Delivery of Therapeutic Services in Special Education Programs for Learners With Severe Handicaps

the services which are provided are appropriate and efficient in attaining a higher quality of life for the person being served.

DIRECT, ISOLATED, CENTRALIZED SERVICES

The current model for the delivery of therapy services may be characterized as direct, isolated, and primarily medical. Direct refers to

A major concern regarding a direct service delivery model is that, in an attempt to provide intensive levels of related therapy services, students have been sent to more restrictive educational placements which tend to be centralized and segregated from nonhandicapped peers. A frequent re-

handicaps is that direct therapy services must be centralized in order to be efficient. A closer look suggests that while it may be more efficient for therapists and administrators, it may not be most efficient or beneficial for the students being served or their families. Centralization of severely handicapped students may lead to any or all of the following results. (1) Long, static bus rides to and from centralized program locations may un-

INDIRECT, INTEGRATED, DECENTRALIZED SERVICES

The transdisciplinary team approach described by Hutchinson[19] has been widely advocated in the professional literature in reference to persons with severe and multiple handicaps.[1,9,23-29] In transferring the transdisciplinary model from medical to educational settings, three major

Within the context of a public school program for students with severe handicapping conditions, a transdisciplinary team which included Jimmy's parents, determined contextually relevant, functional priorities to be included in Jimmy's Individual Education Plan (IEP). One of the priority goal areas selected for training emphasis was improved communication skills. Within this general category, one of a series of objectives was designed to teach Jimmy a more socially acceptable method to

gain the attention of nearby people.

In traditional, isolated models, all communication programming would be delegated to the speech and language pathologist. While input typically would be requested from others disciplines, the primary responsibility for

communication related goals and objectives would remain with the specialist. Conversely, the integrated model relies upon team members applying their varied skills to common goals, with the responsibility being shared by team members. Each team member was asked what they could

tion strategy for monitoring progress and evaluating program effectiveness, and synthesized all of the pertinent input from each team member into a written plan.

learners with severe handicaps.[32] Vermont's I-Team advocates decentralized community-based programs while providing support services to local school districts. These indirect therapeutic support services are provided by employing therapists from the various disciplines to consult with direct service providers as needed. Both Vermont's model and the Release-Time Consultation Model described by Smith and Pasternack[34] emphasize the need for training personnel in the field. While the populations of school districts vary, Taylor[35] has suggested that schools observe the principle of natural proportions. This refers to the natural proportion of nonhandicapped to severely handicapped persons dispersed throughout a [illegible]

therapeutic services in educational settings theoretically addresses many of the concerns described earlier in reference to the more traditional approach and provides a direction toward which we may strive to better meet the needs of persons with severe handicaps.

BARRIERS TO BE OVERCOME

Although the indirect, integrated, decentralized model appears to be logical as well as educationally and therapeutically desirable, currently its implementation is the exception rather than the rule. In order for this

Indirect, integrated models necessarily require greater amounts of time for team planning and interaction.[1] Providing mechanisms for such planning will require administrative support, planning, and flexibility.[37] This administrative involvement should be done cooperatively with direct service staff in order to involve them closely in the planning process since innovations which are imposed from the top down may fail due to lack of perceived involvement by staff.[2]

As pointed out by Sears,[9] many people are generally resistant to change. This resistance may be especially acute if staff are asked to assume roles which differ from their training emphasis and personal preferences. For example, a therapist trained as a direct service provider may be hesitant to

4. Hart V: The use of many disciplines with the severely and profoundly handicapped, in Sontag E, Smith J, Certo N (eds): *Educational Programming for the Severely and Profoundly Handicapped*. Reston, VA, Council for Exceptional Children-Division of Mental Retardation, 1977.

5. Peterson C: Support services, in Wilcox B, York R (eds): *Quality Educational Programming for the Severely Handicapped: The Federal Investment*. Washington DC, Office of Special Education and Rehabilitative Services, 1981.

6. Sternat J, Messina R, Nietupski J, et al: O[illegible]

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