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ABSTRACT

The increased emphasis on having individual developmental disabilities diagnosed by interdisciplinary teams of professionals has raised complex problems involving time and expense in evaluating a child in his home situation. The John F. Kennedy Child Development Center has a plan to avoid moving professionals to observe a child or to having a child's family move to an interdisciplinary evaluation center. The plan is based on the use of videotape recording (VTR) in the child's own home situation. It causes little inconvenience to the family, is more unobtrusive than a group of observers, and makes it possible for a team of specialists miles away to observe directly the dynamics of the family and the behavior of the child. These standard samples of a child's behavioral repertoire can accompany regular written protocols and can record the administration of developmental tests. Evaluation and diagnostic sessions can involve the professionals at the center, the VTR, and professionals in the child's locale, who can participate by means of a long-distance amplified telephone. The training impact of a university-affiliated center's operation would therefore be extended.  
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LONG DISTANCE INTERDISCIPLINARY EVALUATION OF DEVELOPMENTAL DISABILITIES

By: John Meier

November, 1969

In view of the current and increasing emphasis being placed upon the advisability of diagnoses of individual developmental disabilities by teams of professionals from several disciplines, and in view of the fact that these kinds of agencies are relatively rare and expensive to maintain, some means for extending their services to a wider geography and broader spectrum of socio-economic status groups is exigent. Some university-affiliated interdisciplinary evaluation centers have either established or plan to build facilities for families to live in during a diagnostic evaluation of one of the children in the family. These motel-like arrangements facilitate evaluation of family interaction; some are even equipped with one-way vision observation areas in the motel unit itself for study of family dynamics. Although these units do enable the parents to conveniently participate in the evaluation of the whole child, it is still a rather impractical arrangement for low socio-economic status families who must come in from points far distant from the center. These families typically cannot afford to make the trip itself, nor pay for meals in restaurants, nor leave whatever sources of meager income they may have since such an absence not only reduces their scarce income but may even jeopardize continued employment.

An alternative to the family's coming into the center is that of an interdisciplinary team's going to the family. Since this requires an exorbitant investment of man hours in travel and other unrelated activities, it is a most inefficient use of professional time. For a group of interdisciplinary professional persons to spend a half to one and one-half days traveling for each three or four hours of intensive work-ups is obviously contraindicated from the standpoint of both time and effort. Although there are times when the exposure of such an interdisciplinary group to the debilitating or peculiar circumstances of a given family's environment is quite instructive, it is not indicated on a routine basis.

A third alternative to extending services to remote areas of impoverished people is via the application of various new media. Based on satisfactory experiences using videotape recording for various training purposes (Meier, 1967, 1968a, 1968b, 1969), it is suggested that one of the primary objections to doing diagnoses without the actual presence of the patient might be overcome by having the patient "seen" on a videotape recording. It is not a coincidence that clinics typically refer to the number of patients seen since most clinicians feel quite uneasy about blindly discussing a patient or client whose physical characteristics and behavioral features are known only from abstract report protocols. The videotape recording (VTR) system could become an integral part of a cooperating clinic's diagnostic equipment or an itinerant technician could take the quite portable VTR system from clinic to clinic; in either case it is a very inexpensive solution to providing interdisciplinary evaluations to children who cannot otherwise avail themselves of the service.

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It is proposed, therefore, that standard samples of a child's behavioral repertoire be captured on a VTR to supplement the written protocols and to enable the clinician to assess some of the child's functioning by indirect TV observation. The standardized samples of the child's behavior includes both unstructured and structured episodes of relatively short duration, thus filling no more than one total hour of several behavior samples recorded on videotape. These include the administration of a given series of developmental tests under standardized conditions. One such test, which can be satisfactorily used by members of a number of different disciplines, is the Denver Developmental Screening Test. The referring agency administers the DDST to the child and videotapes all procedures, including some close-up recordings of specified physical features of the child. Of course, samples from other more elaborate tests such as the Yale Developmental Scales, the Bayley Infant Scales, the Stanford-Binet or Wechsler Intelligence Scales, or the Illinois Test of Psycholinguistic Abilities could also be used in a similar manner.

In addition to the aforementioned VTR samples of real behavior, a series of written criteria are assessed and checked on written forms; several examples of such data collection instruments are included as a part of this paper\*. Completion of these coding forms by the respective local specialists insures both a standard set of data on each child and the involvement of the local professionals with whom responsibility for the case's management ultimately rests. The rather detailed forms also insure that certain salient information is not neglected in any given evaluation (Meier & Martin, 1969).

The Patient Flow System Chart (Figure 1) indicates the procedures through which children typically pass in order to receive a complete interdisciplinary evaluation at the JFK Child Development Center. The steps are clearly identified but, in the case of long-distance evaluations, the usual procedures are somewhat modified in order to have local professionals perform much of the hands-on diagnostic work and record this on written forms and videotape which are mailed to the JFK Center.

At a prearranged time, the JFK Center staff holds an evaluation session regarding the child in question so that the professionals in the child's locale who participated in gathering the diagnostic data can be included in the case conferencing by means of long-distance amplified telephone conversations. Thus, a case conference is held at the JFK Center with members of various disciplines present to comment upon the coded diagnostic data and the videotaped recording of the child's behavior. In cases where a tele-lecture arrangement is not feasible, the possibility of videotape recording the case conference and sending it back to the referring agency for review is another option which causes an additional delay in getting on with the treatment recommendations and suffers from the absence of a give-and-take conversation. A somewhat more elaborate approach in especially complex cases uses the coded information, laboratory findings from samples mailed to the JFK Center and analyzed in the B.F. Stolin sky Laboratories here, a videotape recording of the child's behavior under structured and unstructured conditions, a videotape recorded case conference mailed back to

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\*The writer is indebted to numerous members of the JFK Child Development Center staff for providing expert input into the content of these forms. The location listed on the upper right-hand corner of the first page of any coding form corresponds to its respective location in the Patient Flow System (Figure 1).

the referring agency, and a follow-up conference call or tele-lecture arrangement for the professionals involved to discuss controversial or ambiguous findings and recommendations. Various modifications of this procedure would be instituted in individual cases in order to accommodate whatever idiosyncratic complications may be presented.

Once a series of satellite centers for long-distance evaluations have been established, not only diagnostic evaluations might be conducted in this fashion, but also additional training experiences in recommended management could readily be programmed around individual cases referred to the JFK Center. This would facilitate constant interaction among professionals and the sharing of interdisciplinary expertise with the isolated private practitioner around cases with which he is intimately familiar and deeply invested. This would extend the training impact of a university-affiliated center's operation which is most compatible with its primary reason for being - namely, the training of interdisciplinary professionals working with children who have various developmental disabilities.

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