Survey of Need for a New Professional

The Clinic Liaison Educator

HARVEY IS 8 YEARS OLD. He came to the clinic for evaluation because his teacher reported that, although he is pleasant, cooperative, and conversant on many topics, he has great difficulty reading. He omits words, confuses similar words, and loses his place regularly. His writing is awkward and careless with omitted and run-on parts; he cannot write in a straight line. In gym he constantly confuses directions and has difficulty dressing himself. The principal and social worker report that he cries when his mother leaves him at school and again when she picks him up, and he doesn't relate well to other children. He looks pale and stunted for his age and, according to his mother, he takes medication for an allergy and "low blood." The school psychologist found him difficult to test because he was "constantly moving and manipulating any object he could get his hands on." His mother says she fears he is retarded. His father travels and is almost never home.

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CLINIC: (to school) We have diagnosed Harvey's problem as a case of idiopathic hypoglycemia with possible minimal cerebral dysfunction. But not conclusively.

SCHOOL: (to clinic) What does that mean?

CLINIC: This means that Harvey has many of the symptoms of the effects of low blood sugar, but that these symptoms could also reflect other common medical problems. In addition, he seems to have emotional problems which, in such cases, usually tend to mask actual physical symptoms. Such overlapping renders a definitive diagnosis almost impossible.

SCHOOL: What do you suggest we do?

CLINIC: We recommend special class placement in a learning disabilities classroom. He may also need additional private tutoring.

SCHOOL: Where do we find someone qualified to conduct this special tutoring?

CLINIC: We cannot guarantee we will find a tutor for Harvey. This is not actually part of our job, and we usually leave this responsibility with the schools.

SCHOOL: Have you made prescriptive educational recommendations for Harvey?

CLINIC: Not exactly. Most of that will be up to you. Our clinic is staffed only by diagnosticians in pediatrics, neurology, psychiatry, psychology, and speech and hearing. Regrettably, we have been unable to find a qualified clinic professional who would be of more help to you. We are also struggling financially and might not be able to employ someone anyway. We must rely on you for educational assessment and diagnosis. Is someone available to do that?

SCHOOL: Maybe, maybe not. There are several very capable teachers in the system who have had such experience, but they have their own regular classrooms. Even our school psychologists are not qualified to deal professionally

with cases such as Harvey's. Of course, we'll do the best we can. Send us a copy of what findings and recommendations you do have; perhaps we can find someone to interpret their educational implications. Meanwhile, what do you suggest we tell his parents?

CLINIC: We have discussed the problem with them already. We feel they are beginning to understand that Harvey is not retarded and that he has emotional problems, but we have done all we can. They seem very anxious, and we feel that they need counseling. We suggest you recommend someone or provide a counselor for them.

SCHOOL: Our teachers are our only parent counselors, and Harvey's teacher just can't give his parents any more time. His mother calls her nearly every day, and she's actually not trained for counseling parents. We will try, however, to find a community agency that can help them. Do you feel that Harvey needs special materials that we might not have here at the school?

CLINIC: That depends on the results of your educational diagnosis. Medically speaking, no. If you need help in this area, you might call the special education department of the university. That's the only suggestion we feel confident in giving.

SCHOOL: We have had these problems before. It's always the same. We need help.

CLINIC: Yes, it's exasperating. We wish we could help you more. If you have questions, call and we will do what we can.

SCHOOL: Thanks very much. Let us know if we can be of service to you.

The preceding dialog is a grim illustration of the less than perfect communication between schools and clinics. Training programs have not produced the professional who could dissipate the confusion. This professional would need to function particularly in five roles.

1. Retrieve educational data concerning a particular child's current school performance for clinical evaluation

2. Conduct educational evaluations within the clinic which result in prescriptive educational recommendations

3. Consult with the clinical staff regarding availability of special school services, appropriate educational techniques and materials, and the practicality of implementing clinical recommendations at the school level

4. Interpret clinic findings to local school staff and parents

5. Assist schools in finding effective alternative methods of working with a particular student. These would include supplying sources of materials, informing teachers of similar cases and how they were handled, and aiding schools in securing additional support from auxiliary programs which provide financial resources or equipment such as wheelchairs.

This professional could then expedite resolution of the postdiagnostic confusion and implement Harvey's remediation in 2 weeks instead of 2 months. In this paper, the connecting link between schools and both mental retardation and psychiatric clinics is referred to as the liaison educator.

The difficulty confronting those who would seek to become this newly developing specialist is a lack of training programs. Professionals at the University of Cincinnati recognized the need and began designing a program specifically for educators who wish to work in clinical settings. Orientation was weighted necessarily toward an interdisciplinary approach with corresponding practical experience.

With these concerns in mind, we devised a questionnaire and sent it to the directors of more than 250 mental retardation (MR) and psychiatric clinics. Fifty-three percent of the questionnaires were returned. From the responses, 32 pairs (one MR and one psychiatric clinic) were matched according to location of the clinics, size of the geographic area they serve, and size of the student population they represent. Results have been interpreted only in general terms; the emphasis is on the new and important information revealed by the results.

Clinic directors were referred to the previously defined job responsibilities of the liaison educator and asked whether they employed such a person, whether they needed one, what level of training he should have, to whom he would be directly responsible, what geographic area and total population he would serve, and what salary he would receive.

In addition, the participating clinics were asked specific questions about their particular setting, including how many students they served directly annually, what proportion of the total population in their area they served, and what age categories the clinic served. Two important considerations concerned the areas of exceptionality that clinics were evaluating among their clients (and therefore those areas for which the liaison educator would

be responsible) and what competencies the educator must have to qualify for the liaison position. Respondents were cooperative and enthusiastic.

Need for a Liaison Educator

The need for the liaison educator as a personnel position was overwhelmingly verified. A composite drawn from the responses indicated that both types of clinics wanted a person who would be directly responsible to the director of the agency and would serve a population of more than 100,000 students living in several counties. The clinics would pay $9,000 to $12,000 a year to a liaison educator with a master's degree. The need was established, at least in a general sense, on the basis of these responses from the clinics, expressed in percentages:

Question-answer	*Mental retardation*	*Psychiatric*
Yes, we do employ a person who functions in a capacity similar to that of a liaison educator ..	40.6	34.4
No, we do not employ one	59.4	65.6
Yes, we need a liaison educator	90.6	75.0
No, we do not need one	9.4	15.6
We're not sure	..	9.4

Between 72 and 81 percent preferred a specialist on the master's level. Preference for someone with a bachelor's degree was negligible, and a doctoral degree holder was selected by 19 percent of the MR clinics and 42 percent of the psychiatric clinics.

The discrepancy between selection of the educational levels could reflect the clinic directors' belief that a master's graduate could fill the responsibilities while, understandably, they might have most confidence in a PhD degree holder.

The question of salary probably also lends appeal to the selection of persons with a master's degree. The comparatively sizable response to the choice of someone with a doctorate might also reflect underlying attitudes about existing master's programs; that is, present programs simply are not comprehensive enough to encompass the considerable spectrum of training a liaison educator needs. This point warrants discussion, which will be taken up later.

Salary and Supervision

"If only we had the money" and "no funds" were among the comments in response to questions of training level and salary. References to the Federal budget squeeze provided insight into the financial situation affecting many clinics. The message which seemed to emerge from the responses was "this sounds great, but please, we'd rather not see a pretty pie we can't eat." Despite possible monetary limitations, the salary level most often selected from the six salary scales presented was the $9,000–$12,000 bracket, the base salary for a master's degree holder. Salaries and responses, in percentages, were as follows:

Salary	*Mental retardation*	*Psychiatric*
Bachelor of science:		
$6,000–$9,000	28.1	18.6
$9,000–$12,000	15.6	21.9
Master of education:		
$9,000–$12,000	53.1	56.3
$12,000–$15,000	28.1	18.6
Doctor of philosophy:		
$14,000–$17,000	34.3	40.6
$17,000 or more	6.3	6.3

Many clinics listed several responses to the salary question, which coincided with varied responses to the level of training that would be appropriate to the clinic's needs. One reason could be that those in the service professions tend to hire the most qualified person in terms of his personal suitability to a particular clinic rather than in terms of his actual credentials. In other words, this field remains one area in which employment depends largely upon the individual person.

Another possibility might be that, although between 72 and 81 percent of the clinics wanted a master's graduate, between 44 and 40 percent of them selected a salary between $6,000 and $8,000. Admittedly, this inconsistency might reflect the difficulty with the question format; there were six answer choices in three categories (bachelor's, master's, and doctorate degree holders).

Table 1. Areas of the liaison educator's responsibilities, by type of disability (in percentages)

Type of disability	Mental retardation	Psychiatric
Educable mentally retarded	96.9	53.1
Trainable mentally retarded	96.9	37.5
Emotionally disturbed	75.0	100.0
Socially maladjusted	78.1	84.4
Learning disabilities	87.5	87.5
Speech impaired	78.1	15.6
Physically handicapped	78.1	15.6
Chronic health problems	56.3	15.6
Hard of hearing	68.8	9.4
Deaf	59.4	6.3
Partially sighted	68.8	9.4
Blind	53.1	3.1

Possibly respondents are indicating that they want the best and most qualified person, but they cannot quite come up with the cash to pay him. It seems reasonable to assume that clinics do not expect to employ a master's graduate for a bachelor's level salary.

The clinic directors were decisive about the person to whom the liaison educator would be directly responsible. The responses, in percentages, follow:

Supervisor	*Mental retardation*	*Psychiatric*
Clinic director	75.9	74.2
Director of special education	13.8	16.1
Other (pediatrician, medical director, coordinator of children's services, social work director, and so forth)	10.3	9.7
Total	100.0	100.0

Client Population

The question, For what geographic area would the liaison educator be responsible? produced the following answers, expressed in percentages:

Area	*Mental retardation*	*Psychiatric*
Counties	50.0	40.6
County	37.5	50.0
City	9.4	9.4
No response	3.1	..
Total	100.0	100.0

Difficulty in answering this question probably stems from a fundamental difference between the two types of clinics. The mental retardation clinic serves primarily a diagnostic function and the psychiatric clinic, a treatment function. Staff of mental retardation clinics see more clients than psychiatric clinics and serve as an evaluative and referral unit. It is unlikely that MR clinics will have many classrooms. In contrast, psychiatric clinics tend to house not only classrooms and residential services, but they also receive numerous referrals from the more comprehensive MR diagnostic clinics. In addition, diagnostic concerns of the psychiatric clinic generally are limited to the psychological realm, while a broader spectrum of problems may be handled through the diagnostic procedures of the MR clinic. Psychiatric evaluation is a major function of the MR clinic, but all evaluations are not conducted in terms of psychiatry, as is customary in a psychiatric clinic. This situation could be caused in part because psychiatric clinics are administered by psychiatrists, while MR clinics tend to be more interdisciplinary and are headed by physicians, psychiatrists, social workers, speech and hearing specialists, and educators.

Answers, in percentages, to the question, How large is the student population your clinic serves? were as follows:

Size of student body	*Mental retardation*	*Psychiatric*
Less than 10,000	12.5	25.0
25,000	9.4	9.4
50,000	15.6	18.6
100,000 or more	62.5	37.5
No response	0	9.5
Total	100.0	100.0

Respondents may have been confused about whether the question sought to ascertain the population directly served or the population which direct service represents.

Funding sources for the two types of clinics are similar and perhaps, depending upon the clinic's function and size, are equivocal in total budget monies. MR diagnostic clinics, however, may be less dependent upon private monetary sources than psychiatric clinics. In some instances, therefore, psychiatric administrators may have latitude in selecting those who qualify for their service. Mental retardation clinics are simply more dependent upon the public than psychiatric clinics since they need and expect more support from public than private sources. This fact implies that the general public should be able to demand a greater accountability to its needs. (Chances are that Harvey's family will take him to a county diagnostic clinic or general hospital clinic, rather than an orthogenic school, although he may need and get exactly the same evaluative treatment at either place.)

What is most important, regardless of size of population represented, source of funding, or function of the institution, is that respondents confirmed that the competencies of a liaison person needed by either type of clinic are the same.

Duties of the Liaison Educator

Areas of disability for which the liaison educator would be responsible differ markedly between the clinic types, as evidenced by the data in table 1. That the MR diagnostic clinic serves a more comprehensive spectrum of children is demonstrated by the responses.

For example, Roger, the liaison educator in an MR diagnostic clinic, evaluates those who are re-

tarded, blind, partially seeing, deaf, hard-of-hearing, speech-impaired, physically handicapped, brain damaged, and disturbed. He knows that his training must be kaleidescopic and that he is expected to deal with every area of exceptionality. Ray, the liaison educator in the psychiatric clinic, evaluates mostly the disturbed and maladjusted, partly as a result of referrals from Roger, and partly because his clinic is specialized. But there is a good possibility he may encounter those who have speech, auditory, visual, physical, cerebral, or central nervous system disorders. He knows that the balance of his work will be primarily in one area but that he should be ready for those with multiple disabilities. Therefore, both men must command similar expertise. In addition, both must deal extensively with the public in counseling parents, consulting with staff and schools, understanding available community resources, evaluating individual problems, and recommending prescriptive programs.

The competencies needed by the liaison educator, as expressed by the clinic directors, are ranked in table 2. Major differences in ranking can be accounted for in terms of institutional function and the role that the educator would, of necessity, assume. Possible explanations of the differences revealed in table 2 follow.

Table 2. Rank order of competencies or duties according to frequency

Competence or duty	Mental retardation	Psychiatric
Prescriptive teaching techniques for remediation	1	1
Individual educational assessments	2	5
Knowledge of resources (school, community, pupil personnel)	3	3.5
Diagnosis and remediation of severe educational problems	4.5	2
Interdisciplinary orientation	4.5	7.5
Behavior modification	6.5	3.5
Parent counseling	6.5	6
Knowledge of instructional materials	8	11
Interviewing	9	10
Classroom observational techniques	11	9
Learning theory	11	13.5
Group dynamics	11	13.5
Diagnostic tutoring	13	7.5
Report writing	15	16
Knowledge of medical terminology	15	18
Applied research	15	17
Evaluation of reading and visual literacy	17.5	15
Development of education remediation packets	17.5	12
Systems analysis	19	([1])

[1] Not selected.

1. MR clinics make referrals for those needing diagnostic tutoring; psychiatric clinics provide it, in part, onsite through the development of education remediation packets.

2. Because MR clinics are more comprehensive and less specialized than psychiatric clinics, they lean toward interdisciplinary orientation; consequently, those trained in a discipline such as social work would be able to assume more of their professional job responsibilities.

3. Behavior modification is probably used more in psychiatric treatment programs; MR clinics are not as treatment oriented.

4. Classroom orientation techniques are fundamental to behavior modification.

5. The comprehensive spectrum of MR evaluation demands greater knowledge of medical terminology than does psychiatric diagnosis.

6. Because treatment in psychiatric clinics is usually long range, the liaison educator will naturally have sustained contact with parents, which requires greater emphasis on interviewing and parent counseling techniques. Conversely, the liaison educator in an MR clinic would need greater specialization in making initial educational diagnoses.

The composite picture of this professional is that of a multifaceted specialist who puts in considerable time dealing clinically with the overload of questions which physicians, neurologists, psychiatrists, speech and hearing specialists, psychologists, and social workers are asked but cannot be expected to answer. He understands the jobs of these other professionals, but he is the one who ties together all the loose ends of parents-school-community after having helped determine the interdisciplinary diagnosis.

When Harvey's mother asks the neurologist whom she can hire for diagnostic tutoring, he will no longer turn away with no answer or suggestions; neither will the clinic psychologist waste time trying to find the company that sells the appropriate pencil and paper for the child's work. The liaison educator can provide these services and help the clinics serve their clients as effectively as possible. The authors hope that, as a result of the survey, training programs will begin to emerge and trained professionals will then be available to fill these new positions in clinics.