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There is increasing evidence that early detection of children's handicaps, whether social, physical or academic, leads to better adjustments when the problems are treated. More coordination and long range planning regarding early detection of problems should be considered at the elementary school level. In this study, an elementary guidance counselor and a pediatrician were added to the staff of the pupil personnel team of an elementary school. Data was also collected for a control school so that referral patterns, staffing patterns, service functions and outcomes could be compared. Certain trends have become evident: (1) teachers can become sensitized to early identification of student problems; (2) the pediatrician has a valuable contribution to make, aiding the teacher in the understanding of children; (3) a full time elementary guidance counselor helps coordinate the personnel team, adds to the teacher's sensitivity of pupil problems, and helps move the mental health program towards the individual child; (4) the personnel team can have immediate relevance with suggestions for the teacher of the problem child; (5) parents are willing to become involved if given the opportunity; and (6) use of substitute teachers enhances the classroom teachers involvement. (JS)

AN INNOVATIVE APPROACH UTILIZING A PUPIL PERSONNEL-MEDICAL TEAM FOR THE EARLY DETECTION AND PREVENTION OF PUPIL PROBLEMS

Principal Investigators

Mr. Sanford Goldstein, Mr. Raymond Coleman

Implementing Agency

PENFIELD CENTRAL SCHOOL DISTRICT #1

February, 1969

Final Report

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Implementing Agency

PENFIELD CENTRAL SCHOOL DISTRICT #1

Penfield, New York 14526

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Edward O'Brien, Guidance Counselor
Bayard Allmond, M.D., Pediatrician
Cynthia Arem, School Psychologist
Janet Allen, School Social Worker
Alma Olofson, School Nurse-Teacher
Joan Stover, Speech Correction Teacher
Virginia Johnson, Reading Consultant

The teaching staffs without whose cooperation, encouragement, and support none of this would be worthwhile or possible.

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INTRODUCTION

> The sooner a child with a handicap - emotional, social or physical - is identified, the sooner he can overcome it, learn to compensate for it, or learn to live with it. But he cannot learn alone. Without the help of some understanding adult, his handicap sets him apart and interferes with his school work. Guidance consultants in the elementary schools can help parents and teachers understand and aid children when they show the first signs of being handicapped.[1]

It had been increasingly evident in Monroe County that more coordination and long-range planning should be done with regard to early detection of learning problems which can effect children in their school and personal/social adjustment.

For example, the School Services Committee and the SubCommittee on Preventive Services for School Age Children of the Monroe County Mental Health Council had been addressing themselves to the problem of long-range planning. One of the proposals of the School Services Committee to this Mental Health Council had been the establishment of an elementary counselor position. The person in this position would serve as the major school financed and directed mental health person and would work on a team basis with school social workers, psychologists and other members in the pupil personnel team.

The elementary counselor position was a relatively new one in Monroe County. Positions had been financed in several schools under N.D.E.A. Title V (Hilton, Rochester, Honeoye Falls), but the position had not been established freely without this financial incentive. Also, there had been evidence of strong feelings about this person's place in the mental health or pupil personnel structure on the part of the other mental health service workers. The establishment of elementary guidance needs the support of the school administration, parents, faculty and particularly the other members of the pupil personnel team. Without this support, the counselor is unable to work effectively.

Therefore, one of the most valid points of reasoning behind this project was to establish an elementary counselor position in a location where the desire for such personnel did exist; where the faculty had discussed the

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[1]Eckerson, Louise Omwake and Hyrum M. Smith, "Guidance in the Elementary School". Reprinted from School Life, U. S. Department of Health, Education, and Welfare, Office of Education. May, June and July, 1962, p.1.

possibility of this resource and especially where the person directing this project was knowledgeable not only about the specific position, but also about the roles of psychological and social work personnel who would be members of the team. The climate of Penfield was accepting of such a project.

Another point in the initiation of the project was the role many felt that the elementary counselor should play in prevention and early detection of problems. Many would immediately feel that money should be expanded in urban areas for this type of position. However, the suburbs are not without their problems. In recent surveys, problems in the educational area (especially underachievement) have been identified; in the area of behavior, statistics have indicated that the greatest increase in arrests has been in the suburban areas.

This project had been prompted not only by school officials, but by community members as well. For example, the Coordinator of Pupil Personnel Services had been working with a committee consisting of three area pediatricians and two school physicians on the further coordination of school mental health services. This committee had been especially concerned about lack of communication between the school community and the medical community. They felt that this was a general problem, not one found in any specific area, and they also felt that it was a problem that could be remedied. This and coordination problems can bring about a lag in dealing with children's problems. A parent may bring a basically educational problem to the pediatrician or, conversely, the school may suspect a medical problem. Either of these types of problems may have an effect on the child's mental health and his performance in the school setting. If this type of problem is known to both of these agencies then cooperation can begin, a solution can be found or worked on or further diagnosis can take place; therefore, hopefully doing something about this problem before it becomes more difficult or must be referred to further outside agencies.

In working further on this problem, the Pediatrics staff at the University of Rochester became interested. The head of this department, Dr. Haggerty, who was formerly with Harvard Medical School as head of the Family Care Program, had been interested in involving his department more in the community. There is a feeling that Residents in Pediatrics learn on inner-city children and then practice on suburban children whose problems are significantly different. (Children in suburbs generally have good physical health and instead present mental health problems which many pediatricians are not equipped to handle.)

The University of Rochester has probably the most full-time faculty members in the United States who are interested in the area of psychiatry in pediatrics. Several of their faculty have had training in both psychiatry and pediatrics. The department was interested in working with the schools and felt that, especially in the suburbs, this was the agency which

could offer access to the greatest number of children. This brought about the inclusion of a University of Rochester, School of Medicine faculty member who has a specific interest in psychological pediatrics and the early detection of learning disabilities. Through a specific arrangement, Dr. Bayard Allmond (see Personnel section) was able to spend 1/5 time in this school setting working with the school counselor and the other members of the pupil personnel team.

Review of the Literature:

As a result of meetings in 1964 regarding the Dimensions of Elementary Guidance, Anna R. Meeks has indicated: "Guidance in the American secondary school has been developing for half a century, but guidance in the elementary school is of more recent origin. Late in starting, the growth of elementary school guidance in the past decade has been rapid, but in multiple and uncharted directions. School administrators, organizations that work with children, and the 1960 White House Conference on Children and Youth have all sought to extend counseling services to meet the needs of the pre-adolescent ...General acceptance of a need for elementary school guidance services, indeed actual pressure for such services, does not mean that the issues of role and function have been clarified or understood...such clarification will be achieved only through patient exploration and research since guidance is not a branch of any one discipline, but rather draws insights and methods from many disciplines; it must apply the results of research to the solution of practical problems."[2]

This basic concern has been followed up with much effort during the past three years. This effort has been in three main directions: (1) to further define the role and function of the elementary counselor, (2) to fund programs involving the elementary counselor and closely watch their progress, and (3) to encourage development of institutes primarily aimed at training the elementary counselor.

In the effort to clarify role and function, the American School Counselor's Association and the American Counselor Educators Society has issued a preliminary statement. Among other things general agreement has been reached in the following areas: "We believe that guidance for all children is an essential component of the total educational experience in the elementary school; we envision a counselor as a member of the staff of each elementary school; and the counselor will have three major responsibilities: counseling, consultation and coordination."

In the area of establishing elementary counselor positions, the Bureau of Guidance in the State Education Department has issued a report entitled "Status of Elementary School Guidance Pilot Projects in New York State - A First Year Report". This study reported on the first year activities of 30 elementary counselors and includes the objectives of the program, activities developed for pupils, for parents and staff members. Of greatest impact for this particular proposal is the evaluation and summary of these pilot projects:

EVALUATION OF THE PILOT PROJECTS

The evaluation of the pilot projects has been derived from the counselors' appraisals of their individual programs and observations made by the Field Service Section of the Bureau of Guidance. The general tenor of the reports is one of optimism and enthusiasm for what has been accomplished during the first year of Elementary School

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[2]Anna R. Meeks, Dimensions of Elementary School Guidance. Office of Education. October 1964, p.1

Guidance Pilot Project. The projects have been able to demonstrate the need for providing guidance services on the elementary school level. The enthusiastic response to the projects has created a favorable climate for greater extension and expansion of guidance services. The receptiveness and cooperation which the counselors found are some indication of the value of their programs. The pilot projects have reported an increased demand for guidance services from parents, pupils, teachers, and administrators. They have evidenced an eagerness to become involved in the elementary school guidance program and to contribute to it.

Evaluation has not been an easy process and certain schools plan to investigate this area more thoroughly during the forthcoming school year. They seek the development of some refined evaluative measures which can be utilized effectively.

Questionnaires were developed and distributed during the past year to a variety of individuals, e.g. parents, pupils, teachers, and administrators. Although the majority of the schools sought responses from adults, a few schools attempted to survey the pupils' responses to the program. Since their developmental level presents unique problems, several schools are attempting to develop special self-report devices which will allow for a pupil's appraisal of the guidance program.

The ACES-ASCA Preliminary Statement on Elementary School Guidance was used by some projects to investigate teachers' attitudes towards elementary school guidance programs. One pilot project reported an attitudinal study by the use of a pre-test and post-test comparison. This project was able to demonstrate a significant favorable shift in teachers' attitudes regarding the value of elementary school guidance services and the role of the elementary school counselor.

Other projects utilized the resources of their guidance committees in the evaluation process. The committee reacted to written statements which were submitted by all professional personnel involved in the program. This approach made it possible to examine the strong and weak points from a variety of viewpoints.

In addition to using formal evaluation instruments, considerable information of a subjective nature was gathered. These informal evaluations have been conveyed to the counselors through contacts with parents, pupils, teachers and administrators. These individuals generally have expressed substantial satisfaction with the program and strongly support its continuation and expansion. The informal comments correlate highly with the more formal findings which are also available. It is typical to find a dearth of unfavorable comments regarding the program.

Some counselors evidence a concern for coordinating their efforts more closely with the counselors on the junior and senior high school levels. They

recognize a need for organizing guidance services on a K-12 basis.

Many programs mentioned that they are trying to establish a developmental focus for their elementary school guidance programs. However, this has been only partially successful due to the high pupil/counselor ratio which has produced a somewhat problem-centered orientation.

The counselors are eager for the Bureau of Guidance to supply them with guidelines for continued program development and additional information on other elementary school guidance programs. They are enthusiastic about their unique role within the elementary school setting. They seek opportunities to share and explore their experiences and findings with other elementary school counselors.

The climate created by the pilot projects is most conductive for the continuation of the pilot projects and appears to point towards considerable program support in the future.

SUMMARY

From all indications, the first year of the elementary school guidance pilot projects was successful. The experimental nature of the program allowed for innovation within the general framework of the projects' objectives.

The geographical distribution of the pilot projects served a two-fold function. It provided a role-model for other school districts concerned with developing a guidance program on the elementary school level. Secondly, a wide geographical distribution resulted in a range in the socio-economic levels of pupils, a diversification of school organizational patterns and a variety of philosophies which underlie the programs.

Since the pupil population was diverse, the objectives and activities developed by the counselors to meet their needs varied also. The counselors were able to define and establish a unique role for the elementary school counselor which is not merely a downward extension of the role assumed by secondary school counselors. Their functions seemed to be trisected into activities involving counseling, consulting, and coordinating to serve pupils, parents, teachers, and administrators.

Many of the ultimate outcomes of ESGPP cannot be assessed until the program has been established for a longer period of time. However, the first year of the pilot projects resulted in important contributions to the elementary school program and revealed a potential for continued contributions. Elementary school guidance represents an attempt to individualize education for the pupils,[3] by implementing many of the theoretical beliefs which underlie education.

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[3]Status of Elementary School Guidance Pilot Projects in New York State - A First Year Report. State Education Dept. Jan. 1967, P. 19, 20, 21.

In the area of training elementary counselors, the N.D.E.A. has provided opportunities for proposals to be submitted and as a result of competitive selection, colleges in various geographic areas in the U. S. have received funding for this type of program. These institutes are either for a year or, in some cases, have been during summer sessions.

As substantiation for the involvement of the pediatrician with psychiatric orientation in this project, reference is made to the Report on the Committee on School Health of the American Academy of Pediatrics which states in its introduction:

> School is the major activity of most children in the United States. They go to school to learn; and to learn most effectively they must be healthy. For this reason, school health programs have been developed to promote optimal health in pupils.
>
> Physicians have a major role to play in providing adequate health programs for school children and must work collaboratively with educators to develop and carry them out. Such joint action has in the past been a source of gratification both to educators and to physicians and has resulted in significant improvement in school health programs. There is, of course, as with all human activities, room for improvement - for example, in communication between physicians and educators. To this end, the Committee on School Health of the American Academy of Pediatrics developed this report which discusses matters of school health policy, presents background information and, in some cases, outlines techniques used in school health services.[4]

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[4]Report of the Committee on School Health of the American Academy of Pediatrics. Evanston, Illinois, 1966 p. 1

The objectives of the program were:

a. To bring into the district a certified elementary counselor who will serve full-time in this capacity. This person will be a member of an elementary school staff having not more than 550 students in grades K-6.

b. To demonstrate the value of a planned program of guidance at the elementary school level.

c. To counsel children through a developmental program:

   (1) Discovering and analyzing their needs, interests, aptitudes, abilities and progress.

   (2) Providing individual and group counseling.

   (3) Referring children to other members of the pupil personnel team or community agencies when deemed necessary.

   (4) Helping to orient children to their school environment whether in beginning school or in transferring from another school.

   (5) Assisting pupils in making educational progress and plans commensurate with their abilities, aptitudes and interests.

d. To meet with parents either individually or in groups to help them to understand the school guidance program as it relates to their children.

e. To bring into the pupil-personnel team a pediatrician to explore his role both as a team member and liaison with community medical services.

   (1) To contact parents and home physicians regarding medical aspects of learning disabilities.

   (2) To work as a member of the School Pupil Personnel Team to aid in problem situations.

f. To clarify the <u>team</u> roles and inter-relationships of the pupil personnel staff.

g. To improve the effectiveness of the pupil personnel staff through the on-going involvement of the classroom teacher as a member of the team.

h. To improve the assignment and servicing of student problem cases through the utilization of regularly scheduled staffing conferences.

i. To explore, through the involvement of a medical specialist, the ability of the school to effectively translate medical data into meaningful educational guidance for the classroom teacher.

   (1) To meet with teachers and administrators to discuss modifications in educational programs needed as a result of medical problems.

   (2) To clarify with home physician the educational need of students that relate to medical problems.

j. To evaluate the effectiveness of the elementary guidance program and the additional staffing of the pupil personnel team.

VII. METHODS AND PROCEDURES

A. Subjects involved in the investigation

The subjects involved in the investigation consisted of the entire student body and faculty of the Baird Road Elementary School in Penfield, New York who served as the experimental group and the entire student body and faculty of the Atlantic Avenue Elementary School in Penfield, New York who served as the control group.

Pre-study test data consisting of achievement, ability and teacher attitude revealed no statistically significant difference between the groups.

B. Educational Treatments or Activities

The addition of a pediatrician and a full time elementary guidance counselor to the usual services provided by the psychologist, social worker, reading consultant, and speech teacher made it inevitable that much time would be spent on becoming a cohesive fully functioning team.

During the early part of the 1967 academic year, many approaches were explored to find out how to best utilize the personnel to provide services for boys and girls, teachers, and parents.

Some other main concerns were:

(1) how to get more teacher and parent involvement
(2) how to utilize the data in setting up an educational program for those students with special needs
(3) how to get such a proposed program implemented within the limitations of the school.

Based on the early experiences and concerns, it was decided that the building principal and guidance counselor would screen the referrals made by the teacher. In some cases the referral would be assigned to the reading consultant, pediatrician, or speech worker. If the referred child had special needs then the referral became an appropriate one for the Pupil Personnel Team.

To insure teacher involvement the project provided funds for a substitute teacher to relieve the teacher making the referral to come and discuss her concerns and share her observations about the child. This approach was a positive one in the eyes of the faculty as they no longer had to sacrifice

their only free period, stay after school, or at best catch the member of the team during the twenty-five minute lunch period. The building principal would attend all Pupil Personnel Team meetings as his schedule allowed him to.

Then the Team and the teacher would decide the next steps to be taken. In a typical situation if the referred child was of primary age, the psychologist might initiate a series of tests, the pediatrician might contact the family doctor and/or give the child a neurologic screening test. Usually the social worker would become involved with the parents to make them aware of the school's concern and take the developmental history of the child. Sometimes the reading consultant and/or speech teacher might be asked to evaluate the child. The school nurse-teacher would review the medical history.

When the data was put together the Team would staff the case and again the teacher would be present. The building principal would attend the staffing as this meeting usually resulted in recommendations which needed his sanction.

With the staffing of the case it became apparent that just sharing the data with the teacher was not enough. Therefore the Team would prepare a list of appropriate learning tasks that could be used with the child on an individual basis to remediate some specific disability. If the child needed more than the classroom teacher could provide, then the Team enrolled the aid of two part time teachers working in an ESEA TITLE I, Reading Program. In this situation the TITLE I teacher would become involved in the staffing and would then help the classroom teacher implement the recommended program by providing the extra instructional time needed. Again this approach was met favorably by the staff because they not only gained support for their concerns, but they gained understanding and concrete suggestions and materials in order to help the child learn. To follow through on the parent involvement the Team would assign appropriate members to meet with the parents and outline what the school was attempting to do and make similar suggestions so that the parent could feel that they were being helpful to their child and thus their needs were met.

The elementary guidance person being the only full time member of the Team, was available to co-ordinate the efforts of the specilists, follow up the Team's recommendations, help teachers implement instructional programs, deal with the concerns of the anxious parents, and act as liaison between the school and outside agencies. The counselor also saw individual children for on-going counseling as well as working with small groups of children in dealing with interpersonal relations.

As the year progressed, the team found that flexibility within the group lent itself to providing a more comprehensive type of service to boys and girls. For example, the pediatrician found himself working with the school nurse-teacher, and fifth and sixth grade teachers in conducting a sex educational program. The doctor served not only as a consultant but actually worked with classes of boys and girls. The school social worker saw some boys and girls on a weekly basis at the request of classroom teachers.

From the standpoint of time the psychologist's role became quite complex. The psychologist had to be present at the initiation of a referral, usually do comprehensive testing of the child, evaluate the data in preparation for the staffing, work on setting up specific remediation techniques, and interpret the test results to the parents. The impact of the psychologist's role has many implications as the Team looks ahead to the next academic year.

On several occasions throughout the year, the Team provided inservice experiences for the staff. These were done on an informal basis to get some feeling for what the needs of the staff were, so that a formal inservice course with credit could be planned for the 1968-1969 academic year.

Another phase of the project was to share with interested schools, the kinds of things that were taking place at Baird Road School. Presentations were made for the personnel at the Board of Co-operative Services, NDEA Elementary Guidance Institute at the University of Rochester, Penfield Child Study Group, and Penfield Central's Pupil Personnel Council. Several other schools requested visitations (Webster, Pittsford, Wayne Central, Fairport, University of Rochester graduate students).

The Team also felt the need to set up better communications with other professionals within the community that were working with children from Baird Road School. As a result, conferences were initiated with personnel from the Rochester Mental Health Clinic, some of which were held at the hospital and others in the school. Local pediatricians were asked to attend conferences involving their patients and on one occasion an optometrist met with the Team to discuss his role in working with boys and girls with learning problems.

In the spring of 1968, the Team began to look at the program as it developed during the year. Although pleased with the accomplishments and directions that the project had taken, it was felt that a new way should be explored as to how to best serve the normal boys and girls as well as the usual remedial cases. It was decided to begin with the new kindergarten population slated to begin their formal public education in September 1968. As a result of much deliberation, it was decided to make up a questionnaire that would serve our local needs. The questionnaire was mailed to the parents and 105 questionnaires of 110 were returned.

In June, an evening meeting for all parents of entering kindergarteners was arranged. The format allowed for the principal to deal with the usual concerns of assigning children, bus schedules, etc. The elementary guidance counselor provided an overview of the Pupil Personnel Team Project and the school-nurse-teacher talked about physicals and related subjects. Then the reading consultant and speech teacher talked about their field in relationship to five year olds. The pediatrician summarized the data from the questionnaires and dealt with the significance of the questions in relationship to the child's having a successful kindergarten experience.

C. Instruments used

While an innovative rather than an experimental study, a number of instruments were utilized and/or developed to aid in the investigation.

Those utilized by the Team included:

a. Face Sheet (Appendix A) provided the base data on each subject. Included on the Face Sheet were: students name, age, grade, date of birth, sex, date of referral, by whom and to whom the referral was made, reason for referral, method of referral and final disposition of the case. All data on the Face Sheet was self explanitory with the exception of the method of referral. This was divided into two catagories — formal or informal. A formal referral designated that the referral was received on a written document used specifically by the teachers and staff to refer students to the mental health services of the school. An informal referral was a referral received verbally without any formal written method being employed.

b. Contact Sheet (Appendix B) was utilized by staff members to list their contacts with pupils, parents, teachers or other persons or agencies concerned with the case. Also listed was the action taken, the time involved in each contact, and the result of the action taken.

c. The Casework Interview (Appendix C) clarified for the social worker and the Team, the content and intent of the initial social worker's contact with the parent.

d. The Medical Screening Guide (Appendix D) was utilized by the pediatrician to aid in determining the extent of physiological involvement in the presenting problem. This screen was accomplished on a one-to-one basis between doctor and student.

e. The Minnesota Teacher Attitude Inventory was utilized to determine whether there was a significant difference in attitude toward students in the control and experimental schools. A post-test will be utilized to determine shifts in attitude.

VIII. RESULTS

Following the natural sequence of events with regard to a referral made in a school, we must first consider the source of the referral. The next steps in our study considered the reason for referral, the staff contacts or interaction and finally the disposition of the case.

For a comparison of the experimental school with the study school, we will consider the functions of identical disciplines, (i.e. social worker and psychologist) and at the same time examine the roles of the guidance counselor and other team members.

TABLE I

SOURCE OF REFERRALS

Experimental School

	Boys		Girls		Total	
	%	No.	%	No.	%	No.
Teacher to Counselor	46.8	(36)	50.0	(21)	47.9	(57)
Other School Staff to Counselor	16.9	(13)	14.3	(6)	16.0	(19)
Teacher to Psychologist	10.4	(8)	2.3	(1)	7.6	(9)
Parents to Counselor	9.1	(7)	11.9	(5)	10.0	(12)
Students, Family Doctor, BOCES to Counselor	6.5	(5)	9.5	(4)	7.6	(9)
Miscellaneous	10.4	(8)	11.9	(5)	10.9	(13)

Control School

	Boys		Girls		Total	
	%	No.	%	No.	%	No.
Teacher to Psychologist	66.7	(28)	83.3	(15)	71.6	(43)
Teacher to Social Worker	14.3	(6)	5.6	(1)	11.7	(7)
Miscellaneous	19.0	(8)	11.1	(2)	16.7	(10)

The preceding tables indicate the sources of referrals for the experimental school and the control school.

The referrals made to the guidance counselor in the experimental school consisted of 47.9% from the teachers, 16.0% from other school staff, 10% from parents and 7.6% from students, family doctor and BOCES; giving the counselor a total of 81.5% of the referrals received in the school.

Examining the control school, it becomes apparent that the school psychologist received the greatest number of referrals (71.6%), and all from teachers.

Thus, we have seen a shift as to whom the referrals are made when a guidance counselor is present with the psychologist. In the experimental school, the psychologist received 7.6% compared to 71.6% in the control school.

Perhaps of equal importance are the other sources from whom the guidance counselor obtained his referrals; such as, other school staff 16%; parents 10%; students, family doctor, BOCES 7.6%; miscellaneous 10.9%; which accounts for about 43% of the referrals.

Neither the social worker in the experimental school nor the pediatrician received any referrals from teachers or outside sources. The social worker in the control school received 11.7% of the referrals from teachers.

Looking at the overall picture, we find the elementary guidance counselor as the primary contact person for the teachers and the community. He acts as coordinator of the pupil personnel team. He utilizes the resources of the community, as well as the consultative persons who work with him each week... the pediatrician, psychologist and social worker. A most pertinent factor which must be considered is that the guidance counselor is present in the school five days per week while all other persons in the study were present only one day per week. The guidance counselor had been employed as a teacher in the experimental school before assuming his present role. Such a factor may have helped to establish a relationship with the teachers, and perhaps gave the teachers some identification with the counselor in his new role. The counselor interacted with the school staff for 63% of referrals received.

To further support the importance of the relationship which the guidance counselor demonstrated with the teachers of his school, an examination of the means of referrals was considered. All of the referrals received by the guidance counselor were "informal." Informal indicates that the referral was received verbally and at a later date was transferred to paper. All of the referrals received by the psychologist in the control school were of a formal nature; that is, on a formal referral sheet. The availability and the relationship of the counselor with the teachers was indeed a factor in the method of referral. The counselor's presence probably was significant

in accounting for the experimental school obtaining about 50% more referrals during the school year.

TABLE II

REASONS FOR REFERRALS

	Experimental School		Control School	
	%	No.	%	No.
Emotional Problems	56.4	(56)	26.7	(16)
Academic Problems	21.8	(26)	66.7	(40)
Physical Problems	5.0	(6)		
Physical and Academic	5.0	(6)	1.6	(1)
Miscellaneous	13.4	(16)	1.6	(1)
	42 Girls 77 Boys		18 Girls 42 Boys	

The above table attempts to break into specific categories the initial reason for referring the child to the counselor, team member or mental health services in both schools.

The first category, "emotional problems," immediately shows that a little more than 50% of the referrals at the experimental school were based on emotional problems, whereas 30% in the control school were on the same basis.

The largest percentage of referrals in the control school were due to academic problems 66.7%, whereas the experimental school had 21.8% of this nature.

Considering these two major categories, one must again be aware of the ongoing contact of the guidance counselor as well as the availability of the team functioning as a unit in the experimental school. The teachers have been constantly orientated as to the nature of emotional problems and have become more educated in perceiving such problems. Therefore, referrals of a more distinct and specific nature are made concerning emotional problems such as the withdrawn child, the child who is stealing, the child who is constantly fighting, the hyperactive child, or the abusive child. The above type of

referrals accounted for 54.6% of the total referrals in the experimental school, but the majority were of a different nature. . . that being academic, which accounted for 66.7%; and the emotional type accounting for about 30%. One can safely say that some of the academic referrals definitely had strong possibilities of underlying emotional problems. Perhaps the familiarity with the team and its members, as well as the accessability of such persons for verbal contact, were factors which enabled the teacher to make a more specific, accurate referral. The association and communication with the team may have also reduced the amount of anxiety or other resistive factors which a teacher may encounter or feel when making a referral. We therefore have seen a shift from the more traditional academic type of referral to a more explicit, definitive referral.

TABLE III

GRADE LEVEL OF REFERRALS

Experimental School			Control School		
CASES PER GRADE			CASES PER GRADE		
	%	No.		%	No.
K	16.0	(19)	K	5.0	(3)
1	15.1	(18)	1	16.7	(10)
2	22.7	(27)	2	11.7	(7)
3	10.0	(12)	3	21.7	(13)
4	9.2	(11)	4	18.0	(11)
5	18.5	(22)	5	16.7	(10)
6	8.4	(10)	6	10.0	(6)

Table III indicates the number of referrals received at each grade level in each school.

Considering that the control school had 21.7% of its referrals in third grade and 66% from third grade on, it is evident that the majority of the referrals appear after the children have reached a more difficult academic level. One can only speculate as to the number of unrecognized problems prevalent in earlier grades.

The pattern in the experimental school indicates that the majority of referrals appear during the first three years of school (53.8%), with the greatest percentage being evident at the second grade level.

Referrals made during the first three years of school when skills teaching is predominent, tend to reflect concerns relative to the emotional development of students as is seen in the experimental school. If one agrees with the premise stated above, then it would necessarily follow that teachers must have more orientation toward recognition of behavior or emotional problems if they are referring such problems at an earlier grade. The Pupil Personnel Team at the experimental school has been a most influential factor in producing this shift in the referral processes which seeks help for children at an earlier age.

TABLE IV

STAFF CONTACTS

Control School

	Psychologist				Social Worker			
	Cont.		Hours		Cont.		Hours	
	%	No.	%	No.	%	No.	%	No.
TEACHER	6.5	(6)	1.9	(1 3/4)	25.6	(44)	12.3	(13)
STUDENTS	67.4	(62)	81.4	(75 3/4)	30.2	(52)	34.2	(35 3/4)
PARENTS	9.8	(9)	7.2	(6 3/4)	23.2	(40)	30.5	(32 1/4)
CLASSROOM OBSERVATION	1.1	(1)	.5	(1/2)	1.7	(3)	1.4	(1 1/2)
OUTSIDE CONFERENCES	3.3	(3)	1.1	(1)	9.3	(16)	4.8	(5)
MEETINGS WITH SCHOOL STAFF AND TEAM MEMBERS	10.9	(10)	7.2	(6 3/4)	9.3	(16)	15.7	(16 1/2)
MEETINGS WITH PARENTS, TEACHERS AND TEAM MEMBERS	1.1	(1)	.3	(1/4)	.6	(1)	1.0	(1)

TABLE V

STAFF CONTACTS

Experimental School

	Psychologist				Social Worker			
	Cont.		Hours		Cont.		Hours	
	%	No.	%	No.	%	No.	%	No.
TEACHER	1.5	(1)	1.1	(1/4)	22	(11)	11.4	(4 1/2)
STUDENTS	95.4	(62)	94.3	(42 1/4)	8	(4)	5.7	(2 1/2)
PARENTS	1.5	(1)	2.3	(1)	42	(21)	60.5	(23 3/4)
OUTSIDE CONFERENCES	1.5	(1)	2.3	(1)	14	(7)	6.3	(2 1/2)
MEETINGS WITH SCHOOL STAFF AND TEAM MEMBERS					12	(6)	11.3	(4 1/2)
MEETINGS WITH PARENT, TEACHERS AND TEAM MEMBERS					2	(1)	3.8	(1 1/2)

The staff contacts, or the manner in which each person utilizes his time, is an interesting reflection of some of the preceeding material.

Studying Table IV which tabulates the contacts of the mental health workers of the control school, we note that the psychologist spent about 67% of his contacts with students, about 9% with parents and 10.9% with school staff and team members. The psychologist in the experimental school, Table V, has a similar distribution of contacts with a greater distribution allotted to the students, 95.4%. In both cases, however, we see a minimal of contacts with parents and teachers on an individual basis. These findings reflect that each psychologist spent most of his time in individual contacts with the students, which is perhaps quite traditional for psychologists. The question arises, however, whether more time should be allotted to contacts with parents, teachers and other staff. Some of the need is fulfilled by the social worker in the Control School who has 25.6% of her contacts with teachers and 23.2% with parents.

In the experimental school, we see some of the same need being met by the social worker (Table V) who had 22% of her contacts with teachers and 42% with parents. Thus, we have the psychologist and social worker utilizing their time somewhat similarly in each school with the exception of the team meetings which are not recorded on Table IV or V. The reader should keep in mind that Table IV and V do not include the meetings whereby the entire pupil personnel team conferred. Such meetings are recorded on Table VI.

The purpose of pointing out the similarity of roles among the social workers and the psychologists in the control and experimental school is to show the added impetus, interaction and effectiveness of the pupil personnel team, while at the same time pointing out the essential and effective roles of the social workers and psychologists.

Perhaps the most obvious effect of the team is reflected in the volume or number of cases seen in each school. The volume difference is about double, with approximately 119 children seen in the experimental school and 60 in the control school.

In addition to a larger number of referrals, we have also seen referrals at an earlier grade level and of a different nature.

TABLE VI (See Page 21)

Having considered the disciplines of a similar nature in each setting, it now becomes appropriate to examine the unique personnel who existed in the experimental school, such as the guidance counselor, the pupil personnel team and the pediatrician. The method utilized to record the function of the above team members is demonstrated on Table VI which recorded the staff contacts with suggestion of team interaction.

The guidance counselor had about 48% of his contacts with students and about 23% with teachers. The contacts with teachers were about the same as the contacts each social worker had with teachers. The guidance counselor had about one half as many contacts with students as did the psychologist. His individual contact with parents accounted for about 13.9% of all his contacts. Therefore, we have the counselor absorbing a considerable number of the contacts with teachers, students and parents while at the same time not causing an appreciable dilution of the roles of the other staff members. The work he did is probably in parallel and/or in conjunction with his other team members. Therefore, it follows that he must have met some of the needs of teachers and students which would otherwise be unmet if his presence were not available.

Following the next and equally important item on Table VI are the contacts of the pupil personnel team. Such contacts were recorded only when the entire team was present. The other Tables, IV and V, cover the instances when team

TABLE VI

STAFF CONTACTS

Experimental School

	Guidance Counselor				P. P. Team				Pediatrician			
	Cont.		Hours		Cont.		Hours		Cont.		Hours	
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.
TEACHER	23.4	(160)	17.8	(70)	50.0	(30)	42.0	(18 1/2)	4.3	(2)	2.1	(3/4)
STUDENTS	44.1	(301)	42.3	(166)					32.6	(15)	24.9	(10 3/4)
PARENTS	13.9	(95)	17.8	(69)	6.7	(4)	9.1	(4)	23.9	(11)	38.2	(13 3/4)
OUTSIDE CONFERENCES	4.4	(30)	3.6	(14 1/2)	8.3	(5)	11.9	(5 1/4)	13.0	(6)	4.2	(1 1/2)
STUDENT GROUP CONFERENCES	5.3	(36)	5.4	(21)								
CLASSROOM OBSERVATION	2.2	(15)	2.2	(9)					19.6	(9)	20.8	(7 1/2)
MEETINGS WITH SCHOOL STAFF AND TEAM MEMBERS	4.5	(31)	4.1	(16 1/4)	31.7	(19)	24.0	(12 3/4)	2.2	(1)	1.4	(1/2)
MEETINGS WITH PARENT, TEACHERS AND TEAM MEMBERS	3.7	(25)	6.4	(25 1/2)	3.3	(2)	7.4	(3 1/4)	4.3	(2)	3.5	(1 1/4)

members met individually or outside of the team with parents, teachers, etc.

One can immediately realize that much of the team's efforts, (50% and more) were devoted to helping teachers....if we include the category, "meetings with parents, teachers and team members."

There is no doubt that such an investment of time with the teachers, usually discussing children's problems, has produced a more knowledgeable faculty with regard to understanding children and their problems. The relationships among the team and the teachers as well as the knowledge shared and learned are intangible factors which no doubt contributed heavily to the effects seen thus far.

Meetings with school staff and team members accounted for 31.7% of the team's contacts. This category included meetings whereby the team met with the nurse and principal; the teacher, nurse and principal; or any such combination. Again the team focused heavily upon the school staff in helping to enhance their knowledge, as well as adding to increased interaction among staff members.

We therefore see the team with over 80% of its contacts being utilized in conferences involving school staff. Such communication played a significant part in effecting more referrals and a more positive attitude toward dealing with problems on the part of the entire staff.

The role of the pediatrician from the University of Rochester was a very unique one because of his availability and knowledge. He was present each Tuesday, all day, acting as an integral part of the team. He brought with him an excellent knowledge of neurological problems as well as extensive understanding of learning disabilities. Through his teaching efforts the team and many of the teachers in the experimental school acquired new perspectives with regard to recognizing and assisting in the remediation of learning problems. His skills enhanced the role of the other team members as each person contributed to the analyzation of a problem. Perhaps of greater importance was the movement toward seeking remediation of referred problems which required the team to extend itself to the teachers and community.

The pediatrician's individual contacts were mostly with students, 32.6% and parents, 23.9%. Frequently a neurological assessment of the child was made with a follow-up conference with the parents in order to interpret the findings. This service to the school and the parents provided an immediate resource not available in many schools. The findings of the pediatrician enabled the team to move with more assurance because another dimension had been added to the diagnostic process. Frequently children wait a month or much longer to obtain a neurological examination which might have been indicated by school mental health workers. The obtaining of a complete diagnostic picture involving all team members enhanced and expedited the help needed by the pupil.

The pediatrician had 4.3% of his individual contacts with teachers; however, we must also consider that 19.6% of his contacts were in classroom observation. The material learned by observing the child in the classroom was shared with the team and the teacher. It is also very probable that some discussion was had with the teacher during the classroom observation even though such data was not recorded. The observation did increase the association between the teacher, the children and the pediatrician. He became better known and accepted as an integral part of the school.

The other significant contact area for the pediatrician was that of outside contacts, 13.0%. He frequently acted as a liaison between the school and the community, or private doctors; meeting them as a peer and a person interested in their patients. A similar role existed when the pediatrician consulted with agencies such as hospitals and clinics.

Having a pediatrician for a full day each week in a school has proven to be a most rewarding learning experience. His contributions to the school and the team were of great value and very significant. Perhaps in the future, some method could be devised for more frequent utilization of pediatricians in the school.

TABLE VII (See Page 24)

In Table VII, "Disposition of Cases," there are some trends prevalent which have existed throughout the study.

Under the heading "conferences", which implies that the case was terminated with a conference among the persons listed, such as, "pupil personnel team and teacher" or "teacher, principal and psychologist, etc.," we find our first consistancy.

In the control school we see the 43.3% of the cases ended with a conference among "teacher, principal and psychologist." Such cases for the most part were concerned with the academic placement of the child. Parental involvement at a later date regarding such placement was not covered in this study. If a serious problem was presented, one can safely say that parents would be involved.

The control school shows direct parental involvement in more than 12% of the cases in Table VII, which indicated either the recognition of a more serious problem or the desire to have parents more involved in the decision making process.

Under the heading "Counseling and/or Therapy," 8.4% of the children were referred to an agency and 6.7% were referred to special class. Such cases by their very nature demand parental cooperation and contact. The above

TABLE VII

DISPOSITION OF CASES

Experimental School Conferences	%	No.
P. P. Team and Teacher	6.7	(8)
Conf. Involving Teacher, Parent, and One or More Team Members	6.7	(8)
Conf. Involving Parent and One or More Team Members	5.9	(7)
Teacher and Guidance Counselor	5.0	(6)
Miscellaneous Conferences	5.9	(7)
	30.3	(36)
Ongoing Counseling by G. C.	21.8	(26)
Referred to Agency	8.4	(10)
Referred to Special Class	6.7	(8)
Academic Placement Recommended	2.5	(3)
	39.5	(47)
Further Evaluation Required	14.3	(17)
Cases Terminated	12.6	(15)
Miscellaneous	3.4	(4)

Control School Conferences	%	No.
Teacher, Principal and Psychologist	43.3	(26)
Teacher and Psychologist	13.3	(8)
Psychologist and Parent	5.0	(3)
Miscellaneous	3.3	(2)
	65.0	(39)
Academic Placement Recommended	10.0	(6)
Referred to Agency	8.3	(5)
Ongoing Counseling by Social Worker	5.0	(3)
Referred to Special Class	1.7	(1)
	23.3	(15)
Further Evaluation Required	3.3	(2)
Cases Terminated	6.7	(4)

percentages combined are greater than the parental contacts indicated (12%). This may be accounted for in each of the schools because the principal's contacts with parents were not recorded. Frequently the principal is the person who becomes involved with parents about matters of special class or placement. The principal was very involved with the team as was the school nurse, and it certainly would be of great significance in future studies to record their activities in a more comprehensive manner.

The experimental school had 30.3% of its' cases ending in conferences, whereas the control school had 65% ending with conferences. When a case terminated with a conference, this usually implied that an academic placement was recommended or that suggestions and/or interpretations of the findings were presented to the parent or teacher.

Considering the category, "Counseling and/or Therapy," we find the guidance counselor involved in ongoing counseling with about 21.8% of the cases. In contrast, the social worker in the control school is involved in about 5% of such cases. Again, we find a need being met by the counselor which cannot be met sufficiently on a one day a week basis.

The academic placement recommendation accounted for 10% of the cases in the control school compared to a 2.5% in the experimental school. This trend follows the pattern which has existed. A factor which no doubt contributes to the difference in the percentages is the fact that the guidance counselor is capable of helping more children on an ongoing basis in addition to more emotional problem type of referrals which have existed in the experimental school. The control school lists 3.3% of the cases requiring further evaluation, compared to 14.3% in the experimental school. The possibility of pressure in the control school might indeed explain the need to conclude a case as efficiently and effectively as possible. The pressure of many referrals and having only one day a week to carry out all required work would necessitate a limited amount of extensive or prolonged evaluations. The 14.3% in the experimental school reflects the presence of the guidance counselor as well as the greater number of team members. One must also consider the possibility that a referral of a more emotional nature would usually require more investment of time and perhaps further evaluation for an accurate disposition.

COMMENTS

During the course of this study much emphasis has been placed on the type of referral or the primary problem of the child being referred. One of the most significant factors of a conserted team effort was to obtain as accurate a diagnosis of the problem as possible. If, with the help of a pediatrician well trained in neurological and perceptual problems; and the close interaction of the social worker, guidance counselor and psychologist; we find a more emotional type of problem being exposed, then it must be quite

significant. We must also consider the fact that the guidance counselor was well trained in academic matters, having been a teacher for several years.

Of ultimate importance was the interaction of the team. The physical presence of all team members on the same day may be taken for granted in this study; but frequently the psychologist and social worker are rarely in the same building at the same time. The role of the guidance counselor as a coordinating constant figure with whom the teachers can relate every day, rather than waiting for his once a week appearance, was a factor of greatest importance. He had knowledge of each case in the school, making himself available to the team, teachers and community.

The probability of having a pediatrician one day a week in a school may be remote. The possibility of having a guidance counselor at the elementary level is quite realistic. If we consider the complete role of the guidance counselor from this study, it becomes very apparent that his position is most essential for the welfare of the students, assistance to the teachers and coordination of school problems.

IX. DISCUSSION

A. Implications

The implications throughout this study became quite apparent as the data and results were evaluated. There has been a definite trend to make referrals involving a younger age group and lower grade level. More than 50% of the referrals in the experimental school were from grades 1 through 3. In addition to the younger children being referred, the type of referral has been of a more emotional nature rather than of an academic nature. Such findings indicate earlier treatment and/or remediation, and hopefully more successful academic careers for the children involved.

The number of referrals received by the counselor was quite significant. He had assumed the role of being the primary contact person with the teachers as well as coordinator and liaison person between the Team and teachers. The role of the counselor could not have been adequately filled on a once a week basis. His constant presence and availability were essential to the functioning of the Team.

Perhaps of equal importance was the presence of all team members, meeting and working together as a unit. Coordination, cooperation and team effort were the essential ingredients required for a successful program. Such a program helped to expedite the handling and diagnosis of cases, thus providing greater service to more children, parents and teachers.

The study also implies that a greater amount of interaction by the mental health workers with the teachers is required. A substitute teacher was made available to relieve the classroom teacher for conferences with the Team. This service was an important factor in developing the desired interaction. Such interaction provided increased relationships of a more positive nature, more referrals and provided the teachers with more understanding of childrens' problems.

The role of the pediatrician as an integral part of the Team was a factor which helped provide more accurate diagnosis and better understanding of medical factors. The necessity of referring a child to an outside agency for a neurological or physical examination was greatly diminished. This reduced the amount of time spent on each case. A more effective processing of the cases necessarily followed, allowing for a greater number of cases to be served in more depth.

IX. DISCUSSION

B. Recommendations

The findings presented in the study as well as the stated implications lead to the following recommendations:

(a) That an elementary guidance counselor be provided when and wherever possible in each elementary school.

(b) That a consulting pediatrician schooled in the area of neurology and learning disabilities, be available.

(c) That a team composed of a guidance counselor, pediatrician, school social worker and psychologist be utilized in each school. If all of the above team members are not available, the team members assigned to the school should be in the school on the same day and function as a team.

(d) That a substitute teacher be provided to release the classroom teacher for conferences with the team.

(e) That referrals be made at an earlier grade when possible.

(f) That additional inservice training be provided for teachers with specific emphasis on learning disabilities.

(g) That more intensive follow-up be provided for each case referred to the team.

(h) That adequate secretarial time is essential to the effective functioning of the pupil personnel team.

X. SUMMARY

It has become increasingly evident that more coordination and long-range planning should be considered regarding the early detection of learning problems which can effect children in their school and personal/social adjustment. The utilization of the traditional pupil personnel team (i.e., psychologist and social worker) was not accomplishing this goal. Would the addition of an elementary guidance counselor and a medical specialist aid in accomplishing the stated goals?

A full time elementary guidance counselor was assigned to one elementary school. He had available the services of a pupil personnel team augmented by the addition of a medical specialist in behavioral pediatrics.

The Team functioned together for the first of its three-year project exploring its role and function as it attempted to serve the student populations of the school. A second school was selected to serve as a control school so that referral patterns, staffing patterns, service functions and outcomes could be compared.

While completing only the first of a projected three-year project certain trends have become evident.

(1) It is possible, through informal work with teachers, to sensitize them to the need for early identification of student problems.

(2) The medical specialist has valuable contributions to make in aiding the teacher to develop a better understanding of her children.

(3) The addition of a full-time elementary guidance worker contributes to:

a. Better coordination of the pupil personnel team.

b. Additional sensitivity on the part of the teacher regarding his students as reflected in a larger number of students reviewed by the Team.

c. The opportunity to implement a developmental mental health program moving away from the problem-centered approach to children.

(4) Educational programs can be developed by a pupil personnel team which have immediate relevance to the classroom teacher.

(5) Given the opportunity, parents are willing to be involved in the educational process.

(6) The use of the substitute teacher to allow the classroom teacher to meet with a pupil personnel team enhances the classroom teacher's involvement.

(7) Specialists not usually regarded as part of the pupil personnel team (i.e., school nurse-teacher, speech teacher, reading consultant) have valuable contributions to make in the diagnostic and planning activities of the group.

To complete the evaluation there must be some mention of the subjective feeling tone in the school. While objective data is available and more will be collected in the future; those who worked closely with the Project were most impressed by what they perceived as a change in "climate" in the experimental school. They saw teachers who were trying new techniques with students; a freer flow of communication among staff and between staff and the Pupil Personnel Team; change in the kinds of questions staff was asking specialist; greater parental involvement; and a host of other observations which appeared to relate to the impact of the Team.

The program will continue and focus on the preventative aspects a pupil personnel team can provide in a school. There will be a shift of focus regarding the involvement of teacher with the Team; the parent will be included to a greater extent; less diagnosis and more program planning will take place; the teacher will become a more significant agent for change; other techniques and approaches will be explored.

The first year set a stage.... the next will provide an opportunity to test many of the original hypotheses.

XII

APPENDIXES

APPENDIX A

FACE SHEET

_____
SCHOOL

NAME _____

AGE _____ DATE OF BIRTH _____ BOY GIRL (Circle one)

GRADE _____

DATE OF REFERRAL _____

REFERRED BY _____ TO _____

Please List Person by Occupation Only (Teacher, Psychologist, etc.)

REASON FOR REFERRAL _____

METHOD OF REFERRAL FORMAL INFORMAL (Circle one)

(Formal means via referral sheet without former contact.)

(Informal means received verbally --further action then taken.)

FINAL DISPOSITION

DATE OF FINAL DISPOSITION _____

APPENDIX B

STAFF CONTACT RE: _____

STAFF MEMBER (By profession)	Date	CONTACT WITH Mtr	FR	Chld	Other	ACTION TAKEN	TIME INVOLVED	RESULT OF ACTION

APPENDIX C

THE CASEWORK INTERVIEW

School Social Worker
Baird Road School
Pupil Personnel Team Project

In the practice of the art and skill of social work interviewing the most important, most meaningful information is never the content but the subtle signals and indications of the quality of the client's relatedness to the social worker and the inferences which may be drawn about his relationships with others. The content of the interview, kinds of life experiences, life style in addition to other signs and signals such as physical aspect, dress, physical distance and a myriad of others, provide framework and documentation for assessment of the client's strengths and for the uniquely personal basis for effective treatment. Because the practiced social worker tailors each interview to the needs of his client the mode and order necessarily varies. In intake interviews, especially, certain factual information is elicited and in itself can be therapeutic as it lends itself to structure and purpose. On-going treatment interviews continue to be diagnostic as the therapeutic relationship developes and more definitive planning is possible.

I briefly introduce myself and outline the reason for the interview. I then ask the client for his perceptions of the situation. There follows an outline of some of the major areas covered in an intake interview. Many of these areas will be referred to in subsequent interviews. Some of the information is useful for itself and often for the feeling tone it engenders.

Face Sheet Information

Name, age, address, school placement, employment, ordinal position in family.

History

Preganacy, labor, delivery, readiness for a child

General Development

Date walked, talked, habit training

Neurological Development

Gait, tenseness, sleep habits, bed rocking, night terrors.
Colic
Persistant symptoms - vomitting etc.

Health History

Illnesses, trauma, medical and surgical procedures

Family Interaction

Husband-wife, parent-child, child-child

School History

Nursery, kindergarten, first grade, junior high, high school, college

Client's assessment of the total situation

Client's expectation of social work (PPT)

Brief recapitulation of the interview

Explanation of further activity, more interviews, consultation with others, referral, etc.

A dynamic treatment plan implies change and fluidity, hence, no premium is placed on specifics nor on accuracy in any interview. The careful assessment of the meaning of the facts presented by the client remains essential. By extension these same professional observations and evaluations pertain to the information presented by the referring persons and others involved with the client and his treatment.

Teacher and other school personnel
Community agencies
Health
Social
Psychological evaluations
Other:
Employment
Church
Other

APPENDIX - D

A Screening Guide for the Physician in Identifying a Child with a Psychoneurologic Learning Disability

INTRODUCTION

Most all of us now are familiar with the term "perceptually impaired". It is an increasingly popular phrase and seems sometimes rather loosely applied to almost any non-psychotic child of normal intelligence who is failing to keep academic pace with his peers in school. Unfortunately the term may be either too restrictive or too all encompassing in a given situation. As Johnson and Myklebust state:

> "To infer that all children with neurogenic learning disabilities have perceptual disturbances is to be in error and to grossly oversimplify. Often the effect is not on perception per se, but on symbolic processes or on conceptualization. In other words brain dysfunction might impede learning at any level of experience, not only one, perception.
>
> Another disadvantage of this term should be cited. Perception can be disturbed for a number of reasons not only as a result of a dysfunction in the brain. Children having certain types and degrees of emotional disturbance, deafness, blindness, or mental retardation can be shown to have disorders of the type commonly referred to as perceptual".

Moral: Perceptual handicap and brain dysfunction are not always synonymous terms.

Other terms in other parts of the country are equally popular, equally overused. These include:

congenital word blindness
minimal brain damage
minimal cerebral dysfunction
specific reading disability

developmental dyslexia
strephosymbolia
primary reading retardation

I will however use in this summary guide the words psychoneurologic learning disability to encompass perceptual handicap and all of the above diagnostic descriptions.

> "The root of the term, neurological, discloses that the basic condition is organic and involves the central nervous system. The prefix, psycho, appropriately emphasizes that an important concomitant is behavioral...
> The crux of the definition must be those features that designate the group's homogeneity. In the cerebral palsied it is the motor involvement rather than the difficulty in learning that constitutes the common denominator. In the mentally retarded it is the generalized intellectual inferiority that brings about homogeneity. In the hearing and the visually impaired it is the sensory impairment...likewise in the emotionally disturbed it is the psychic maladjustment that prevails. In those having a psychoneurologic learning disability it is the fact of relatively adequate motor ability, relatively average intelligence, relatively adequate hearing and vision, relatively adequate emotional adjustment together with a deficiency in learning that constitutes the basis for homogeneity."

Understand that the screening information I am suggesting applies to the child with a dysfunction within his central nervous system which is affecting that child's school performance and learning ability. It is not intended to select out the youngster, equally non-learning, with primary severe and handicapping emotional difficulties. The presence of one however must never exclude the possible additional presence of the other (i.e. A disturbed child may also have a psychoneurologic learning disability and a child with a psychoneurologic learning disability is all to often a child with significant emotional difficulties).

This screen then is intended to help you detect the psycho-neurologic learning disability <u>wherever</u> it happens to reside - alongside a healthy or not so healthy psyche.

CLUES IN THE HISTORY

Frequent Chief Complaints

The child:

1. is hyperactive, won't settle down
2. has short attention span; doesn't follow directions
3. is lazy - won't try
4. can't read
5. seems bright, but is failing in school
6. has a speech problem
7. is clumsy
8. writes letters backwards
9. can recite his work, but can't write it
10. can write his work, but can't recite it
11. can't remember

Teacher's Observations

The child:

1. is a frequent behavior problem - the class clown, hyperactive, impulsive
2. just can't learn phonics
3. can't remember flash cards from one lesson to the next
4. reads very poorly
5. has frequent misspellings - often bizarre
6. is quiet and withdrawn
7. reverses letters, syllables, and/or words in sequence
8. doesn't play well with other children - labile
9. turns in messy work - clumsy in the class and on the playground
10. seems unable to follow class directions
11. handles pencil, scissors awkwardly
12. just can't learn. Period

School Psychologist Observations

1. On group testing child shows somewhat low overall intelligence scores

2. On individual testing child shows problems with eye-hand or visual motor coordination. (often noted on Bender Gestalt or on coding subtest of the WISC).

3. There is a disparity between verbal and non-verbal scores on tests such as the WISC (i.e. 82 on verbal, 104 on non-verbal - or visa versa).

4. Child shows wide "scatter" on WISC subtest scores.

Psychologist may conclude in his report that the child has faulty visual perception or a perceptual motor handicap. To have reached this conclusion he should have administered at least the following in the individual test battery:

1. a measure of overall intelligence - the WISC or Stanford - Binet
2. a Bender Visual Motor Gestalt Test
3. a Goodenough Draw-a-Man Test
4. a measure of the child's academic achievement - WRAT (Wide Range Achievement Test) and something such as the Durrell Analysis of Reading Difficulty or Gray's Oral Reading Test.

and hopefully:

5. Frostig Test of Visual Perception
6. ITPA (Illinois Test of Psycholinguistic Abilities)
7. Wepman Test of Auditory Discrimination

Historical Items of Importance

1. Any prenatal, perinatal or postnatal events which would be potential causes of brain damage such as:

   prematurity
   precipitous delivery
   prolonged labor
   intracranial birth hemorrhage
   neonatal asphyxia or infection
   hyperbilirubinemia
   head injury
   seizures
   encephalitis, meningitis or other severe CNS illness

2. Evidence of delayed or dysfunctional speech and language development.
3. Evidence of delayed motor development

4. Other members of the family (males especially) with a history of reading, spelling, speech or language problems.

AMPLIFIED NEUROLOGIC EXAM

Child with a suspected psychoneurologic learning disability should have the classical neurologic examination plus:

1. A Screen for Visual and Hearing Acuity

2. Evaluation of Gross Motor Coordination

Observe the child:

a. skipping
b. hopping
c. crouching
d. walk on toes
e. walk on heels
f. stand on one foot for 10 seconds (age 6)
g. stand toe to heel for 5 seconds (age 6-7)
h. walk on line for 6 feet, toe to heal forward and backward (age 6-7)

Note:

a. loss of balance
b. asymmetry of associated arm swing
   1. restriction: indicates spasticity or rigidity (corticospinal or extrapyramidal dysfunction).

   2. excessive outward swing (flailing): indicates hypotonus (cerebellar dysfunction)

   3. athetoid posture: bizarre rotation of arm and/or flexion or extension of hand (extrapyramidal dysfunction).

c. foot placement

   1. asymmetry, toeing inward, circumduction: possible mild hemiplegia

   2. excessive eversion or inversion (altered tonus)

d. lack of esthetic quality.

3. Evaluation of Fine Motor Coordination

Observe child during:

a. undressing, unbuttoning
b. tying shoes
c. rapid alternating touch of fingertips by thumb
d. door knob rattle forearm maneuvers
e. light bulb twist
f. pencil grasp and use; penmanship
g. rapid tongue movements
h. foot tapping
i. hand grip
j. inversion of both feet. (Look for similar movements of the hands. See below).
k. his repeating several times rapidly kitty, kitty, pa - ta - ka. (Accurate reproduction of these sounds generally indicates adequate articulatory coordination

Note:

a. on items c, d, e, and i opposite side of the body showing fragmentary movements which mirror those of the test side. These are called abnormal associated movements, mirror movements or synkinesia. After approximately age 8, these movements indicate a lack of normal cortical inhibition. They are often worse on the affected side.

b. excessive pressure on pencil points; or pencil held too lightly. Fingers placed directly over points; or fingers placed too far (> 1 inch) from point. All may indicate a problem with coordination of fine musculature of the hands.

c. presence of dysdiadochokinesia, noting speed, accuracy, and sequencing of maneuvers

4. Evaluation of Special Sensory Skills

a. dual simultaneous sensory tests (face-hand testing)

With patient's eyes closed simultaneously

1. touch both cheeks
2. touch both hands
3. touch right cheek and contralateral hand
4. touch right cheek and homolateral hand

5. touch left cheek and contralateral hand
6. touch left cheek and homolateral hand

Note:

1. rostral dominance: failure to perceive hand stimulus when face is simultaneously touched

2. inattention: failure to perceive one stimulus when opposite parts of body are simultaneously touched

3. displacement: grossly defective localization of one stimulus

These all indicate, after about age 5-6, parietal 'obe dysfunction

b. finger localization test (finger agnosia test). Touch two fingers or two spots on one finger simultaneously with patient's eyes closed. He then points to spots touched.

Note:

1. The number of correct responses in 8 trials for each hand. Generally $\geq$ 50% (5/8 or more) is considered normal. This test reflects child's orientation in space, concept of body image, praxic ability, sensation to touch and position sense.

c. stereognosis

d. position sense

e. visual figure - ground discrimination. May use A-O HRR plates and ask patient to trace what he sees.

5. <u>Evaluation of Child's Laterality and Body Orientation in Space</u>.

a. peripheral dominance
Record child's preference during each of the following:

1. sighting (eye)
2. writing (hand)
3. kicking (foot)
4. armfold: dominant arm on top
5. hand clasp: dominant thumb on top
6. clap: dominant hand on top

7. hairwhorl:
   right handed - whorl normally on left side of head, clockwise
   left handed - whorl normally on right side of head, counter clockwise

b. "central" dominance (arm extension test). Child stands, arms extended, parallel, eyes closed, fingers separated for 15 seconds.

Examiner uses his own extended fingers as reference points.

Note:

1. Normal response, after about age 8, of slight (1-3 cm) upward and lateral deviation of dominant hand for writing.

2. abnormal response:
   downward deviation
   no deviation of either extremity
   upward deviation of non-writing arm
   exaggerated upward or lateral deviation of either arm

3. choreoathetoid movements, tremor, abnormal posturing of either extremity

Mature response depends on integrity and maturation of entire motor system.

c. imitation of gestures
Have child imitate these gestures performed by the examiner:

1. extend little finger
2. extend little and index finger
3. extend index and middle fingers
4. fingertips to chin
5. finger to contralateral eye
6. fist - palm
7. fingertips - palm
8. finger in hole

Note:

1. after age 6-7 right - left confusion, disorientation in space. This test reflects ability with finger discrimination, postural praxis, awareness of self image, right-left, front-back, up-down orientation -- all parietal lobe functions.

2. difficulty with fine finger manipulation

3. child's mirroring the examiner in terms of hand used for imitative gesture. This is sometimes called echopraxia - a frontal lobe dysfunction and is not considered abnormal until after about age 8.

d. following directions

1. show me your left hand
2. show me your right ear
3. show me your left eye

Age 6

4. Point to my left ear
5. Point to my right eye
6. Point to my left hand
7. Touch your left elbow with your right hand
8. Touch your right ear with your left hand
9. Touch your left knee with your left hand

? Age 7-8

Note:

1. Aside from correct versus incorrect responses, note also any difficulty with following sequence of directions.

6. Educational Screening

Aim: to get a beginning idea -- how does the child learn? With his eyes, ears, and/or hands. Likewise, where is he having confusion? -- with his eyes, his ears and/or his hands.

a. reading

Use Durrell cards (attached). Have patient read orally. Ask 1 or 2 comprehension questions following

#1	age 6-7
#2	age 8-9
#3	age 9-10
#5	age 10-12

Note:

1. reading style
2. confusion with letters b-d, p-q, m-w, n-u-v, h-n, v-y, d-t, s-z.
3. difficulty with sequence of letters in words -- its for sit, three for there, was for saw, etc.
4. omission of letters -- bother for brother, etc.

5. child knows the first part of the word but guesses the last part - grass for grant, children for chicken.
6. does child understand what he reads?
7. can he write the answers to comprehension questions as fluently as he verbalizes them or visa versa.

b. spelling and handwriting
Dictate a sentence from Durrell Cards. Ask child to write it.

Note:

1. spelling errors
2. are any difficulties listed above noted when such an auditory stimulus, not visual, is used. Does child seem more confused when he looks at a word or when he hears it? or both?
3. handwriting and coordination with pencil as already mentioned. Is writing labored, cramped, slow, messy, poorly spaced with irregular letters on and off the lines? Again note letter confusions and reversals. (Writing only his name is not adequate; it is usually too practiced).

c. arithmetic
Use Durrell cards as for reading. Have child do problems on paper.

Note:

1. confusion with number sequences, reversals (e.g. 6 for 9, 14 for 41, etc.).
2. trouble keeping numbers in proper columns

d. auditory memory and sequencing
Use memory for sentences test (attached)

e. visual memory
Show child list of several printed words prepared from appropriate Durrell card (one he is able to read) for 5 seconds. Remove and ask him to recite or write them. For the younger child the same thing may be done, using instead, geometric designs

Note:

1. difficulty with recall of presented material

A child of relatively normal intelligence who experiences significant difficulty with parts of this screening examination certainly merits serious consideration for the tentative diagnosis of psychoneurologic learning disability.

But remember it is only a screen -- and a gross one at that. Some children with a bonafide but subtle disability will be missed. This information then is not intended as a replacement for thorough and thoughtful psychologic evaluation when such is available.

Should the physician find himself in the role of instant authority -- with a child who fits, no psychologic assistance, and a teacher complaining, "ok, Doc very nice; but what do I do with the kid?" -- the enclosed article may be helpful. I suggest that every teacher (and physician) faced with a child with a psychoneurologic learning disability obtain a copy of:

Learning Disabilities
Educational Principles and Practices
by
Doris J. Johnson, Helmer R. Myklebust
Grune & Stratton, New York 1967.

MEMORY FOR SENTENCES

This test was constructed by E. M. Spencer and reported in her Ph.D. thesis completed at Northwestern University in 1958. Some of the items were borrowed from the 1937 Stanford-Binet. Norms to Age 6 are from Spencer. Norms for higher age levels are from H. MacGrady's Ph.D. thesis completed at Northwestern in 1964.

Procedure: Tell the child: "I want you to say something for me. Say, "Big boy" ("Big girl"). Now say, "I am a big boy" (or "girl"). Now say . . . . . "

1. I went downtown..
2. Mama is in the car.
3. I am going home.
4. I went outside to pick some flowers.
5. We are going to buy some candy.
6. Jack likes to feed the little puppies.
7. Jane wants to build a big castle in her playhouse.
8. Tom has lots of fun playing ball with his sister.
9. Mama asked Nancy to bring the brown dog in the house.
10. Fred asked his father to take him to see the clowns in the circus.
11. Billy has made a beautiful boat out of wood with his sharp knife.
12. Mama bought Susie a chocolate ice cream cone after the movie yesterday.

If the child hesitates, urge him to try by asking him to "Say it." For objective scoring, it is not permissible to repeat the sentences. Stop testing after three consecutive failures.

Scoring:
Misarticulations and contractions do not count as errors. Omissions, substitutions, or additions of words are errors. Changes in word form or word order are also considered as errors. The test score is simply the number of sentences repeated without errors. For qualitative interpretation,

the child's responses should be transcribed.

Norms:	Age	Median Score	Age	Median Score
	4-0	5	8-6	10
	4-6	6	9-6	11
	5-0	7		
	5-6	8		
	6-0	8.5		
	7-6	9		

Durrell #1

MY DOG SEE BOY

Durrell #2

A little black dog ran away from home. He played with two big dogs. They ran away from him. It began to rain. He went under a tree. He wanted to go home, but he did not know the way. He saw a boy he knew. The boy took him home.

Durrell #3

$$\begin{array}{r} 5204 \\ -530 \\ \hline \end{array} \qquad \begin{array}{r} 23 \\ \times 3 \\ \hline \end{array} \qquad \begin{array}{r} 834 \\ \times 7 \\ \hline \end{array}$$

Durrell $5

$$9\overline{)72} \qquad 31\overline{)62}$$

$$\begin{array}{r} 420 \\ \times 29 \\ \hline \end{array}$$