

# Lessons Learned

*"Providing Quality Education for ALL Children"*

Summer 1997

## **Sensitive Issues, Sensitive Answers: Discipline, Behavior and Intervention**

This issue of Lessons Learned focuses on discipline and education for children with disabilities. Discipline has been one of the key areas of discussion for Congress as it worked on reauthorization of the Individuals with Disabilities Education Act (IDEA), and continues to be a controversial subject in special education.

Many educators and parents feel that providing an appropriate -- much less an excellent -- education to students with challenging behaviors is one of the most difficult tasks in the field of special education.

While the new IDEA does not permit school districts to stop providing services to disruptive, dangerous students in special education, it does provide more room to discipline those students if they bring guns, other weapons and illegal drugs to school. Find more details on the new law on page 5.

### ***Children with Behavioral Disabilities***

#### ***Who Are They and What Works***

*by Dr. Al Duchnowski, University of South Florida,  
Tampa*

Children with serious emotional and behavioral disabilities -- and their families -- are getting more attention from advocates, researchers and policy makers since Jane Knitzer's landmark study "Unclaimed Children" was published in 1982. Knitzer characterized the prospects for children needing mental health services, and for their families, as "dismal." In the 15 years since the publication of "Unclaimed Children" the system serving children and their families has improved, but Knitzer still describes it as "fragile and in need of vigilance."

Several recent studies look at both services and outcomes for children with emotional and behavioral disabilities in special education programs. The results are not encouraging.

The Office of Special Education and Rehabilitation Services (OSERS) reports annually to Congress on the implementation of Individuals with Disabilities Education Act (IDEA). Mary Wagner and her colleagues at SRI International have been commissioned to evaluate IDEA and published their findings.

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## Children with Behavioral Disabilities

### Who are They and What Works

The National Mental Health Association and the Federation for Children's Mental Health have also published a report of a study conducted by Koyanagi and Gaines in 1993 entitled "All Systems Failure." The results from these studies can be summarized as follows:

- (1) Children who have serious emotional and behavioral disabilities have a graduation rate of 36% compared to 54% for all disability groups and 71% for all students.
- (2) They have a grade point average of 1.7 compared to 2.0 for all disability groups and 2.6 for all students. Almost half have failing grades.
- (3) Less than 18% attend post-secondary school, compared to 23% for all disability groups and 56% for all students.

They also have low rates of employment and little success finding jobs within five years after leaving school. They become involved with the criminal justice system (50%), mental health, welfare and the public health systems at a very high rate.

#### Who Are the Children and Their Families?

The Research and Training Center for Children's Mental Health at the Florida Mental Health Institute, University of South Florida has conducted several studies that describe the children who have serious emotional and behavioral disabilities, their families, the types of services they receive and the outcomes for children over time.

In one study, the National Adolescent and Child Treatment Study (NACTS), we studied over 800 children and their families, from six states, over a seven-year period. The children were aged nine to 17 at the start of the study and half were in residential centers while the other half were in public school special education programs. We found that the children had multiple and complex problems. While 66% had a diagnosis of conduct disorder, 50% had at least one other problem, such as depression, anxiety, substance abuse

or attention deficit. They were performing almost two grade levels below in math and reading and most were in the clinical range on tests of emotional behavior<sup>1</sup>. One third of the families were below the poverty level and another third were very marginal, financially. The other third represented a very broad range of income levels. Over half the families first noticed a problem before the child was six years old; on the average it took almost two years before the first intervention occurred. Many families were involved with the child welfare system, often because that was the only way to get funding for services.

At the conclusion of the study, we found that the outcomes for youths in the study were generally poor. While there was some improvement on measures of emotional behavior, the measures of social and adaptive functioning indicated that these youths were far below their peers in adaptive and social skills. Specifically, they were not as skilled as their peers in areas such as self care, dressing appropriately, participating in activities with friends, sports and recreation, understanding when to say "please" and "thank you," using the telephone to make a long distance call<sup>2</sup>. Consequently, they were doing very poorly in terms of employment and transitioning into adult roles. Only 18% graduated from high school and the average reading and math scores remained low. About 65% had some encounter

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Tests of emotional behavior can indicate the presence and severity of a variety of behaviors, such as severe anxiety attacks, strange thoughts, depression, crying a great deal. Children scoring above a certain threshold are considered to have a clinical pathology.

2

Researchers have speculated about whether the settings in which many children with serious emotional disturbances are educated contribute to their lack of adaptive skills. Most are in segregated education settings with other young people with emotional disabilities, and as a result have limited opportunities to interact with typically developing peers. Peer modeling and opportunities to practice social skills may be an important factor in learning many of these skills.

with the justice system and about a fifth served time in jail.

#### The Development of Community-Based Services

As states began trying to improve the service system for children and their families, they developed new approaches and created services at the community level. An approach known as "wrap around" began to be implemented in many programs across the country.

The philosophy behind "wrap around" advocates is a "don't give up, don't reject" approach. Programs try to do whatever it takes to help a child and his or her family. Programs work with entire families, rather than only identified children. As much as possible, children's and families' strengths are emphasized, and programs plan carefully to help enhance their strengths. Families are viewed as equal decision making partners with professionals, and cultural and ethnic diversity is respected. Interventions and supports are designed to work with children and families in all settings and to take into account the interactions of many factors in their lives. It is an approach, then, that "wraps itself around" children and families at home, in school, in the community, looking at and responding to a wide array of influences beyond a child's diagnosis.

It is perhaps not surprising that traditional mental health services have a diminished role in a wrap around approach. Instead, since many children come from poor families, economic issues are often the most pressing. Programs must often answer questions about how best to improve and stabilize families' situations to arrive at better outcomes for children. If the family, for example, can't afford a new battery for the family car, that is likely to take priority over most counseling or therapy services, or much of anything else that requires transportation. Service coordination, which help families line up resources, is a prominent service in a wraparound approach.

In 1990, the Research and Training Center began an evaluation of some community-based programs across the country that were nominated as exemplary models of service delivery. Called Alternatives to Residential Treatment Study (ARTS), it investigated the following programs: the Ventura County (CA) Children's Demonstration Project; the Alaska Youth Initiative; Vermont's New Directions Program; Kaleidoscope in Chicago; and a therapeutic foster care

program at Pressley Ridge (PRYDE) in Pennsylvania.

The outcomes in this study were much more encouraging. We found that the children in these programs had very serious and long lasting problems, similar to and in some cases worse than the children in the NACTS study. However, after a one year follow-up we found improvement in several areas. Their reading scores improved significantly and they were not losing ground in math, as is the usual case. Children were in less restrictive settings in school and in their living arrangements. All of the children had a case manager and they received services from multiple agencies. While the major service was outpatient therapy, the majority of children received several supportive services such as respite care, income maintenance, transportation and health care.

Dr. Scott Henggeler and his colleagues at the Medical College of South Carolina, in Charleston, South Carolina have also produced some encouraging results in their studies of a new approach to working with families and children. Their observation is that *improved results occur when a more holistic approach is available that uses comprehensive services*. They have developed a program called Multi Systemic Therapy (MST) which addresses all aspects of the child's life, family, school, friends and community. They have conducted several studies evaluating the effectiveness of MST and their results show much improvement in the children who receive this type of intervention.

#### Using the Knowledge We Already Have

These are relatively new approaches to helping children who have serious emotional and behavioral disabilities. However, there is also an extensive history of other types of programs that work. Since the 1950's, educational psychologists have demonstrated that the effective use of rewards could greatly improve the behavior of children who were exhibiting a variety of problems. Very carefully conducted studies indicated that these programs work and that they can be used by teachers, other professionals and parents.

These techniques are not now being widely used across the country, in part because many people incorrectly view using rewards as bribery. A bribe is a payment given to someone for doing something wrong. An example is trying



to bribe a judge to find a person not guilty when in fact he or she is. This is not positive reinforcement. Similarly, who would consider his paycheck a bribe? It is a payment earned for hard work. Likewise, a child may be rewarded for paying attention in class, because for him that is very hard work. When he pays attention, he learns better and gets higher grades, all desirable outcomes. Eventually the tangible rewards can be phased out, because the child will be working for the satisfaction of learning and getting good grades.

Another problem with the reward approach today is that many teachers do not use it to increase positive behavior. Instead, they use the loss of reward as a punishment and have developed what Jane Knitzer has called the "Curriculum of Control." Teachers in some cases seem to have forgotten what they were taught as undergraduates, and do not have the supervisory support to help them develop more effective behavioral programs in their classes. In spite of its bad reputation, behavioral approaches work when used correctly. Many children could be doing better with such a program.

### ***Changing the System to Improve Outcomes***

When outcomes for children with emotional and behavioral disabilities is so poor and both proven and promising interventions are available, how do we implement these approaches on a large enough scale to make a difference?

Our Center has been funded by OSERS and the U.S. Center for Mental Health Services to conduct a study in which we will identify promising practices in public school programs. We will look at schools involved in reform activities, using the best knowledge available, and ones which can demonstrate improved outcomes for children who have emotional and behavioral disabilities. Our description of what is happening in these schools will let schools and communities all over the country adopt and adapt these practices in their own schools.

We started this study in the fall of 1995 and have preliminary results that are very encouraging. We conducted a national appeal for nominations of model programs and eventually will include 10 schools that meet our criteria. So far, we are collecting data in four schools. We interview key staff and get a picture of how the school operates. We also interview outside agencies that work with the schools to

provide services. We interview the parents of children in the special education program for children with emotional and behavioral disabilities. Finally, we interview the children, review their records and collect baseline data. We will follow the children for two years.

From the data collected at our first four schools we discovered some interesting results:

- (1) Principals share decision making with an advisory committee that includes teachers and parents. The district supports school based management.
- (2) We found an atmosphere in which all teachers feel they are responsible for all children. There is much team meeting. Also, even where there are self-contained classes, children who have emotional and behavioral disabilities are included to a high degree in the school day.
- (3) Parents are very pleased with the programs. Every school uses a behavior reporting system which is communicated to parents daily. Teachers know how to use rewards correctly.
- (4) The innovations in regular education carry over to children in special education. They are all improving together.
- (5) The schools put a high value on accountability. They use several methods, including testing, to measure achievement of all students.

These results are preliminary -- but clearly, good things are happening in some places. If our results are supportive of our hypotheses about school improvement, we feel that we will be able to disseminate some valuable information to teachers, parents and administrators. In the meantime, we would encourage parents to take an active role in the school advisory committees in their districts. Parents need to get their ideas on the agenda of change.

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***encouraged to contact the Center for a listing of their materials (most of which are free) and training activities:***

***RTC for Children's Mental Health 13301 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 974-4661 (Voice) (813) 974-4406 (Fax) <http://lumpy.fmhi.usf.edu>***  
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### ***Congress Reauthorizes IDEA!***

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On June 4, 1997, President Clinton signed into law the Individuals with Disabilities Education Act Amendments of 1997. Discipline has been one of the most controversial and difficult issues throughout the reauthorization process. Some of the amendments included in earlier drafts, which many advocates viewed as particularly harmful, were eventually dropped.

One amendment would have allowed education services to be stopped if students with disabilities violated certain

school rules. The other would have put disciplinary measures for students found to be "disruptive" into place which many advocates viewed as harsh.

The new IDEA clarifies the substantive and procedural protections<sup>1</sup> for students with disabilities in the area of school discipline. The amendments are designed to strike a careful balance between school districts' duties to "ensure that school environments are safe and conducive to learning for all children, including children with disabilities, and . . . the continuing obligation to ensure that students with disabilities receive a free appropriate public education."

For the most part, the amendments codify, or put into statutory law, the current case law and policy interpretations from the United States Departments of Education and Office of Civil Rights.

However, the amendments also both create new procedures that permit school districts to unilaterally remove students from their educational programs under extraordinary circumstances, and extend the authority of impartial hearing officers to order interim programs for students with behavioral difficulties. This article provides an outline of how the amendments apply to student discipline.

### ***When To Have a CSE Meeting?***

When students' behavior impedes their learning or others' learning, the amendments require local Committees on Special Education (CSE's) to consider using strategies, including positive behavioral interventions and behavioral supports, supplementary aids and services, program modifications, and support for school personnel. This, then, ought to be the first response to a student's behavioral needs.

Under the amendments, the CSE must meet whenever the district plans to move a student to an alternative

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In this context, *substantive safeguards* refer to the specific rights of students with disabilities under the IDEA. For example, eligible students have a right to an appropriate education in the least restrictive setting. *Procedural safeguards* are more like the rules of the game -- how students get what they have a right to, or how those rights are enforced. For example, parents have a right to be meaningfully involved in the CSE process, and have a *procedural right* to timely notice of meetings, to ensure that they can.



educational setting for more than ten days. As discussed further below, under certain circumstances, the CSE must make a "manifestation" determination, which looks at the relationship between the student's conduct and his or her disability. The student's parents must receive a due process notice no later than the date that the district's decision to take disciplinary action is made.

The amendments also require that students' regular education teachers participate, to the extent appropriate, at CSE meetings.

**Advocacy Tip:** Parents and advocates can invite regular education teachers to CSE meetings. It can also be helpful for parents to request independent behavioral assessments, when appropriate. This can be a tool for lining up supporting data when advocating for specific behavioral interventions at CSE meetings.

Parents may wish to contact their local Special Education Training and Resource Centers (SETRC's) or Developmental Services Offices (DSO's)<sup>1</sup> for information on appropriate behavior intervention strategies which can be presented to the CSE.

Finally, parents should keep in mind that they have the right to initiate a CSE meeting at any time, and that it is usually better to request a meeting as soon as behavior difficulties are beginning to emerge, rather than at the point when the district is considering an alternative placement.

### **Can School Districts Place Students in Alternative Placements Without Parents' Consent?**

The 1997 IDEA amendments codify the "Ten Day Rule" established by the Supreme Court in Honig v. Doe. School personnel are allowed to order a change in the placement of a child with a disability to an appropriate

interim alternative educational setting or to suspend the child from school, for not more than 10 days. In response to growing public concern about the safety of all children in school, the amendments also allow school districts to order a change in a child's placement for up to 45 school days under the following limited circumstances:

- ▶ The student carries a weapon (device or substance that is used for or is readily capable of causing death or serious bodily injury, except that such term does not include a pocket knife with a blade of less than 2.5 inches in length) to school or a school function;
- ▶ The student knowingly possesses or uses illegal drugs or sells or solicits the sale of a controlled substance while at school or a school function.

Alternative placements for students with disabilities are permitted only to the extent that the placement would be applied to children without disabilities. The amendments require state education departments to examine data submitted by districts in order to understand the rate of long term suspensions of, and expulsions of students with disabilities. State education departments must look at rates of expulsions and suspensions in individual districts, comparing the rates between disabled and non-disabled students; and throughout the state, to determine if there are regional areas of concern.

**Advocacy Tip:** Parents are encouraged to examine the data submitted by their school districts. Are disciplinary alternatives being applied in a comparable way to students with and without disabilities?

When a district does order an alternative placement as part of a disciplinary action, the amendments require the district to take certain steps either before the action, or not later than ten days after the action. The district must conduct a functional behavioral assessment and implement a behavior plan for the student if it has not already done so. If the student already has a behavioral plan, the CSE must review the plan and modify it as necessary to address the behavior.

<sup>1</sup>  
To find the local SETRC, look in the business section of the white pages in your local phone book under Board of Cooperative Services (BOCES); DSO's are usually listed in the Government listings, the New York State Government Offices section, under the Office of Mental Retardation and Developmental Disabilities (OMRDD).

**Advocacy Tip:** Parents are encouraged to contact their local Protection and Advocacy Office<sup>3</sup> for further legal assistance or guidance if they are faced with a district plan to remove a student from his or her educational placement for more than ten days.

### **What Authority Do Hearing Officers Have to Order Alternative Placements?**

In the past, if a school district wanted to change a child's placement for more than ten days without a parent's consent, and in a situation that is perceived to be an emergency -- one that endangers the safety of the student or others -- the school district would need to have obtained a court order allowing the change. With the amendments, an impartial hearing officer (IHO) can approve such a change through an expedited hearing process. IHO's can now order a change in placement for a child with a disability to an appropriate interim alternative educational setting for not more than 45 days if the IHO determines that:

- ▶ The district has taken reasonable efforts to minimize the risk of harm in the student's current placement, including the use of supplementary aids and services;
- ▶ The district has demonstrated by substantial evidence that maintaining the current placement of the child is substantially likely to result in injury to the child or others;
- ▶ The interim alternative educational setting will enable the student to participate in the general curriculum, receive appropriate services to meet his or her IEP goals and objectives, and receive services and modifications designed to address the behavior difficulties so they don't recur.

**Advocacy Tip:** Parents can remind school districts that changing a child's environment will not necessarily make challenging behaviors disappear. It is often preferable to address the behavior difficulty in the setting in which they

<sup>3</sup>  
To find the nearest Protection and Advocacy Office in New York State, call the New York State Commission on Quality of Care at 1-800-624-4143.

happen so that students are not "rewarded" by a change in placement and the attention and/or escape they may have been looking for in the first place through their behavior. Behavior plans do not work over night, but when applied with consistency in all environments, they are often effective in addressing behavior difficulties without the need for a change in placement.

Furthermore, recent court decisions have clarified that threats alone are not enough evidence to prove that a child is "substantially likely to cause injury." Court decisions, which impartial hearing officers are likely to follow, have required school districts to show a long standing pattern of violent behavior in order to meet this standard.

### **Manifest Determination: Is the Student's Conduct the Result of His or Her Disability?**

Whenever a school district considers disciplinary action which involves a change in placement for more than ten days, it must meet -- preferably immediately, but at least within ten days of its decision-- to review the relationship between the child's disability and the behavior for which he or she is being disciplined.

This meeting is commonly referred to as a "nexus" or "manifestation" meeting. Under the new IDEA amendments, the CSE cannot determine that there is no relationship between the conduct and a student's disability without first reviewing all the relevant information, including evaluation and diagnostic results, including results or information provided by the student's parents, observations of the student, and the child's IEP and placement.

Finally, the CSE must determine two other significant things in order to find that a student's behavior are not related to his or her disability. The student's disability cannot have impaired the child's ability to understand the impact and consequences of the behavior in question; also, the disability cannot have impaired the child's ability to control the behavior.

If the CSE determines that the student's conduct was not related to his disability, the district may discipline the student using the same policies it would apply to students without disabilities.



### ***Status Quo Provisions: What About Placements When Parents Request Mediation or a Hearing to Challenge a District's Discipline Decision?***

The IDEA Amendments confirm that, generally, a student has the right to stay in his last agreed upon ("status quo") educational placement when a parent requests due process to challenge a school district decision to change a student's educational program for more than ten days.

However, the amendments also provide an exception to this general rule. School districts can request that the impartial hearing officer hold an expedited hearing when the district feels that maintaining the student in his current program is dangerous for the child. The hearing officer can order a different "status quo" placement at this expedited hearing.

### ***Protections for Students Suspected of Having a Disability***

The new IDEA amendments make it clear that under some circumstances, children not yet classified do have rights under IDEA so far as discipline goes. The student can assert IDEA protections if the district knew about his or her disability. A district is deemed to have knowledge under four circumstances:

- ▶ The student's parent has expressed concern in writing that the student needs special education services;
- ▶ the student's behavior or performance indicates the need for special education services;
- ▶ the student's parent has requested an evaluation of the student;
- ▶ the teacher of the child or other school district employee has expressed concern about the student's behavior or performance to the director of special education.

The IDEA amendments allow school districts to apply the same disciplinary rules to a student with disabilities as they do students without disabilities if they did not know about the student's disability before the disciplinary action

was contemplated. However, a parent can request an expedited referral to the CSE for classification during the period a child is being disciplined. While waiting for the results of CSE review, the student would then stay in the educational placement determined by the district.

Children with disabilities should benefit from these amendments. These changes require districts to focus on addressing behavioral difficulties in a student's current educational environment. They extend protections to students not yet classified by the CSE. They seek to ensure the safety of all students when behavioral needs of a student cannot be adequately addressed in the student's current program. Finally, they ensure that school districts cannot make lengthy unilateral changes in a student's placement without giving the student and his or her parents the opportunity to exercise their rights through the IDEA's due process system.

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*Albany Law School, Disabilities Law Project is one of the offices under a statewide network of regional protection and advocacy offices. The protection and advocacy offices have been set up through the Advocacy Services Bureau, which is part of the New York State Commission on Quality of Care. In addition to providing direct services, the Advocacy Services Bureau also administers through contracts with several legal and advocacy agencies, such as the Disabilities Law Project.*

*For more information, contact the New York State Commission on Quality of Care at 1-800-624-4143.*

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## ***New York's Early Intervention Impasse***

After weeks of impasse, the Governor and the New York State Legislature have still not agreed to a State budget as Lessons Learned goes to press. Democrats and Republicans still differ on how much money is available to spend next year, and what it should be used for. Broadly, the Assembly would prefer additional spending, while the Senate wants tax cuts.

Early intervention is also an unresolved issue at press time. In the Assembly: The Assembly passed an early intervention bill earlier in the session (A.5375 Bragman). The Bragman bill would not permit charging parents fees for early intervention services; would try to ensure better access for infants and toddlers under the age of 18 months; would reauthorize the funding methodology; make the New York State Commission on Quality of Care, not the Department of Health, responsible for investigating systems complaints; and would provide an additional 10% in state aid.

In the Senate: S.4040-A (Cook) was passed at the end of the regular legislative session. The Senate bill would include the following provisions: Prohibits charging parents fees for early intervention services. Tracks the enrollment of infants and toddlers under the age of 18 months. Requires coordination of services when more than one service provider serves a child, unless the providers have a formal relationship with a service agency. Prohibits "selective

contracting." The law would stipulate that counties "shall" contract with approved early intervention providers (currently, the law says counties "may" contract with early intervention providers). However, counties would not be required to contract with individual early intervention professionals not affiliated with an agency, incorporated entity or partnership. Reauthorizes the reimbursement methodology and would provide for pilot and demonstration alternatives to reimbursement. Clarifies that any service guidelines developed by the Department of Health can only be used to help properly implement federal and state laws and regulations.

### ***Now What?***

Once the Senate passes its version of an Early Intervention bill, the Senate and Assembly will have to reach agreement on final legislation. The outstanding issues are expected to include the 10% reduction in counties' financial share for the program; the role of the Commission on Quality of Care; and the "selective contracting" issue. The first two issues are in the Assembly version but the Senate version of the bill; the third issue is included in the Senate's bill, but not the Assembly's.

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## ***Pharmacological Interventions for Students with Behavioral Disabilities (The First in a Two-Part Article)***

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### ***Introduction***

Using prescription medications in school age children has raised a lot of controversy and misunderstanding, though it is an approach which can be very helpful for some children.

The use of prescription medications in school age children is controversial because professionals (physicians and teachers) often recommend medication for behavioral problems that might be better addressed by more educational resources such as increased staffing or improved training. It is controversial also because, as a society we equate these drugs with street drugs. "Say no to drugs" and creating drug free schools are important ideas in our culture and our psyches. In reality, our children and young adults sometimes use street drugs to self medicate biologically based behavioral disorders that have not been properly recognized.



The efficacy of pharmacological interventions -- for some children -- can be compared to managing a vitamin deficiency or diabetes. The objective is to replace, balance or stabilize neurotransmitter systems which are deficient or out of balance in the brain.

In this essay, I will refer to the neuropsychiatric disorders of school age children as behavioral problems which have a medical (i.e., biologic) basis as opposed to a behavioral/environmental basis. I am referring here to problems which are severe and recurrent, disruptive to the child's ability to function at school and at home. In particular, these are problems more efficiently and effectively amenable to treatment with medical/pharmacological therapies than behavioral approaches or increased staffing.

Of note, these are problems that are often poorly recognized by educators and pediatricians due to lack of proper training, particularly since many of these disorders were not thought to begin so early in life.

### Overview

Clinicians and researchers in mental health are beginning to understand that the major psychological/psychiatric disorders which are known to exist in adults are actually emerging in childhood.

In my own practice, the more I ask adolescents and young adults who are beginning to suffer acutely from symptoms of depression, mania or anxiety, I learn more about how these people first began to experience excessive sadness, happiness, anxiety or even panic in early elementary school. When I review earlier records of high school age children with depression or anxiety -- the comments of their teachers on report cards or the psychological testing -- I see references to primordial symptoms and signs of these major neuropsychiatric disorders of adulthood. Recognizing these disorders early is important because they are often readily treatable.

Beginning proper treatment in young children can be profoundly effective. Critical developmental milestones can be interrupted or altered by untreated anxiety, depression, or mania, and making up for those interruptions can be very difficult later in life. Moreover, unrecognized and untreated disorders -- and particularly when there is a family history of

anxiety and depression -- can lead to drug abuse (which may be attempts at self medication), sexual promiscuity, and aggressive/destructive acts as teenagers.

### General Principles

Medication should only be considered when there is not a clear psychosocial cause for the problem. This is determined by taking a careful family history and understanding the psychosocial dynamics of the family. When there are likely social or psychological causes -- such as a serious illness or death in the family or another trauma, physical or sexual abuse -- medication should only be considered if the problem has not responded to other appropriate psychosocial interventions.

Medication for a child or adolescent should be considered when a child's behavior problem is so severe that it interferes with his or her classroom performance and/or relationships at home, and when other therapies (talk therapies, behavioral therapies) have failed. Here are some things to look for in considering medication:

- (1) The child's behavior seems to be interfering with personal academic progress or that of peers;
- (2) The child is refusing to attend school or is unable because of frequent medical complaints;
- (3) There is an inability to pay attention for a proper period of time or there is marked motor or verbal hyperactivity;
- (4) There is inappropriate physical aggression toward other children or destruction of property;
- (5) There is a positive family history of a neuropsychiatric disorder. This is an important principle. Often, a parent under treatment for depression, anxiety or attention deficit disorder will say, "You know, my child reminds me of what I was like at his or her age."
- (6) There is significant drug abuse.

A knowledgeable and experienced pediatrician or primary care physician can appropriately prescribe medication. A specialist should review more challenging or complicated situations.

At times, treatment is iterative (that is, informed trial and error). The brain and our genetic make up is one of the most complicated phenomena in the universe. The

evaluation and treatment of these problems take a great deal of patience on the part of the child, parents and professional.

The input from teachers is essential. It must be a team effort.

In my own experience working with the most severely disturbed children, most medications which are used for adults can be used in children as long as it is done cautiously ("start low, go slow"), with full informed consent, and

frequent follow-up. This can be costly short term, but not when compared to the long-range alternative.

### Problem Behaviors -- What They May Mean

Severe, recurrent behavior problems can have correlation with potential neuropsychiatric disorders. They, in turn, suggest effective pharmacological therapies. The following chart may be helpful for considering psychiatric disorders in the presence of particular behavioral symptoms and signs.

### Problem Behaviors and Their Psychiatric Import

Stealing	Obsessive Compulsive Anxiety Spectrum
Resistance to Change	Obsessive Compulsive Anxiety Spectrum
Willfulness/Stubbornness	Obsessive Compulsive Anxiety Spectrum, Depression
Of Making a Mistake/Perfectionism	Obsessive Compulsive Anxiety Spectrum
"Walking on Eggshells"	Obsessive Compulsive Anxiety Spectrum, Mood Disorder
Lying	Mood Disorder
Jealousy	Mood Disorder
Tantrums	Mood Disorder
Destructiveness	Mood Disorder, Anxiety
Self Injury	Mood Disorder, Anxiety
Head Banging	Mood Disorder
Skin Picking/Nail Biting	Obsessive Compulsive Anxiety Spectrum
Hair Twirling/Pulling	Obsessive Compulsive Anxiety Spectrum
Fearfulness	Anxiety
Drug Abuse	
Marijuana	Anxiety
Alcohol	Anxiety, Depression
Nicotine	Anxiety, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder
Inattention	Anxiety, Attention Deficit Disorder
Hyperactivity	Attention Deficit Hyperactivity Disorder, Manic Depressive Disorder
Cyclically	Manic Depressive Disorder



## Part Two

Part Two will appear in the next issue of Lessons Learned. It will cover specific disorders and their pharmacological treatment. Questions, comments and feedback to Dr. Hardy are most welcome as he prepares Part Two. Please mail or e-mail to: Paul Millard Hardy, M.D., Heathcare Associates, P.C., 62 Derby Street, Hingham, MA 02043-3718. Fax: 617-740-8242. E-mail: pmhardy@mindspring.com

### About the Author

Dr. Hardy did his medical and neurological training at the University of Rochester School of Medicine and Strong Memorial Hospital in Rochester, New York. In 1977, he

completed the Joseph P. Kennedy Jr. Fellowship in Medical Ethics at Harvard University and in 1978 finished his fellowship in Behavioral Neurology at Boston University. He has been on the faculty of the University of Rochester, Harvard University, and Tufts University Schools of Medicine. Currently, he is in private practice specializing in neuropsychiatry disorder throughout the life cycle.



## Positive Behavioral Interventions

By Barbara Zimmerman, Ph.D.  
Capital Region BOCES, Albany, NY

As a behavior specialist, I work with teachers, students and parents in behavior management. I conduct training and in-service courses on positive behavior management, and I provide individual and classroom consultations for the behavior management needs of specific students.

Kids have reasons for the things they do! Children behave inappropriately. It is the job of adults to understand their behaviors (identify what it is that is bothering them in the first place) and help them to do the appropriate thing, namely express their needs in ways that help them get their needs met. Inappropriate actions, then, help students communicate a need or a want. Once adults understand the causes of behavior, it helps explain why it occurs. Then they can suggest alternatives and solutions which will work better.

### Creating Environments for Success

As a behavioral specialist, my job is helping teachers and parents enlarge their repertoire of responses to inappropriate behavior. I always emphasize how important it is to create an environment that supports kids' cooperation and positive interactions with others. As they try to manage children's behavior, teachers and parents tend to react to inappropriate behavior. I like to suggest proactive methods that help eliminate the need for inappropriate behavior.

What a relief it can be for everyone when adults succeed in creating an environment that supports cooperation and positive social interaction -- one in which kids no longer need to behave inappropriately.

Here are the measures I like to suggest, at home and at school, to help create a positive environment.

- 1. Respect the child.** Children learn how to respect others when they are respected themselves.
- 2. Have consistent rules and limit setting.** The child must be clear on "how far" he or she can go. Rules should be clear and direct. Rules should be reasonable and achievable. Follow-through is essential. A rule is useless if it is not enforced.
- 3. Include children in decisions about behavior and discipline.** Children adhere more diligently to rules they generate themselves. This helps a child to mature. Children will look more closely at their needs and monitor their own behavior.
- 4. Be yourself with children.** Share yourself with them. They care about you and want to know who you are. Give them opportunities to show their sensitivity to you. Be open, honest and direct.
- 5. Be available emotionally and physically.**
- 6. Avoid power struggles --** "push and pull" situations. Choose your battles. Demonstrate compromise.
- 7. Understand that every action causes a reaction.** Children should understand that there are always consequences for behavior -- both natural and imposed.
- 8. Reinforce appropriate behavior.** Instead of the "squeaky wheel getting the grease," catch children being appropriate.
- 9. Be good role models for children.** They will follow your lead!
- 10. Laugh as much and as often as possible.**

## Behavioral Intervention Plans

Even in the best of all possible school and home environments, some individuals need a behavioral intervention plan. When designing a behavior plan, be sure to include the student or child as much as possible. Even very young children can help plan ways to make success more possible for them. Also, most people will be much more willing to cooperate with a plan if they have helped design it.

Many interventions used at school can be modified for home use, and vice versa. In fact, it is a good idea to make interventions as similar as possible in both environments for the sake of consistency and to help eliminate confusion for the child. Devise a plan that will help get a child to work at school, and use a similar plan to get him to do his chores at home, for example.

Negative consequences in any plan should fit the "crime," without undue harshness. This does not mean that children should not have consequences for inappropriate behavior, just that the consequences should be well thought out and appropriate.

Always try to think of the "big picture" and what you hope to accomplish and teach children with the consequences. One helpful way to analyze the "big picture" is to answer the following questions. What is causing the behavior? What happened before the behavior started? What might have started the behavior? What, exactly, is the child doing. What are the reactions to the behavior -- the teacher's, peers', siblings'? Finally, what are the consequences of the behavior and how does everyone react to the consequence?

Having expectations that people cannot meet creates frustration, not success. Keep in mind that few people can go from zero to sixty in one step, so don't give directions that kids simply cannot manage. Consider, for example a child who dawdles so much that it is a major, ongoing problem. If it usually takes an hour to do one specific task, like getting dressed, suddenly saying "I want you ready in ten minutes!" will probably not lead to the desired outcome. On the other hand, maybe she can do the task in 40 minutes instead of an hour. It can take time to learn how to use new strategies.

Look for the next step in the behavior chain -- the next step from where the student or child is now -- by breaking behaviors down into their parts. If a child interrupts, determine whether he is reporting a fire (or some other emergency). If not, ask yourself, "Can this child wait? Can I stretch his tolerance some?" Then decide on a reasonable amount of time he can be expected to wait, after he raises his hand and before calling on him.

## How Not to Humiliate People

I urge anyone working with people to heed these words: **avoid using humiliation as a behavior strategy.** It undermines self esteem and there is no need for it! The very human inclination to "get back" at anyone who hurts us is almost universal. However, even if someone is compliant for the time being because she has been humiliated, the long term effects are horrendous. Humiliation further feeds the doubts already planted in the person's mind. It attacks self confidence and causes anger and hostility. Worst of all, once the child's friends, classmates and siblings see an adult humiliating the person, they will do it, too.

No one should be subjected to public personal attacks. Avoid statements like "You're acting like a baby," "Can't you grow up," "You're so hyper." Using "I" statements takes the focus off the individual child and describes the *behavior* and its impact on others. For example you might say, "I get very distracted when you talk while another student is talking. Let Mary finish and I'll listen to you."

## Who, Me? In appropriate?

Half the battle for some individuals is coming to a conscious recognition of their own inappropriate behavior: what it is, why it happens and when it happens or what stimulates it. Adults and peers can help by providing cues and prompts. Be sure to deliver the message in a firm, gentle, caring manner. Once the person is aware of the inappropriate behavior, he can begin to formulate a plan of action.

Parents and teachers spend considerable time telling children what to do and what not to do. It is easy to mistakenly think the person knows how to do what we ask. We may tell someone who is frustrated or angry not to yell or hit anyone, for example. If we want to give her a road map describing how to "get there," we also need to acknowledge



the person's feelings and help her learn how to deal with those feelings. In this way, we can give the person a "bag of tricks" or coping strategies to help her make positive choices. The person may not always be successful choosing a trick from the bag every time one is needed. It is still important, though, to work with her to develop strategies she can choose from, and then help her practice using them. Without this preparation and repetitive practice, the person simply may have no acceptable behavioral options to choose from.

Both at home and in the classroom, children need help discovering successful strategies for monitoring their actions<sup>1</sup>. Then, once they have learned some strategies that work, they can be generalized across different situations. Good tricks for parents and teachers to know include:

- (1) learning to effectively preset children by warning them about what's coming up next and what to expect. That way, they can already be thinking of a plan of action before they get to Aunt Bertha's house;
- (2) creating an environment that cooperation more than competition. If one child has had a problem, for example, the whole class would not receive the punishment. Rather, because Joey is having such a good morning, maybe the whole class should take an extra ten minutes of recess;
- (3) learning to react more quickly: read children's needs and teach them skills accordingly. Children may be having difficulties dealing with teasing, a noisy cafeteria, substitute teachers, homework, nagging. Identify the need and teach to the need.

The idea is to give students some success by teaching them "social problem-solving skills" -- analysis and planning they can use in a variety of situations and settings. One approach is teaching children to talk themselves (internally), so they can guide and mediate their own behavior. Children can say these steps to themselves:

1. Stop! What is the problem?
2. What are the plans?
3. What is the best plan?

4. Do the plan.
5. Did the plan work?

### *Is It Working? How to Tell*

Charting and documenting behavior is important because it is easy to lose perspective in the push and pull of everyday life in the classroom or the home environment. Getting a "baseline," or a measurement of the behavior before the intervention, helps delineate whether the intervention is succeeding. As an example, if a student continually calls out, you may want to reward the student with five minutes of computer time for every fifteen he controls calling out. This may work well for the next 27 school days. But if the student comes into school on day 28 and calls out from the time he steps off the bus in the morning until the time he steps back on the bus after school, the tendency is to feel the plan is not working. If you've charted the progress of the intervention, you can quickly take a look and realize the student is just having a bad day.

Another reason to document in a school setting is to provide evidence that a student needs more support. No administrator likes to see a hysterical teacher run into her office yelling, "Get him in the resource room! He's driving me crazy!" Document actual behaviors, the interventions you've tried and the results of interventions. In most schools, the referral process for special education services requires precisely this information before the referral will be accepted.

Documentation and charting does not have to become a major project. I used a simple daily documentation sheet that had on it the names of all my students, with room to write two to three lines under each name, each day. If there was a problem I tried to write down what happened before the problem, what the problem was, what the consequence was, and the results of the consequences. If something good happened, I wrote that down, too. It took me about seven to ten minutes to write the documentation sheet for twelve to fourteen students. I also used the chart to help my students see patterns. If a student asked to be mainstreamed into lunch, I would pull out the documentation book and review with the student the entries for three weeks. We would decide together if we thought the time was right. If the student wasn't ready, we would set a date in the future to review the book again. It was quite effective.

<sup>1</sup>  
Rick Lavoie is an educator credited with describing the approach of some children as "Ready, fire, aim

Parents have told me they don't have time to write in journals to document behavior. Using a tape recorder may be an easier method. You can simply spend a few minutes each night reviewing the day.

In my experience, children don't stay up late at night thinking of ways to torture their teachers and parents. Children don't want to have behavior problems. They don't want to be different. They want to be more like their peers. Instead, kids have inappropriate behaviors for some reason. It is adults' job to get to the bottom of the behavior and help children express their needs and get them met in the most appropriate way.

Children are so powerless. Paradoxically, though, they still have a lot of power. A child who refuses his homework manages to have a lot of power. Common sense, empathy and consistency are important tools in my bag of tricks for dealing with inappropriate behavior. Using these tools keeps us all on our best behavior.

*Dr. Zimmerman, a behavioral specialist, works with teachers on classroom management programs, and with individual students. She is an adjunct professor at the College of St. Rose in Albany, New York.*



## ***Never Say Never: Building Bridges To Special Education with Scarce Resources***

*by Dr. Ruth Walker, Hamilton, Coordinator, Bridges Project*

The residents of Franklin County, Vermont live in a breath-takingly beautiful, extremely rural area just south of the Canadian border. Because of their geographical isolation, families must either travel at least an hour to get many kinds of services -- or go without. Hospital services,

community mental health services, other counseling or psychological services, help from social services, physical or occupational therapy and many other kinds of services are not available locally.

### ***History of Collaboration***

As a result, says Ruth Hamilton, coordinator of the Bridges Project, "Kids often lose out."

Over the years, however, the town of Montgomery has formulated some practical answers to the problems brought on by the isolation that is a part of rural life. The Bridges Project is helping this small community disseminate these strategies to other schools and communities.

The Bridges Project is a unique and successful community development project. Located within Montgomery Elementary School in Franklin County, Bridges helps the Montgomery School and community provide needed services to children and families who wouldn't otherwise have access to them, even in very extreme cases. Montgomery Elementary School has about 100 students in grades Kindergarten through eighth grade. The staff at the school includes ten teachers (not all of whom are full-time, and including the principal, who is also a special education teacher).

Bridges is based on other successful programs that originated in Vermont, and in particular one called the Homecoming Project, which started in the early 1980's. Homecoming was a program associated with the University Affiliated Program at the University of Vermont, coordinated by Dr. Jackie Thousand. The program started in the Franklin Northwest School District. The school invited the wider community to participate in focus group discussions about where and how students in special education should go to school. Until then, special education students attended school in alternative placements or classrooms just for special education students.

Regular and special educators, parents, other members of the community, related service providers, paraprofessionals, and administrators all participated in the discussion. The community made a commitment to supporting all students' needs within their own school. "Homecoming" is now an important symbol for the



widely-held belief that all children belong in the "regular" community, living with their families and getting the best education possible -- in their local school.

One strategy that was instrumental to Homecoming, and which is now a key component of the Bridges Project, was Individual Student Support Teams. Individual Student Support Teams originally helped children in special education move back to their local public schools. The teams developed appropriate educational plans, services and accommodations, and then designed transition plans between grades. Montgomery Elementary School uses Individual Student Support Teams now to help students in special education services, or those students who are at risk, but not necessarily eligible for special education.

According to Dr. Hamilton, the teams help teachers, families, and children gather information, plan together, develop, put into place and evaluate support strategies for individual children, and communicate effectively across settings.

"As much as anything, (the Individual Student Support Team) is a philosophy and a blueprint," says Dr. Hamilton, "a way to get things done through collaboration."

Dr. Hamilton says that Individual Student Support Teams start with the family. School staff ask the family whether they want such a structure to be "built" around their child. They ask the family to identify who should be part of the team, and the family and school work together to decide when and where to meet.

"The outcomes are better with family involvement," Dr. Hamilton says simply.

Asked what the school has done when families are reluctant or unable to be involved at the level she described, Dr. Hamilton reports that the school still tries to figure out ways to communicate regularly with families. Perhaps one member of the Team is designated to represent the family, and that person stays in close touch with the family and keeps current with the family's ideas and priorities.

The teams function well when their members agree on clear goals and agendas, and agree to norms or rules by

which the team will work. They are effective, Dr. Hamilton says, when teams share information equitably and exclude "outside agendas."

How do teachers, administrators, parents and others feel about meeting so much? Dr. Hamilton says finding the time to meet is always a challenge, but when the needs of a student become overwhelming, "teaming" can offer support and tangible help that lightens teachers' loads. Before meeting together collaboratively, teachers have sometimes logged in up to twenty-five hours a week -- after, during and before school -- trying to meet the extraordinary needs of a single child with unusual learning differences or behavioral challenges. "Teaming" can add people to the teaching equation with new, effective strategies, put more heads together to problem-solve and think through everyday issues, and it can let teachers shift some of their burgeoning responsibilities to others.

Adding students with different needs to classrooms can bring some teachers to a realization that the teaching strategies they had used for years no longer work. Then teachers are faced with two options: (1) remove those students with the assumption that they do not belong in that classroom setting; or (2) say to themselves, "I have to do something different, because this is not working." In Montgomery and other classrooms across much of Vermont, the first option is not a possibility.

Most of the students who returned as part of Homecoming had cognitive challenges and multiple disabilities. More recently, schools have focused on the needs of children with serious emotional disabilities and those at risk.

### *Bridges: More of a Good Thing*

In November 1995, the Montgomery Elementary School was chosen to be a model program so that the successful approaches the school had put into place could be replicated in other areas of the country. The three-year outreach project, funded by the U.S. Department of Education, allows the Montgomery School to provide training to other schools, states and communities in educating all students in a general education setting. Montgomery Elementary School selected the name "Bridges" for this project.

According to Dr. Hamilton, Montgomery was chosen because of its small, rural character and the high incidence of poverty in the county -- and because of the success of the school and the community in supporting the needs of all students in the school.

### *Building Capacity*

Within the Montgomery School, the main thrust of the Bridges Project is building the school's and the community's capacity to meet the needs of all their children, particularly children with learning and behavioral disabilities, in a general education setting. Their experiences and expertise with this effort, in turn, are what the project has to offer other communities. Here is what Bridges staff (the project funds 1 1/2 positions, including Dr. Hamilton's) devote their time to: providing workshops, inservice training and direct technical assistance to teachers, administrators, families and community members; sitting in on the individual student support team meetings -- including students in both special education and the general student body; and acting as resource consultants to school faculty and administration, and the community.

Why would the Montgomery School -- with its distinguished track record welcoming and educating all the children in the community -- need the help of a program like Bridges to build capacity? The reason is that the resources any school needs to educate students with highly diverse needs are not developed and in place, though they are usually available, somewhere, somehow. Bridges helps Montgomery figure out where, and how.

Vermont has a state law that mandates coordination of services for children among and between the state agencies serving children and families. How practically useful the law is depends on how well it is understood and used. The law itself does not make the introductions for the people who work in schools, county mental health agencies and local social rehabilitation services, and it does not tell people how to find what they need. It does not make people familiar or comfortable with the process it mandates, and nothing in the law gave "the players" extra time to learn how to make it work.

Bridges helped one rural school "work the systems" to the benefit of its students and their families. Networking,

developing contracts, agreements or other arrangements, discovering resources and figuring out access -- these are the tasks of capacity-building.

A recent example involved a very young child at risk of suicide. Bridges helped the school and family identify the responsible people within the county so they could form an interagency team. Forming the team brought together the relevant state and local agencies to help. Some of the things that needed to happen to keep the child safe included finding both psychological and psychiatric expertise that wasn't too far away. Incidentally, transportation to related services such as psychological services is sometimes a problem. The Montgomery School has sometimes provided transportation as a related service when families cannot.

Next, they set up crisis responses at home and at school, and notified the county mental health agency about the situation and its seriousness. They helped the school and family make changes in the environment, like setting up safety checks and making drastic increases in the amount of supervision the child received. At school, they formed an Individual Student Support Team, and the members of that team shared responsibility for monitoring the child's safety. At home, parents, siblings, babysitters and a mentor from the community were all enlisted in helping.

Because the child's needs were very intense, they helped the family understand eligibility for other kinds of help, like mental health case management and respite care. They helped the family get and complete forms and deal effectively with the steps they had to take to get help.

### *Getting the Project Going*

Early in the project, a planning group of teachers, administrators, parents, paraprofessionals and other members of the community identified three main priority areas for the project. They are:

(1) The School-Community Team, which focuses on developing more community support and involvement in the school, and better links between the school, families and the wider community.

Unlike the other components of the project, this priority laid out new tasks rather than replicating something. The



focus of the School-Community Team is building community support and capacity for educating all children in the local public school. The School-Community Team (school personnel, students and members of the community) wrote a mission for itself: they would be looking for new ways for the community to address the needs of all children. The team picked three initial goals: (1) Finding ways for senior citizens to share their knowledge and experience with students; (2) Helping students, parents and other members of the community become more knowledgeable about computer technology; and (3) providing mentoring opportunities for all children -- with and without disabilities.

The activities connected with these tasks have been successful in bringing the community into the school in rewarding and interesting ways. Students and senior members of the community are creating a documentary film about the educational practices at Montgomery -- and some remarkable similarities between current practices and the education offered nearly a century ago in the local one-room schoolhouse. Wednesday evenings in Montgomery mean being at the school for many members of the community. Some activities available include learning about computers and the Internet, or participating in a mentoring project.

(2) The Model School Team helps the school coordinate and implement the many educational initiatives from local, State and Federal levels in a way that makes the most sense for them.

They have prioritized "best educational practices" for their school by sorting through the practices and priorities in the many initiatives (Goals 2000, Green Mountain Challenge, The National Agenda for children with serious emotional disturbances), and then identifying which ones Montgomery needed most, and were most consistent with their philosophies and goals. Then they sketched out objectives and action plans for meeting these goals. Two examples of priorities identified through this process are the development of curriculum based standards, and improved communication between the teachers, school, families and the community.

(3) Individual Student Support Teams, which are described above, support the teachers, support staff, and parents of children with learning and behavioral or emotional

challenges. However, teams can be formed for any student needing more help than is typical. Twelve of Montgomery's approximately 100 students have had Individual Student Support Teams, and only a few of them were part of special education.

In addition to teaching, the Montgomery faculty also participate on the above three teams. Montgomery School teachers also provide inservice training to other schools within Vermont, have done presentations at national conferences, and will facilitate an institute in Montgomery each summer or fall for other rural schools who are interested in experiencing their model for supporting all children in general education and the community.

### *Fall Institute in Montgomery*

The Montgomery Elementary School will be sharing its experiences and approaches with other small, rural schools throughout the United States at the Fall Institute in Montgomery, October 1 - 5, 1997. Teachers, parents and members of the Montgomery community will host the Institute, offering opportunities to observe actual classes, several mini-workshops and individualized team meetings for the participating schools.

To learn more about the Institute, to get information to attend, or just to talk about the Bridges Project or visit the Montgomery Elementary School, contact Ruth Walker Hamilton, Coordinator, Bridges Project, at (802) 326-4618 or (802) 656-1131. To visit the project's web site, point your web browser to: <http://www.uvm.edu/~uapvt/programs/bridges.html>



## *Transition Planning!* *Finding Support and Training* *Part II in a Series*

by Rick Swierat, Westchester ARC

After the last inclusion article for *Lessons Learned*, "Top Three Questions for the Plan", I received a number of calls from parents. They wanted to know my views about who is responsible for the transition plan.

Well, I have answers to that question. Undoubtedly, the school is legally responsible for transition planning, but I feel the parent is essentially responsible. The plain truth, as I see it, is schools are not prepared or informed enough about the student, the wide range of options, resources and training, and they are not capable of evaluating a successful plan for a student with special needs. Besides, effective planning is a life long process which does not begin or end with the school day. We --parents and students -- must take charge of our own plan.

This suggests the topic for this article on transition planning -- finding the supports and training. Using the top three questions (outlined in the first transition article, March/April 1997 issue of *Lessons Learned*), we now have a crude road map to identify resources. In fact, we have a beginning list of people, interests and personal assets for the student. The questionnaire, remember, is a snapshot in time, and should be updated periodically as the student gains age and experience. I would suggest updating it at least annually.

### *Identifying Resources for Support and Training*

**I** Create a list of all activities that the student likes, has had positive experiences with, and seems to show skill. Can these activities be seen as a job?

Remember, everyone starts his or her working career with a particular interest or skill which is part of a larger job. What skills or activities does the student seem to have skills or abilities in, which can be part of a larger job?

A number of students we know have shown interests and abilities in seemingly different areas. Envision someone who seems to like the idea of putting things in order, reading or films, and who tends to be extremely sociable and willing to discuss their interests with almost anyone. This student's skills do not fit your idea of what would be required to have an "assembly type job" in a sheltered workshop. The social skills would be a disadvantage for "staying on task."

We found opportunities for students with similar skills and interests as clerks in libraries, book stores or video stores. Also, small museums and nature centers have hired students with these skills for cleaning the displays and as "docents" (tour guides).

What skills and interests in your questionnaire can be parlayed into a job -- volunteer or paid? What local organizations are available to you to test out these skills in some job?

Often, jobs begin as a volunteer position which can lead to a paid position, or at the very least, a recommendation and notation for a resume.

**2** Using the questionnaire, graphically organize all the people who are listed and their level of involvement with the student (a best friend, people I help, people I know who could give advice, people I know who could give me a job, etc.). This list will grow as you begin to review and update the questionnaire. In fact, the questionnaire only elicited information about people directly related to the student. What about your contacts as a parent? I have used my contacts to get jobs for my children. That is true for most young adults. Using this expanded list, look at the student's interests and skills again and think about who could offer an opportunity, paid or volunteer, the student could use to get experience in the work world.



3 The first two lists will suggest obstacles. This is another not-so-mysterious part of transition planning: students will need to overcome obstacles. Transportation, supervision and job coaching, physical accessibility to the job or to specific tasks, the hours of the job and the student's availability and many more will be part of the planning process.

Before getting too deeply into resolutions to some of these questions, be sure obstacles are noted in the student's Individualized Education Plan (IEP). This will help getting needed supports lined up during the transition process.

Who can help with this part of the plan? Well, this is the time to start a community resource contact list. This list will grow over time.

The first contact should be the school. But whom? Generally the special education teacher has little contact with the job world or the world of accommodation. However, schools have guidance departments which are connected with community resources. My suggestion is to find the guidance counselor who seems to be involved with community organizations.

Next, call the local rehabilitation organizations -- ARC, United Cerebral Palsy (UCP), the Independent Living Center and so on, to find out who is involved in transition planning and programs. You may find organizations (like Westchester ARC) which has a dedicated staff for transition planning.

Also, at this time call local and state offices concerned with transition from school to adult life. While they may or may not be helpful initially, students must become "known" to these agencies. Be aware that some of these agencies may not be interested in taking the information you want to give them until the person is 18 or 19 years old, but I recommend insisting that they do it anyway. Tell them you will contact them later and you want the student's name "in the system," along with any future needs you can identify. The reason for "being known to the system" is this: in many areas of the State, it is getting harder and taking longer to get services people need as the rules for entering service systems change. Being on a list can simplify this process.

- ▶ Vocational and Educational Services for Individuals with Disabilities (VESID) State agency number: (518) 473-8097

- ▶ New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) and its regional Developmental Services Offices (DSO's) State agency number: (518) 473-9689

- ▶ New York State Department of Mental Health and County Departments of Mental Hygiene State agency number: (518) 474-2568

4 Think about other parents who have a child with a disability also going through transition. Parent to parent relationships often find answers because someone else may have already resolved one of the problems you struggle with. Or, like other family activities such as sports, you can work together to form a network for transportation and other needs. Parent groups can be very successful developing their own socialization programs for youth in transition, identify job opportunities among families and other supportive activities.

I mentioned the idea of developing a resume off-handedly. I recommend starting a resume as soon as possible, because it is important to document the experience and skills the student acquires during the transition years. A resume will let future employers judge the true skills and past experiences of the students's work capabilities. It also creates a list of references to call on for future support.

Alright, this is enough for now. Next time, I will offer a map of those skills and activities which, for a smooth transition, should be part of the student's life training between the ages of 15 and 21.

**For more information about this approach and its application with students, contact Ric Swierat, Westchester ARC, 74 Westmoreland Avenue, White Plains, New York 10606 (914) 428-0322.**



## Whatever It Takes

### *The Family Support Page*

Here is a list of resources, mostly national in focus, many of which offer help, information and/or support to parents of children with emotional and behavioral disabilities.

#### *National Resource List: Behavioral Disabilities*

Regional and New York State Resources for Parents of Children with Emotional, Behavioral and Mental Disorders

Families Together in New York State, Inc., P.O. Box 8630, 405 Quail St. Albany, NY 12208; 1-888-fam-togh (1-888-326-8644). Ninety eight family support projects throughout the State offer networking, information and support to families. For information, call Families Together.

National Disability Organizations And Agencies

Alexander Graham Bell Association for the Deaf, 3417 Volta Place NW, Washington, DC 20007-2778, 202/337-5220 V/TTY

Alzheimer's Association, 919 North Michigan Ave., Suite 1000, Chicago, IL 60611, 312/335-8700 V, 312/335-8882, 800/272-3900

American Association of the Deaf-Blind, 814 Thayer Av., #302, Silver Spring, MD 20910, 301/588-6545 TTY only

American Association of University Affiliated Programs for Persons with Developmental Disabilities, 8630 Fenton St., #410, Silver Spring, MD 20910, 301/588-8252, 588-3319 TTY

American Association on Mental Retardation, 444 N. Capitol St., NW, #846, Washington, DC 20001-1570, 202/387-1968 V, 800/424-3688, Fax 202/387-2193

American Council of the Blind, 1155-15th St., NW, #720, Washington, DC 20005, 202/467-5081 V, 800/424-8666, Fax 202/467-5085

American Diabetes Association (ADA), Diabetes Info Service Ctr., 1660 Duke St., Alexandria, VA 22314, 800/ADA-DISC

American Foundation for the Blind, 11 Perm Plaza, Suite 300, New York, NY 10001-2018, 212/620-2000 or 800/232-5463, 212/620-2158 TTY

American Society for Deaf Children, 2848 Arden Way, #210, Sacramento, CA 95825-1373, 916/482-0120 V/TTY, 800/942-ASDC V/TTY, Fax 916/482-0121

American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, MD 20852, 301/897-5700; Consumer Affairs: 800/638-8255, 301/897-0157 TTY; Fax 301/571-0457

Arc of the U.S., 500 E. Border St., #300, Arlington, TX 76010; 817/261-6003, 817/277-0553 TTY, 800/433-5255, 800/277-0553 TTY, Fax 817/277-3491

Arthritis Foundation, 1330 W. Peachtree St., Atlanta, GA 30309, 404/872-7100, 800/283-7800, Fax 404/872-0457

Association for the Care of Children's Health (ACCH), 7910 Woodmont Av., #300, Bethesda, MD 20814, 301/654-6549V

Association of Birth Defect Children, Inc. (ABDC), 827 Irma Ave., Orlando, FL 32803, 407/245-7035 V, 800/313-2232 V, Fax 407/245-7087

Autism Society of America, Inc., 7910 Woodmont Avenue, #650, Bethesda, MD 20814, 301/657-0881 V, 800/3-AUTISM



Bazelon Center for Mental Health Law (formerly Mental Health Law Project), 1101-15th St. NW, #1212, Washington, DC 20005; 202/467-5730, 202/467-4232 TTY, Fax 223-0409

Beach Center on Families and Disability, Bureau of Child Research, University of Kansas, 3111 Haworth Hall, Lawrence, KS 66045, 913/864-7600, Fax 913/864-7605

Better Hearing Institute, Hearing Helpline, P.O. Box 1840, Washington, DC 20013, 800/327-9355, Fax 703/750-9302

Brain Injury Association, 1776 Massachusetts Ave. NW, #100, Washington, DC 20036, 202/296-6443, 800/444-6443, Fax 202/296-8850

Cancer Fax, 301/402-5874 (National Cancer Institute) Cancer Information Service, 800/4-CANCER

Candlelighters' Childhood Cancer Foundation, 7910 Woodmont Av., #460, Bethesda, MD 20814, 301/657-8401, 800/366-CCCF, Fax 301/718-2686

Challenge (Attention Deficit Disorder Association), P.O. Box 488, West Newbury, MA 01985, 508/462-0495

Child and Adolescent Service System Program (CASSP) Nat'l Institute of Mental Health (NIMH), Parklawn Bldg., 5600 Fishers Lane, Rm. 11C-09, Rockville, MD 20857, 301/443-1333

Children with Attention Deficit Disorder (ChADD), 499 NW 70th Av., #308, Plantation, FL 33317, 305/587-3700

Children's Defense Fund, 25 E St. NW, Washington, DC 20001, 202/628-8787, Fax 202/662-3510

Cornelia deLange Syndrome Foundation, 60 Dyer Av., Collinsville, CT 06022, 800/223-8355, Fax 203/693-6819

Council for Exceptional Children (CEC), 1920 Association Dr., Reston, VA 22091-1589, 703/620-3660, 703/264-9446 TTY, 800/328-0272, Fax 703/264-9494

Disability Rights Education and Defense Fund (DREDF), 2212-6th St., Berkeley, CA 94710, 415/644-2555

Epilepsy Foundation of America (and National Epilepsy Library & Resource Center), 4351 Garden City Dr.,

Landover, MD 20785, 301/459-3700, 800/332-1000, 800/332-2070 TTY, Fax 301/577-2684

ERIC Clearinghouse on Adult Career & Vocational Education, 1900 Kenny Rd., Columbus, OH 43210, 614/292-4353 in OH, 800/848-4815, Fax 614/292-1260

ERIC Clearinghouse on Disability & Gifted Education, 1920 Association Dr., Reston, VA 22091, 703/620-3660 V, Fax 703/264-9494

Estate Planning for Persons with Disabilities, 2801 Hwy. 280 So., Birmingham, AL 35223-2407, 800/934-1929

Family Voices, P.O. Box 769, Algodones, NM 87001

Families of Spinal Muscular Atrophy, P.O. Box 196, Libertyville, IL 60048; 800/886-1762

Federation of Families for Children's Mental Health, 1021 Prince St., Alexandria, VA 22314-2971, 703/684-7710, Fax 703/836-1040

HEAL (Human Ecology Action League), P.O. Box 49126, Atlanta, GA 30359-1126; 404/248-1898 (for persons with environmental illnesses)

HEATH Resource Center, One Dupont Circle NW, #855, Washington, DC 20036-1110; 202/939-9320 T/TTY, 800/544-3284, Fax 833-4760 (national clearinghouse on postsecondary education for people with disabilities)

Helen Keller National Center for Deaf-Blind Youths & Adults (HKNC)/Technical Assistance Center, 111 Middle Neck Road, Sands Point, NY 11050, 516/944-8900, 516/944-8637 TTY, Fax 516/944-7302

Human Growth Foundation, 7777 Leesburg Pike, Falls Church, VA 22043, 703/883-1773, 800/451-6434, Fax 703/883-1776

Immune Deficiency Foundation, 25 W. Chesapeake Ave. #206, Baltimore, MD 21204-4820, 410/321-6647 in MD, 800/296-4433, Fax 410/321-9165

Institute for Families of Blind Children, P.O. Box 54700, MS 111, Los Angeles, CA 90054-0700, 213/669-4649 V, Fax 666-6283

International Fibrodysplasia Ossificans Progressiva Assoc., P.O. Box 3578, Winter Springs, FL 32708, 407/365-4194 V/Fax

Job Accommodation Network, West Virginia University, P.O. Box 6080, 918 Chestnut Ridge Rd., #1, Morgantown, WV 26506, 800/232-9675 or 800/526-7234 V/TTY, Fax 304/293-5407

Juvenile Diabetes Foundation International (JDF), 120 Wall St., New York, NY 10005-3904, 212/785-9500, 800/223-1138 V/TTY, Fax 212/785-9595

Learning Disabilities Association of America, 4156 Library Rd., Pittsburgh, PA 15234, 412/341-1515, 341-8077 V, Fax 412-344-0224

Leukemia Society of America, 600-3rd Av., 4th flr., New York, NY 10016, 212/573-8484, Fax 212/856-9686, 800/955-4654

Lowe's Syndrome Association, 222 Lincoln St., West Lafayette, IN 47906, 317/743-3634 V

Lupus Foundation of America, Inc., 130 Piccard, Suite 200, Rockville, MD 20850, 301/670-9292 V, 800/558-0121, 301/670-9486

March of Dimes Birth Defects Foundation, 1275 Mamaroneck Av., White Plains, NY 10605, 914/428-7100 V/TTY, Fax 914/428-8203

Muscular Dystrophy Association, 3300 E. Sunrise Dr., Tucson, AZ 85718; 602/529-2000 V, 800/572-1717, Fax 602/529-5300

National Alliance for the Mentally Ill, 200 No. Glebe Rd. #1015, Arlington, VA 22203-3754, 703/524-7600V, 703/516-7991 TTY, 800/950-NAMI, Fax 703/524-9094

National Association for Parents of the Visually Impaired, Inc., P.O. Box 317, Watertown, MA 02272, 617/972-7441, 800/562-6265, Fax 617/972-7444

National Association of Protection and Advocacy Systems, 900-2nd St. NE, #211, Washington, D.C. 20002, 202/408-9514 V, 202/408-9521, Fax 202/408-9520

National Association of the Deaf, 814 Thayer Av., Silver

Spring, MD 20910-4500, 301/587-1788, 301/587-1789 TTY, Fax 301/587-1791

National Association of State Directors of Special Education (NASDSE), 1800 Diagonal Rd., #320, Alexandria, VA 22314-2840, 703/519-3800, 703/519-7008 TTY, Fax 703/519-3908

National Autism Hotline, P.O. Box 507, Huntington, WV 25710-0507, 304/525-8014 V, Fax 304/525-8026

National Brain Injury Research Foundation, 14408 Newton Patent Ct., Centreville, VA 22020, 703/818-0078, 800/447-8445

National Captioning Institute, 5203 Leesburg Pike, 15th Flr., Falls Church, VA 22041, 800/533-WORD, 800/321-TTYS TTY

National Center for Clinical Infant Programs, 2000-14th Street N., #380, Arlington, VA 22201, 703/528-4300, 703/528-0419 TTY, Fax 703/528-6848

National Center for Education in Maternal & Child Health, 2200-15th St. N., #701, Arlington, VA 22201, 703/524-7802 V, Fax 703/52-9335

National Center for Law and the Deaf, 800 Florida Av. NE, Washington, DC 20002, 202/651-5454 TTY

National Center for Stuttering, 200 E. 33rd St., #17C, New York, NY 10016, 800/221-2483, Fax 212/683-1372

National Chronic Pain Outreach Association (NCPOA), 7979 Old Georgetown Rd., #100, Bethesda, MD 20814, 301/652-4948 V, Fax 301/907-0745

National Clearinghouse on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, OR 97207-0751, 800/628-1696, 503/725-4165 TTY

National Coalition on Deaf-Blindness, 175 North Beach St., Watertown, MA 02172, 617/972-7347

National Council on Disability, 800 Independence Av. SW, #814, Washington, DC 20591, 202/267-3846, 202/267-3846 TTY



National Cystic Fibrosis Foundation, 6931 Arlington Rd., Bethesda, MD 20814, 301/951-4422 V/TTY, 800/344-4823 V/TTY, Fax 301/951-6378

National Diabetes Information Clearinghouse (NDIC), 1 Information Way, Bethesda, MD 20892-3560, 301/654-3327 V, 301/657-2172 TTY

National Down Syndrome Congress, 1605 Chantilly Dr. NE, #250, Atlanta, GA 30324-3269, 404/633-1555 V, 800/232-NDSC V, Fax 404/633-2817

National Down Syndrome Society, 666 Broadway, #810, New York, NY 10012-2317, 212/460-9330 V, 800/221-4602, Fax 212/979-2873

National Early Childhood Technical Assistance System (NEC\*TAS), 137 E. Franklin St., 500 Nation's Bank Plaza, Chapel Hill, NC 27514, 919/962-2001 V, 919/966-4041 TTY, Fax 919/966-7463

National Easter Seal Society, 230 W. Monroe, #1800, Chicago, IL 60606, 312/726-6200, 726-4258 TTY, 800/221-6827, Fax 312/726-1494

National Fragile X Foundation, 1441 York St., #303, Denver, CO 80206, 303/333-6155, 800/688-8765

National Health Information Center (Office of Disease Prevention and Health Promotion), P.O. Box 1133, Washington, DC 20013-1133, 800/336-4797

National Hearing Aid Society, 20361 Middle Belt Rd., Livonia, MI 48152, 810/478-2610, 800/521-5247, Fax 810/478-4520

National Information Center for Children and Youth with Disabilities (NICHCY), Mailing Address: P.O. Box 1492, Washington, DC 20013, 202/884-8200 V/TTY, 800/695-0285 V/TTY, Fax 202/884-8441

National Information Center on Deafness, Gallaudet University, 800 Florida Av. NE, Washington, D.C. 20002-3625, 202/651-5051, 202/651-5052 TTY, Fax 202/651-5054

National Information Clearinghouse for Infants with Disabilities and Life-Threatening Conditions, CDD/USC, Benson Bldg., 1st Flr., Columbia, SC 29208, 803/777-4435,

803/777-7826 TTY, 800/922-9234, Fax 803/777-6058

National Institute on Disability and Rehabilitation Research (NIDRR), Department of Education, 600 Independent Ave. SW, Washington, DC 20202-2572, 202/205-8134 V, 202/205-9136 TTY, Fax 202/205-8515

National Library Service for the Blind and Physically Handicapped, Library of Congress, 1291 Taylor St. NW, Washington, DC 20542, 202/707-5100 V, 707-0744 TTY, 800/424-8567 V/TTY, Fax 202/707-0712

National Mental Health Association, 1021 Prince St., Alexandria, VA 22314-2971, 703/684-7722, 800/969-6642

National Multiple Sclerosis Society, 733-3rd Av., New York, NY 10017, 212/986-3240, 800/344-4867, Fax 212/986-7981

National Organization for Albinism & Hypopigmentation, 1500 Locust St., #1816, Philadelphia, PA 19102, 215/545-2322

National Organization for Rare Disorders (NORD), P.O. Box 8923, New Fairfield, CT 06812, 203/746-6518, 202/746-6927 TTY, 800/999-NORD V, Fax 203/746-6481

National Organization on Disability, 910-16th St. NW, #600, Washington, DC 20006, 202/293-5960, 202/293-5968 TTY, Fax 202/293-7999

National Parent Network on Disabilities, 1727 King St., Suite 305, Alexandria, VA 22314, 703/684-6763 V/TTY, Fax 836-1232

National Rehabilitation Information Center (ABLEDATA), 8455 Colesville Rd., #935, Silver Spring, MD 20910-3319, 301/588-9284 V, 301/495-5626 TTY, 800/346-2742, Fax 301/587-1967

National Retinitis Pigmentosa Foundation, Inc., 11350 McCormick Rd., #800, Hunt Valley, MD 21031-1002, 800/638-5683 TTY

National Spinal Cord Injury Assn., 8300 Colesville Rd., Suite 5515, Silver Springs, MD 20910, 301/588-6959 V, 800/962-9629, Fax 301/588-9414

National Tourette Syndrome Association, 4240 Bell Blvd., Suite 205, Bayside, NY 11361, 718/224-2999, 800/237-0717, Fax 718/279-9596

National Tuberous Sclerosis Association, 8181 Professional Place, Suite 110, Landover, MD 20785, 300/459-9888 V, 800/225-NTSA, Fax 301/459-0394

Office for Civil Rights National Office, Department of Education, Rm. 5000, Switzer Bldg., 400 Maryland Av. SW, Washington, DC 20202

Office of Civil Rights, Region 5, Department of Education, 111 No. Canal Street, Suite 1053, Chicago, IL 60606, 312/886-8438 (region covering Minnesota)

Office of Special Education Programs (OSEP), Switzer Bldg., 400 Maryland Av. SW, Stop 2651, Washington, DC 20202-2651, 202/205-5507 V, Fax 202/260-0416

Office of Special Education & Rehabilitative Services (OSERS), Rm. 3006 Switzer Bldg., 330 C St. SW, Washington, DC 20202-2500, 202/205-5465 V/TTY, Fax 202/205-9252

Orton Society, 8600 LaSalle Rd., Chester Bldg., #382, Baltimore, MD 21286-2044, 301/296-0232 (dyslexia)

Osteogenesis Imperfecta Foundation, Inc., P.O. Box 24776, Tampa, FL 33623-4776, 813/855-7077 Pacer Center, 4826 Chicago Avenue South, Minneapolis, MN 55417. Web site: <http://www.pacer.org> E-mail: [mnpac@edu.gte.net](mailto:mnpac@edu.gte.net)

People First, Inc., 800/433-5255 (self-advocacy group) Prader-Willi Syndrome Association, 2510 S. Brentwood Blvd., #220, St. Louis, MO 63144, 314/962-7644, 800/926-4797, Fax 314/962-7869

Protection and Advocacy for Mentally Ill Program (PAMI), National Institute of Mental Health, Rm. 15C-21, 5600 Fishers Lane, Rockville, MD 20857, 301/443-3667, Fax 301/443-7926

Resource Access Project (RAP), Univ. of Illinois, Dept. of Spec. Ed., 403 E. Healey, Champaign, IL 61820, 217/333-3876, Fax 217/333-4293

Schools Are For Everyone (SAFE), 7800 Shoal Creek Blvd., #171-E, Austin, TX 78757

Self-Help for Hard of Hearing People, Inc., 7910 Woodmont

Ave., #1200, Bethesda, MD 20814, 301/657-2248, 657-2249 TTY, Fax 301/913-9413

SEPT/TA (Supported Employment Parents Transition & Technical Assistance), c/o PACER Center, 4826 Chicago Av. S., Mpls., MN 55417; 612/827-2966 V/TTY, Fax 827-3065

Short Stature Foundation (formerly Little People of America), P.O. Box 9897, Washington, DC 20016, 800/24DWARF

Sick Kids Need Involved People, Inc. (SKIP), 216 Newport Dr., Severna Park, MD 21146

Spina Bifida Association of America, 4590 MacArthur Blvd. NW, Suite 250, Washington, D.C. 20007, 202/944-3285, 800/621-3141, Fax 202/944-3295

Technical Assistance for Parent Programs (TAPP), 95 Berkeley St., #104, Boston, MA 02116, 617/482-2915 V/TTY

National Center for Research in Vocational Education, University of Illinois, Rm. 345 Education Building, 1310 S. Sixth St., Champaign, IL 61820, 217/333-2609 V/TTY, Fax 217/244-5632

Technical Assistance on Training about the Rehabilitation Act (TATRA), c/o PACER Center, 4826 Chicago Ave. S., Mpls., MN 55417-1098; 612/827-2966 V/TTY, 800/53PACER (for parents in greater Minnesota), Fax 612/827-3065

The Association for Persons with Severe Handicaps (TASH), 29 W. Susquehanna Ave., Suite 210, Baltimore, MD 21204, 410/828-1306 V/TTY, 800/482-TASH, Fax 410/828-6706

United Cerebral Palsy Association, 1522 K St., NW, #1112, Washington, D.C. 20005, 202/842-1266 V/TTY, 800/872-5827

Very Special Arts, 1331 F Street NW, #800, Washington, DC 20004, 202/844-9040 V, 202/737-0645 TTY, 800/933-8721, Fax 202/737-0725

Williams Syndrome Association, P.O. Box 297, Clawson, MI 48017, 810/541-3630

World Institute on Disability, 510-16th St., #100, Oakland, CA 94612, 510/763-4100, 510/208-9493 TTY



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