

## TERMS

Adapted Physical Education - modifications of traditional physical activities to enable the disabled to participate safely and with satisfaction

Corrective Physical Education - activity designed to alleviate deficiencies in posture or mechanical alignment of the body

Developmental Physical Education - development of motor ability and physical fitness in those who are below the desired level

Disabled - an individual who has lost physical, social, or psychological functioning that significantly interferes with normal life and work (this term is considered preferable to handicapped)

Disorder - malfunction of the general mental, physical, or psychological processes

Habilitation - an educational term that indicates the disabled person is taught basic skills needed for independence

Handicapped - a person who is at a disadvantage in displaying the reactions and behavior patterns of the normal segment of society because of physical, mental, sensory, or emotional disability or combination of these (this term was used in legislation - however, disabled is the preferred term)

The term "handicapped" is used by the Federal Government under P. L. 94-142 to include individuals who are mentally retarded, hard of hearing, deaf, speech impaired, visually disabled, seriously emotionally disturbed, orthopedically impaired, deaf-blind, multi-handicapped, or specific learning disabled

Individual Physical Education - physical education programs responding to the unique needs of each individual

Rehabilitation - a term indicating a disabled person is re-taught basic skills for independence

Remedial Physical Education - correction of faulty movement patterns and development of fundamental skills through selected activities

Special Physical Education - a broad term indicating programs designed to enhance the physical and motor fitness of disabled persons through modified and developmentally sequenced sport, games, and movement experiences individualized for each participant

Therapeutic Physical Education - rehabilitation of those who have temporary disabilities through prescribed exercise

Physical Education for the handicapped was specifically and simply defined in P. L. 94-142. It includes:

1. The development of
  - a. Physical and motor fitness
  - b. Fundamental motor skills and patterns
  - c. Skills in aquatics, dance, and individual and group games and sports (including lifetime sports)
2. The term includes special physical education, adapted physical education, movement education, and motor development

## TERMS PERTAINING TO GENERAL CHARACTERISTICS OF DISABLING CONDITIONS

- Congenital Disability** - all disablements that develop during prenatal growth or during birth are congenital. Please note that congenital disabilities may be hereditary, but then again some congenital disabilities may not be hereditary. For example, fetal alcohol syndrome is a congenital disability that is not hereditary. Hemophilia on the other hand is a congenital hereditary disability.
- Acquired Disability** - all disabling conditions that are not congenital are acquired and are incurred after birth, usually because of injury or illness. Mental retardation resulting from meningitis is an example of a disability acquired through illness.
- Acute Disability** - not all disabilities last forever. Some disabling conditions are acute and may cause significant problems for a few weeks or months. A fractured collarbone is an example of an acute disability, a temporary condition from which complete recovery is possible.
- Chronic Disability** - long-term, but not necessarily lifelong disability. These disabilities may persist for years. Juvenile rheumatoid arthritis is a chronic disability that typically persists for years, yet when the disease is in complete remission, there is usually no residual joint damage and no disability remains.
- Permanent Disability** - some conditions do increase in extent or severity, are considered permanent, and remain throughout life. Down syndrome, a frequent cause of mental retardation, is permanent.
- Nonprogressive Disability** - disabilities that do not increase in extent or severity are nonprogressive. Cerebral palsy is a permanent, but nonprogressive disabling condition.
- Progressive Disability** - disabilities that increase in extent or severity are considered progressive. A condition that is progressive is not necessarily fatal. For example, certain arthritic conditions are chronically and progressively debilitating but are not fatal. Other disabilities are relentless progressive and may end in death. Among school-aged children, muscular dystrophy (Duchenne type) is presently the most devastating example of a fatal progressive disability for which there is no known cure.

## PSYCHOLOGICAL ASPECTS OF DISABILITY

The person with a disability is faced with preconceived, distorted perceptions of his life. His family, his teachers, and society hold these misconceptions. The fact that a disabled person may be different in appearance, behavior, or habits often suggests to others (and eventually to himself) that there is something deviant about him. The distorted perceptions of others can often lead the disabled person to distort his self-image, his sense of self-worth, and a negative self-concept.

If a disabled person can be perceived as "a person with a disability" rather than a "disabled person," there may be greater emphasis placed upon the person and less placed upon the disability. When we focus primarily on the person and secondarily on the disability as only one of the person's many traits, we realize that many persons with a disability are not disabled at all times.

Dealing with the individual first and with the disability second does not avoid or ignore the disability. Treating the disability as if it were nonexistent does not allow the individual to accept limitations, to make an accurate appraisal of strengths and abilities, or to apply concerted effort toward achievable ends. Therefore, one must make a concerted effort to deal with the individual, and then the disability, but be certain not to ignore or deny the impairment.

The image of one's own body and the value of that image are significant in formulating self-concept. The body is the hub of one's identity. Therefore, it should not be surprising that the more visible the disability, the greater the difficulty in adjusting socially and developing a positive self-concept.

Empirical evidence suggests that severe disability does not necessarily go hand in hand with maladjustment. Conversely, mild disability offers no guarantee of positive adjustment. A person with mild disability, because he is relatively normal, may recognize greater potential for hiding his disability. The hiding process prompts denial and thwarts adjustment.

In society, persons with severe congenital disabilities often experience the least status in the community. Persons with severe acquired disabilities experience a higher social status. Some think that a severe congenital disability, because it is present from birth, greatly limits experiences that ensure status in the community.

## EMPATHY VERSUS SYMPATHY

Empathy and sympathy are similar in sound only. Recognizing the difference in the meaning of these words and the different concepts that they embody is critical for those who teach or otherwise function in a professional or personal relationship with people who have disabilities.

**Empathy** is the mature, genuine understanding of another's situation and circumstances. In other words "Walk a mile in my shoes," before you make judgments about me. Empathy is the ability to understand another's thoughts or state of mind without actually having experienced the person's circumstances. Inability to empathize with another diminishes the teacher's potential to influence positively the learner's development. The ability to empathize goes beyond establishing rapport; it fosters insight, which creates an effective working relationship.

**Sympathy** is feeling sorry for another. It connotes, "Oh, you poor thing!" Sympathy is synonymous with pity; pity devalues worth, and devalued worth causes additional suffering. People want understanding, not pity. Stories about outstanding achievements by persons with disabilities often unwittingly provoke sympathy and pity. Take care when relating inspirational stories about people triumphing over their disability. Every effort should be made to avoid a "we-they dichotomy," which based on disability alone, sets the disabled person apart from the able-bodied. This is not to suggest that inspirational messages be eliminated. However, they should be tempered with empathy and an understanding that undertones can devalue the self-worth of the persons for whom the message is intended.

**THE HELPING RELATIONSHIP:** In a helping relationship, the person being helped is often assumed unable to help herself. The person receiving assistance can interpret the act of helping another as perceived helplessness. The perception of helplessness can be held by the helper, the person receiving help, or by persons observing the assistance. Because helping suggests a one-sided relationship, value judgments are made about the person receiving aid. The person who receives help consistently may be judged inferior to others who seem self-reliant and independent.

Virtually everyone needs help sometimes, and one's sensitivity to receiving help is highly individual. Most people respond positively to assistance if it is genuinely needed and is not offered primarily to satisfy the helper's ego.

A person with a disability usually wants minimum assistance and only when necessary. Before helping, always obtain the consent of the person involved. Do not assume that help is needed or wanted. Assistance, particularly unsolicited assistance, may be interpreted as denial of the person's independence. If a person wants to help but uncertainty exists about what is needed, the helper should simply ask. Assistance should be focused on the task, not on the relationship. Fuss and emotional display by the helper suggest ego feeding at the expense of the person receiving assistance.

## LABELING

**Labeling** individuals with disabilities has perpetuated the earlier belief that the "problem is in the child." In various ways, society has created and continues to create many conditions under which individuals are disabled.

Terms such as **impaired**, **disabled**, and **handicapped** are often used synonymously and interchangeably to label individuals, allowing for no real understanding of their strengths and limitations. Too often, an individual's potential - what he or she can do - is discussed but not implemented because programs, activities, and efforts focus on the person's disability and deficiency - what he or she cannot do.

**Impaired** individuals have identifiable organic or functional conditions; that is, some part of the body is missing, part of an anatomical structure is gone, or one or more parts of the body do not function properly or adequately. The condition may be permanent, as with an amputation, cerebral palsy, or congenital heart defect; or it may be temporary, as with temporary paralysis, various emotional problems, certain social maladjustments, or special movement deficiencies.

Individuals who are **disabled** because of impairments are limited or restricted in executing some skills, doing specific jobs or tasks, or performing certain activities. Individuals with impairments should not be included automatically from activities because their conditions make it appear that they cannot participate safely, successfully, or with satisfaction. Indeed, for many disabled individuals, appropriate modification and/or adaptations of activities would enable their participation.

**Handicapped** should be defined in a social context. If impairment prevents an individual from performing that which society perceives to be important, the individual is devalued by society and thus labeled "handicapped." Although the word has been used in legislation, the term preferred by those personally affected is disability. The use of the term disability is meant to give primary emphasis to individuals instead of their disabilities.

Individuals with disabilities have been successful in many contexts, and in the process, their disabilities have often been forgotten or overlooked. Consider the following individuals. Harry Cordellos, a blind marathon runner, completed the Boston Marathon with a sighted partner (2 hr 57 min 42 s). Wilma Rudolph, a famous sprinter and victim of a congenital birth defect and polio, won three Olympic Gold medals in the 1960 Rome Olympics. Jim "Catfish" Hunter, suffered from severe diabetes, yet played major league baseball pitcher and named to the Baseball Hall of Fame. Bobby Jones, a former UNC and professional basketball player, has epilepsy. Pete Gray had his right arm-amputated and went on to play center field for the St. Louis Browns in 1945. Tom Dempsey, a professional football place kicker who was born with only half of his right foot, kicked a 63-yard field goal in 1970. It set a NFL record that still stands today. Yancy Sutton was deaf and played linebacker in the NFL. Patty Wilson, an epileptic, is a long distance runner. Jim Ryan, an asthmatic, was a record-breaking long distance runner. Karen Farmer, an amputee athlete, earned an athletic scholarship to compete on a university's track team and was honored by the Women's Sports Foundation as its first winner of the Up and Coming Award for a physically challenged female athlete. Jim Abbott, formerly an award-winning pitcher at the University of Michigan, is now a major league baseball pitcher with the California Angels. Abbott was born without a hand on his left arm. Candace Cable Brooks, Curt Brinkman, Sharon Hendrick, Jim Martinson, and George Murray, although confined to wheelchairs, finished the Boston Marathon in record times. Chris Burke, an actor with Down syndrome, has gained acclaim as a star on the television show "Life Goes On." Marlee Matlin, an actor who is deaf, won an Academy Award for "Children of a Lesser God." Matlin also starred in a primetime television show. Rick Allen, the drummer for Def Leopard has only one arm. The country music singer Mel Tillis stutters. Each of these people are disabled in some way, yet in other important ways is not.

## THE EFFECTS OF LABELING

Labels are commonplace in our society; this is especially true of identifying individuals with disabilities. Since traditional categorical labeling is used in federal and state legislation, this identification by categories (or handicapping conditions) is easily recognizable and currently necessary for obtaining government services and assistance. Traditional categorical labeling has few benefits, however, when weighed against the detrimental effects observed in the practical application of educating individuals with disabilities.

Many problems are inherent with labeling. The system of labeling encourages **over-generalization** about a disability and the individuals with that disability. Labeling assumes homogeneity of the population - that all those in the population are alike, which is simply not true. Not all so-called blind individuals are totally blind. Cerebral palsied individuals vary in their motor ability, depending on the type and degree of impairment. No two mentally retarded individuals are identical any more than two non-retarded individuals are the same.

Labeling encourages **under-expectation**. Research has shown that teachers' expectations can change depending on what they are told about a given student. Because of the stereotypes attributed to those with disabilities, so-called handicapped students often are not expected to perform at the same level as their peers.

Labels become **permanent**. A label and its characteristics become a possession that an individual carries throughout life. Labeling emphasizes the condition, not the individual. By focusing on the disability, a reading problem becomes "dyslexia," and problems encountered in learning are labeled "learning disabilities." Thus, problems may be merely renamed rather than resolved.

Labels can be used to **dodge responsibility** for changing behavior. Labeling perpetuates the outdated idea that the problem is "in the child," thus relieving the educator from the responsibility for affecting any behavior change. Labels emphasize stability, not change, and change is what is needed in the education of individuals with disabilities.

Although the characteristics of the categories of handicapping conditions should be used in understanding, evaluating, and programming, this information should provide guidelines only. The emphasis should be placed on the individual's needs and capabilities, with attention paid to possible limitations. Categories can and have sometimes been used to place undue limitations on an individual's potential performance. The categories, and their characteristics, must be employed in the fashion that best serves the individual with disabilities.

## STAGES OF ADJUSTMENT

To understand individuals with disabilities, we must progress beyond our perceptions to identify the facts and deal with them objectively. It is important to understand the stages of adjustment through which individuals with disabilities will pass. Although the following stages of adjustment are commonly found with those who have acquired a disability, those who are congenitally disabled will experience similar stages of adjustment.

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|---------------------------|--|
| Stage 1: Denial           | At this point the individual cannot accept his or her limitations and thus attempts to deny their existence.   |
| Stage 2: Quasi-Acceptance | This stage is characterized by depression, mourning, anger, frustration, and self-pity. These emotional responses are positive signs that the person is beginning to accept his or her disability. |
| Stage 3: Acceptance       | The individual exhibits full and complete acceptance of the disability.  |

The speed of progression through the stages is influenced by two factors:

- (1) The severity of the disability and
- (2) The personal value associated with the disability.

The more severe the disability and/or the greater the personal value of the loss, the longer the period of adjustment will be.

The Mourning Process - Parents of disabled children go through a similar series of stages, called the mourning process, that parallel the adjustments just listed. It is as if they are mourning the loss of a normal child and moving toward acceptance of the disabled child.

The environment can influence the individual's adjustment to a disability. Thus, it is important for both teachers and able-bodied peers to understand the stages of adjustment. The teacher should also recognize that not all students with disabilities, or their parents, make it through the entire range of emotions and arrive at "acceptance" at a given point in time. Some never accept their disabilities, but a greater acceptance by peers can help both disabled individuals and their parents. The teacher should provide opportunities for the able-bodied to find understanding and acceptance of each other. The following suggestions are offered for promoting a positive environment to foster mutual respect and acceptance:

1. Disability awareness activities
  - a. Perform a physical task while blindfolded (blind).
  - b. Perform a locomotor task with Saran Wrap over eyes (visual impairment).
  - c. Experience movement via wheelchair, canes, crutches, scooter boards, and so forth.
  - d. Ask directions without verbalization; respondent does not verbalize either
  - e. Write sentence or word using nonpreferred hand while looking in a mirror
2. Hold class discussion with individuals with disabilities to foster awareness.
3. Have children view films and/or read books about individuals with disabilities.
4. Hold group discussions about disabilities with able-bodied and disabled students from the same class; ask students with disabilities to share experiences.
5. Discuss misconceptions and myths about individuals with disabilities such as:
  - a. Severely physically disabled individuals are mentally retarded because they cannot speak.
  - b. Most blind individuals cannot see, and read Braille.
  - c. Learning disabled individuals are mentally retarded.
  - d. Disabled individuals cannot live independently, work, marry, and so on.

## DESIRABLE GOALS OF ADAPTED PHYSICAL EDUCATION

The ultimate goal of all services to the disabled is to help them to live healthy, independent, fulfilling lives.

1. Develop recreational motor skills for independent functioning in the community.
2. Develop physical fitness for maintenance of health.
3. Develop ambulatory skills to master mobility in domestic and community environments.
4. Develop physical and motor prerequisites to self-help skills required for independent living.
5. Develop physical and motor prerequisites to vocational skills required for independent living.
6. Develop prerequisite motor skills necessary for participation in self-fulfilling social activity.

PREVALENCE OF STUDENTS WITH DISABILITIES AGES 6-21  
SERVED DURING THE 1989-1990 SCHOOL YEAR

Specific Learning Disabilities	2,064,892
Speech or Language Impairments	976,186
Mental Retardation	566,150
Serious Emotional Disturbance	382,570
Multiple Disabilities	87,956
Hearing Impairments	58,164
Orthopedic Impairments	47,999
Other Health Impairments	53,165
Visual Impairments	22,960
Deaf-Blindness	1,634
TOTAL	4,261,676

PREVALENCE OF STUDENTS WITH DISABILITIES AGES 6-21  
SERVED DURING THE 1990 - 1991 SCHOOL YEAR

<u>Disabling Condition</u>	<u>Total Population</u>	<u>% of Disabled Population</u>
	2,144,377	49.10
Specific Learning Disabilities	990,186	22.70
Speech or Language Impaired	552,658	12.70
Mental Retardation	392,559	9.00
Serious Emotional Disturbance	97,625	2.20
Multiple Disabilities	59,312	1.40
Hearing Impairments	49,393	1.10
Orthopedic Impairments	56,312	1.30
Other Health Impairments	23,686	0.50
Visual Impairments	1,522	0.01
Deaf-Blindness	4,367,630	TOTAL 100.01

Percentage of Pupils Age 6-21 Served in  
Different Educational Environments by Disabilities:  
School Year 1990 - 1991

<u>Disabling Condition</u>	% in Regular Class	% in Resrce Room	% in Separte Class	% in Separte School	% in Residntal Facilities	% Homebnd or Hospital
	20.7	56.1	21.7	1.3	0.10	0.1
Specific Learning Disabilities	76.8	17.7	21.7	1.5	0.10	0.1
Speech or Language Impaired	6.7	20.1	3.8	10.5	0.14	0.4
Mental Retardation	14.9	28.5	61.1	13.9	3.60	2.0
Serious Emotional Disturbance	5.9	14.3	37.1	29.5	3.90	2.7
Multiple Disabilities	27.0	18.2	43.7	10.6	12.30	0.2
Hearing Impairments	29.6	18.9	31.7	9.9	1.00	5.9
Orthopedic Impairments	31.2	22.3	34.7	7.8	1.00	13.1
Other Health Impairments	39.3	23.7	24.6	4.5	10.80	0.6
Visual Impairments	8.0	16.3	21.1	16.6	28.40	1.0
Deaf-Blindness			29.9			
All Disabilities	31.5	37.6	24.9	4.6	0.90	0.6

The number of children birth through 21 who received special education and related services was 4,587,370 in the 1989-1990 school year. The expectation is that the number will continue to grow.

It is estimated that 12 percent of the total population of individuals from birth to age 22 are disabled. However, the population actually served in schools is less than 12 percent.

The data from 1990-1991 school year indicates that 94 percent of U.S. pupils with disabilities (or suspected of having disabilities) from 6 to 21 years of age, were educate in regular school environments (Level I or Level II environments).

The data from the 1989-1990 and 1990-1991 school years demonstrate a national increase in most disabling categories, except mental retardation, which has decreased steadily over recent years.

1. There were over 4.3 million disabled children ages 3-21 during the 1989-1990 school year.
2. Disabled children were about 12 percent of the school-aged population during the 1989-1990 school year.
3. About 90 percent of the school-aged population who received special education were mildly disabled during the 1989-1990 school year.
4. Twice as many males as females received special education during the 1989-1990 school year.
5. About 10.2 million people are disabled each year by accidents; of this number, around 380,000 remain permanently impaired.
6. The number of multi-disabled is increasing primarily due to the higher survival rate of premature infants and advanced technology is keeping children with one or more disabilities alive.
7. In general, the number of disabled is increasing because medical technology is saving people who would have died previously.

## HISTORY

### EARLY HISTORY

One characteristic of early primitive cultures was their preoccupation with survival. Defective children generally died at an early age or were put to death. Older members unable to contribute to their own care either were killed, left to die of exposure or starvation, or were made to suffer low social status. In some societies, persons displaying obvious behavioral deviations were considered either filled with evil or touched by God.

Physical education for individuals with disabilities can be traced to the curative physical regimens found in China in 2700 B.C. They relied on activities such as gymnastics, preventive exercise, and therapeutic exercise to alleviate physical disorders and illnesses.

Even in the civilized societies of early Greece and Rome, the disabled were excluded from society, neglected, and often left to die. The Spartan father of a crippled child was expected to carry the baby to the hills and leave the child to die. The Athenians, whom we consider more humanitarian than the Spartans, permitted disabled babies to die of neglect. During the days of the Romans, crippled babies also allowed to die of lack of care.

The onset of Christianity eventually changed the practice of leaving the disabled to die. Mentally retarded people were considered "innocents," free of sin. However, the mentally ill were thought to be evil and possessed by devils.

### THE MIDDLE AGES

Some disabled people found acceptance as court jesters during the middle ages. Nevertheless, the prevailing attitude was of superstition and fear. Physical and mental disabilities were believed to be caused by Satan, and the disabled person was viewed as sinful and evil. Therefore, the disabled either were treated harshly or were carefully avoided.

### RENAISSANCE ERA

The Renaissance was a time of great social and cultural progress. During this time a genuine concern for the individual developed, giving each person dignity. With a desire for social reform, came many improvements to life. Reforms dealing with peace, prison conditions, and insanity were organized. The humanistic philosophy of this time no doubt softened the general attitude toward the physically disabled, but the change in philosophy did little to forward the treatment, care, and education of the disabled.

During the 17th and 18th century, there were advances in the treatment and cure of disabling conditions. (Just think of the movie "The Elephant Man" or the treatment Renfield received in the novel "Dracula"). This interest resulted in establishment of residential schools for the mentally retarded, asylums for the mentally ill, schools for the deaf and blind.

### THE NINETEENTH CENTURY

Many social and moral problems were attacked in the first decade of the 19th century. For instance, during the Industrial Revolution, some laws were passed preventing conditions that often led to crippling injuries. However, during the 19th century emphasis moved away from "curing" the individual and the institutions were maintained as lifelong residences.

Medical gymnastics were developed by European cultures, (Swedish and German Gymnastics movements were examples) for individuals with disabilities. Because exercise was considered the best medicine, a large part of medical gymnastics consisted of prescribed exercises to remediate specific disorders.

### THE TWENTIETH CENTURY

In the early 20th century, the medical gymnastics model for physical education was brought to America. In the U. S., preventive and corrective exercise was still emphasized.

As indicated earlier, in the 19th century, persons with disabilities were shut away in state institutions. In the first decades of the 20th century, disabled individuals were often sterilized against their will, and usually without their knowledge. The U. S. Supreme Court case of Buck v. Bell (1921) legalized the sterilization of the disabled (especially the mentally retarded). These sterilization practices remained legal until the 1970s.

During the latter part of the 19th century, emphasis was placed on development of instructional methods to educate intellectually disabled persons. The Montessori approach was developed for work with the mentally retarded during the early part of the 20th century. In this system, learners used sequential materials that could accommodate the ability levels of each student. The Montessori approach was the forerunner of individualized instruction, which is widely used today.

Three major events of the 19th century significantly influenced the treatment of the disabled and fostered the emergence of special education. The first 2 events occurred early in the century. The first was the development of the IQ test (Intelligence Quotient). Because the IQ test was based on the school curriculum of that time, it was wrongly believed that IQ scores could predict school achievement. Naturally, children who had not gone to school scored low on the test and, as a result were labeled mentally retarded.

The second event was the enactment of child labor and compulsory school attendance laws. These laws guaranteed "education for all," not just the elite, and resulted in an influx of children from the work force into the schools. These "working children" had trouble with education; they did poorly on the IQ test and it was concluded that they were retarded. Special classes were soon developed that included a watered-down curriculum for these so-called "morons."

The third significant event of this century was the decision rendered in 1954 in the case of *Brown vs. Board of Education*. The court stated that schools must be integrated because separate but equal for black children was illegal. Many black children had trouble in integrated classroom education, and many of them were placed in special education classes. This social movement of integration created new problems in the schools and a new category of retardation: the educable mentally retarded.

The result of these three major events was the emergence of special education and firm establishment of an early belief that the problem of those children requiring special education (and thus labeled handicapped) is "within the child." No examination of the school curriculum was made. Many of the individuals placed in special education were not necessarily "handicapped in society," but were "handicapped in school." In the early 1900s, only individuals with clear, obvious impairments were labeled "handicapped." Today, the reverse is true; 85 to 90 percent of those identified as disabled do not have obvious impairments.

Prior to the World Wars, virtually no formal physical education was provided for those with physical and mental impairments. Little changed until the World War I years. Around 1916 the American public first became widely aware of the problems of the disabled. In 1916, there was an epidemic of infantile paralysis due to polio. Shortly after that, the wounded and disabled returned from World War I. Society's desire to help the victims of paralysis and the disabled soldiers forged a new attitude toward the disabled that spurred new laws and new approaches to education. This new awareness also gave new emphasis to the development of techniques of orthopedic surgery to treat crippled children and WWI veterans.

The success of physical rehabilitation for war veterans helped promote the use of physical activity in the schools for the development and enjoyment of those with disabilities. These early programs of corrective physical education functioned under the medical model, being both remedial and therapeutic in nature. From the 1920s to the 1950s, corrective physical education developed as a separate entity from physical education.

During the period between the wars, the contribution of President Franklin D. Roosevelt, who had been partially crippled by polio, led to increased support in the fight against crippling diseases such as poliomyelitis.

World War II gave further emphasis to the development of techniques of orthopedic surgery that had been developed to treat crippled children and WWI veterans. In 1943, legislation increased the scope of aid to the veterans of WWII and provided rehabilitation of soldiers through the Veterans Administration. Gradually, services expanded to include physically disabled civilians. From the movement to rehabilitate the crippled soldiers came a movement to rehabilitate the disabled, to help them become useful, self-sufficient citizens. Occupational therapy has its roots in curative workshops that taught purposeful activities for their therapeutic value.

From the 1940s to the present, there has been an expansion of services to the disabled. Physical education for individuals with disabilities, or adapted physical education, really developed in the 1950s. However, it remained tied to the medical model and corrective physical education. It wasn't until the 1960s that physical education for individuals with disabilities began to emerge as a separate field. Thus, adapted physical education evolved out of the medical model into the educational model and the emphasis changed from curative and preventative to rehabilitation and finally to habilitation.

## Two Laws That Have General Applications to Legislation for the Disabled

THE CIVIL RIGHTS ACT OF 1964 - forbid discrimination based on race, color, creed, or national origin: Title VI forbid discrimination in education programs receiving federal funds: Title VII extended protection to non-educational settings - in the case of employment, discrimination could be punished by having to hire the person denied employment or reinstate a dismissed employee with back pay

TITLE IX OF THE EDUCATION AMENDMENTS of 1972 - forbid discrimination based on sex in programs receiving federal funds - guaranteed equal educational opportunity regardless of sex

Some general thoughts - a single isolated incident is not necessarily discrimination (example sexual harassment) - employers must know discrimination is occurring to be negligent - the person discriminated against has a duty to report the discrimination, employee must take reasonable action to stop the discrimination (i.e., follow internal complaint procedures) - employer must document "reasonable care" in preventing discrimination

Franklin v. Gwinnett County Public Schools (1992) - In this case, which actually revolved around sexual harassment, the court determined that plaintiffs could now receive monetary damages if intentional sex discrimination is proven - this decision is being generalized to include other types of discrimination suits

Title IX - <http://bailiwick.lib.uiowa/ge/index.html#200>

## COURT DECISIONS AND FEDERAL LEGISLATION AFFECTING THE DISABLED

During the 19th century, federal laws concerning the individuals with disabilities were designed primarily to meet the needs of groups with specific disability problems such as deafness or blindness. Not until the 1920s, were laws enacted to provide services for all people with disabilities. This was achieved through vocational rehabilitation laws that were drafted to help those disabled during World War I or injured while working in the rapidly growing industrial society. Legislation for individuals with disabilities over the next 35 years focused mainly, although not exclusively, on services and programs for persons who were blind. These early laws did little for the child with disabilities in the public schools.

1954 **BROWN V. BOARD OF EDUCATION OF TOPEKA** - established the right of all children to equal educational opportunity - declared unconstitutional and abolished the "separate, but equal" doctrine of segregation by race in the public schools - this was the judicial precedent for all civil rights court decisions and legislation to follow, including establishing the rights of the disabled - the opportunities that the state undertakes to provide must be provided for all equally

The 1960's were a time of expanded social consciousness and the physically and mentally disabled were not ignored during this time. The 1970s were also a time of expansion of services with landmark legislation affecting the education and everyday life of the disabled individual. The strong advocacy of the disabled, parents, and professional groups, coupled with research findings documenting needs, led to legislation for training professional personnel to work with disabled students.

1961 P. L. 87-276 **SPECIAL EDUCATION ACT** - designed to train professionals to prepare professionals to prepare teachers for deaf children.

1965 P. L. 89-10 **ELEMENTARY AND SECONDARY EDUCATION ACT** - enabled the states and local school districts through the provision of monies from federal government to develop programs for economically disadvantaged children.

1966 P. L. 89-750 **AMENDMENTS TO THE ELEMENTARY AND SECONDARY EDUCATION ACT** - created the Bureau of Education for the Handicapped. It became the Office for Special Education and Rehabilitation Services in 1980. For the first time, there was a federal agency with the sole purpose of administering programs and projects related to education of the disabled.

1967 **HOBSON V. HANSON** (Washington, D.C.) - the use of standardized tests to track students for special education placement that discriminated against the black and poor children was declared unconstitutional.

1967 P. L. 90-170 - funded training, research, and demonstration projects specifically in physical education and recreation for handicapped individuals. It has funded thousands of graduate assistants in colleges and universities to encourage students to become adapted physical education specialists.

Since P. L. 90-170 and subsequent legislation encompassing physical education for the handicapped are parts of special education laws, the mid-1960s can be generalized as the beginning of the merger of physical education and special education and the beginning of the multi-disciplinary approach to adapted physical education.

It may be of some use to note that as we look at the legislation and judicial rulings of the 1970s, that physical education, as well as all school subjects has been influenced tremendously by two federal laws enacted during that decade. They were P. L. 93-112 **THE VOCATIONAL REHABILITATION ACT OF 1973** (especially Section 504) and P. L. 94-142 **THE EDUCATION FOR ALL HANDICAPPED CHILDREN ACT OF 1975**. The rules and regulations for implementing these two laws appeared in the Federal Register in 1977. (Note the time differential between the passage of the bills and the publication of the rules for implementation.) Whereas P. L. 94-142

affected school-based instruction primarily, Section 504 of the Rehabilitation Act influenced all aspects of life.

- 1970 DIANA V. CALIFORNIA BOARD OF EDUCATION - the court ruled that children couldn't be placed in special education based on culturally biased tests.
- 1971 PENNSYLVANIA ASSOCIATION FOR RETARDED CHILDREN V. COMMONWEALTH OF PENNSYLVANIA - the PARC sued on behalf of 13 mentally retarded children. Citing constitutional guarantees of due process and equal protection under the law, the suit argued that these children's access to public education should be equal to that afforded other children. In a consent agreement, the court ruled in favor of the children. This suit launched a national phenomenon and the courts started exerting even more pressure.
- 1972 MILLS V. STATE BOARD OF EDUCATION OF THE DISTRICT OF COLUMBIA - established that every child has a right to an equal opportunity for free public education regardless of the child's mental, physical, or emotional disability or impairment. Emotionally disturbed children cannot be excluded from school and the lack of funds is not an acceptable excuse for lack of educational opportunity.
- 1972 LARRY B. V. RILES (California) - The court ruled that I.Q. tests couldn't be used as sole basis for placing children in special classes.

During the next few years, an avalanche of suits followed as concerned groups in other jurisdictions asked the courts to enforce the constitutional rights of children with disabilities. (From 1972 to 1975, 46 right-to-education cases related to disabled persons were tried in 28 different states). The impact of these rulings has not only opened school doors but has also stimulated states to improve the quality and comprehensiveness of education offered to individuals with disabilities.

- 1973 P. L. 93-112 THE VOCATIONAL REHABILITATION ACT OF 1973, SECTION 504 - declared that handicapped people couldn't be excluded from any program or activity receiving federal funds based on handicapped alone. It affected the total social structure of the U.S. and all aspects of the handicapped individual's life. Although not specifically stated, it includes all aspects of physical education instruction, intramural and interscholastic sports.

P. L. 93-112 is best known for SECTION 504, which is often called the "NONDISCRIMINATION CLAUSE." Section 504 states that NO OTHERWISE QUALIFIED INDIVIDUAL shall be denied participation in, or the benefits of, or be subjected to discrimination, under any PROGRAM RECEIVING FEDERAL FUNDS SOLELY ON THE BASIS OF HANDICAP ALONE.

This means that schools that conduct interscholastic athletics and intramural activities must provide qualified handicapped students an equal opportunity for participation with the nonhandicapped. Specifically, Section 504 states that separation or differentiation with respect to physical education and athletic activities is permissible only if qualified students are also allowed opportunities to compete for regular teams or participate in one or more regular physical education and athletic activities. For example, a student in a wheelchair can participate in a wrestling course.

Section 504 also makes some common practices illegal, such as barring persons with artificial limbs or one eye or kidney from participating in sports competition. Likewise, athletic events in public places receiving federal funds (almost all do) must be accessible to all spectators, including those in wheelchairs. Remember that facilities do not have to be accessible as long as programs are accessible. Disabled students must have access to at least one swimming pool, gymnasium, and playing field if able-bodied students are provided opportunities for sports, dance, and aquatic programs. For example, if a disabled student is scheduled for a class in a room inaccessible to him or her, the class can be moved to accommodate them. The disabled do not have to have access to a specific classroom as long as the class is accessible to them.

ACCESSIBILITY refers to communication (the ability to understand) as well as architecture; therefore, interpreters for deaf persons must be available as well as Braille or tape-recorded signs/directions for blind persons. This type of accessibility should be kept in mind when planning workshops, tournaments, and meets.

DUE PROCESS - The Office of Civil Rights is responsible for administering PL 93-112. OCR does not take action until a SPECIFIC COMPLAINT FOR NONCOMPLIANCE is registered. Most schools, agencies, and universities prefer to handle Section 504 problems to having to cope with legal action brought by the OCR. Therefore, institutions that receive federal funds may designate one of their staff as a compliance officer, or the institution may appoint a compliance committee. This person or committee is the point of contact for students, teacher, parents, or others regarding problems, grievances, and solutions related to an accessible and nondiscriminatory physical, learning, and work environment. The committee may also work as an advisory board to the compliance officer or as an advocacy board for disabled individuals.

- 1974 P. L. 93-380 EDUCATION AMENDMENT ACT - Authorized giving higher more federal aid to the states for use in special education. It guaranteed the rights of disabled persons in programs for which schools and other sponsoring agencies receive federal funds. P. L. 93-380 identified, in particular, the principle of ensuring that disabled individuals are placed in the least restrictive environment commensurate with their needs. To the maximum extent appropriate, disabled children should be educated with children who are not disabled. Special classes, separate schooling, or other means of removal of disabled children from the regular educational environment should occur only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Under 93-380 the states not only had to establish a goal of providing full educational services to children with disabilities but states also had to develop a plan that indicated how and when the state expected to achieve that goal.
- 1975 P. L. 94-103 DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT - affirmed the rights of mentally retarded and other developmentally disabled individuals.
- 1975 P. L. 94-142 EDUCATION FOR ALL HANDICAPPED CHILDREN ACT - created a FREE APPROPRIATE PUBLIC EDUCATION for all handicapped children **between the ages of 3 and 21**. Required that an INDIVIDUAL EDUCATION PLAN (IEP) be developed for each handicapped child and that the disabled student receive the program in the LEAST RESTRICTIVE ENVIRONMENT. Physical education was the ONLY CURRICULUM AREA SPECIFICALLY MENTIONED. Physical education was identified as a part of special education and thus a DIRECT SERVICE as opposed to a RELATED SERVICE. Intramural and interscholastic competition is to be provided to the same extent as for non-handicapped students. Interestingly, unlike many other federal education laws, P. L. 94-142 had no expiration date and was regarded as a permanent instrument. It represented a specific commitment to all children with disabilities and set forth as national policy the proposition that education must be extended as a fundamental right to individuals with disabling conditions.

It provides the legal basis for adapted physical education in relation to disabled children and youth, including the funding of specifically designed physical education for students who meet the eligibility requirements of needing some type of special education or related service

The most important mandate within P. L. 94-142 is the requirement that physical education services, specifically designed if necessary, must be made available to every handicapped student and that these must be free, appropriate, and in the least restrictive environment.

FREE means that a local education agency is legally obligated to accept and educate a child with special needs without cost to the parent or guardian.

APPROPRIATE means that, by valid assessment and evaluation, education will be individualized to meet the child's unique needs.

CHILD FIND is a principle that was first identified under P. L. 94-142 and it is a key component of the law. Child find means that **all** children in the state, despite the severity of their disabilities, who need special education and related services, must be located, identified, and evaluated. This provision extends the moral and legal commitment that all children can learn if given appropriate educational opportunity, and that society can no longer use as an excuse the old cliché "We didn't know they were there." Youngsters with disabilities, often ignored before, must be accounted for by local governments.

LEAST RESTRICTIVE ENVIRONMENT means that the child cannot be removed arbitrarily from the regular mainstream educational environment. The child is placed in a modified educational setting only when results of individual assessment and evaluation justify such placement. Above all, the law guarantees that the child's individual needs, rather than a categorical disability grouping, must determine appropriate education of the child.

The MULTI-DISCIPLINARY BASIS OF ADAPTED PHYSICAL EDUCATION is established by P. L. 94-142. The multi-disciplinary approach was established by designating a team of professionals to work with the parents (and the student when appropriate) to design an INDIVIDUAL EDUCATION PLAN, commonly referred to by the initials, I.E.P., which meets all of the students' special needs. As P. L. 94-142 defines specially designed physical education as a part of special education, remember that adapted physical education is much broader than service delivery to handicapped students. Adapted physical education includes the entire spectrum of individual differences that require adaptations in pedagogy, equipment, and/or environment for optimal success.

P. L. 94-142 separates direct services from related services. DIRECT SERVICES (required special education) are those special educational services that are mandated. RELATED SERVICES are not mandated unless proven prerequisite for the student to benefit from special education. Transportation and such developmental, corrective, and other supportive services are examples of services that may be required for a handicapped child to benefit from physical education. By including physical education as a part of the special education definition, P. L. 94-142 specifies physical education as a direct and therefore required service.

- 1978 P. L. 95-606 Amateur Sports Act - charged the U.S. Olympic Committee (through the establishment of the Committee on Sports for the Disabled, a standing committee of the USOC) to encourage and provide assistance to amateur athletic programs and competition for disabled individuals and to expand opportunities for meaningful participation by disabled persons. This act especially addressed the inclusion of disabled persons in programs of athletic competition for the able-bodied. The COSD has been active in fostering education, organizing competition, and obtaining facilities and other services for the training of disabled athletes. Today disabled athletes use the U.S. Olympic Training center at Colorado Springs and sports organizations for the disabled are helped by the USOC.
- 1979 ARMSTRONG V. KLINE (Pennsylvania) - severely retarded children who regress and cannot recoup from extended layoffs from school are entitled to an extended school year through the summer.
- 1982 ROWLEY V. HENDRIFF (Hudson, NY School District) - declared a handicapped child's right to a personalized program of instruction and necessary supportive services and required that the IEP be reasonably calculated so that the child may benefit from it.
- 1983 P. L. 98-199 AMENDMENTS TO THE EDUCATION FOR ALL HANDICAPPED CHILDREN ACT - required states to collect data to determine the anticipated service needs of handicapped children. It provided incentives for states to provide the necessary special

services to disabled infants and children from birth to 3 years of age. The state discretion to extend the age range, it was not a mandate.

- 1986 DOE V. MAHER (California) - handicapped children cannot be excluded from school for misbehavior that is handicap-related. Educational services can be stopped only if the misbehavior is not related to the handicapping condition.
- 1986 P. L. 99-372 HANDICAPPED CHILDREN'S PROTECTION ACT - attorneys' fees were reimbursed to parents who were forced to go to court to secure an appropriate education for their child. Parents who prevailed in a hearing or a court case could recover the cost incurred for lawyers to represent them.
- 1986 P. L. 99-457 EDUCATION FOR ALL HANDICAPPED CHILDREN AMENDMENTS OF 1986 - This law, and especially the section known as Part H, is having a tremendous impact on the lives of the families of infants and toddlers who are born with disabilities or are at high risk of being disabled. The law required states to develop comprehensive interdisciplinary services for disabled infants and toddlers, birth through 3 years of age and to expand services for preschool children ages 3 through 5 years. Combining the requirements of this law with P. L. 94-142 expands the ages of coverage from birth to age 21. Again, the financing of this education is coming from federal and state money.

A new term was introduced with this law: the INDIVIDUALIZED FAMILY SERVICE PLAN. The IFSP recognizes the importance of parental involvement in the education of children. Parents must be given guidance in determining their child's needs and the services to be provided. In addition, they will be actively involved in the assessment process and are strongly encouraged to help in the development of the IFSP. The IFSP is essentially the same as the IEP. The main differences between the two are reflections of the needs of families with disabled children too young to go to school.

This legislation emphasizes that motor development is critical to preschool children, whether handicapped or not. To minimize the potential for physical delays, disabled infants and toddlers should routinely be provided with physical education programs. Physical education programs for these young children would enhance their movement capabilities and thus reduce the educational cost to our society because of the need for special education and costly related services involving motor skill development after the children reach school age would be minimized. In addition, an effective early physical education program would minimize the likelihood of institutionalization of some of the more severely handicapped individuals and would maximize their potential for independent living in society.

#### THE NEWEST LEGISLATION

- 1990 P. L. 101-476 - Officially changed the name of P. L. 94-142 to the INDIVIDUALS WITH DISABILITIES EDUCATION ACT and is commonly referred to by its initials as the I.D.E.A. All parts of the 1975 law are still intact (i.e., free appropriate public education, priority children, the IEP, least restrictive environment, and due process). Additionally, the mandates of P. L. 99-457 Educational Amendments of 1986 ("at-risk" children - birth to 5 years of age) are integral components of I.D.E.A. This law will continue to affect the kind and quality of education for disabled children.

Public Law 101-476, the Individuals With Disabilities Education Act (IDEA), identifies the following disabling conditions: **autism**, mentally disabled, deaf and hard of hearing, visually disabled, deaf-blind, speech impaired, seriously emotionally disturbed, orthopedically impaired, specific learning disabilities, multi-disabled, **traumatic brain injury** and other health impaired. Students, who meet the regulations for one of these conditions, and needs special services in the curricular area of physical education, are eligible for an adapted physical education program. (Note that autism and traumatic brain injury were not listed among qualifying disabilities under PL. 94-142.)

COMMENTARY: The IDEA is comprehensive and specific, but it poses particular concerns for physical educators. IDEA is foremost a **special education act**, and physical education is included as part special education. Writers of the PL. 94-142 and IDEA were not physical educators. They perceived physical education as a purely physical phenomenon (i.e., physical and motor fitness; fundamental motor skills and patterns; and skills in aquatics, dance, and individual group games and sports, including intramural and lifetime sports). The law does not recognize the role of physical education in facilitating nonphysical outcomes of physical education experiences. Most physical educators include self-esteem and social development as two important nonphysical outcomes of physical education. The significance of these two outcomes warrants their inclusion as part of the physical education experience of all children.

Helping a child to achieve a higher level of self-esteem through successful participation in physical education is **not one of the school's IDEA physical education-related legal obligations**. The law makes no mention of physical education's nonphysical outcomes. Despite the law, however, achieving greater self-esteem can be important to the child who, because of heightened self-esteem, spends more time actively pursuing communication with others. The child with a disability often has few opportunities for social development under any circumstances. Physical education with its emphasis on individual-to-group relationships seems to facilitate the socialization process of the child with unique needs.

IDEA falls short in yet another way. It fails to recognize many children who have movement-centered special needs. For example, obese, underdeveloped, awkward, clumsy, and temporarily (acutely) disabled youngsters have needs unrecognized by IDEA. Physical educators are obligated professionally, if not legally, to ensure that such children, who may be truly disabled, receive a physical education tailored to meet their unique needs.

The IDEA would be significantly more complete if it addressed the special outcomes of physical education and the needs of the all children. However, the law does represent a giant step forward in the education of children with special needs. Subsequent steps on behalf of these children will undoubtedly follow this progress.

1990 P. L. 101-336 THE AMERICANS WITH DISABILITIES ACT - The ADA is arguably the nation's most sweeping civil-rights law since the mid-1960s. It replaces and includes all-important aspects of Section 504 of the Vocational Rehabilitation Act of 1973. (There is a key difference between the two laws, however, under the Rehabilitation Act, people had to bring complaints to the federal agencies, and the agencies investigated their claims. Under the ADA, people can sue institutions directly). The law became operational July 26, 1992. The law states in essence that **individuals with disabilities** must be provided with equal opportunities in all aspects of life. Communities, schools, and employers are now required to comply with the mandates of the ADA. For example, regulations that are more stringent are in effect regarding physical changes in buildings (restrooms, drinking fountains, ramps, elevators, and telephones), parking lots, parks, swimming pools, and schools. Prompting integration of people with disabilities into the mainstream of society is an important objective of the ADA, and usually, separate programs for individuals with disabilities will not be permitted. Even when separate programs are permitted, a disabled individual cannot be denied the opportunity to participate in programs that are not separate or different.

The ADA provides comprehensive civil rights protections for "individuals with disabilities." An individual with a disability is a person who:

1. Has a physical or mental impairment that substantially limits one or more "major life activities," or
2. Has a record of such an impairment, or
3. Is regarded as having such impairment.

"Major life activities" include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Examples of physical or mental impairments include, but are not limited to, such contagious and noncontagious diseases and conditions as:

Orthopedic  
Visual  
Speech and hearing impairments  
Cerebral palsy  
Epilepsy  
Muscular dystrophy  
Multiple sclerosis  
Cancer  
Heart disease

Diabetes  
Mental retardation  
Emotional illness  
Specific learning disabilities  
HIV disease (symptomatic or asymptomatic)  
Tuberculosis  
Drug addiction  
Alcoholism  
Homosexuality & bisexuality not ADA impairments

Those currently engaged in illegal use of drugs are not protected by the ADA when action is taken because of current drug use.

There are 3 important parts to the law:

Title I affirms the right of equal opportunity for the disabled and expands the concept to cover businesses even if they do not receive federal funds.

Title II of the ADA is most noted for the legal mandate that public entities provide services "in the most integrated setting appropriate to the needs of individuals with disabilities."

Title III covers public accommodations (i.e., private entities that own, operate, rent, or lease to places of public accommodation), commercial facilities, and private entities that offer exams and courses related to educational and occupational certification

## TITLE I

Part of Title I expands the law to include employment policies for individuals with disabilities. Companies with 25 or more workers were affected immediately. As of 1994, companies with 15 or more workers had to comply. Business owners must meet the following requirements:

1. Existing facilities used by employees must be made readily accessible to and usable by persons with disabilities.
2. Job restructuring, modifying work schedules, and reassignment to a vacant position must be utilized.
3. Equipment, devices, examinations, training materials, and policies must be acquired or modified, and qualified readers or interpreters must be provided.

The underlying principle here is one of REASONABLE ACCOMMODATION. Reasonable accommodation is any change in the environment or in the way things are customarily done that enables an individual with a disability to enjoy equal opportunity. In the workplace, it is any change in the work environment or in the way things are usually done that enables a disabled person to enjoy equal employment opportunity. Ideally, the employer and the employee together identify the precise limitations imposed by the disability and explore potential accommodations that would overcome those limitations.

Regarding physical education and athletic programs in the public schools, an individual cannot be denied access to classes or activities because of a disability. People with disabilities cannot be prevented from participating in an activity just because they are not able to perform **all** of the activity. If the person can do any part of the activity, then accommodations and adaptations must be made for them.

While aiding some disabled people in their quest to enter the work force, the law serves mainly to help injured or impaired workers to keep their jobs. Reassignment, of a disabled employee, to a vacant position is listed as a potential reasonable accommodation. (Reassignment is not available to applicants.) Reassignment should be considered only when accommodation within the current position would pose undue hardships.

Employers should reassign the individual to an equivalent position, in terms of pay, status, etc., if the employee is qualified, and if the equivalent position is vacant within a reasonable amount of time.

An employer may reassign an individual to a lower graded position if there are no accommodations that would enable the employee to remain in the current position and there are no vacant positions for which the individual is qualified with or without reasonable accommodation. An employer, however, is not required to maintain the reassigned individual with a disability at the salary of the higher graded position if it does not so maintain reassigned employees who are not disabled. It should also be noted that an employer is not required to promote an individual with a disability as an accommodation.

The Equal Employment Opportunity Commission (EEOC) has issued guidelines that cover the effects that the ADA has had on the hiring process. In general, employers cannot ask any questions that might lead a prospective worker to reveal a disability before he or she has been offered a job. The theory is that these questions may "muddy" the hiring decisions with prejudice and stereotypes. An interviewer cannot ask about the existence, nature, or severity of a potential disability. An employer cannot conduct a medical examination until after it makes a conditional job offer. If a medical exam is given, it must be given to all prospective employees in the job category. If a medical exam screens out someone who has a disability, the "exclusionary criteria" must be job-related and consistent with business necessity.

## EXAMPLES OF LEGAL AND ILLEGAL EMPLOYER QUESTIONS

### LEGAL

Can you perform this job with or without reasonable accommodation?

Can you meet the attendance requirements of this job?

How many days of leave did you take last year?

Do you have the required licenses to perform this job?

Do you have a cold? Have you ever tried Tylenol for fever? How did you break your leg?

Do you drink alcohol? Do you illegally use drugs? Have you used illegal drugs in the last two years?

How much do you weigh? How tall are you? Do you regularly eat three meals a day?

### ILLEGAL

Do you need reasonable accommodation to do this job?

Do you have a disability that would interfere with your ability to perform the job?

How many days were you sick last year?

Have you ever filed for worker's compensation? Have you ever been injured on the job?

Do you have AIDS? Do you have asthma? How did you become disabled?

In the past, how often did you use illegal drugs? Have you ever been addicted to drugs?

Have you ever been treated for mental health problems?

Have you ever taken AZT? What prescription drugs are you currently taking?

Employers are allowed to ask candidates to explain or demonstrate how they would perform a job and once the job has been offered, employers may require a medical examination, which may reveal an acceptable disability-related reason to withdraw the job offer. The definition of "reasonable accommodation" is negotiable and usually requires more common sense than expense.

## TITLE II

Title II of the ADA is most noted for the legal mandate that public entities provide services "in the most integrated setting appropriate to the needs of individuals with disabilities." The general prohibitions against discrimination by recipients of federal funds already existed under Section 504, and therefore were already familiar to state and local governments. Title II extends this prohibition against discrimination to all activities of state and local governments, including those that do not receive federal financial aid. The overall effect of the ADA was to extend federal civil rights protection for the disabled to services not already covered by Section 504 (i.e., generally, private and commercial accommodations and services that are not the recipients of federal funding).

## TITLE III

Title III's coverage of public accommodations includes over 5 million private establishments, such as restaurants, hotels, theaters, convention centers, retail stores, shopping centers, dry cleaners, laundromats, pharmacies, doctor's offices, hospitals, museums, libraries, parks, zoos, amusement parks, private schools, day care centers, health spas, and bowling alleys. Under the law, commercial facilities are nonresidential facilities, including office buildings, factories, and warehouses, whose operations affect commerce. Title III does not apply to religious organizations, including places of worship. Private clubs are also excluded, except to the extent that the facilities must be made available to customers or patrons of a place of public accommodation. Under Title III, public accommodations:

1. Provide goods and services in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity. (Simply put this is the concept of "the least restrictive environment" expanded to public accommodations).
2. Make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration would result in the nature of the goods and services provided.
3. Furnish auxiliary aids (but not personal items such as wheel chairs, eyeglasses, or hearing aids) when necessary to ensure effective communication, unless an undue burden or fundamental alteration would result.
4. Remove architectural and structural communication barriers in existing facilities where readily achievable and provide reasonable alternatives when removal of barriers is not readily achievable.
5. Provide equivalent transportation services and purchase accessible vehicles in certain circumstances.
6. Comply with the ADA when undertaking new construction or altering existing facilities.

## DISCUSSION

Requirements that tend to screen out individuals with disabilities are prohibited. For example, requiring a blind person to produce a driver's license as the sole means of identification for cashing a check would violate the ADA.

Safety requirements that tend to screen out the disabled may be imposed only if they are necessary for safe operation. The requirements must be based on actual risks and not on mere speculation, stereotypes, or generalizations about individuals with disabilities. For example, an amusement park may impose height requirements for rides when required for safety. All participants in a recreational rafting expedition could reasonably be required to be able to possess a certain level of swimming competence.

Extra charges may not be imposed on individuals with disabilities to cover the costs of measures necessary to ensure nondiscriminatory treatment, such as removing barriers or providing qualified interpreters.

Specialists are not required to provide services outside their areas of specialization. For example, a doctor who specializes exclusively in burn treatment may refer a disabled person who is not seeking burn treatment to another doctor, but the burn specialist may not refuse burn treatment to a person with HIV disease.

Auxiliary aids include such services or devices as qualified interpreters, assistive listening headsets, television captioning, and decoders, telecommunications devices for deaf persons (TDD's), videotext displays, readers, taped texts, Braille materials, and large print materials. The auxiliary aid requirement is flexible. For example, a Braille menu is not required, if waiters are instructed to read the menu to blind customers.

There is nothing in the law that can be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit that he or she chooses not to accept. The ADA requires public entities to allow the "qualified individuals with a disability" to choose whether to participate in a program "not designed to accommodate individuals with disabilities."

#### EFFECTS OF THE ADA

The law became operational July 26, 1992. By the end of August, the Justice Department and the EEOC had received more than 16,000 complaints of discrimination against the disabled. In addition, 26 lawsuits had been filed and the limits of the legislation are still being tested. In fact, there are some lawyers who represent companies being sued under the ADA that point to the EEOC's caseload to prove that the law is being expanded beyond what Congress intended. For example, complaints to the EEOC are 90% job-bias complaints, with back impairment (19%) and mental illness (10%) being the two largest categories.

In fact, according to the New York Times (10-23-94), the number of disabled people entering the work force has not significantly increased although the number of disabled high school and college graduates has continued to increase. Only 31% of disabled people (age 16-64) were working part time or full time, down slightly from the 33% that were employed in a 1986 survey.

According to Newsweek (11-7-94), almost 35,000 ADA complaints have been received by the EEOC since 1992. Then, about 2/3rds of all severely disabled adults remain unemployed. However, people already in the workplace have brought a full 85% of the discrimination claims under review. Half allege that they have been wrongly discharged. The most commonly cited disabilities are back pain and ailments like carpal tunnel syndrome and depression, which together account for 40% of the cases. By contrast, the blind and the deaf have filed only 6% of the actions.

Newsweek also reports that people with traditional disabilities are not exploiting the law as expected, partly because many fear losing comprehensive medical benefits from programs like Medicaid. A December 1990 survey of disabled persons who receive Supplementary Security Income (SSI) payments found that 6.5% of disabled SSI recipients were working (besides the SSI payments), while the figures for December of 1994 revealed only 5.8% were working. Perhaps the explanation of this is that many disabled, especially the severely disabled, can only work at or near the minimum wage. Thus, even working full-time might mean that they bring home less money than if they continue to receive full Social Security cash payments. In effect, since the passage of the ADA, the number of people with disabilities receiving Social Security benefits has risen and the number of people receiving benefits who are also employed has also risen, but they represent a smaller percentage of the total number receiving benefits.

The disabled community is divided over what to do next. Many activists vigorously defend the law, which has forced public buildings and businesses to install wheelchair ramps and Braille signs. However, others are outraged at abuses and fear a backlash by businesses that will hurt the people that the law was intended to help.

#### ADA DEMANDS ON COLLEGES

Nearly 1 in 11 freshmen report some kind of disability and colleges responded in a variety of ways. Many remodeled buildings and changed policies to accommodate students and employees with disabilities. However, occasionally, colleges believe disabled persons cannot meet legitimate curricular requirements.

## CONCEPTS FROM LEGISLATION CONCERNING PHYSICAL EDUCATION

1. School personnel must write achievable objectives in detail and be accountable for subsequent evaluation.
2. Parents must be fully informed of the nature of the programs in which their children participate.
3. The education should take place in the most integrated setting, with normal children in regular classes, if possible and if appropriate.
4. Testing, assessment, and evaluation of the individuals needs must be valid and objective.

## COMMON QUESTIONS ABOUT THE LEGISLATION ASSERTING THE RIGHTS OF THE DISABLED

Laws, in their written form, can often be confusing. Too often, teachers and school administrators have a distorted view of the law's true intent. So, let's look at some common questions.

**QUESTION:** Do all people with disabilities have special needs?

**ANSWER:** The answer is "yes and no." For example, a deaf child may have special needs during a square dance unit but not during a gymnastics unit. Special needs vary for people with different disabling conditions, and needs vary among individuals with the same type of disability depending on the severity of the condition. Generally, the person with a disability tends to be more like, than different from the nondisabled. The person with a disability usually has some limitations and special needs, but not in every area and not in most areas.

**QUESTION:** Is physical education required for children with disabilities if it is not required for nondisabled students?

**ANSWER:** If, after appropriate assessment procedures, an individual is identified as having special physical or motor needs, then that child must be given an individualized program, despite whether able-bodied students are required to take physical education or not.

**QUESTION:** If a child with a disability is placed in a regular physical education class, must an IEP be developed for that child?

**ANSWER:** No. A total IEP evolves from the initial assessment of the child. The multi-disciplinary team (the authors of the IEP) would indicate that the child does not need a specially designed adapted physical education program beyond the program provided for peers with no disabilities. The child therefore need only participate in the regular and comprehensive physical education program. That physical education program will meet all of the child's psychomotor needs, and will thus include positive reinforcement in the cognitive, affective, and psychomotor domains.

**QUESTION:** Must children be placed in regular physical education if their needs can be more effectively be met in a separated setting such as an adapted physical education class?

**ANSWER:** The student's needs dictate the placement. The adapted class is therefore less restrictive than the regular class would be. Both the setting and the time involved in meeting the child's needs must be considered. Children identified as disabled who receive special education services do not automatically need an adapted physical education program. The process moves from assessment, to programming, and then to placement. No longer can placements be a function of organizational pattern or administrative inflexibility by the school or the teacher. If a child cannot learn in one way, then the teacher must teach another way that enables the child to learn.

**QUESTION:** Should a special education class consisting entirely of students who are grouped homogeneously according to specific disabling conditions (e.g., all moderately mentally retarded) be sent as a group to physical education class?

**ANSWER:** Emphatically no! One of the main reasons for drafting P.L. 94-142 was to stop such indiscriminate placement and to force educators to look specifically at each child's unique needs. Each child must be placed according to individual, not group, needs. Grouping children categorically by disabling condition is not appropriate in terms of the intent or the letter of the law. Once a child has been assessed and found to possess physical and motor abilities consistent with those of children with no disabilities, then the school district should follow the same process and procedures that govern all nondisabled children in its jurisdiction. A child who is blind, for example, should not be placed automatically in an adapted physical education swimming class if his or her potential to learn swimming techniques is similar to that of children with no disabilities. Decisions for all students, including the blind student, should be made based on present ability

level (i.e., beginning swimmer, intermediate swimmer). In this situation, the teacher should move the child's arms instead of demonstrating the freestyle stroke.

**QUESTION:** If a child is so disruptive that he makes it difficult for others to learn or function effectively, must he be kept in a given educational setting?

**ANSWER:** No. The laws emphasize that when a child with a disability impairs the learning opportunity of another child, then placement is not considered appropriate, and additional assessment is necessary. Assignment must be made to an alternate least restrictive environment setting (e.g., an adapted physical education class could afford a lower teacher-pupil ratio and thus provide a more individualized program).

**QUESTION:** If a regular or special education classroom teacher uses motor, physical, or recreational activities that reach certain students, has physical education requirement been satisfied?

**ANSWER:** No. To satisfy the requirements of IDEA, a certified physical education instructor must make a clear-cut effort to meet the child's motor needs. Although classroom teachers should be encouraged to provide additional physical and developmental activities, these opportunities are in addition to, and not in place of, instruction by a professional physical educator. Free play, recess, or recreational activities do not meet the intent of physical education for the IEP.

**QUESTION:** Do the same provisions that apply to children with disabilities also apply to students who are obese or malnourished, or who possess low levels of physical fitness or have poor motor development?

**ANSWER:** Students not legally identified as disabled may also need an adapted physical education program to meet their needs effectively. Despite the need, however, there are no legal or binding statements requiring development of an IEP for these children. All physical educators need to be committed to a flexible physical education program that will meet the needs of all children.

**QUESTION:** What can be done for students with disabilities who are excused completely from physical education because no adapted physical education program exists?

**ANSWER:** According to IDEA and Section 504, which mandates a free appropriate education for every child with a disability, no child should be excused from physical education. Both laws require that each child's special needs be met through individualized programs. The fact that a local education agency or school does not have a particular service is not an acceptable justification. Needed services are to be provided whether they are currently available or not. This is the responsibility of the local education agency.

## THE SPORTS MOVEMENT AND COMPETITIVE SPORTS FOR THE DISABLED

The European countries were far ahead of the U. S. in providing sports for the disabled. International competition for deaf athletes has been available since 1924.

The large number of soldiers disabled in World War II posed a great challenge to medical authorities. Traditional methods of rehabilitation did not satisfactorily respond to the medical and psychological needs of the war injured. For example, those with spinal paralysis were considered hopeless cripples with a life span of only 2 - 3 years. Early deaths were attributed to infection of the paralyzed bladder, resulting in death of the kidneys.

Recognizing this problem, the British government, in 1944, opened the Spinal Injuries Center at Stoke Mandeville Hospital under the direction of Dr. Ludwig Guttmann. This is the most significant event in the history of sport for the paraplegic, perhaps for all disabled persons (rivaled by the Special Olympics).

To alleviate boredom and enhance the neuromuscular system, Dr. Guttmann and his staff introduced sport to their patients as a form of recreation. The patients at Stoke Mandeville Center participated in ball exercises, rope climbing, wheelchair polo, and wheelchair basketball (now the most popular sport of the paralyzed).

This attempt to incorporate sport into the medical rehabilitation of the paralyzed soon spread from Great Britain to other countries, including the U. S.

The incorporation of sport into the U. S. methodology of rehabilitation is perhaps due to a combination of factors. First, it may be useful to note that American medical staff and American casualties interacted with British medical services during that time. As a result, some disabled veterans became very interested in sport and some Veteran's Administration Hospitals began encouraging other disabled veterans to become active sport participants. A 1946 U. S. tour of the Flying Wheels Basketball Team of Van Nuys, California helped both the disabled and the able-bodied to comprehend the value and enjoyment sport holds for disabled athletes.

In the late 1940s and early 1950s, several other wheelchair basketball teams were organized. However, a visit by Dr. Guttmann to the U. S. in the mid-1950s gave wheelchair sport additional emphasis. As a result, new events such as 60, 100, and 200-yard dashes were developed and national associations for wheelchair sports were formed. The National Wheelchair Athletic Association was formed in 1956, the National Wheelchair Games were held in 1958, and Americans competed in the first Olympic Games for the Disabled in 1960 in Rome. From that date, international games were held every 4 years, about the same time as the regular Olympics and where possible in the same country.

### SPECIAL OLYMPICS

Physical education for the mentally retarded began to receive attention in the early 1960s. The family of President Kennedy fostered interest in the movement. The Joseph P. Kennedy, Jr. Foundation proved their concern for the welfare of the mentally retarded by starting the Special Olympics. It consists of year-round training for mentally retarded athletes in several sports, highlighted by seasonal competition at local, district, state, and international levels. The first International Special Olympic Games were held in 1968 in Chicago.

Of the many contributions made by this sports movement, perhaps the greatest is the creation of strong advocates whose belief in athletics for the disabled carries over into the struggle for quality physical education programming for all children. The philosophy of the Special Olympics supports the belief that striving is more important than success, and determination is more important than winning.

Except for the founding of the National Handicapped Sports and Recreation Association, which governs winter sports and the creation of the Special Olympics, little happened until the 1976 Olympiad. At that time, the Olympic Games for the Disabled were broadened to include

blind and amputee athletes. In the 1980 Olympics for the Physically Disabled, ambulatory cerebral palsied athletes participated for the first time. In 1983, the International Games for the Disabled included non-ambulatory cerebral palsied athletes.

Thus, the early development of athletic programs for the disabled contributed to the growth of an adapted physical education by increasing public awareness concerning the needs, interests, and abilities of special populations. From the 1960s on, the sports organizations for the disabled contributed to the changing nature of adapted physical education and to shifting it away from the medical model to a sports movement model focused on abilities.

Medical Model - earlier decades emphasized the correction or alleviation of physical defects and/or perceptual-motor problems.

Sports Movement - focused on abilities by finding or creating sports in which students could participate. Disabled persons led the movement. Sports were seen as self-actualizing, a means of improving both mental and physical health and of achieving recognition for individual talent and hard work.

No longer are disabled persons willing to work on motor skills and physical fitness just for the sake of improving locomotion and health. Sports are integral parts of American life, and disabled persons want equal opportunity for learning and competing in sports. They, more than any other force, are helping to define the differences between physical therapy and education. Most have had years of exercises with various therapists; they do not want physical education simply to be more exercise. Instead, they seek opportunities to learn specific sports skills, rules, and strategies.

From the rule books of the different organizations physical educators can learn the sports events in which students with specific conditions are most likely to succeed. Contemporary adapted physical education emphasizes the teaching of skills, rules, and strategies that can be carried into present and adult leisure. Local, regional, and national competition is now available to many disabled persons from age 8 and older.

When the U. S. Olympic Committee was reorganized in the 1970s and plans were made for better promotion and coordination of amateur athletics, sports for disabled athletes were included in the master plan. Specifically, P. L. 95-606, the Amateur Sports Act of 1978 charged the USOC to encourage and provide assistance to amateur athletic programs and competition for disabled individuals. The USOC also expanded opportunities for meaningful participation by disabled individuals in programs of athletic competition for the able-bodied.

Today disabled athletes use the US Olympic Training Center at Colorado Springs and sports organizations for the disabled are assisted by the USOC. New role models are emerging from within the ranks of disabled persons. Contemporary adapted physical education exposes students to these role models and uses a variety of motivation techniques to encourage students to develop lifetime patterns of sports involvement and exercise.

## PROFESSIONAL ORGANIZATIONS

Professional organizations work for legislation and educational policy favorable to physical education, conduct conferences at which theory and practice are shared. In this manner, professional organizations increase the knowledge base of a profession; provide professional relationships and ethical guidelines for members.

American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD) substructures have contributed to the evolution of contemporary physical education. Some AAHPERD substructures follow.

Adapted Physical Activity Council - centers attention on handicapped children and their special physical education needs. It is under the governance of ARAPCS (Association for Research, Administration, Professional Councils and Societies). When paying annual AAHPERD dues, adapted physical educators should check ARAPCS as one of their two structures. The official publication of the Adapted Physical Activity Council is Able Bodies.

Therapeutics Council - concerned about providing all special populations, including elderly participants, with quality programs of physical activity. It is also under the governance of ARAPCS.

Unit on Programs for the Handicapped - a clearinghouse of up-to-date information about the physical education and leisure needs of the disabled. It is also under the governance of ARAPCS.

National Consortium of Physical Education and Recreation for the Handicapped - is exclusively devoted to physical education and recreation for disabled persons. The purpose of NCPERH is to promote, stimulate, encourage, and conduct professional preparation and research in physical education and recreation for disabled persons. This organization has played a major role in shaping the future of adapted physical education, particularly as a graduate specialization and/or profession/discipline. Its membership has been active in promoting legislation and funding favorable to physical education for disabled persons, in distributing information about P. L. 94-142, Section 504, IDEA, and the ADA, and generating a growing body of knowledge for adapted physical education through research and demonstration. Membership is currently open to anyone who is or has been involved in training, demonstration, or research activity related to physical education and recreation for disabled persons. The newsletter is called The Advocate.

Council for Exceptional Children - (CEC) The national organization with which most special educators affiliate - its focus is the promotion of quality special education programs for exceptional students, including talented and gifted. Their journals are Exceptional Children and Teaching Exceptional Children.

In recent years, many adapted physical educators have joined CEC, leading to increased awareness by special educators and physical educators of the contributions each can make to disabled children. Fortunately, the CEC is also including more information about physical education in its journals and conferences.