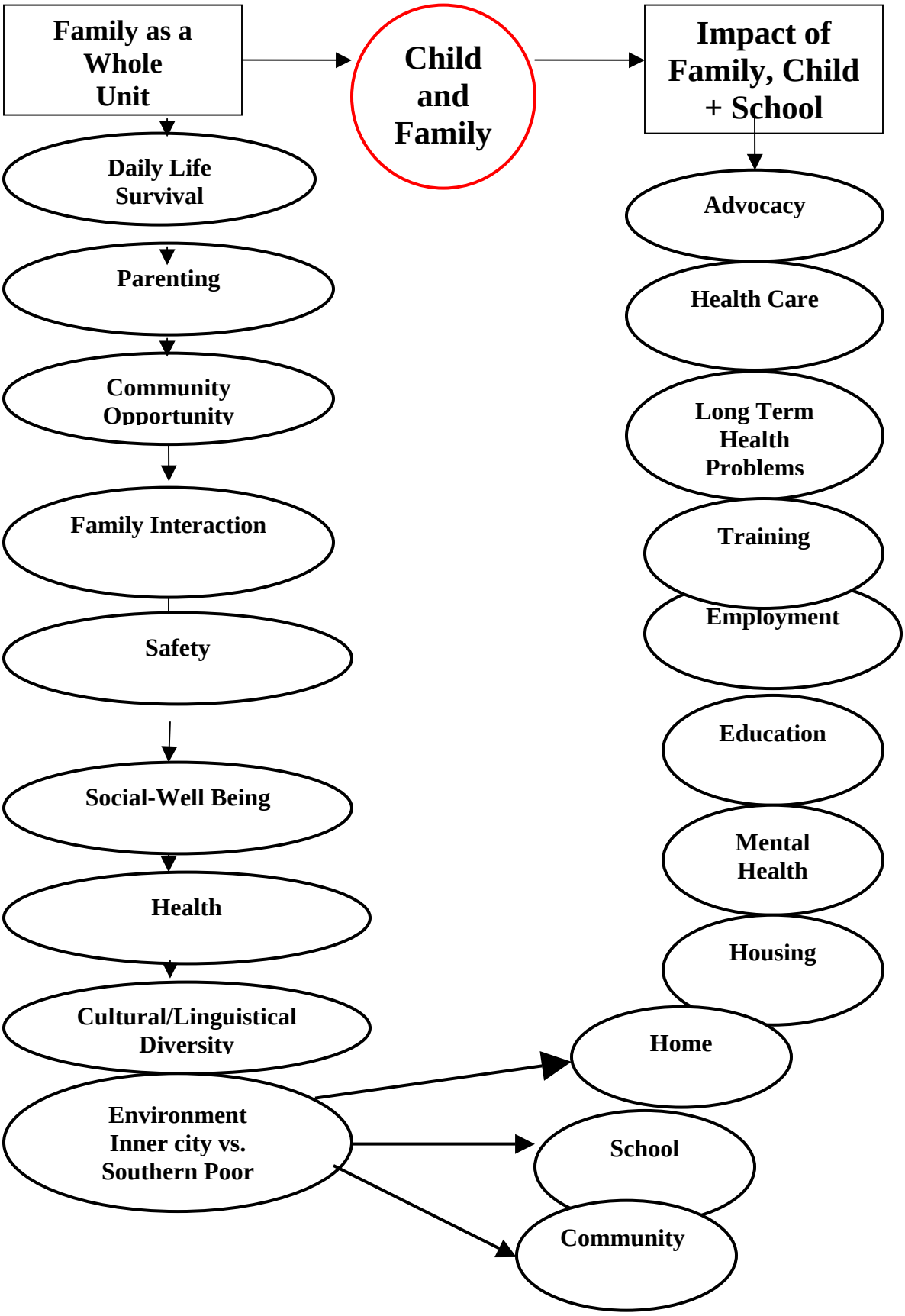
For over two decades, there has been a strong emphasis on quality of life of individuals with disabilities.[22, 23, 24] Family quality of life can best be understood from a definition as an experience at the family level, as family members having their needs met, enjoying life and having opportunities to pursue and achieve goals that are meaningful to them.[25] Consistent with the emerging agreement among research teams internationally, we advance components to family quality of life:

- ✓ **Family and its influence on others**
- ✓ **Cultural values and beliefs from one family to another passed on into one generation to another.**
- ✓ **Family quality of life changes as each family member experiences life.**

Impact of Poverty on Family Quality of Life

We applied the family quality of life conceptual framework as a working model for this article.[26]

Family Quality of Life of Families of Children with Disabilities



Advocacy

There is a growing need for professionals to begin to advocate more for their children and families with disabilities. Families rely on professionals to open doors for their family within the communities where they reside. The saying "it takes a village to raise a child" is no longer true "it takes a world to raise a child" is what is needed in order to enhance the quality of life for children and families with disabilities. Educators need to be aware that there are many agencies and organizations that are available and willing to collaborate if one explains the need for the children and family.

Impacts on Health Care

The impacts of poverty on health related to hunger, under nutrition, underweight during pregnancy, and barriers to health care are diverse and complex. Services are frequently unavailable or difficult to access at any given time. Families of children with disabilities who are poorly educated and preoccupied with day to day survival skills are often unaware of preventive medical health measures and may overlook minor illnesses until they become a crisis. Both rural and inner-city parents have difficulty getting transportation to doctors' offices and clinics. Those who rely on buses may have to arrive far in advance of their appointment time. Physicians and their staff tend to provide second class care to poor patients (clinics have been known to schedule 25 poor patients into a single time slot). These and other factors make obtaining medical care a discouraging process. One of the major barriers to health care is the cost of that care. One third of US families living below the poverty level have no health insurance. The children of these uninsured families receive approximately forty percent less physician care and fifty percent less hospital care than do insured children.[26] While medical needs

for children often are more frequent due to their at risk living environments and inadequate food supplies, services are frequently unavailable or difficult to reach.

Long-Term Health Problems

Poor individuals are susceptible to many major health problems including AIDS, diabetes, kidney failure, high blood pressure, heart disease, and stroke. Many factors including sedentary lifestyle to diet, environmental hazards, poor hygiene, substance abuse, contaminated water, and stress contribute to many of the health problems of the poor. Some of these problems could be reduced or eliminated to a certain point through understanding preventive health practices.

Employment

A major cause of poverty across the United States is the fact that there is lack of decent paying jobs that match the limited skills of many residents. Routine manufacturing industries requiring fewer skills are moving out of rural areas toward a cheaper foreign labor force, a phenomenon clearly described in the business world as outsourcing. Employment and employability opportunities for those in the southeastern regions of the United States are limited. In many instances, the difficulty that individuals face is generational. Family members for many years have seen few opportunities for better jobs and are content with a set of values focusing on the family and community rather than aspiring to move upward within mainstream society.

Education

Low levels of achievement are clearly linked to poverty. One in four high school dropouts is unemployed.[2] Today's youth in poverty, who need skills to match the rapidly changing directions of our society, are failing academically. More than seventy

five percent of poor youths have below average basic skills and almost fifty percent are in the bottom fifth of basic skills because of poor reading and math skills.[2] Poverty alone can cause low academic achievement. Poverty along with cultural and linguistical differences, tends to lower academic achievement and result in very high drop out rates.[2] Though educators try to meet the academic needs and demands of children and their families with disabilities, they too face barriers. Inadequate staffing to meet the needs of today's increasing numbers of poor children clearly affects the child's ability to perform.

Training

Many professionals lack the knowledge and competency needed to work with cultural and linguistic diverse populations. Some populations try to bestow their own values and belief systems on families which lead to stress and frustration.

Mental Health

Poor people's lives are full of stress and frustration, which can lead to depression. Depression can lead in turn to self-abuse and abuse of others. Antidepressants are commonly prescribed for poor mothers; unfortunately, these medications can make problems worse by creating dependency and diminishing the mothers control and effectiveness. For many families and their children with disabilities who need quality help from mental health experts, it is difficult and rather challenging. One of the many challenges for professionals helping the poor are where to start and how much change to hope for in terms of the family and child.

Housing

The majority of poor families are clustered in America's inner city housing developments. Increasing numbers of poor families are homeless, forced to live on the

streets or periodically in shelters reserved for the homeless. Those living in housing developments must often deal with a high incidence of crime; violence, drug selling, and prostitution which are quite common within these communities. Safety is another problem in these communities, children in these communities have no safe place to play outside or interact with other children. This simply creates a hazardous environment for children to live and explore. Privacy is also an issue due to families living so close in proximity. Friendships become strained as individuals know too much about each other. Too often tenants who are fearful of becoming homeless or evicted, are careful not to complain.

Who are the children with disabilities?

The children with disabilities range from a variety of inconsistent classification systems on a national and international basis. Most children with disabilities who require special education services can be classified into two groups: A.) children with defined medical conditions and syndromes including severe intellectual (cognitive), physical, and sensory disabilities. These children are identified with these disabilities at birth, during preschool years, or either onset of a disability acquired later in childhood. B.) children with socially judgmental and/or constructed disabilities. This set of children with disabilities do not have a clear defined medical characteristic and are not identified until they enter school. The World Health Organization (WHO), United States Agency for International Development (USAID), and the United Nations (UN) agree that approximately ten percent of the total population have some type of mental, physical, or sensory impairment.[27] Eighty percent of individuals with disabilities live in developing countries and conditions such as poverty, abuse, violence, and HIV/AIDS results in much of a

higher level of persons with disabilities.[27] WHO indicates that the percentage of individuals with disabilities cannot be determined due to the lack of accuracy of the classification systems that determines a disability.[27] Currently, there is not a common definition of special education that has been adopted by any country at this time, and it is rather difficulty to develop a method that would be comparable and consistent from one country to another. The programs used to provide the educational services to the physically, emotionally, and mentally impaired vary from country to another. In 2001, WHO developed the International Classification of Functioning and Disability (ICF) tool in order to classify a disease.[27] The current version of ICF uses education, health, rehabilitation, policy, and statistics as a mode in relating to children with disabilities and their families. The infusion of families within the WHO classification system although missing at this time is a necessary part of the ICF component. We must improve on working within the educational communities in order to increase the awareness about children with disabilities and their families.

SUGGESTIONS ON INCREASING AWARENESS:

- ✓ **Advocate for policy change.**
- ✓ **Reach out to families to educate them about the programs and services available.**
- ✓ **Develop and revise a reliable and consistent classification system nationally and internationally.**
- ✓ **Develop cultural learning communities for resources and support.**
- ✓ **Bridge the gap between the child, school, family, and community by having neighborhood events.**

There are a number of disabilities that are used in the national and. international classification system of children with disabilities. For example: learning disabled, speech and language impairment, dyslexia, cerebral palsy, mental retardation, emotional disorder, behavior disorder, autism, etc. Special education personnel have variety of tests assessment procedures, and protocols to choose from when they begin the process of evaluating a student who is suspected of having a disability. Despite this large number of tests, procedures, and protocols, there are more languages and cultures than there are tests. As our schools become diverse, the gap between available tests, procedures, and the cultures requiring assessment will only widen. Families of children who have been referred for assessment should be full partners in the process, and should participate in every step of the way.[11] Professionals must work toward rehabilitating the school climate in order to be receptive to the differences in which children learn. In order for the assessment process to be successful the child, school, and parent are to engage in the following practices: [11, 26] 1). Develop a prereferral process and intervention which would entail gathering data over a period of three to four weeks. 2). Reduce professional's reliance on standardized tests (this is problematic in many ways and standardized test scores only should not be used to qualify children as having a disability when the norms do not apply to the child. This happens in most cases when the test items are bias or beyond the child's experience. Standardized tests can be used to express the child's strengths and weaknesses. 3). Use alternative assessment methods for example, curriculum-based assessment, authentic assessment, portfolios, student's work, and interviews from teacher, parent, and community. 4). Checklists, rating scales, and most importantly observations.

Empowerment Community Support for Children and Families with Disabilities: The Poverty Life Model

This model proposes to strengthen individuals and communities discouraged by barriers in life including poverty on a long term basis. It is a community development family life train; the trainer and advocate model that teaches skills to enable families to improve the quality of life in neighborhoods. This model supports and mentors families in need of family life information, encourages and empowers networking within poor communities through information sharing and group building. This model is unique because it builds and collects strengths from within the community collaboratively, rather than bringing in support from outside.

- ✓ **Improve community environment**
- ✓ **Identify strengths within poor community**
- ✓ **Use those strengths to help support feelings of empowerment of families**
- ✓ **Offer short term services to help in a crisis situation rather than dependence on "the system.**
- ✓ **Encourage individuals to take care of their own problems through learning information and community support.**
- ✓ **Create environments that build upon strengths and create linkages between the poverty community and mainstream society.**
- ✓ **Bridge the gap between the school and community by having communities adopt schools and families.**
- ✓ **Help for all as it all is for help attitude in order to improve quality of life.**
- ✓ **Leave a road map for community and family success.**

Conceptual professional collaboration model for related services

Global policymakers are working relentlessly in an attempt to determine ways to restructure education with significant focus on educational services for children with

disabilities.[11] Amongst the major issues in a collaborative model of service delivery for children with disabilities are professional identity, function, intervention targets, assessment instruments, evaluation of effectiveness, and proven conceptual professional collaboration model. Although all the above issues are very relevant to the discussion of the impact of poverty on quality of life families of children with disabilities, the current focus of interest is conceptual professional collaboration model. Collaboration occurs between individuals as well as between groups of individuals, disciplines, and professionals from various disciplines.[11] This can be conceptualized as teamwork. Teamwork requires nothing less than a paradigm shift in mental models and adopting a team model in which each professional is assigned a role and responsibility.[28] Also, a team is defined as a group of people whose purpose and function stem from a common philosophy and shared goals.[29] Team service delivery models can range from pull-out to integrated service delivery.[30] Knowledge about the ways in which integrated programs can meet the needs of families, parents, and children with disabilities for high quality service delivery models has grown significantly.[11] The active involvement of families, parents, para-professionals, administrators, regular, and special educators is now viewed as critical in developing successful integrated programs for children with disabilities. Although the number of professionals on a team varies according to the individual child needs and type of disability, families and parents must always be a member of the team. Always, it is easy to think about professional collaboration model for service delivery within the boundaries of individuals' own discipline. We have been conditioned to think this way largely as a result of how academic programs are structured with little or no preparation on the value and spirit of teamwork, how the work of other disciplines

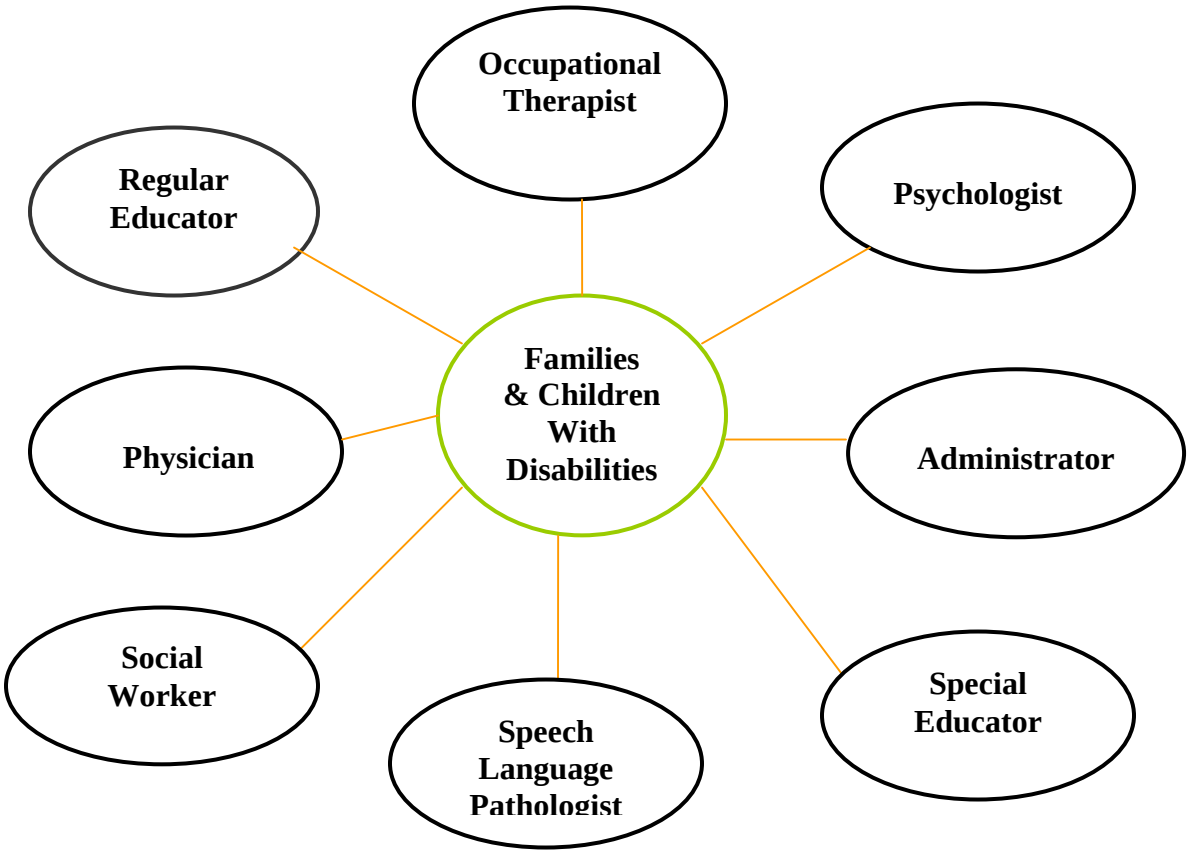
intersects with ours, and integrated service delivery models (for example, interdisciplinary approach) towards service delivery. As a result we continue to witness many academic training programs at the undergraduate and graduate levels continue to neglect preparation of students on team formation and effective team collaboration strategies. Pertinent questions professionals in a collaborative team should be asking are: could the involvement of several professionals improve the quality of life of families and children with disabilities? Are there benefits to families and children with disabilities of several professionals being a member of the collaboration model? Can an individual professional's service be enhanced by the participation of several professionals? Are there ways of working together that are in the best interest of families and children with disabilities? Perhaps the answers to the above questions are relatively positive. Therefore, as professionals we should welcome, rather than discourage the interest of other professionals in a collaborative model of service delivery. Indeed, as a result of collaboration, we can be assured of greater carryover, greater implementation of service delivery models throughout routine daily care provision, service is continuous rather than periodic, than high quality of services guaranteed, and better outcomes expected. It is important for professionals to make the paradigm shift, a mental shift, comma required in order for teaming to be successful. Nevertheless, it is also a given for this kind of collaborative models to be against the organizational structure or management approach that encourages and rewards unhealthy competition between departments and professionals. Inherent in such organizations is the growth in unfounded fears, the ear of being replaced, the ear of losing autonomy, the fear of loosing recognition, and more importantly, the fear of failure. These fears create barriers which are not only difficult to

overcome but impact the life of families of children with disabilities negatively. A systematic effort to conquer these fears by professionals should begin with awareness. Many proponents believe that teamwork is endemic to systems in which all employees are working for a common good, have a common aim, and work together to achieve that aim.

Three professional collaborative team approaches are essential to successful service delivery to families of children with disabilities. These are multidisciplinary, interdisciplinary, and transdisciplinary team approaches. The suitability of an approach to families of children with disabilities revolves around the families' current needs and values. The multidisciplinary collaborative team approach to service delivery means that professionals from several disciplines are involved in the provision of service. The team approach is disciplined-oriented with each team member responsible for only service activities related to their discipline. Each discipline formulates separate goals that limit knowledge base and skills to a particular discipline. Thus, in rehabilitation or school setting, a child with disabilities might receive services from a physician, physical therapist, occupational therapist, speech language pathologists, nurse, regular and special educator, but there is no systematic effort to form these individual services into a cohesive plan. Communication across disciplines is often lacking and service recipients are left feeling overwhelmed by multiple services, sensing lack of communication that translates to poor quality of services. The major disadvantage of the multidisciplinary team collaboration model is that it addresses each individual disability separately, while tending to loose sight of how all the disabilities involved affect both families and children with disabilities. This approach can be visualized as a wheel with the families and

children with disabilities at the center, the spokes representing the various disciplines but without any kind of collaboration and communication. The team approach originated as multidisciplinary and it is slowly evolving into an interdisciplinary model.[29]

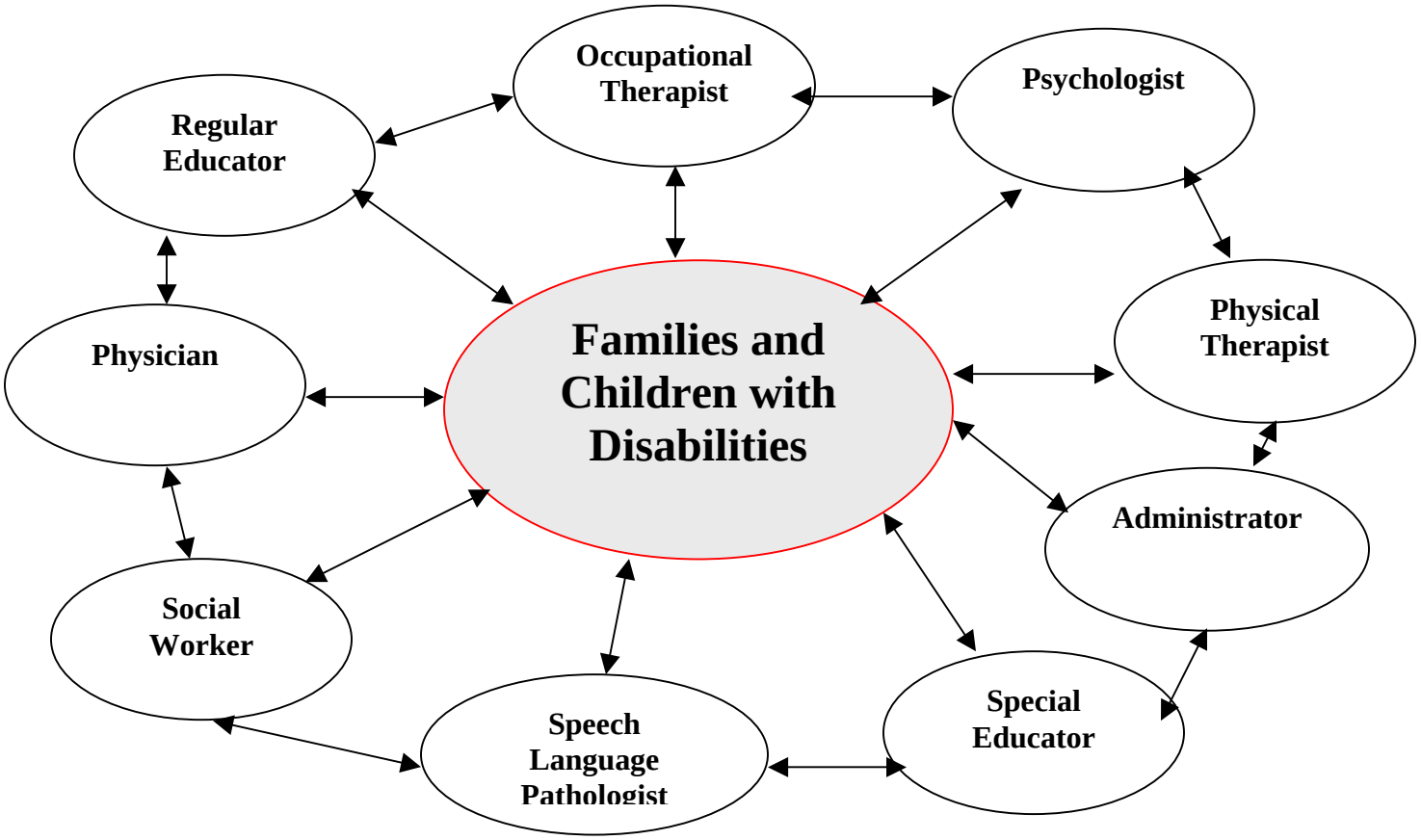
Multidisciplinary Collaborative Team Approach (MCTA)



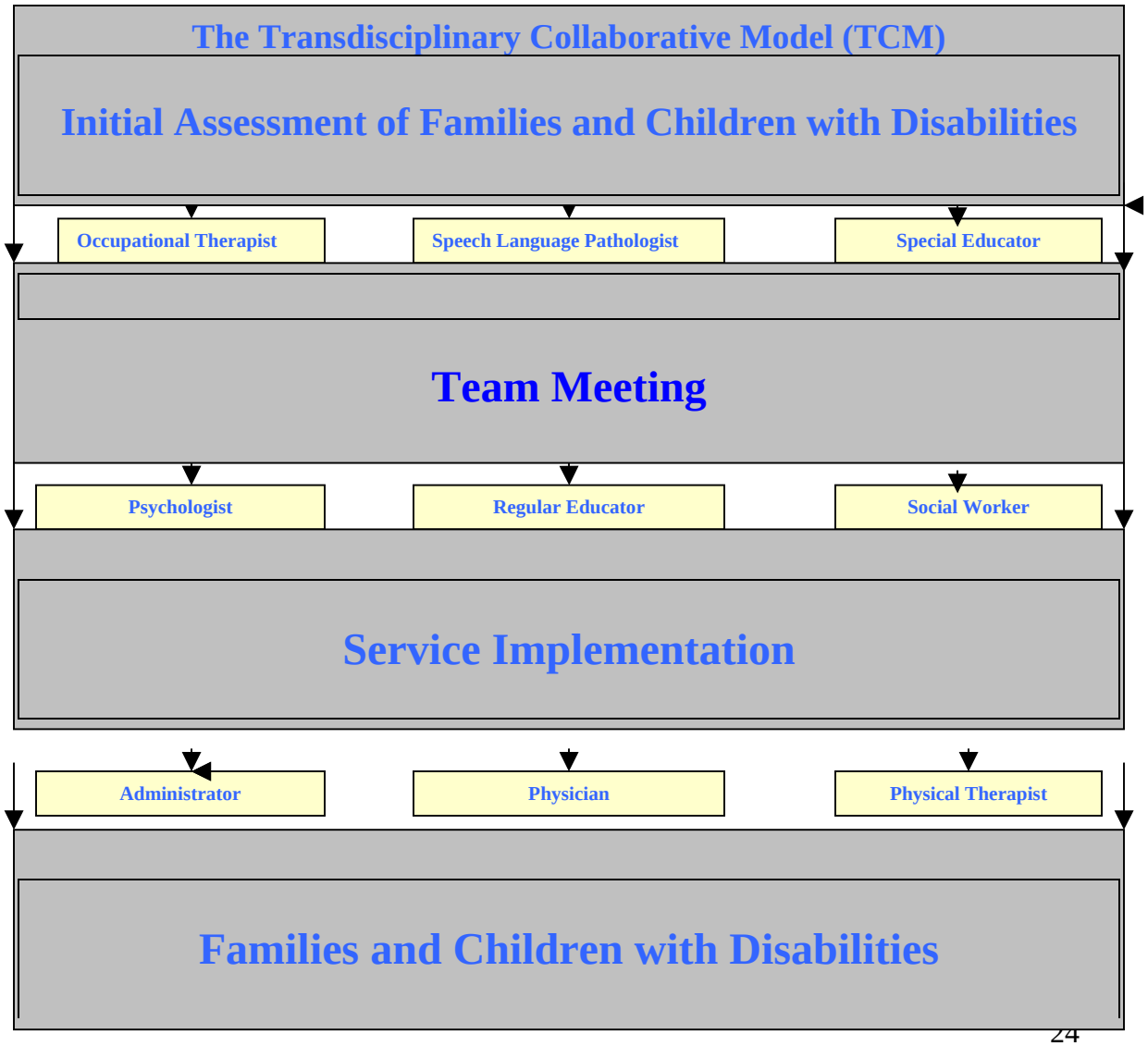
The interdisciplinary collaborative team approach involves professionals from several disciplines; however their collective activities are planned and performed to achieve a common goal because of the added responsibility called group effort. Each professional addresses the integrated plan of service; for example, if the plan includes work on language retraining, the speech language pathologist may coordinate this aspect of the

service delivery, nursing staff may carry out the plan on medical service, and the prescribed technique will be used during occupational therapy and physical therapy services. The sharing of therapeutic approach is encouraged by this technique. The goal of this technique is to increase participation of families, increase learning and performance trials, that results in less chance for service recipient to forget or loose important skills, and to a greater extent firmly instilling and generalizing target behaviors. The interdisciplinary approach can be visualized as a wheel with both the families and children with disabilities at the center, the spokes representing the various professionals joined by a rim of collaboration and communication. Families and children with disabilities are considered members of the team.

Interdisciplinary Collaborative Team Approach (ICTA)



The transdisciplinary collaborative team approach assumes that no one professional or individual has adequate knowledge base or sufficient expertise to execute all service delivery functions (assessment, planning, and interventions) related services. There are many variations of the trandisciplinary collaborative approach. Trandisciplinary service delivery model is conceptualized to produce the highest level of integrated service; members carry forward the group effort by reinforcing and teaching across discipline lines when and where that reinforcement is appropriate and timely for the needs of the service recipient.[31] The concept of co-service provider, co-teaching, and co-treatment comes from this interpretation.[31]



Conclusion:

Global policymakers are working relentlessly in an attempt to determine ways to restructure education with significant focus on educational services for children with disabilities.[11] If our government indeed wants to help poor families of children with disabilities out of poverty, and then there must be a fundamental change in policy. Policy makers must look at poverty itself, rather than at specific problems that could result from poverty. They just simply look at how our public assistance system disempowers children and their families with disabilities. Budget-cutting policies in areas of housing, education, health care, and employment need to be re-examined. It is clear that policies targeted a raising family incomes can contribute to increasing children's cognitive development and academic accomplishments.

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