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ARTICLE

## Collaborative Intervention Practices for the Successful Inclusion of Children with and Without Disabilities

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### Abstract

According to Rig-Veda "Health is not everything but everything else is nothing without health". However in the present scenario Indian rural health care faces a crisis unmatched to any other social sector. Approximately 86% of the medical visits in India are made by majority in rural areas still people travelling more than 100 km to avail health care facility of which 70-80% is born from poverty line. Passiveness of the primary health care created a breach in referral system which should serve as an entry point for the individual and continuous comprehensive coordination at all level of health care. The only way which could lead to the goal of health inclusion is by incorporating impoverish needy rural population through creative community participation. Health is an important and integral part of intervention programme. The main objective of this practice is to improve both developmental and educational skills, reduce feeling of separation, stress, frustration and help to make productive and self-dependent individuals through collaborative intervention. Collaborative Intervention (CI) refers to those services which are being delivered for families of infants and toddlers with developmental delays or disabilities to develop sensory, motor, speech, language, communication, social, behavioural and academic skills by the trained and skilled professionals at the grass root level. Collaborative intervention works on the principle of Promoting Learning through Active Interactions (PLAI) in the classroom and out of the classroom. To prevent and reduce the ratio of the disabilities the Persons with Disabilities Act-1995, chapter-iv, has made provision for prevention and early detection of disabilities and the chapter xiii, focuses about the social security of all persons with disabilities.

## Introduction

**“Health is not everything but everything else is nothing without health”**

**Rig-Veda**

Collaborative intervention practice is defined as the provision of early intervention services by appropriate qualified personnel to a group of eligible children at an approved intervention service centre or in a community-based setting where children under five years of age are typically found and this group may also include children without disabilities. Collaborative intervention services may include typically developing children to maximize peer socialization and the development of communication skills. This may be accomplished by delivering group developmental intervention services in combination with other early childhood services, such as in a child care centre. When intervention services include typically developing children, there are a number of questions that should be considered, in order to ensure that all children should benefit from participating in the particular programs. The structure of collaborative intervention is made from the collaboration of highly trained and skilled professional team, para- professional team, ASHA, Anganwadi worker and social workers who deliver the appropriate services with accountability to children with and without disabilities from the age of 0-5years free of cost on the basis of parent’s Aadhar card.

Young children with disabilities have specific needs and challenges. Many of them young children faces challenges to communicate their wants and needs, to freely move their body from one place to another place, to access and engage their world and to learn abstract concepts and ideas. The intensity of their needs means that delays are likely to have a pervasive impact on the child’s development and are likely to continue to impact the family and the child well beyond the early childhood years (Chen, 1997). In addition, however, these young children are a widely heterogeneous group in terms of their characteristics, aptitude, attitude and learning needs. They may share some attributes, but they possess their own uniqueness as well. The professionals, para- professionals and families working together must identify the individual supports each child needs to ensure that the young child with disabilities is an active participant in all aspects of their lives and makes meaningful progress toward valued life outcomes. Basically medical, physical, language, speech, communication, learning, and social emotional needs should be addressed in developing interventions for young children with and without disabilities. It is estimated that young children with disabilities often have

chronic health needs that may require substantial effort by adults, professionals, para- professionals and families must work together for improving the child's developments and learning experiences in the same way equally or lesser the need of children without disabilities should be addressed. The variety of combinations of medical, physical, language, speech, communication, learning, and social emotional challenges that young children with significant multiple disabilities bring to each learning environment, a diverse set of individuals and disciplines is needed to provide support. As early as the 1950s, those in the field of special education have recognized that the collaborative team appropriately meet the diverse and often extensive needs of children with and without disabilities (Snell & Brown, 2011).

### **Objectives:**

The major objectives of this paper are as under-

- ✓ To share the information about the collaborative intervention.
- ✓ To discuss the real picture of intervention in rural areas.
- ✓ To discuss the challenges to access the intervention services.
- ✓ To discuss the creative approaches for the successful inclusion

### **Significance:**

Traditionally, the medical professional focuses on the treatment of physical symptoms, diseases, and physical injuries, whereas social, emotional, psychological, and spiritual and adjustment need may not properly fulfilled by the existing intervention model. There is an urgent and substantial need to identify as early as possible those infants and toddlers in need of services to ensure that intervention is provided when the developing brain is most capable of change. High quality early intervention programs for vulnerable infants and toddlers can reduce the incidence of future problems in their learning, behaviour and health status. Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later. It is noticed that most of children often have high rates of physical, cognitive, social-emotional, relational and psychological problems due to delayed intervention. Interdisciplinary, multidisciplinary and trans-disciplinary based approaches are being executed at gross-root level which benefits only fewer children with disabilities. Approximately 10-11% of all new born have prenatal substance exposure, a risk factor for poor developmental outcomes. It is estimated that 90-95% of these infants are deprived at birth without being identified or referred for services. Positive early experiences are essential prerequisites for later

success in school, the workplace, and the community. Intervention practices to young children who have or are at risk for developmental delays have been shown to positively impact outcomes across developmental domains, including health, language and communication, cognitive development and social/emotional development. Families benefit from early intervention by being able to better meet their children's special needs from an early age and throughout their lives. Benefits to society include reducing economic burden through a decreased need for special education.

### **Review**

Intervention programs help to prepare children to enter preschool and kindergarten, and they are also expected to know more when they enter kindergarten (Ryan et al., 2006). Intervention programs focus on various stages of child development, ranging from prenatal development to early elementary school. The intervention programs for at-risk children and their effects on children development. The intervention programs are designed to help young children and their families flourish and may often target for poor families (Shonkoff, 2007). The intervention programs positively impact on poor families of children from high quality early childhood programs than their less poor counterparts (Johnson & Brooks-Gunn, 2012). Knudsen et al. (2006) also stress that prevention produces cost effective better results. Sandeep Singh and SorabhBadaya (2014) studied on "Health care in rural India: A lack between need and feed". In their study it was found that only 0.5% of the rural enjoy basic facilities while a major population affected by the various health ailments. Felling seriously ill they either move towards the urban setup or the backward communities or leave them on their destiny. Another study by the Perry Preschool Project (PPP) was designed to improve the academic outcomes of disadvantaged children, and the program successfully met that goal. The study found that a lower percentage of children in the treatment group were later placed into special education for mental impairment compared to children in the control group, 15 and 34 percent, respectively (Park, 2000; Schweinhart, 2010). Children in the control group performed worse on language tests between preschool and the age of 7, which suggests that the treatment was successful (Schweinhart, 2010). Children who received the preschool intervention scored higher on school achievement tests when they were 9, 10, and 14 years old, which provides additional support for the benefits of treatment (Park, 2000; Schweinhart, 2010). Children in the program also had higher grade point

averages and higher high school graduation rates than children in the control group (65 and 45 percent, respectively) (Park, 2000; Schweinhart, 2010).

### **Suggestions**

Some appropriate and logical suggestions are essential to maintain and improve the collaborative intervention practices at gross- root level are given below-

- ✓ Including full team of Doctors Physiotherapist, Occupational therapist, speech & language pathologist (DMRW), CBR worker, ANM/GNM, special educator, care giver and early intervention specialist should be appointed at Primary Health Centre (PHC) and Community Health Centre(CHC) level.
- ✓ ASHA and Anganwadi worker should be linked with collaborative team of primary health centre to collect and report the recent information to concerned authority.
- ✓ To promote and insure this service under the 'Health for All' scheme and make provision that on the basis Aadhar card, the parent can access all intervention services free of cost either in private or Govt. rehabilitation centres.
- ✓ The Govt. should tie-up with reputed and qualitative local private institution and also provides remuneration as per prorata basis and make accountable towards intervention services.
- ✓ Periodical check- up services should be provided into the consideration of disability or developmental disorder.
- ✓ Sudden inspection should be conducted at the level of PHC and other Govt/non-Govt agencies which are involve in collaborative intervention services.

### **Conclusion:**

Disability should be considered as an important issue by the Government so that this important public health problem can be tackled in the community. The services should cover all types of disabled and non-disabled who need rehabilitation services and it should be part of mainstream development of the community, by the community and for the community. It is crucial need of society to expand the collaborative intervention services on gross-root level. In this regard the Ministry of Social Justice and Empowerment, Govt. of India is running various programme through various National Institutions/ autonomous agencies and non-Govt. agencies but due to lack of appropriate budget, human resource, infra-

structure, awareness of parent and attitude of the society, these practices meet the need of only fewer children with and without disabilities. Various rehabilitation professional are dealing and delivering services by providing private basis which is too costly to afford by a poor family. One of the biggest challenges is providing intervention services to the unreached children with and without disabilities living in rural areas, hilly areas and in scattered population. The Govt. should come forward and provide sufficient budget for survey, fundamental research and examine the real status of the intervention practices. It would be better to establish each primary health centre (PHC) and community health centre (CHC) as collaborative intervention service centres for holistic habitation and rehabilitation. To maintain the quality of collaborative intervention practices, the Govt. should make provision to orient the collaborative team globally time to time. To execute it qualitatively in gross-root level the government should conduct strict monitoring process and make punishable offence policy for wrong doer and appropriate reward for administrator, professional, para- professional, Parents, siblings, peer group and other social worker who actively involves in habitation and rehabilitation of children with and without disabilities.

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