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SPEECH THERAPY SERVICES FOR DISADVANTAGED PUPILS IN NON-PUBLIC SCHOOLS--REGULAR DAY SCHOOLS AND INTERIM AFTER-SCHOOL CENTERS.

BY- RIGRODSKY, SEYMOUR
CENTER FOR URBAN EDUCATION, NEW YORK, N.Y.

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THE PROCEDURES USED IN SPEECH THERAPY PROGRAMS WHICH PROVIDED WEEKLY SMALL-GROUP REMEDIAL TREATMENT TO DISADVANTAGED NONPUBLIC SCHOOL STUDENTS WERE CRITICALLY EVALUATED. RECOMMENDATIONS WERE MADE FOR (1) A WELL-SUPERVISED, CENTRALLY CONTROLLED PROGRAM OF IDENTIFICATION AND SCREENING OF APPLICANTS, (2) DIAGNOSTIC, REFERRAL, AND THERAPY PRACTICES, (3) SELECTION OF STAFF AND FACILITIES, AND (4) EXPERIMENTAL AND EVALUATIVE TECHNIQUES. THE PROJECT WAS NOT IN PROGRESS LONG ENOUGH TO ASSESS PUPIL PROGRESS. THE QUESTIONNAIRE USED FOR THIS EVALUATION WAS APPENDED. (NC)

CENTER FOR URBAN EDUCATION
33 West 42 Street, New York

Educational Practices Division
Nathan Brown, Associate Director

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Joseph Bradley
Research Coordinator, Title I Projects

SPEECH THERAPY SERVICES FOR DISADVANTAGED PUPILS IN NON-PUBLIC SCHOOLS - REGULAR DAY SCHOOLS AND INTERIM AFTER-SCHOOL CENTERS

Dr. Seymour Rigrodsky
Research Director

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Project Description
and Objectives:

This project is designed to provide therapy for disadvantaged pupils who have the additional handicap of defective speech. The program will provide speech therapy once a week in small groups. The speech correction teacher will confer as needed with parents and classroom teachers and, if necessary, make appropriate referral for related services. Alleviation of pupil speech problems should contribute to improved emotional adjustment and educational achievement. As these pupils improve in their ability to communicate, it is expected that they will develop greater social effectiveness and become more easily integrated in the main stream of the community.

The specific objectives are: (a) Identification of disadvantaged pupils having speech defects conspicuous enough to be handicapping in nature. (b) Diagnosis and placement of speech defective pupils in clinic groups. (c) Identification and remediation of underlying causes of speech handicap through appropriate referrals. (d) Remediation and correction of speech defects through direct therapy. (e) Emotional adjustment and improved educational achievement through remediation of defects that have been a block to effective learning. (f) Carry-over of improved

speech skills in meaningful speaking experiences in pupils' home and school environment.

Procedures:

I. Purpose

The purpose of the evaluation was to determine the effectiveness of the non-public school speech therapy program. It was immediately apparent to the evaluators that all personnel involved in the project were justifiably concerned about the lack of sufficient time needed to measure the efficiency of this program, particularly pupil progress. In some cases because of administrative and other problems, children may have only received a total of two hours of therapy time. Since a reasonable period of time (at least three months) is deemed necessary to measure the effects of speech therapy, the program planners wisely postponed efforts to record the speech behavior of the children prior to the initiation of the therapy program. Therefore, this evaluation consists of a critical review of all procedures used in this study rather than a measurement of pupil progress. An additional objective of this evaluation was to develop a series of recommendations or guide-lines which would be of value in planning future programs of this type, including efforts to experimentally measure speech behavior in a clinical setting.

II. Methods of Evaluation

A. The Director and Associate Directors developed an outline which was to be used by the field evaluators (see attached sheets).

B. Field Evaluators were selected and trained by the Project Director to administer the evaluation form.

C. The Director selected six representative schools from the list of schools receiving services. It was believed that this was an adequate sample since many of the clinicians at the sample schools also served other project schools during the week.

D. The Field Evaluators visited each school and interviewed each of the clinicians at the school (10 clinicians).

E. The Project Director than interviewed each of the three field evaluators.

F. The Director and Associate Director analyzed the field evaluation sheets.

G. The Project Director interviewed on separate occasions both the Board of Education Project Director, Mrs. Ruth Chapey, and the Director of the Bureau of Speech Improvement, Dr. Helen Donovan.

H. These procedures served as the basis for the final evaluation.

III. Results and Recommendations

For purposes of clarity and organization the results and recommendations will follow the form of the evaluation data sheets developed by the Project Director. Although the final results reflect the opinions of the Project Director and his staff, the thinking of all those involved in the project are in evidence throughout the report.

A. Identification Procedures

1. Screening Procedures

There was some difficulty reported in identifying all those children in need of speech therapy services. The procedures used were teacher referral, and then screening by the speech clinician of those children referred, as well as a personal screening of all the 2nd and 7th grade children by the speech clinicians. Major source of error of these procedures was the dependence upon the ability of the classroom teacher to identify speech problems of all the children in her class, and the screening methods used by the speech clinicians.

Recommendations for Screening

1. The speech clinician should routinely screen each entering third grade pupil. By the age of eight years, the child is expected to have completed his speech sound acquisition. The presence of articulatory errors in the third grade, when not attributable to second language learning or to non-standard dialect, indicates the need for clinical help. Limiting routine screening to one

grade would expedite the setting up of a therapy schedule at the earliest possible date after the beginning of the school year. The purpose, scope and results of the screening test should be explained to each participating classroom teacher as well as to the principal and other staff personnel involved in health services in order to secure their maximum cooperation. To determine articulatory adequacy, the screening test should sample the fricative sounds and selected blends by means of picture naming. The desired responses to pictures should consist of words within the children's spoken vocabulary in order that imitative responses not solely reflect the children's auditory memory span. The speech clinician should employ informal conversation and serial naming, e.g., days of the week, to determine the adequacy of the child's voice, rate, and rhythm. A uniform data sheet should be used by each speech clinician in order to increase the effectiveness of clinical and reporting procedures. Several research studies have indicated that with a minimum of training, classroom teachers can serve as effective sources of referrals. Training should take the form of an orientation session which is conducted by the school speech clinician. A handout should describe the various communicative disorders which are included in the clinical speech program. A uniform

referral slip should be distributed on which deviant oral communicative behavior is checked. A minimum of time needed in filling in the slip should encourage maximum teacher cooperation. The results of the speech clinician's screening test of each pupil referred should be discussed with the classroom teacher to further increase a close working relationship.

2. Diagnostic Testing

There was a lack of uniformity in the diagnostic procedures that were used in the program. Aside from the issue of the lack of time, differences in the speech clinicians training, experience and ability to do speech evaluations were basically responsible for the lack of uniformity in diagnostic testing.

Recommendations for Diagnostic Evaluations

Uniform diagnostic procedures and data sheets should be developed for all speech clinicians. Diagnostic procedures should include an evaluation of the peripheral speech mechanism including the structure and function of the articulators and a description of the child's phoneme usage and stimulability, voice, rate, and rhythm. The diagnostic evaluation should be geared toward providing information regarding the clinical syndrome, suspected etiology, recommendations, and prognosis. Each speech clinician should be provided with a diagnostic type of articulation test and norms regarding articulatory diadochokinesis and non-standard speech patterns.

B. Referral System

It is apparent, from the speech clinicians surveyed, that despite the need to refer children to outside agencies, referrals were not made, and that clinicians were generally unaware of the resources, if any, that were available to them. It is well recognized that other professionals can frequently make a significant contribution to the management of children with speech (and hearing) problems. Therefore, it is essential that speech clinicians have available to them community resources that would assist the clinicians in achieving their therapeutic goals. The following professional services should form the nucleus of a referral constellation:

(1) audiological services

(2) psychological services

(3) medical services including provision for pediatric, neurologic, otolaryngologic, and psychiatric referrals

(4) social work services

(5) remedial reading services

(6) guidance counseling

Obviously, the development of such a referral complex is not an easy task in the non-public school setting. It may be that only one or, at the most, several resources could be developed initially, with the full-range of services unavailable for several years. Once a referral system has been developed, all clinicians should be made aware of the availability of the outside resources, the procedures for

making referrals, the forms used, and so forth. This awareness can be developed through orientation lectures, through written memoranda, and through contact with supervisory personnel. A second aspect of the referral problem is the specification of exactly how a decision for referral is made. A referral should not be made by the speech clinician alone. Rather, a decision on referral should be made after the speech clinician, the clinician's supervisor, the classroom teacher, and the school counselor (or school principal) have decided that the child's progress in therapy is either being impeded by or dependent upon the management of some other problem (e.g., unrepaired cleft palate, hearing loss, etcetera). Once having decided that a referral is needed, the group would also specify to whom the referral(s) should be made. It should be noted that in most cases, speech therapy will be carried on even in the absence of the information sought from a referral agency. There will be a number of cases, however, for whom therapy may have to be discontinued until additional information is obtained or until outside management has been completed. Still another aspect of referral deals with coordination and follow-up. One individual, the supervisor, should be responsible for seeing to it that all referral sources have responded, to follow-up in those instances where no action has been taken, and perhaps most importantly, for evaluating, synthesizing, and utilizing the information provided by the referral agency.

C. Therapy

The decision to provide speech therapy in groups no larger than 5 children of similar age and with similar defects was in keeping with the recommendations of recent professional thought in this area. The major problems reported in this area include insufficient therapy time, (an average of a half hour a week of therapy), extremely poor attendance in the after-school program, lack of supervision of the less experienced clinicians in the program, and no standardized methods of reporting changes in speech behavior.

Recommendations for Therapy

In order to insure the most efficient speech therapy service it is recommended that a team of highly trained supervisors be employed. It would be the responsibility of these supervisors, operating under the direction of the Program Director, (who would have available program consultants from the major training programs in the locale), to establish clinical procedures, including report writing, to provide consistent and periodic professional guidance. Flexibility in therapy procedures would thus be insured within a framework of acceptable clinical practice. Although it may necessitate the dropping of some smaller school programs it is also recommended that a minimum of an hour a week of therapy be provided. Following the interviews with the Board of Education personnel by the Project Director it is recommended that if the program is to be continued during the coming year that

the after-school program be dropped. Poor attendance, inadequate cooperation from school personnel and parents, and lack of interest is cited as the major reasons for this decision.

D. Facilities

The clinicians reported that the facilities were generally adequate for therapy purposes. The problems of space are identical to those encountered in most public school settings throughout the country, and most therapists learn to adjust successfully to these problems. The lack of equipment and supplies which was reported, was directly related to the lack of time needed to purchase the necessary supplies. The money for supplies became available just at the time that the program had to be initiated. Again most therapists using their own initiative were able to adjust successfully to these problems.

E. Clinicians and Their Preparation for the Program

The clinicians employed in this project were typical of the individuals employed in most public school settings. They all held at least minimum certification from the New York City Board of Education. The professional experience of the clinicians ranged from no experience to three or more years experience. Some of the clinicians had not been employed for some time, since they may have been out on sabbaticals, maternity leaves or had taken extended leaves in order to raise families. All of the clinicians received orientation lectures and believed that they were minimally prepared for the program. Some of the clinicians

indicated they they would have preferred additional orientation directed to the therapy process itself.

IV. Major Recommendations

A. Establishment of a central office with a Director (from the Board of Education), program consultants from major training and research centers, research assistants and highly qualified supervisors.

B. The central office develope guidelines for screening, diagnostics, referrals and record keeping.

C. Methods of recording therapy samples as well as test instruments be developed so that overall effectiveness of the program can be measured.

D. Principles of acceptable therapy procedures be outlined and disseminated in writing and in orientation lectures by the supervisors to the clinicians.

E. Maximum supervision of all therapists involved in the program including sufficient time for discussion of the supervisory reports.

F. Orientation lectures to be presented by the central office to all personnel directly involved in the project, particularly those involved in measuring and understanding pupil progress.

G. Establishment of experimental pilot projects developed by the research staff to measure therapy progress.

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Research Director:

Dr. Seymour Rigrodsky, Associate Professor, Teachers College, Columbia University

Research Staff:

Dr. Ralph Haller, Clinical Associate, Teachers College, Columbia University

Dr. Ira Ventry, Associate Professor, Teachers College, Columbia University

Mrs. Eleanor Morrison, Instructor, Teachers College, Columbia University

Mr. Ronald Baken, Instructor, Columbia College

Miss Doris Jacobs, V. A. Trainee, Bronx VA Hospital

Center for Urban Education
33 West 42nd Street, N.Y.C.

Educational Practices Division
Title I Evaluations

I. Identification procedure

1. What procedures are used to identify children in need of speech therapy services?
(referrals from teachers? screening? others?)

2. What problems are encountered in identifying children?

3. How is diagnostic testing being done?
(artic tests? standardized tests? teacher-made tests?)

4. In what areas are evaluations being done?
(hearing? peripheral speech mech. evals.? voice?)

5. Of those children already identified and evaluated:

   a. how many are now in therapy?

   b. how many are on waiting lists, etc.?

   c. what criteria were used to determine those who were to be placed in therapy immediately?

6. What is the approximate incidence of the various disorders among all those so far identified?

II. The Referral system

1. Is there a referral system for those children who require services that this program cannot provide? How are these referrals handled?

2. What sort of problems have arisen that require referral? Incidence of each type?

3. Is there an opportunity for the therapist to relate to the classroom teacher? How is this done?

4. Is there an opportunity to confer with the child's parent?

III. Therapy

1. Individual or group therapy?
   a. size of group?
   b. homogenous grouping by defect?
2. How many sessions/day for the therapist?
3. How are attendance records kept?
4. How many children are scheduled to receive therapy per day?
5. How good is attendance?
6. How are therapy records kept?
   (daily logs? pre- and post-therapy recordings?)

IV. Facilities

1. Physical space —where is therapy held?
2. Quiet? Privacy? Furnishings?
3. Equipment available?

V. Therapists

1. Certification: city? state? ASHA?
2. Highest degree held?
3. Experience?
4. What other professional duties does therapist currently have?

VI. Preparation for Program

1. How was the therapist oriented to screening, diagnostics and therapy under this program?
2. Does the therapist follow a pre-determined curriculum?