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Where There Are No Therapists: The Related Services Assistant Alternative

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Chronic shortages of related services personnel in the areas of physical therapy, occupational therapy, and speech-language pathology have severely limited services for students with disabilities in rural areas of the U.S. Pacific jurisdictions. A training model with a functional approach to support students with severe disabilities to achieve IEP objectives was developed and implemented in partnership between the College of Micronesia, Federated States of Micronesia (FSM), and the Hawaii University Affiliated Program at the University of Hawaii. Nineteen teachers completed the training program, with positive impacts for students reported by families, teachers, and administrators in the FSM. Discussion focuses on the challenges and implications, of the Related Services Assistant training model to implement functional supports where related services are lacking in rural communities.

Shortages of related services personnel to serve students in educational settings in physical therapy, occupational therapy, and speech-language pathology are reported across the U.S. and particularly in rural areas (Fire, 1991). The rural areas of the U.S. Pacific jurisdictions include the territories of American Samoa and Guam; the Commonwealth of the Northern Marianas Islands; and the Federated States of Micronesia (FSM), the Republic of the Marshall Islands and the Republic of Palau. In these areas, barriers to services are created by distance, diverse cultures and languages, and limited funding (Sadao, Robinson, & Magrab, 1997). Certified and licensed professionals in physical therapy, occupational therapy, and speech-language pathology are unavailable in most Pacific Island nations. The geographical distance from professional training programs has created a long-standing lack of the personnel for providing related services to students in special education programs under the Individuals with Disabilities Education Act (IDEA).

In the FSM states of Pohnpei, Yap, Kosrae, and Chuuk, the need for personnel to fulfill roles in related services with students identified as eligible for special education is particularly critical (Ratokalau, Tada, Lee, Rekemesik, & Habuchmai, 1995). The need for related services personnel with skills in child find, family support, functional assessment, Individual Education Plan and Individual Family Services Plan development, adaptive equipment, and motor and communication development was further documented by child count data reported by the FSM Department of Education (Cantero, 1993). In 1993, for example, there were 868 students between the ages of 6-22 enrolled in special education and related services programs, with an additional 3,155 students identified as eligible for special education and related services. In addition to the school-age population of students in need of special education and related services, 491 children in the 0-5 age range group were served and an estimated 961 children were unserved. The lack of professional personnel to provide related services to students who are eligible for special education under IDEA raises challenging issues and the need for alternative personnel and training models in the outer islands of the U.S. Pacific Island jurisdictions.

Extensive planning included a faculty team of professionals in physical therapy, speech-language pathology, and special education at the University of Hawaii and the College of Micronesia in the FSM. The team faced the difficult issues of professional certification requirements, supervision for assistant-level personnel, and the need for

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a training model that directly responded to unserved and underserved students with severe disabilities in the Micronesian region. The team recognized that the personnel trained would be required to implement services and supports with students in remote locations without supervision and minimal, infrequent contact with professionally certified therapists.

From the outset, the focus of the Related Services Assistant (RSA) training model was to identify functional skills to create a "specialized" provider to implement services in the areas of motor, communication, self-help, and other areas to support students with severe disabilities to participate in home, village, and school settings. The team members were cognizant of the limitations and challenges of such a model, in view of national standards for certification and licensing in related services disciplines and formalized training programs for physical therapy assistants, occupational therapy assistants, and communication aides. The goal of the RSA training model clearly was not to train professionals in related services or assistant-level personnel as currently defined in the disciplines listed above. For this reason, the name Related Services Assistant is perhaps a misnomer as the individuals trained represent a new type of specialist, with applied skills that are critically needed in remote and rural locations such as the Pacific Islands. The long-term needs for professional-level supervision remain a critical shortage in the Pacific, and require careful development for a sustainable system of "related services" for children, families, and educators in remote and culturally diverse locations of the U.S.

The development of the RSA training program was based on locally-responsive personnel training models developed through the University of Hawaii. These models provided practical skills and knowledge in island and village-based health care, such as rehabilitation technicians with basic skills in physical therapy and medical officers with basic medical training. For example, one rehabilitation technician in each state provides physical therapy services after having received intensive and periodic training in basic rehabilitative physical therapy skills. However, these individuals are responsible for providing services in medical settings to persons with disabilities of all ages and are not able to provide effective educational supports and outreach with families and children with disabilities in remote island communities. The goal of the RSA training program was to assure that students with disabilities receive related services that allow them to participate in, and benefit from, their educational programs. In addition, the provision of related services was intended to (a) increase family member's involvement and satisfaction with educational services; (b) provide teachers with the support they need to include students with disabilities in their classrooms; and (c) increase the level of services provided to students with severe disabilities (many of whom are home-bound).

The primary format of training was based on a team approach using an integrated therapy model that represents best practice in special education and related services. The collaborative team model requires shared resources across providers, rather than a medical model where students are removed from class and treated individually in an isolated therapy room (Forest & Pearpoint, 1992; Rainforth, York, & Macdonald, 1992; Writer, 1987). The collaborative, or team approach, was selected as the best fit with cultural practices in the island communities where collective problem-solving in a group of concerned family members and providers was recommended by local faculty members at the College of Micronesia-Federated States of Micronesia (COM-FSM) (Ratokalau, Tada, et al., 1995).

Methods

The development and implementation of the RSA training program at the COM-FSM campus in Pohnpei was conducted from September 1994 to May 1995, with special education funding and representation of all FSM states and the Republic of the Marshall Islands. Participants in the RSA Training Program were selected by their administrators with minimum criteria of an associate degree in education and interests in learning to provide supports for students with severe disabilities. The RSA training program was based on values that demonstrated (a) respect for local cultures, languages, resources, and traditions and (b) support for families and individuals with disabilities to participate fully in home, school, and community settings (Whyte & Ingstad, 1995). The curriculum included hands-on experience with students with disabilities and families throughout the program with the emphasis on immediate application of curriculum content.

RSA Curriculum Content

The content of the RSA training program focused on the following areas:

- Functional Assessment
- Team Work
- Adaptations
- Communication and Social Skills
- Physical/Motor Development
- Self-Help Skills
- Nutrition and Feeding Skills
- CPR, First Aid, and Safety
- Safe Lifting, Carrying, and Transferring
- IEP Development

Table 1 shows the scope of the RSA training program.

Table 1
Related Services Assistant Training Program Content and Scope

Module	Content/Focus	Suggested Academic Credits
Module I	Introduction to Related Services 1. Introductions 2. History of Special Education (local and national) 3. Disability Awareness 4. Disability Characteristics 5. RSA Roles and Responsibilities 6. Screening and Child Find	4 credits
Module II	Involving Families in Related Services 1. Culture and Family Roles 2. Overview of the Laws: IDEA, Parents Rights, Impartial and Due Process, IEP Placement, Advocacy 3. Quality of Life: Inclusion 4. Interagency Assessment Team Roles 5. Interview, Mapping 6. IEP Writing & Meeting (functional goals, current level of performance, activity-based objectives, task analysis, lesson plans)	4 credits
Module III	Functional Skills Development 1. Observation and Assessment (motor, positioning, oral motor/feeding, communication) 2. Adaptations with Local resources (mobility, positioning, communication, self-help) 3. Nutrition and Feeding Development 4. New Games for Inclusion	6 credits
Module IV	Health and Safety 1. First Aid 2. Nutrition & Feeding Skills 3. Required RSA Roles: Health and Education Team Collaboration	6 credits
Module V	RSA Practicum I & II (central location) 1. Communicating with Families: Child Find and Screening 2. Interagency Assessment Team and Follow-up Referrals 3. IEP Development 4. Nutrition and Feeding Intervention 5. Making Adaptations in Home Setting	4 credits
Module VI	RSA Practicum III (home state practicums) 1. Communicating with Families: Cultural Competence 2. Communicating with Families: Assessment, Interviewing Mapping 3. Communicating with Families: IEP Development 4. Partnerships with Families: Inservice Training (safe lifting, CPR, IEPs, Mapping) 5. Partnerships with Families: Making Adaptations for Mobility, Communication, Adaptive Skills in Home Settings 6. Inclusion in School Settings	6 credits
Total Credits		30 credits

RSA Curriculum Components

The RSA training program model was based on the following six components.

Values-based training. The training program was based on values that represent best practice in the disability field with relevance and adaptation to the local communities in which training is conducted. While the RSA training curriculum was competency-based in the provision of services for children with severe disabilities and their families, practices were adapted to island cultures to promote inclusion of persons with disabilities in village life.

Culturally competent practices. Cultural competence is related to values-based training and infused throughout the curriculum. Curriculum content was delivered, and training methods were conducted, in ways that celebrated the cultural and linguistic diversity of the participants and the families and children with disabilities involved in the training program.

Functional skills and adaptations. The RSA training program was focused on training functional skills at all levels. In the assessment process, for example, the functional perspective considered the strengths and abilities of the individual to participate in daily activities at home and school (e.g., feeding, washing, social interactions with peers, group activities, and learning basic skills to prepare for academic or vocational careers). Rather than focusing on tracking individual progress in a more traditional developmental sequence of motor, language, social, cognitive, and self-help skills, the functional approach emphasized the participation of individuals in activities that are meaningful for their age group. A functional objective for a young child with a physical disability might be to participate in a game of catch with his friends at school. In the process of assisting him to achieve this goal, adaptations are made to increase his mobility, communication, and independence in playing catch. In the school room, a functional objective for a young girl with multiple disabilities who does not talk might be to point to pictures of different kinds of fish in a group activity. In this activity, her functional abilities to communicate with her peers are assisted with a pictures and possibly sign language cues provided by the teacher. The functional approach has been shown to be effective with individuals with disabilities in many of the Pacific Island communities to date (Ratokalau, Tada, et al., 1995).

Mentorship with local instructors. As one of the primary goals of the training program was to build local capacity for training local personnel, the mentorship model was considered particularly well suited for the RSA training program. Mentorship was provided in a two-way process. An off-island instructor with expertise in special education and severe disabilities was hired to work side-by-side with the Special Education Instructor at COM-FSM. In addition, consultants in Speech-Language Pathology and Physical Therapy from the Hawaii UAP were contracted to work as a team in the mentorship of COM-FSM faculty. All faculty participated in mentorship as the COM-FSM Special Education Faculty member assisted the off-island instructors in the adaptation and implementation of the RSA curriculum to meet the needs of local languages, cultures, and learning styles of the trainees. The COM-FSM faculty was provided with access to current information and practices in serving and supporting students with severe disabilities in home and school settings.

Family involvement. The involvement of family members was critical to the implementation of the RSA training program. Families and individuals with disabilities participated with the RSAs as part of their field work and practicum assignments. A key component of the training program was a community-based practicum that included home visits with families, which provided opportunities for trainees to apply their knowledge. For example, during home visits RSA trainees were required to complete assignments involving observational assessment and family interviewing. Local schools and Head Start Programs provided contacts and arrangements with individual families who participated in the RSA training program. Each RSA trainee assumed responsibility for "target children" within families throughout the year to complete assignments that fulfilled the content and competencies required by the curriculum.

Building local capacity. The major emphasis of the RSA training was to build local capacity for the FSM to have a training program that meets local needs for related services personnel. The mentorship of local instructors was intended to develop a pool of "faculty" with knowledge and skills to provide high quality training based on best practice in special education and adapted to meet local resources and needs.

Evaluation

Evaluation of the RSA training model was conducted in three phases: (a) midway through the first program year in January 1995; (b) following the completion of the program in June 1995; and (c) 1-year post completion in May 1996. The impacts on students, families, programs, and individual trainees were assessed. Methods for evaluation included interviews with families, trainees, and administrators, in addition to records of services provided to individual students with disabilities. Specific examples follow:

- course evaluations and qualitative interviews with trainees;
- parent and family member evaluations regarding the impacts of the training program;
- individual outcome data regarding the number of children served in screening, assessment,

program plans, and interventions;descriptive outcomes regarding the types of adaptations and resolutions made for individuals with disabilities and family members;
- administrative and agency outcomes based on services provided to families and individuals with disabilities; and
- interagency documentation regarding impacts of the training program on effectiveness of collaborative referrals, assessments, and interventions in special education and early intervention programs.

Results

The 19 RSAs who completed the first training program in 1995 mastered a competency-based training program with 30 semester credits beyond the associate degree. Results of the RSA training program are reported below.

Services for Unserved and Underserved Students with Disabilities

Services for students with disabilities were included as part of the RSA training program throughout the 9-month training in Pohnpei and final practicum in home states. Over the duration of the RSA training program, each RSA was responsible to complete assessments, IEP goals and objectives, lesson plans, and services with 3-4 target students each. A total of 61 students with disabilities were served directly as a result of the training program, and many more were served in screening and assessment sessions conducted in Pohnpei, Chuuk, Kosrae, Yap and the Republic of the Marshall Islands (RMI). The 61 students who received services during and after the training program were primarily students with severe disabilities who remained at home throughout the day. Educational services were provided by RSA trainees in the home setting, under supervision of the practicum supervisor based at COM-FSM. Due to the remote locations of outlying villages and atolls where these students and their families live, many had not had regular special education and related services prior to RSA training. An additional finding showed that 45 students had their first IEP completed as a result of services provided by RSA trainees. Further aspects of services included the location, type of disability reported, and functional adaptations, as described below.

Location of services. The majority of students served were in home-based settings. RSAs traveled long distances by boat, car, and foot to reach the families and students. Those students served in school-based programs represented 30% of the total number of students served while 70% of students were served in home-based settings.

Types of disabilities. The RSAs and local school personnel identified those students who received services as part of the RSA training program. The most frequent age range was between 7-12 years of age, although a large portion of the children served were 4-6 years of age. The oldest student served was 20 years of age and the youngest was 2 years of age. Of the total 61 students served, 37 were reported to have severe and multiple disabilities. Other students were described as having disabilities including deafness, blindness, or a combination of the two.

Functional adaptations. RSA trainees introduced the use of adaptive equipment. Rather than ordering costly equipment from off-island, RSA trainees learned to create and make adaptive equipment from locally available materials. Adaptations provided equipment that allowed students with multiple disabilities to move around their environments and communicate for the first time. Examples of adaptations made for students in the FSM and RMI included a rope to assist a blind child to walk around her home, communication boards, parallel bars, corner chairs, and even a wheelbarrow to bring a non-ambulatory child down a rough trail to bathe in the river. A total of 28 adaptive devices were made or planned during the final practicum.

Comments from several RSAs in Pohnpei State indicate further positive impacts of increased services for the students in home-based settings:

> Attitudes about these students [with disabilities] are changing. More and more children with disabilities are being included in village activities, churches, and family celebrations.

> One 5-year old boy is sitting in a corner-chair built by RSAs and a young girl who is blind is walking independently.

Family Satisfaction with the RSA Training Program

Families of students served by RSA trainees provided feedback regarding their involvement in the training program, the outcomes for their children, and the perceived impacts on family life. Interviews were conducted with families in each of the FSM states and the RMI at the conclusion of the final practicum.

MAPPING with families. Working with families was a central part of the RSA training program, beginning with family interviews to determine family priorities and dreams for their children in a process called "mapping," adapted from the McGill Action Planning System (MAPS [Forest & Pearpoint, 1992]). Through mapping sessions that included family members, friends, teachers, and the student with disabilities, the RSA trainees learned to identify not only the strengths and needs of the student, but the dreams,

Table 2
Numbers of RSAs Employed in FSM and RMI in Fall 1996

State/ Nation	Number of RSAs Working in SPED	Number Trained
RMI	1	2
Pohnpei	5	6
Kosrae	3	4
Chuuk	4	4
Yap	2	3
Total	15	19

nightmares, and goals of the parents and other caregivers. The mapping reports completed by RSA trainees included family preferences for inclusion in the Individual Education Plan goals, objectives, and lesson plans.

Family reports of student progress. In order to evaluate the effectiveness of the services provided by RSA trainees, families were asked to comment on the areas targeted for their sons and daughters, including adaptations, communication supports, social skills, self-help skills, positioning, movement, feeding, and safe lifting. Twenty families were interviewed, and all reported positive impacts for their children. Examples of specific comments are:

> All areas were improved: self-help skills, including grooming, positioning, and safe lifting.
>
> The RSAs provided exercises on how to help develop my child's body.
>
> My child is now able to communicate through pictures.
>
> My son can reach for a cup and put it to his mouth by himself. Before, he could not.

In addition to reporting positive changes for their children, family members reported that information provided by the RSAs was beneficial, as shown in parents' comments:

> I know how to lift, feed, and position my son now.
>
> I have more hopes for my child.

Program Capacity to Provide Related Services

RSA trainees and their administrators in each state evaluated the impact on program capacity to provide related services to children with severe disabilities in special education and family members through reports. Areas of evaluation included identification of program strengths, areas to further improve the RSA training program, and administrative support issues. The number of personnel with skills to conduct functional assessments, develop IEPs, and provide interventions with students, teachers, and families directly impacted program capacity. The number of RSAs working in special education in fall 1996 is shown in Table 2.

As this table shows, 15 individuals were reportedly working in special education one year following the training, with attrition of 4 individuals due to moving away from the island.

RSA training program strengths. RSAs were asked to rate the effectiveness of the training to prepare them for new job roles in the special education service system in their home states in two ways: (a) those areas that they felt most prepared to implement, and (b) their own particular areas of strength. Ten RSAs consistently rated skills in motor development the highest. Comments from RSAs regarding the most successful and satisfying skill areas included:

> getting to know the families I have not worked with before, feeling closer to the families;
>
> providing inservices with families, particularly on safe-lifting practices;
>
> making communication boards and mapping;
>
> developing IEP goals with families and helping families to work with the child;
>
> the ability to get information and feedback, learn from parents what their needs are for the child;
>
> working with the family as a team to come up with a plan for the child; and
>
> helping the family members to help their children in respectful ways and to know them and understand them better.

RSA training program improvements. RSAs were also asked to identify areas that could be improved in the training program and in the supports provided in their home states. Changes requested in the training program included:

- more time with communication and physical therapy trainers;
- more materials and resources for the students with disabilities;
- more RSAs;
- practicum closer to RSAs' home communities;
- more supervision from instructors during the final practicum;
- include parents as trainers in the program; and
- more time spent on sign language.

The RSA training program demonstrated an effective, applied learning model for teachers to learn basic knowledge in functional motor, communication, and self-help skills, and to apply new knowledge and skills with children and families in rural island communities in Micronesia.

Since the implementation of the RSA training program in 1994-1995, the roles and responsibilities of the RSAs have been an important part of national and regional meetings held in Pohnpei, Guam, Hawaii, and most recently at the Pacific Basin Interagency Leadership Conference in Palau in March 1996. At the Palau conference, the RSA model was shared as an effective approach for rural, remote island communities to meet the related service needs of children with disabilities who need a team approach and intensive support for their development in many areas.

Follow-up Evaluation

In June 1996, further impacts of the RSA training program were assessed in Pohnpei, Yap, Kosrae, and Chuuk (all part of the Federated States of Micronesia). The evaluation was conducted through interviews with administrators, teachers, family members, and RSAs. Several needs for additional training and administrative support were identified in areas below (Ratokalau, Atkinson, et al., 1995).

Roles and responsibilities of RSAs in special education. Individuals trained as RSAs were underutilized in their newly acquired knowledge and skills. Many RSAs were assigned classroom teaching duties that were similar to roles prior to becoming trained as an RSA and did not provide related services for children with severe disabilities in their home communities. Administrators, teachers, and RSAs identified three general barriers to implementation of the RSA role: transportation, delayed job reclassification, and classroom teacher shortages.

Interagency roles of RSAs. Prior to the implementation of the RSA training program in the FSM and the RMI, education and health administrators identified the need for coordination among the agencies responsible for serving children with disabilities. An emerging effort to address the need for coordinated identification and services is the Interagency Assessment Team.[1] The role of RSAs to involve educators in the Interagency Team was reinforced in practicum experiences conducted as part of the RSA training program. However, the numbers of RSAs who participate actively with the Interagency Assessment Teams in each island state was reported to be very limited. Among the barriers to participation were the need for joint training for health and education personnel to understand individual provider roles, conduct assessments, make home visits, and provide services collaboratively.

RSA personnel development needs. The need for further training in early intervention with children ages 0-5 years was identified in the majority of follow-up interviews with administrators, teachers, and RSAs. The RSA training program focused specifically on working with students from 5-21 years of age. In addition to the need for training to work with young children with disabilities, specific areas of further skill development were identified: (a) outreach services for children and families in remote islands and villages; (b) indicators and strategies to obtain support for families in cases of child abuse and neglect; (c) communication skills to build partnerships with families; (d) nutrition and feeding problems; and (e) team building with all available health, education, and social services personnel on the island.

Following the completion of the first cohort of RSAs, many have successfully implemented the competencies learned in the training program. However, continued needs for training and administrative support for current and new RSAs are found throughout the FSM states to effectively implement their roles and responsibilities with special education teachers, families, and other providers in Head Start and health agencies. In addition, the skills of the RSAs can only be fully implemented with teamwork and interagency collaboration (Ratokalau, Atkinson, et al., 1995).

A long-term training program is currently proposed that will improve and enhance the FSM system of special education and early intervention services to families and children with disabilities. The curriculum content and training methods were directed toward increasing the knowledge and skills of selected teachers from each of the FSM states and the RMI. While team work and collaboration were addressed in the training program, the implementation of team skills following the training program were limited due to the separation of selected individuals from their home communities for a major part of the training program. Future training needs to focus on local capacity development and application of skills to participate with families and providers in the home base of each RSA. Several provisions are planned to address collaboration and team skills in future RSA training efforts, including (a) the delivery of training for new RSAs in home states through local COM-

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FSM campuses and special education faculty in those sites; (b) inclusion of special education and Interagency Team members in RSA training activities; and (c) completion of required projects in team settings that include family members in home-based settings.

Conclusions

Limitations and Considerations for Future Implementation

There are several limitations of the RSA training program and several issues that require further development for future implementation of the RSA model in the Pacific islands and similar rural areas. A continuing concern is the limitation of the skills and training level of the RSA personnel. When faced with specialized problems and medically based disabilities, resources and professional expertise are limited in the Pacific Islands. For example, the RSA who encounters a child with a chronic medical condition or disability must rely on local health care providers who are often limited in number and in specialized skills. The RSA must rely on available resources that may include traditional healers, family members, public health workers, and nursing professionals, when available. The chronic lack of health and medical care in the Pacific Islands continues to be a systemic need that is complicated by many factors, including diversity in cultural traditions, geographical location, economy, limitation in local health care infrastructure, and limited numbers of personnel.

Sustainability of the RSA training program and personnel who complete the program is another area of concern for the implementation and adaptation of such training programs. Funding and faculty are needed in order to expand existing community college curricula in remote and rural locations. Partnerships between regional universities and local community colleges and mentorship relationships between faculty from each setting will enhance the sustainability of the training model.

Integration of the RSA training program with existing college curricula presents many challenges for colleges that are attempting simultaneously to meet personnel shortages in basic teacher education. The supervision of RSA trainees in practicum settings requires additional faculty time and expertise that many education and health faculty are not able to provide. One approach to build capacity for local faculty supervision is to train past RSA graduates to provide practicum supervision. Further challenges for sustainability of the program are found in the cooperation and team work that are required for the successful implementation of RSA services for students with severe and multiple disabilities. Interagency Teams in the Pacific Islands, with education and health personnel working collaboratively in assessment and intervention planning, are established in written agreements yet not regularly implemented in practice (Sadao, Robinson, & Magrab, 1997). Due to the limitations in specialized training and personnel to support students with severe disabilities, the RSA is often the provider with the most appropriate training. The extent of services provided to the student and family are often due to the creativity and resourcefulness of the individual RSA to create adaptive devices for the individual in the family or village setting. However, even the use of local resources, such as parallel bars using bamboo poles, requires materials, training, and support for the RSA. Often, commitment of local funds for travel by boat to remote locations, follow-up training, and materials are not provided in local agency budgets. A commitment of funding is needed for sustainability of RSA training and services to families and children.

Through the first implementation of the RSA training program, much was learned about the application of functional support skills with families and students with severe disabilities in remote and rural Pacific Islands. When considering the components of the program that were found to be effective in meeting the needs of students and families, the most positive impacts for students who were previously unserved or underserved. The variables that contributed to increased direct services were: (a) the practicum component was integrated with the program with actual families and students; (b) collaboration of education, health, and Head Start programs to provide transportation to practicum sites; (c) adaptations of functional approaches to support motor, communication, and adaptive skills in local contexts; (d) mentorship of local instructors to carry out the training program; and (e) support for the RSA to implement new roles and skills following completion of the program. The last component was found to be the most critical in terms of sustaining the skills learned by the RSA and also the most difficult to impact due to systemic barriers. Prior to future implementation of the RSA training program in the FSM or in other rural communities, critical evaluation of the feasibility and sustainability of each of the above key components of the training model is needed.

Implications

The design and implementation of the RSA training program in the FSM and RMI were conducted in response to specific needs identified for related services in remote, rural Pacific Island communities. The impacts and future needs of the program were evaluated both qualitatively and quantitatively through interviews with stakeholders, and increases in services for children with disabilities were identified. There are at least three major implications for further development of the RSA training program in the Pacific Basin and in similar rural locations. First, there is a positive impact of a functional, locally relevant curriculum that

is based on local personnel and materials. Second, local infrastructure at the administrative level must support newly trained RSA personnel to effectively implement required roles to assist families and to improve access to education for children with severe disabilities. Third, professional disciplines, such as physical therapy, occupational therapy, and speech-language pathology, must address the roles of "assistant" level personnel in remote, rural locations where professional supervision is limited.

Challenges to professional certification and licensing requirements are significant and must be more fully addressed if the RSA training model is continued in the Pacific Islands or other remote and rural areas of the U.S. However, the reality of shortages of related services personnel in rural areas of the U.S. and its territories requires an innovative response, such as the RSA model. A major challenge facing assistant-level personnel, such as RSAs, is that of supervision by qualified professionals. The RSA training model may be seen as the first phase of long-term capacity-building in rural areas. Additional phases may include (a) further training and consultation for current RSAs with licensed professionals, and (b) professional-level training and certification for at least some RSAs.

Distance education technology shows promise to address the chronic shortages of related services professionals. For example, technology development in the Pacific Basin will add to the capacity for the colleges in the region to sustain innovative and interactive training programs across sites. Continued use of video production is planned to provide locally-relevant demonstrations of effective methods to implement special education and related services with families of diverse cultures and languages in remote island states of the FSM. Technical resources at COM-FSM are expanding to increase the capacity for internet linkages between training sites, faculty, and trainees in each state.

The implications and results of the RSA training program are promising for rural areas of the Pacific Basin and similar locales. Further development and adaptations of the RSA model require attention to all areas discussed above for long-term sustainability and impact.

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