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TO: School Nurses of Minnesota

FROM: Betty Hubbard

RE: Education of Handicapped Children in Minnesota - Past History

Minnesota's public school system has had a long history of concern for handicapped children, although the first mandate was not passed until 1957. The scourge of polio filled classes for post-polio children up until the discovery of the Salk vaccine. There were classes for educable mentally retarded children at the elementary level, starting in the years after World War I, not in every district by any means, but in a number of the larger ones. At the junior and senior high levels, there were few classes, even after the passage of the 1957 law. Because medical science had not yet made the connection between the oxygen given premature infants and retrolental fibroplasia, there were classes for blind children in a few school districts and a state Braille and Sight-Saving School at Faribault, operated by the Department of Public Welfare. There were also classes for hearing impaired children in the metropolitan districts of St. Paul and Minneapolis, and the State School for the Deaf, also in Faribault. There were even classes for trainable children that pre-dated even the permissive law that was passed at the same time as the educable law in 1957. St. Paul's program, reputed to be the second oldest public school program for trainable children in the nation, has an interesting history. It was started as a Works Project Administration (WPA) program in 1934. When the federal funds were exhausted and the City Council, which operated the schools at that time, declined to continue the program, militant parents marched on the State Capitol with their children and demanded that same form of state aid be given to the local schools so that the program could be continued. The city fathers bowed to the pressure and moved the classes into old Crowley School. Built in 1887, the building was notable

chiefly for such insurmountable architectural barriers as long flights of stairs and lavatories located in the basement.

Besides the aforementioned barriers, children were excluded if they had a handicap in addition to their mental retardation. This meant that children who were deaf, blind, physically handicapped or behavior disordered, as well as retarded, were not accepted. The state guidelines specified that, to be eligible for a trainable class, a child had to be ambulatory, toilet trained and able to communicate. This meant that many children spent their most valuable learning years at home while their parents, without help from the schools or any other agency, struggled to give their children the skills they were required to have to assure entree into that exclusive club, the trainable class. Some children did not enter school until they were eleven or twelve years of age. Teachers were trained to teach reading, writing and spelling, and it was commonplace to see strapping 21-year-olds laboriously copying the first few letters of the alphabet or wielding crayons on coloring books meant for five-year-olds. These same young people were frequently unable to dress themselves, brush their teeth, or relate appropriately either to their peers or to the adults in their world. In spite of the tough membership criteria, the school always had a long waiting list of eligible children.

Until the special education law was passed in 1957, teacher training was given in summer sessions at Faribault State School and Colony. After 1957, the University of Minnesota's Department of Psychology offered late afternoon and Saturday morning classes for teachers already in the field, both on the Minneapolis campus and in high school auditoriums throughout the state. All the teachers were what one University professor irreverently described as "retreads". Once the immediate needs were met, the University and the state colleges at Mankato, St. Cloud and Moorhead began recruiting

undergraduates, most of whom did their learning on the job because their training had little to do with the needs of the children they found themselves facing. They were responsible for developing their own special education materials and curricula, or adapting what was available in the building. Many children had the same teacher for their whole elementary experience, and the program was characterized more by what had been removed from the curriculum than by what remained. Most school districts in the state did not have senior high school programs for mentally retarded students and either kept them in junior high school programs until they were old enough to graduate, or, if they could not survive in the regular senior high school, simply encouraged them to leave school.

When I joined the St. Paul Schools in 1966, I tackled something that had bothered me a great deal during my years as the executive director of the ARC of St. Paul. Even before I had the benefit of the D. D. Legal Advocacy Project, it seemed to me that it was surely illegal to keep eligible children on a waiting list for the trainable program, especially since it appeared that the most persistent and vocal parents were the ones who got their children into the few openings. The excuse for maintaining a waiting list instead of expanding the program was that the program was "permissive". My position was that, by any logic, if the district served one eligible child, all similarly eligible children would have to be enrolled. This argument was successful, classes were added, and the waiting list became a thing of the past.

We used the same argument to get mentally retarded children with cerebral palsy, muscular dystrophy and spina bifida into Lindsay School, the district's school for children with physical disabilities. It was not until the discovery of the Salk vaccine that Lindsay School began to accept children with cerebral palsy, and then only those with average or borderline intelligence. Today,

Bridge View School has more children in wheelchairs than Como Elementary School, (the integrated school which succeeded Lindsay School), which houses the East Metropolitan regional program for children with physical and sensory disabilities, proving beyond doubt that the multiphandicapped child is not the rarity that educators once believed.

The ARC parents who lobbied so vigorously and effectively for the passage of the special education law in 1957 soon realized that allowing the education of children with I.Q.'s under 50 to be provided at the whim of school districts was excluding their children from their educational birthright. After trying to right this wrong without success, the Association for Retarded Children took another tack. They invented something called day activity centers, wrote a bill, and lobbied it through the Legislature. The effect of the establishment of DAC's throughout the state was dramatic. It made visible a whole population of children legislators and educators believed were safely warehoused in state institutions. With this visibility came recognition by school administrators and school boards that these were children who looked hauntingly like the educable mentally retarded youngsters in their special classes!. It became very hard to justify excluding children because of an I.Q. point or two. Finally, in 1971, after the most intensive lobbying effort ever devoted to an education bill, all handicapped children were included in Minnesota's special education statute. A sweetly assertive ARC lobbyist turned up in the office of the state director of special education on the day after the governor signed the new bill to remind him that her young son, then living in a state hospital ward, was now eligible for a public school education. Thus began Minnesota's unique policy of requiring the districts in which state hospitals are located to provide education for their school-age residents. It was not until 1975, with P.L. 94-142, the Education for All Handicapped Children Act, looming on the horizon that due process procedures were introduced into Minnesota's statutes.

The Decline of School Health Services. It doesn't do much good at this point to speculate on the reasons for the decline in the numbers of school nurses in Minnesota school districts during the 1970's, but calling some of them to mind might help to insure that comprehensive school health programs will become an essential part of every child's education. Nurses were not seen as an integral part of the school faculty. The concept of teaming was unheard of. The nurse's role was defined by the principal, and many principals did not, (and still do not), understand health promotion, nutrition education, and the importance of the child's medical diagnosis and treatment to the individualized education program. Program decisions continue to be made by teachers and school psychologists, without reference to the important and valuable contributions of the school nurse. Many school nurses have exhibited the traditional subservience to authority that was once carefully trained into nurses, and have accepted roles that do not use their skills, or greatly underuse them.

There is no doubt that restoring professional nurses can only be done successfully as a part of a total school health program, starting in kindergarten, not in junior or senior high school, and using nurses as health educators as well as health practitioners, and members of the building team that assesses and plans for children with disabilities and other health impairments. Educating administrators, building faculty and parents to view nurses as trained observers, communicators, (with physicians, clinics, parents, other community agencies), as screeners, as parent educators, as instructors, as group leaders, and as team members will wipe out the negative image of the school nurse as expendable.

How to Serve as Change Agents. Help your principal to rethink your role. Intrude yourself into the IEP process, especially when you have information that needs to be considered in the planning of the child's program. Join coalitions that help to set legislative priorities. Participate in special education

meetings and workshops representing SNOM. Get a SNOM representative on the agenda of MEA, MFT, MSBA, MASE and MASA meetings, as a part of a panel on the team approach, or health promotion K-12, or the school's responsibility to encourage wellness, or whatever. If SNOM members can't function this way, see that the advocacy organizations have good information so that they can represent your interests (the improved health of children and families) as a part of their interests. Look into co-mingling of funds (Services for Children with Handicaps, preschool incentive grants, Maternal and Child Health block grants, EPS/DT) to help to build aggressive school health programs, developing both urban and rural models. Influence the development of fresh, exciting health education curricula at the state level by seeing that school nurses are included in curriculum planning committees. Use the language in P.L. 94-142 that includes the school nurse in the IEP process to help parents and special educators to recognize the importance of the child's medical and health history in the planning and day-to-day implementation of the IEP. Reach out to the other organizations and agencies that share your concern for prevention, early intervention and health promotion. Get the teacher organizations to understand and value your role on the school faculty, and to support your special interests before the State Legislature.