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ABSTRACT

This program, funded under Title I of the 1965 Elementary Secondary Education Act, is designed to provide speech therapy for approximately 6500 disadvantaged pupils in New York City non-public schools who have the additional handicap of defective speech. The objectives of the program were as follows: (1) to identify pupils with speech defects, (2) to provide diagnostic evaluations and therapeutic programs for these pupils, and, (3) to provide amelioration or remediation of underlying causes of speech problems through referrals to appropriate medical or psychological personnel. The population for this program was determined by a screening test, a Photo-Articulation Test, and by analyzing classroom teachers' evaluations of pupil language skills. Children in grades kindergarten - eight are seen for therapy one half hour per week. Forty- ve minute periods are scheduled for pupils in grades 9-12. Groups range in size from five to six children. Intensive services are offered at selected locations twice a week for pupils with severe speech handicaps. Inservice teacher training, conferences, special programs and activities, parent workshops, and other innovations are accomplished through the involvement of both the field supervisor and his coordinator. Clinical summaries, case histories, questionnaires, tapes, and records are submitted annually to the project coordinator for evaluation of the program. (Author/JM)

AN EVALUATION OF THE SPEECH THERAPY PROGRAM FOR DISADVANTAGED PUPILS IN NON-PUBLIC SCHOOLS

Evaluation of a New York City school district educational project funded under Title I of the Elementary and Secondary Education Act of 1965 (PL 89-10), performed under contract with the Board of Education of the City of New York for the 1970-1971 school year.

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August 31, 1971

Dr. Samuel D. McClelland
Acting Director
Bureau of Educational Research
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OF NEW YORK
110 Livingston Street
Brooklyn, New York 11201

Dear Dr. McClelland:

In fulfillment of the agreement dated April 27, 1971 between the New York City Public Schools and the Center for Field Research and School Services, I am pleased to submit three hundred copies of the final report, An Evaluation of the Speech Therapy Program for Disadvantaged Pupils in Non-Public Schools.

The Bureau of Educational Research and the professional staff of the New York City Public Schools were most cooperative in providing data and facilitating the study in general. Although the objective of the team was to evaluate a project funded under Title I, this report goes beyond this goal. Explicit in this report are recommendations for modifications and improvement of the program. Consequently, this report will serve its purpose best if it is studied and discussed by all who are concerned with education in New York City -- the Board of Education, professional staff, students, lay leaders, and other citizens. To this end, the study team is prepared to assist with the presentation and interpretation of its report. In addition, the study team looks forward to our continued affiliation with the New York City Public Schools.

You may be sure that New York University and its School of Education will maintain a continuing interest in the Schools of New York City.

Respectfully submitted,

Arnold Spinner

ARNOLD SPINNER
Director

AS:n

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I Executive Summary

This program is designed to provide speech therapy for approximately 6,500 disadvantaged pupils in New York City non-public schools who have the additional handicap of defective speech.

Forty-five speech clinicians licensed by the New York City Board of Education serve in 28 assigned positions in non-public schools.

Children in grades kindergarten through eight are seen in groups for therapy one half hour per week. Forty-five minute periods are acheduled for pupils in grades nine through twelve. Intensive services on a one to one basis are offered when needed at selected locations once a week to pupils with severe speech handicaps.

The speech clinician works as a member of a team with guidance counselors, teachers, parents and school health services to assure a coordinated program of therapy integrated as closely as possible to the child's educational program.

A. Purpose of the Evaluation

The purpose of this evaluation was to examine the objectives of the 1971 speech therapy program for non-public schools. The following objectives were examined:

1. Identification of pupils with speech defects.

2. Differential diagnosis.
3. Speech therapy for speech defective pupils.
4. Securing additional diagnostic and supportive assistance.
5. Insuring that the speech clinician work as a member of a team.
6. Improvement in oral communication in other areas of the curriculum with consideration of the following: listening and speaking skills; communicating ideas effectively; developing good attitudes toward and confidence in speech experiences.
7. To discharge 20% of pupils as corrected.

B. Evaluation Methods

The evaluation methods included the following: (1) 40 site visits to examine facilities and materials and to observe therapy and diagnostic activities; (2) selection of a random sample of 200 clinic record cards to evaluate information relative to referral practices, diagnostic information, objectives of pupil's therapy program, statements of progress or recommendations; (3) collection of questionnaire responses completed by speech clinicians, classroom teachers, and parents regarding the identification, diagnosis, referral, therapy, and team appraoch aspects of the speech therapy program; (4) collection of questionnaire responses completed by 71 parents of various aspects of the speech therapy program; (5) evaluation of a random

sample of available pre- and post-therapy tape-recordings for evidence of improvement in specific communicative skills; (6) evaluation of a random sample of pre- and post-testing accomplished by speech clinicians; (7) comparisons between evaluations completed by the speech clinician and evaluations completed by site visit observers.

C. Findings

Based on observations of speech therapy activities and diagnostic activities made by the site visit observers, comparisons of diagnoses made by speech clinicians and site visit observers, evaluations of pre- and post-therapy tape-recordings and pre- and post- speech clinician testing, and an evaluation of the number of youngsters discharged at the end of the program it is safe to say that the speech therapy program for the non-public schools provides a viable and important service to youngsters who are orally handicapped.

Definite improvement in oral communication skills was found and the discharge percentage (20%) appears to have been met.

Comments made about the program from parents and other faculty members and professional workers in the school all were generally positive. More than providing a service which corrects speech problems, the speech program has gone beyond the confines of its therapy rooms to educate

the public, the administration, and the faculty about the speech therapy program.

Site visit observers commented that the recommendations for previous years have been implemented and that the physical facilities and competencies of the speech therapy program personnel are more than adequate.

D. Recommendations

One of the purposes of the site visits to each of the 40 target schools was to evaluate the degree to which the recommendations made by the evaluation team the previous year had been followed, although this was not stated as an objective of the evaluation. The evaluation team did not feel that it was appropriate to include this as a portion of the main body of the report but rather to comment on it along with the recommendations made for this year.

The following are comments made by the site visit observers. The physical condition of the therapy rooms seems to have improved over last year. There is additional storage space and in many of the rooms mirrors have been provided. However, wall mirrors of adequate size are still lacking in several rooms.

It appears that diagnostic materials have been ordered and are readily available to clinicians. Further, electronic equipment such as tape-recorders and phonographs now seem to be readily available to clinicians. Discussions with the

supervisor of the program indicate that cassette tape-recorders will be available for all clinicians for the end of this year and for the beginning of the next year of speech therapy services.

Recommendations regarding therapy material and supplies, diagnostic equipment and electronic equipment are unnecessary this year. The supervisors and program directors are aware of their need and have taken appropriate steps to provide adequate material for therapy.

Recommendations this year will be based on (1) providing speech therapy for the students in the program and (2) the process of running the program. Because the evaluation team feels that the speech therapy program is a viable program of competent speech therapy services, the recommendations will be few. They are as follows:

1. Although it is recognized that, according to the program design, a fixed number of students are to be seen by the speech pathologist in the non-public schools, it is recommended that consideration be given to the possibility of individual work with students. It is recognized that there are centers to which youngsters with severe speech problems may be sent, but it is believed that this recommendation is not always made when youngsters present "borderline serious" speech defects. Possibly, as suggested by some of the clinicians on their questionnaires, time spent in paper work and conferences with classroom teachers

might be spent in individual work with selected children.

2. Possibly one of the most valid ways of describing a youngster's oral communication is to have a group of trained listeners evaluate change over a period of time. This was accomplished in the present evaluation by using pre- and post-therapy tape-recordings. Some minor difficulties arose when using these tape-recordings, however, because of the non-standardized material used for these recordings. That is, one type of material was used for a pre-therapy tape-recording and another type of material was used for the post-therapy recording. It is recommended that for evaluation purposes, whether it be an evaluation within the therapy program itself or by a team of evaluators, the speech clinicians be advised to select collectively a set of materials which will be used uniformly for pre- and post-therapy tape-recordings.

3. One final recommendation in the form of a comment regarding the future conduct of speech therapy evaluations. Because of the apparent unavoidable necessity of clearing evaluation instruments, site visit locations, evaluation personnel, and site visit dates through the office of the director of federally assisted programs at the Board of Education, time to set up an evaluation program which would allow quantitative as well as qualitative assessment of the speech therapy is rather limited. Quantitative evaluation of changes in a student's speech

over the period the program is in operation using a battery of standardized tests would provide a reasonably valid numerical index of program viability. Time would have to be alloted for pre- and post-testing with a reasonable interim (at least six months) between testing dates.

In the evaluation design for this year, it was decided that pre- and post-testing of youngsters in the program would be accomplished provided there was at least a four month minimum interval between testing dates. Because of apparent unavoidable delays we were unable to get started in enough time to provide even this very minimum four month interval between pre- and post-testing.

Oral communication is very complex. One not only measures quantity, but one measures quality as well. Subtle changes in quality often go unnoticed when the change is small. Over a four month interval one would expect very little change in the quality of communication, but one might expect a change in the quantity. It may, therefore, be possible, if time permitted, to evaluate quantitative changes, that is, the number of words spoken correctly, etc., in children enrolled in the program. But truly, this would not provide valid or complete indexes of changes in oral communication as quantity is only one small aspect of oral communication.

When we speak about self-image, self awareness, ease in speaking situations, listening ability and so on,

we are speaking about things which are very difficult to measure and which change very slowly over time. It is mandatory, therefore, that the program for evaluation get off the ground at the very latest in the middle of September and that the evaluators are allowed to go into the school very quickly, possibly by just calling up the school and going in immediately for pretesting when the youngsters begin their therapy for the year. The evaluation team is very well aware of the difficulties involved in this. However, we feel that there are very severe limitations placed on a quantitative evaluation of changes in oral communication skills if this is disallowed.

II Program Description

This program is designed to provide speech therapy for approximately 6,500 disadvantaged pupils in New York City non-public schools who have the additional handicap of defective speech.

The population for this program was determined by a screening test, a Photo-Articulation Test, and by analyzing classroom teachers' evaluations of pupil language skills.

One licensed speech supervisor serves as coordinator of the program. One additional supervisor is provided to serve as field supervisor. Forty-five speech clinicians licensed by the New York City Board of Education serve in 28 assigned positions.

Children in grades kindergarten through eight are seen for therapy one half hour per week. Forty-five minute periods are scheduled for pupils in grades nine through twelve. Groups range in size from five to six children. Intensive services are offered at selected locations twice a week for pupils with severe speech handicaps.

The coordinator and the field supervisor visit each clinician four to six times during the year in order to be in direct contact with the facilities and to keep aware of interpersonal relationships between the pedagogical staff and other school personnel.

In-service teacher training, conferences, special

programs and activities, parent workshops and other innovations are accomplished through the involvement of both the field supervisor and his coordinator. On days when non-public schools are closed, a program of teacher-training is conducted for the pedagogical staff. These conferences focus on refined techniques and testing for differential diagnosis, on individualization of therapy within the structure of group therapy, on sensitivity training, and on characteristics of disadvantaged children, especially those in the Title I non-public schools of New York City. This on-going program is conducted by the project coordinator, the field supervisor and experts in the field of speech pathology, and a college consultant.

Referrals for hearing tests, physical examinations, psychological evaluations, and other services related to the speech defect are made through the school health services, the Bureau of Child Guidance, medical personnel, and appropriate community agencies as needed.

The speech clinician works as a member of a team with guidance counselors, teachers, parents, and school health services to assure a coordinated program of therapy integrated as closely as possible to the child's educational program. The clinician confers with classroom teachers and parents to exchange pertinent information about the child and to keep them informed as to the pupil's needs and progress and to enlist their assistance in carry-over of gains

during clinic sessions to speaking situations in the pupil's normal environment. Referrals are made to outside clinics, to hospitals, to otolaryngologists, to orthodontists, to P.S. 47, to the Bureau for Child Guidance, to social workers, and any other agency whose advice or assistance will aid in the progress of speech rehabilitation.

Clinical summaries, case histories, questionnaires, tapes and records are submitted annually to the project coordinator for evaluation of the program. Clinical data is compiled and disseminated to non-public school representatives, to the Title I non-public school office and to the speech clinicians to be utilized in planning and implementing the program for the following year.

A. Program Objectives - General

The objectives of the program were as follows:

1. To identify pupils with speech defects.

2. To provide diagnostic evaluations and therapeautic programs for these pupils.

3. To provide amelioration or remediation of underlying causes of speech problems through referrals to appropriate medical or psychological personnel.

B. Program Objectives - Specific

The specific objectives of this program were:

1. To develop more acute and effective listening skills.

2. To develop interpersonal relationships and a desirable self-image through training in speech skills.

3. To promote conferences with other members of the faculty, social workers, guidance counselors, and parents to motivate and make the child aware of the importance of his speech and language at all ages and all levels of education.

4. To provide correction of or improvement in oral communication that will be equally evident in other areas of the curriculum such as reading, comprehension, social studies.

5. To support the pupil socially, emotionally, and psychologically by providing confidence in all communication through training in speech skills.

6. To determine the present function of children who receive services in the speech program during the 1970-1971 school year.

7. To discharge as corrected 20% of the pupils serviced.

III Design of the Evaluation

A. Evaluation Objectives

The general objectives of the evaluation were: (A) to examine the degree to which the proposed objectives of the speech therapy program were achieved; (B) to examine the procedures employed in the speech therapy program to achieve the objectives; (C) to generate some conclusions regarding the viability of the speech therapy program; and, (D) if necessary, to present recommendations for improving the effectiveness of the speech therapy program.

Generally, this evaluation examined the following objectives of the speech therapy program in an attempt to comment on the degree to which the objectives were met.

1. To identify pupils with speech defects.
2. To provide differential diagnosis.
3. To provide speech therapy for speech defective pupils.
4. To secure additional diagnostic or supportive assistance for identification and/or remediation of underlying speech handicaps through a program of referrals to professionally competent specialists or agencies.

Specifically, this evaluation considered the following objectives:

1. To evaluate the extent to which speech clinician conferences with other members of the faculty, social workers, guidance counselors and parents are carried out.

2. To evaluate the extent to which improvement in oral communication is evident in other areas of the curriculum with consideration of the following:

a) Learning the listening and speaking skills necessary for success in a total educational experience.

b) Communicating ideas effectively for the development of adequate self-image and for the development of adequate interpersonal relationships.

c) Developing good attitudes toward and confidence in speech experiences.

3. To determine at the end of the program for this year the percentage of pupils discharged as corrected.

4. To evaluate the overall implementation of the speech therapy program as described in the project proposal.

B. Aspects of the Evaluation

For each evaluation objective, a description of the methods and procedures of the evaluation including data gathering instruments, data-processing procedures, statistical analyses are presented as follows:

Objective #1 (General) - To comment on the effectiveness with which pupils with speech defects have been identified.

Subjects. A random sample of 80 students participating in the therapy program, their speech clinicians (N=30), and classroom teachers (N = 51).

Methods and Procedures. Trained evaluators administered a standard (Templin Screening Test of Articulation) test of articulation to 80 randomly selected students in the program classified as possessing articulation disorders to determine the level of articulation defectiveness of the pupils enrolled in the program. They used other clinical evaluative methods (such as an analysis of free running speech) to determine the level of speech defectiveness of pupils classified as possessing speech defects other than articulation problems. These data were used as an index of the degree of severity of speech problems in the program and were viewed indirectly as an indicator of the effectiveness of identifying pupils with speech problems requiring speech therapy.

Further, questionnaires were developed which surveyed the opinions of the speech clinicians and classroom teachers of the 80 pupils regarding the effectiveness of the identification of speech defective pupils.

Analysis. The degree of severity of speech problems is presented and is analyzed with respect to the

percent of pupils requiring speech therapy. Questionnaires were evaluated using content analysis procedures.

Objective #2 (General) - To comment on the effectiveness of differential diagnostic techniques and to comment on the extent to which these techniques are used.

Subjects. A random sample of 80 participating students, the speech therapy program supervisor, and the speech clinicians (N = 30) in a random sample of 40 non-public schools receiving speech therapy services.

Methods and Procedures. Trained evaluators used clinical evaluative methods to determine the speech problems of 80 randomly selected speech students. Comparisons were made between these diagnoses and those made by the speech therapy program personnel. Further, questionnaires were developed to survey the opinions of each of the speech clinicians in the sample schools regarding diagnostic procedures and the availability of diagnostic materials. The speech program supervisor was interviewed by the evaluation director regarding the same information. A site visit to each of the selected schools was made. The availability of diagnostic test equipment was appraised. Clinical record cards were examined for evidence of differential diagnostic information and 14 observations of diagnostic techniques were made.

Analysis. The percentage of favorable and unfavorable diagnostic comparisons is presented to demonstrate the effectiveness of the differential diagnostic techniques used in the program. Questionnaires were evaluated using content analysis procedures to comment on the extent to which these techniques were used.

Objective #3 (General) and Objective #? (Specific) - To comment on the effectiveness of providing speech therapy to speech defective pupils and to evaluate the extent to which improvement of oral communication is evident in other areas of the curriculum with consideration of the following:

to note the extent and direction of change in pupil's listening and speaking skills, self-image, interpersonal relationships, and confidence in speech experiences.

Subjects. A random sample of 80 pupils enrolled in speech therapy, 30 of their speech clinicians, 71 of their parents, and 51 of their classroom teachers.

Methods and Procedures. Pre- and post-therapy tape-recordings of pupils enrolled in the speech therapy program were evaluated by a panel of experts in speech pathology for evidence of improvement in specific communicative skills. Pre- and post-therapy diagnostic tests administered by individual speech clinicians were evaluated by the evaluation team to determine the extent and direction

of change in pupil communicative skills. A pupil evaluation form was developed and filled out by the classroom teacher, the speech clinician and by the pupil's parents. These data were collected only in the 40 schools involved in the site visits. Site visit evaluators observed therapy and filled out a therapy evaluation form. Further, the random group of pupils was given diagnostic evaluations. These evaluations were administered by the trained observers and compared with the results of testing by the speech clinicians.

Analysis. Pre- and post-therapy tape-recordings were evaluated by a panel of experts in speech therapy to determine the extent and direction of changes in pupils' speaking skills. The results are presented as percentages of improvement, no improvement, or regression in pupils' speaking skills. Pre- and post-therapy diagnostic tests administered by individual speech clinicians and by the trained evaluators were compared and results are presented as an indicator of the degree of improvement in pupils' speaking skills. Pupil evaluation forms were subjected to content analysis and results are presented as an indicator of the extent and direction of change in pupils' listening skills, self-image, interpersonal relationships, and confidence in speaking experiences. Further, the questionnaire filled out by the classroom teacher assessed the classroom teacher's opinions regarding improvement in oral communication of those pupils serviced by the speech therapy program.

These questionnaires were also subjected to content analysis.

Objective #4 (General) - To comment on the degree to which additional diagnostic and/or supportive assistance for identification and/or remediation of underlying causes of speech problems is secured through referrals to professionally competent specialists or agencies.

Subjects. The clinic record cards of 80 pupils enrolled in the speech therapy program, 30 speech clinicians, and the program supervisor.

Methods and Procedures. The clinic record cards of 80 pupils were examined for evidence of appropriate referral entries, referral reports, and follow-up on referral information. A questionnaire on referral practices was developed and distributed to speech clinicians in the 40 site visit schools. The project director interviewed the program supervisor concerning referral practices.

Analysis. Frequency type quality and percentage analysis of referral sources, referral reports, and referral follow-up were made.

Objective #1 (Specific) - To evaluate the extent to which speech clinician conferences with other members of the faculty, social workers, guidance counselors, and parents

are carried out.

Subjects. A random sample of 100 faculty, social workers, and guidance counselors that are connected with the 40 site visit schools, parents of 71 speech therapy pupils, and the program supervisor.

Methods and Procedures. A questionnaire was developed and distributed to classroom teachers. A questionnaire was distributed to parents. The program supervisor, social workers, and guidance counselors were interviewed by the project director and/or by one of the project evaluators. Information regarding the number, content, effectiveness and follow-up conferences with school personnel, social workers, and parents was obtained.

Analysis. Percentage and frequency distributions and content analysis were reported.

Objective #3 (Specific) - To determine at the end of the program for this year the percentage of pupils discharged as corrected.

Subjects. All pupils enrolled in the speech therapy program in the 40 site visit schools.

Methods and Procedures. The percentage of pupils discharged was computed.

Objective #4 (Specific) - To evaluate the implementation of the speech therapy program described in the project proposal.

Subjects. A stratified sample of 40 schools proportionately representing the schools in each district was selected.

Methods and Procedures. An observational visit to each of the selected schools was made. Evaluators filled out a site visit report.

Analysis. Frequency and percentage analyses and content analyses of the site visit reports were made.

IV Results of Evaluation

The results of the evaluation are presented in relation to the objectives employed. Each objective is stated and the results presented. Descriptive statistical analysis of the data was used when appropriate.

A. Objective #1 (General) - To identify pupils with speech defects.

Results.

Observer Evaluations. Of 80 children evaluated by the site visit observers, 93% had speech problems which required treatment by a qualified speech pathologist. Seven percent were considered to have speech problems of a very mild degree. Of this 7%, 80% were slated for discharge at the end of the school term.

Classroom Teacher Questionnaire. From 100 classroom teachers, the following responses were received regarding their opinions concerning the effectiveness of the identification of speech defective pupils in the schools. One hundred out of 100 classroom teachers reported that some of their pupils are enrolled in the speech therapy classes. Five hundred and two children from these classes were being serviced by the speech therapy program. This amounts to

approximately 5 per classroom.

In response to the question, "Are there pupils in your classroom whom you would like to have seen by the speech teacher but who are presently not being seen?", 32 classroom teachers responded affirmatively, 68 responded negatively. Of the 32 that responded affirmatively, a total of 64 children had not been identified as needing speech therapy when, according to the classroom teacher, they were in need.

In response to the question, "Do you think that the speech program in your school has successfully identified pupils with speech and/or language problems?", 99 of 100 classroom teachers responded affirmatively.

Speech Clinician Questionnaire. Of 30 speech clinicians, 29 reported that a staff member in the speech program screens every new pupil entering the school during the first or second year of enrollment. On the average, 20% of the new pupils require enrollment and are enrolled in the speech program. Twenty-eight of 30 speech clinicians reported that there are pupils in the school that require enrollment into the speech program, but who, for some reason, are not enrolled. The explanation most commonly offered (94% of the time) is that some schools are serviced only one day a week and there are long waiting lists for children to be enrolled in the program. According to the speech clinicians, as many as 583 students require entrance into the program but are not at this time enrolled.

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to them or at their disposal. Three of the 30 clinicians indicated that the Goldman-Fristo Test of Articulation was also at their disposal if they requested it. Five of the 30 mentioned that they had used the Meacham Verbal Development Scale and 10 of the 30 the Vineland Social Maturity Scale. The Wepman Auditory Discrimination Test was used by two and the Sentences for Memory Test was used by one. The Oserctski Motor Development Scale was used by two and the Bryngelson-Gelaspy Articulation Test was used by three of the 30 clinicians. The Verbal Language Development Scale and the LaRoyden Articulation Scale was used by one clinician.

It was apparent that in 100% of the cases, all of the above mentioned tests were immediately or readily available to the speech clinician upon request.

Twenty-nine of the 30 clinicians expressed that the diagnostic procedures employed by the speech therapy program were adequate. Pupils are diagnosed not only at the beginning of the school term, but new pupils may be diagnosed during the school year. It was reported by the clinicians that on the average two diagnostic test instruments are used per pupil when they are finally accepted into the program. The choice of test instruments is, of course, based on the problems that are presented.

Twenty-nine of 30 clinicians consider the diagnostic procedures used in the speech therapy program to be differ-

ential diagnostics rather than a simple screening procedure. On the average, two professional opinions or two diagnoses are compiled when making a diagnostic statement concerning a pupil.

The 30 speech clinicians reported that for 88% of their pupils, they had what they considered to be reasonably complete diagnostic information. Of the remaining 12%, 80% were in the process of being more thoroughly evaluated and completed diagnostic information had not yet been compiled for this group. For the 20% for which there was incomplete diagnostic information, there were no plans to collect further information.

All of the speech clinicians indicated that the speech program had an adequate procedure for recording in one place all diagnostic information compiled from the speech clinicians and other consults. Also, generally, this information was readily available to the speech clinician for immediate use.

Supervisor Interview. The speech therapy program supervisor confirmed the information that was offered by the speech clinicians. The supervisor indicated that the program continually evaluates new standardized testing procedures for the evaluation of speech problems in the schools and is continually making recommendations for the purchase of new updated test materials. The supervisor feels that there is an adequate battery of standardized

tests which are up to date, complete, and in good working order available to all of the speech clinicians in the program.

Observer Site Visits. The opinions expressed by the speech clinicians and by the program supervisor were generally corroborated by the trained observers at each of the site visit schools. Diagnostic test equipment was readily available and the clinical record cards showed evidence of differential diagnostic information.

Observer Diagnostic Observations. With respect to 14 observations of diagnostic techniques made by the site observers, it was noticed that in all cases an attempt was made to use appropriate differential techniques. Cases observed were youngsters that were referred either by the screening program or by the classroom teachers. All of these youngsters were either articulation or language problems and for each an appropriate test battery was used. The observers report that in all cases rapport had been established and that the clinician demonstrated an ability to handle each child so that a valid and reliable test result could be obtained. It was felt that the clinician in all cases had made an appropriate and accurate diagnosis of the speech problem.

C. Objective #3 (General) and Objective #2 (Specific) - To

comment on the effectiveness of providing speech therapy to speech defective pupils and to evaluate the extent to which the improvement in oral communication is evident in other areas of the curriculum with consideration of the following: to note the extent and direction of change in pupil's listening and speaking skills, self-image, interpersonal relationships, and confidence in speech experiences.

Results.

Pre- and Post-Therapy Tape-Recordings. The pre-therapy and post-therapy tape-recordings of 80 pupils enrolled in the 40 target schools were evaluated by a panel of experts in speech pathology to determine direction of change and improvement in specific communicative skills. Of 80 children, 64% showed specific improvement in communicative skills, 23% showed no improvement and 13% showed some regression in communicative skills. Although this is a small sample, and generalization to the main population enrolled in the program would be risky, the 64% improvement rate, however, is considered quite good for a program providing the kind of clinician-student contact this program provides.

Pre- and Post-Therapy Diagnostic Tests. Pre- and post-therapy diagnostic tests administered by individual speech clinicians were evaluated by the evaluation team to determine the extent and direction of change in pupil

communicative skills. Of 80 children evaluated, 71% showed improvement in communicative skills, 18% showed no improvement, and 11% showed some regression in communication skills.

Pupil Evaluation By Classroom Teacher. Ninety percent of classroom teachers surveyed suggested that there had been a general change in the oral behavior of pupils enrolled in the speech therapy program. Fifty percent of the classroom teachers suggested that there had been a general change in the overall behavior of these pupils. Of these, 100% indicated that this change had been in a positive direction. Ninety-two percent of classroom teachers suggest that their pupils' ability to say sounds and words clearly had improved and that the youngsters expressive vocabulary and receptive vocabulary had increased. Eighty-four percent suggest that these pupils appear to be listening more attentively and that each pupil's communication with others in the classroom seems to have improved. Seventy-three percent of classroom teachers suggest that pupils enrolled in the speech therapy program seem to speak more in class and that these youngsters are more able to organize their thoughts when presenting them orally. Fifty percent suggest that the pupils' general school work improved during the time of attendance at the speech therapy program. One hundred percent of the teachers suggest that the results of the speech work warrant the released time from class.

Eighty-four percent feel that changes in oral behavior and in the youngsters over-all behavior are due to the influence of the speech program. However, 93% of classroom teachers suggest that there had been no change in the youngster's behavior regarding his attendance, over-all appearance, and the number of friends that the pupil associates with.

Pupil Evaluation By Speech Clinicians. In general, the results received from the speech clinician regarding these same questions were very similar to those presented by the classroom teachers. Eighty-nine percent of speech clinicians suggest that the ability of the pupils enrolled in the speech therapy program to say sounds and words clearly had improved. Further, their expressive vocabulary and receptive vocabulary had increased; and the youngsters appeared to be listening more attentively and communicating with others more readily. Again, with respect to general appearance, attendance, and the increase in the number of friends for each youngster, speech clinicians indicated that there had been little or no change.

Pupil Evaluation by Parents. Parents' responses to similar questions were comparable to the responses by the clinicians and teachers. Ninety-four percent of the parents indicated that they noticed a change in their child's oral communication. Seventy-three percent indicated that their youngster was behaving better now than he was when he started speech. Ninety-four percent indicated that their child's

ability to say sounds and words clearly had improved and that the youngster was using and understanding more new words. Further, the youngster appeared to be listening more attentively and talking to more people. Interestingly, 74% of parents felt that their children's general school work had improved since attending speech.

Site Visit Observers Evaluations of Speech Therapy. Group therapy with an average of five students was the main arrangement for therapy observed. There was generally an appropriate lesson plan prepared for each therapy session. The goals of therapy for each session were essentially clear and completely outlined and clinicians followed these plans when appropriate.

In general, each clinician was able to establish and maintain rapport during therapy sessions. Clinicians were able to handle each child within the group as well as the group as a whole. The interest of each child was considered and equal opportunity for participation of each child in the activity was observed.

The majority of clinicians observed provided adequate organization in the therapy session. Further, the aim of the lesson and the progress of the lesson were appropriate for the children observed. Clinicians generally appeared to present clear direction for students and to provide a reasonable and logical progression of material and skills to be mastered.

Observer Diagnostic Evaluations. It was initially decided to have the site visit observers administer a pre- and post-therapy evaluation to each of 80 pupils providing there was a four month interim between evaluations. Because the evaluation got off to such a late start this year it was impossible to administer a pre- and post-therapy evaluation to each student. Some of the initial contacts with schools were made as late as the beginning of June. In each case, however, an evaluation was administered to each of the 80 students from the target schools. The results of these evaluations were compared to the evaluations made by the speech clinician and have been presented in an earlier section.

D. Objective #4 (General) - To comment on the degree to which additional diagnostic and/or supportive assistance for identification and/or remediation of underlying causes of speech problems is secured through referrals to professionally competent specialists or agencies.

Results.

Record Cards. In 93% of the cases (N = 80) evidence of appropriate referral entries, referral reports, and follow-up on referral information was available and recorded on the clinic record cards. Examination of these cards by the site visit observers revealed that in all the cases referrals were appropriate and warranted.

Speech Clinician Questionnaire. Referrals are generally made by the clinician contacting a referral agency directly without consulting other personnel. However, 90% of the speech clinicians surveyed indicated that the decision to refer is not usually made by only one person. There are usually two or more professional individuals involved in a decision to refer. Ninety-eight percent of the speech clinicians consider the referral practices of the speech program to be adequate and consider adequate the frequency with which pupils are referred to other agencies. Eighty-nine percent of the speech clinicians consider the competency of the referral agencies used to be adequate.

In all cases it appears that reports are received promptly from referral agencies and that the reports are readily available to the speech clinician. Seventy-four percent of the speech clinicians reporting consider the reporting of referral agencies to be adequate. Ninety-four percent of the clinicians reporting suggest that the information received from referral sources is useful as an aid to therapy and diagnosis.

Program Supervisor Comments. The program supervisor indicated that referral agencies are continually being evaluated for competency of services to the speech therapy program. Recently, it was reported that a local agency was not providing information which was helpful to the clinicians and for this reason a new agency was sought and found.

E. Objective #1 (Specific) - To evaluate the extent to which speech clinician conferences with other members of the faculty, social workers, guidance counselors, and parents are carried out.

Results.

Parent's Questionnaire. Of 71 parents surveyed, 75% stated that they had been contacted by the speech clinician concerning their child's speech problem. Sixty-three percent reported that they had had a face-to-face meeting with the speech clinician. In these meetings the specifics of the child's speech problem had been discussed and explained to the parents. Eighty-seven percent of the parents reporting indicated that they knew what their child was doing in speech class and that the clinician had sent home speech homework for the child to work on. Ninety-two percent of the parents reporting indicated that they were able to help the youngster with their speech homework and that they felt that the speech therapy program was effective in increasing the youngster's oral communications ability.

Classroom Teacher Questionnaire. Of 100 classroom teachers reporting, 78% stated that they had had an opportunity to discuss the speech problems of their pupils with the speech clinician. Of the teachers who had conferences with the speech clinician, 100% were of the opinion that the conferences had been fruitful and that in the conferences the specific speech problems of the pupils were discussed.

Fifty-nine percent of 100 classroom teachers responding indicated that they had had an opportunity to participate in conferences involving the speech clinician, the guidance counselor, the social worker, and other faculty concerning the speech program.

Guidance and Social Worker Contacts. Twenty-four individual interviews with social workers and guidance counselors in the 40 site visit schools were carried out by the site visit observers. The consensus of opinions regarding these interviews was that when necessary the speech clinicians have contacted these professional persons to gather information regarding a specific student. The social workers and guidance counselors pointed out that it was not always necessary for the speech clinician to make contact with them when there was no reason for an exchange of information. Because of the size of the case loads of the clinicians, the social workers, and the guidance counselors and because of the itinerant nature of the work responsibilities of some of these individuals, conferences were only made when necessary.

It was reported by the speech clinicians, the observers, classroom teachers, and other professionals interviewed that the follow-up conferences held, that is, the therapeutic use of the material that was discussed and disseminated in these conferences, was adequate. Very often, the reason for a child's poor attendance or lack of motivation in a

speech class was made clear to the speech clinician through contacts with the classroom teacher, with the guidance counselor, or with the social worker.

Program Supervisor Comments. The program supervisor's remarks regarding the appropriateness and frequency of conferences with other professionals in schools agreed for the most part with those presented by the faculty, the observers, and the speech clinicians.

F. Objective #3 (Specific) - To determine at the end of the program for this year the percentage of pupils discharged as corrected.

Results. It was determined by evaluating clinic record cards that 19.7% of the youngsters enrolled in the speech therapy program in the 40 target schools were slated for discharge or for a six month follow-up check at the end of the term.

G. Objective #4 (Specific) - To evaluate the implementation of the speech therapy program described in the project proposal.

Results.

Site Visit Reports.

1. Physical Conditions - In six of the 40 schools visited, classrooms were being used as the speech therapy

room. In 10 schools, a special office had been set aside for the speech therapy program. In 8 schools, the teacher's room was used; and in 16 arrangements were made in nurses offices, faculty lounges, etc. Of the 40 schools, 34 of the therapy rooms provided were considered to be quite adequate by the site observers while 6 were inadequate for several reasons. Poor acoustics, poor ventilation, poor lighting were sited as inadequacies. Of the 40 schools investigated, half were considered to be somewhat noisey, the other half quiet. All of the rooms had an adequate table. Thirty-four of the 40 had adequate ventilation, lighting, temperature, and charts. Thirty-one of the 40 had decorations and other aids which were felt to be contributory to the development of good speech. Ten of the 40 schools had mirrors that were considered adequate for speech work. Twenty-four of the 40 had blackboards that were considered adequate.

2. Therapy Session - Group therapy with an average number of five students was the main arrangement for therapy observed. There was generally an appropriate and complete lesson plan prepared for each therapy session. In only one case out of 40 was this not true. In 39 out of 40 cases, rapport had been established and there was an ability indicated to handle each child within the group as well as the group as a whole. The clinician appeared to be able to stimulate and hold the interest of each child

within the group and there was an equal opportunity for each child to participate. In 39 out of 40 cases the overall organization of the therapy plan and subsequent therapy was adequate. The aim of the lesson was appropriate for the needs of the children and progressed adequately. However, in some cases (21%) the observers felt that there was not sufficient flexibility for digression from the lesson plan where appropriate. It appeared, as commented by one observer, that the clinician seemed to be "locked in" to the lesson plan and was unable to move with any great flexibility to a more adequate activity when indicated.

3. Observer Comments - The program appears to have improved in terms of supervision and utilization of meeting times for informative programs. There appears to be, on the average, fairly good communication between Title I personnel, guidance counselors, etc. within the schools although most clinicians would like to see full meetings scheduled twice a year for discussion purposes. Materials appear to be quite satisfactory except for materials for older students. Equipment appears satisfactory but is often stolen from the rooms.

The block program is being used in many schools. It is felt to be quite effective. Some clinicians retain some more severe cases throughout the year this way.

It appears that in most cases clinicians are not too concerned about hearing evaluations for their cases. In

most instances they have been able to get hearing evaluations done within a reasonable period of time. Most, however, would like to have extra time from groups to take some children individually or to see the parents of the children rather than do diagnostics or evaluations. Most clinicians seem to be conscientious and sincerely interested in their program.

V Discussion and Recommendations

A. Discussion

The discussion of the results of this evaluation will be presented with respect to (a) behavioral changes noted in speech therapy pupils; (b) an evaluation of the process of operating the speech therapy program; and (c) the surveyed opinions of speech clinicians, classroom teachers, and parents.

Behavioral. The pre- and post-therapy tape-recordings used to evaluate specific communicative change in pupils and the direction of change provided a reasonable index of improvement in oral skills for the school term. These tape-recordings were made at the beginning of the speech therapy program for the year and then again at the end of the term. Specific changes noted were improvements in overall intelligibility, improvements in articulation skills, improvements in structural complexity of sentences, and improvements in the quantity of verbal output. Further, evaluations in changes of voice quality were made from the tapes, and impressions of overall quality of oral communicative interchange was assessed. The results indicated that 64% of the children studied improved in oral speaking skills. That is, their output was more intelligible, of a higher quality, and in greater quantity. This indicates that a specific change in oral communicative skills has been obtained

for these pupils.

The pre- and post-therapy diagnostic tests that were administered by individual speech clinicians also indicated the degree and extent of change in oral communicative abilities of the pupils enrolled in the speech program. These tests generally assessed articulation, intelligibility, and language usuage. These tests were administered at the start of the therapy for the term and then again at the end and provide a reasonably valid index of communicative change in pupils. As stated before, 71% of the pupils surveyed showed an improvement in communicative skills. Of those surveyed, 19.7% were slated for dismissal or re-evaluation in six months. The results of the testing and tape evaluations indicate that better than 67% of the youngsters surveyed made specific improvements in oral communicative skills.

Speech clinicians, classroom teachers, and parents offered information regarding the extent and direction of change. These changes involved pupil's listening and speaking skills, self-image, interpersonal relationships, and confidence in speech experiences. Classroom teachers evaluated the extent to which speech improvement was evident in other areas of the curriculum. The consensus of opinion of the classroom teachers was that the general oral behavior of youngsters enrolled in their classes who were seen in a speech therapy program had improved over the

school term. Improvements in school work, the number of communicative exchanges observed, and improvement in pupil's ability to say sounds and words clearly indicated that there was definitely a carry-over of oral speaking skills to the classroom situation. Most impressive were the comments by teachers regarding the improvements in expressive vocabulary and receptive vocabulary noted in their students. Also, the degree and number of social contacts made by these youngsters tended to increase and improve in quality over the school term.

Interestingly, the classroom teachers suggested that they noted specific improvements in listening skills demonstrated by the youngsters enrolled in the speech therapy program. Based on comments and reports by classroom teachers, there is little question that the speech therapy program has been quite successful in improving the communicative skills of those youngsters enrolled.

Process. The results of the evaluation indicate that speech clinicians and staff personnel in the speech program appear to have been able to successfully identify students with speech problems. The evaluations that the speech clinicians performed seemed to be a valid and reliable estimate of the extent and nature of the speech problem involved.

The majority of classroom teachers were of the opinion that the speech program had successfully identified pupils

requiring speech therapy.

Based on standardized screening procedures and diagnostic techniques for the identification of speech impaired children, this program seems to have very adequately set up a screening program and a differential diagnostic program for speech defect identification.

Differential diagnostic techniques appear to be quite adequate. Comparisons between the diagnostics performed by the trained observers and those performed by the speech clinicians agreed.

An appropriate battery of test instruments was used by the speech clinician when indicated for a differential diagnosis of a speech problem. All of the clinicians, the site visit observers, and the program supervisor indicated that there was an adequate battery of diagnostic tests in use by the clinicians and that, on the average, at least two diagnostic tests were used to evaluate the speech proficiency of each pupil seen in the program.

Speech clinicians appear to make abundant use of referral sources. Their referrals seem to be appropriate and in most cases provide pertinent information for developing therapy plans and carrying out therapy. Otolaryngologists, audiologists, psychologists, guidance counselors, social workers, and general medical assistance are available to the speech clinician on call. It appears in all cases that speech clinicians have made appropriate referrals and have

made use of the referral information in their speech therapy activities.

Seventy-five percent of the parents of children in the program had indicated that they were contacted at some time during the year by the speech clinician. They had been called on the phone, received information in the mail, or had been invited to the school to either observe or talk to the speech clinician. This suggests that the speech clinicians have a desire to include the parents in the speech activities they perform with the children.

Beyond this contact with parents, speech clinicians have apparently made contact, when appropriate, with individual classroom teachers and guidance counselors in the school in order to get a more complete picture of oral communication and behavior of individual students. In all cases, it appears as though speech clinicians provide a coordinated and viable program of speech therapy services. That is, beyond work simply with the youngsters in the program, they attempt to include and involve other professionals which come in contact with the youngster throughout the year.

In general, the comments made by the site observers regarding the physical facility provided for the speech therapy program are favorable. In only a very few cases were the surroundings considered to be inadequate. With respect to those, the supervisor noted that changes were

being made. Materials and supplies appear to be readily available and, if not immediately at the clinician's hand, were certainly available upon request at the central office.

With respect to observer comments regarding the adequacy of therapy offered in the non-public school program, generally, the therapy observed was of an outstanding quality. Further, supervision has improved this year to the point where specific questions that are asked by speech clinicians are answered thoroughly by the supervisors and often provide considerable guidance for future therapy work with a youngster.

Opinions. Opinions about the speech therapy program were gathered from classroom teachers, speech clinicians, and parents of pupils enrolled in the therapy program. On the average, 90% of all those surveyed indicated that they thought the program of speech therapy services was a viable and important program in the schools.

The most refreshing aspect of this evaluation was the discovery that the speech teachers and program supervisors and other staff personnel connected with the speech therapy program make a concerted effort to educate the public, the parents, and the professionals that come in contact with students in speech therapy. Parents, teachers, and administrators have a very clear idea of what the speech therapy program is and what it does.

B. Recommendations

One of the purposes of the site visits to each of the 40 target schools was to evaluate the degree to which the recommendations made by the evaluation team the previous year had been followed, although this was not stated as an objective of the evaluation. The evaluation team did not feel that it was appropriate to include this as a portion of the main body of the report but rather to comment on it along with the recommendations made for this year.

The following are comments made by the site visit observers. The physical condition of the therapy rooms seems to have improved over last year. There is additional storage space and, in many of the rooms, mirrors have been provided. However, wall mirrors of adequate size are still lacking in several rooms.

It appears that diagnostic materials have been ordered and are readily available to clinicians. Further, electronic equipment such as tape-recorders and phonographs now seem to be readily available to clinicians. Discussions with the supervisor of the program indicate that cassette tape-recorders will be available for all clinicians for the end of this year and for the beginning of the next year of speech therapy services.

Recommendations regarding therapy material and supplies, diagnostic equipment and electronic equipment are unnecessary this year. The supervisors and program directors are aware

of their needs and have taken appropriate steps to provide adequate material for therapy.

Recommendations this year will be based on (1) providing speech therapy for the students in the program and (2) the process of running the program. Because the evaluation team feels that the speech therapy program is a viable program of competent speech therapy services, the recommendations will be few. They are as follows:

1. Although it is recognized that, according to the program design, a fixed number of students are to be seen by the speech pathologist in the non-public schools, it is recommended that more consideration be given to adjusting schedules so that the maximum number of students receive individual work. It is recognized that there are centers to which youngsters with severe speech problems may be sent, but it is believed that this recommendation is not always made when youngsters present "borderline serious" speech defects. Possibly, as suggested by sone of the clinicians on their questionnaires, time spent in paper work and conferences with classroom teachers might be spent in individual work with selected children.

2. Possibly one of the most valid ways of describing a youngster's oral communication is to have a group of trained listeners evaluate change over a period of time. This was accomplished in the present evaluation by using pre- and psot-therapy tape-recordings. Some minor difficulties arose when using these tape-recordings, however, because

of the non-standardized material used for these recordings. That is, one type of material was used for a pre-therapy tape-recording and another type of material was used for the post-therapy recording. It is recommended that for evaluation purposes, whether it be an evaluation within the therapy program itself or by a team of evaluators, the speech clinicians be advised to select collectively a set of materials which will be used unifromly for pre- and post-therapy tape-recordings.

3. One final recommendation in the form of comment regarding the future conduct of speech therapy evaluations is made. Because of the apparent unavoidable necessity of clearing evaluation instruments, site visit locations, evaluation personnel, and site visit dates through the office of the director of federally assisted programs at the Board of Education, time to set up an evaluation program which would allow quantitative as well as qualitative assessment of the speech therapy is rather limited. Quantitative evaluation of changes in a student's speech over the period the program is in operation using a battery of standardized tests would provide a reasonably valid numerical index of program viability. Time would have to be alloted for pre- and post-testing with a reasonable interim (at least six months) between testing dates.

In the evaluation design for this year, it was decided that pre- and post-testing of youngsters in the program

would be accomplished provided there was at least a four month minimum interval between testing dates. Because of apparent unavoidable delays we were unable to get started in enough time to provide even this very minimum four month interval between pre- and post-testing.

Oral communication is very complex. One not only measures quantity, but one measures quality as well. Subtle changes in quality often go unnoticed when the change is small. Over a four month interval one would expect very little change in the quality of communication, but one might expect a change in the quantity. It may, therefore, be possible, if time permitted, to evaluate quantitative changes, that is, the number of words spoken correctly, etc., in children enrolled in the program. But truly, this would not provide valid or complete indexes of changes in oral communication as quantity is only one small aspect of oral communication.

When we speak about self-image, self awareness, ease in speaking situations, listening ability and so on, we are speaking about things which are very difficult to measure and which change very slowly over time. It is mandatory, therefore, that the program for evaluation get off the ground at the very latest in the middle of September and that the evaluators are allowed to go into the school very quickly, possibly by just calling up the school and going in immediately for pretesting when the youngsters

begin their therapy for the year. The evaluation team is very well aware of the difficulties involved in this. However, we feel that there are very severe limitations placed on a quantitative evaluation of changes in oral communication skills if this is disallowed.

APPENDICES

Pupil Evaluation Form

Speech Clinician

Classroom Teacher

Pupil Evaluation Form

Indicate: Speech Clinician _____ Classroom teacher _____

A form of this type should be filled out for each pupil enrolled in your classes who is being seen in the speech program.

1. What is the age of this pupil? _____

	Yes	No Change	No
2. Has there been a general change in the oral behavior of this pupil?	___	___	___
3. Has there been a general change in the overall behavior of this pupil?	___	___	___

4. Has this change been in a positive direction?	Yes	No
oral	___	___
overall	___	___

5. If there have been changes in behavior noted do you consider them due to the influence of the speech program? ___ ___

	Yes	No Change	No
6. Has this child's ability to say sounds and words clearly, improved?	___	___	___
7. Has this pupil's expressive vocabulary increased?	___	___	___
8. Has this pupil's receptive vocabulary increased?	___	___	___
9. Does this pupil appear to be listening more attentively?	___	___	___
10. Has this pupil's communication with others (socialization) improved?	___	___	___
11. Does this pupil speak more in class?	___	___	___
12. Is this pupil more easily able to organize his thoughts when presenting them verbally?	___	___	___
13. Has this pupil's general school work improved since attending speech?	___	___	___
14. Has this pupil commented to you regarding his experiences in the speech program?	___	___	___
15. Do you think the results of the speech work this pupil is receiving warrant the released time from class?	___	___	___

	Yes	No Change	No
16. Has there been a general change in this pupil's overall appearance? (re: dress, gate, grooming)	___	___	___
17. When asked a direct question, does this pupil respond unhesitatingly?	___	___	___
18. Has this pupil's attendance improved?	___	___	___
19. Is this pupil's attendance considered good?	___	___	___
20. Has the number of friends that this pupil associates with increased?	___	___	___

21. What do you consider to be this pupil's speech problem?

Comments:

Child's name _____

Pupil Evaluation Form - Parent

Pupil Evaluation Form (parent)

Dear Parent:

The Title I Speech Therapy Program in your child's school is in the process of being evaluated. In order to properly conduct an evaluation of the program we must gather information from parents concerning their opinions of the program. It would be appreciated if you would fill out these questionnaires and thus help us collect the information. Your responses will be held strictly confidential. Thank you very much.

1. What is the age of your child who is receiving speech therapy? _____

	Yes	No Change	No
2. Have you noticed a change in the way your child has been speaking?	___	___	___
3. Do you think that this change is a good change?	___	___	___
4. Have you noticed a change in the way your child has been behaving?	___	___	___
5a. Is your child behaving better now than he was when he started speech?	___	___	___
5b. If there have been changes in behavior noted, do you consider them due to the influence of the speech program?	___	___	___
6. Has your child's ability to say sounds and words clearly, improved?	___	___	___
7. Do you think that your child is using more new words?	___	___	___
8. Does your child appear to be understanding the things you say a little bit better?	___	___	___
9. Does your child appear to be listening more attentively?	___	___	___
10. Does your child seem to be talking to more people?	___	___	___
11. Does your child speak more at home?	___	___	___
12. Does it appear easier for your child to organize his thoughts when presenting them out loud?	___	___	___
13. Has your child's general school work improved since attending speech?	___	___	___

	Yes	No Change	No
14. Has your child commented to you regarding his experiences in speech?	___	___	___
15. Do you think the results of the speech work your child is receiving warrants the released time from class he receives?	___	___	___
16. When your child is asked a direct question does he respond unhesitatingly?	___	___	___
17. Has the number of friends your child associates with increased?	___	___	___
18. What do you consider to be your child's main speech problem?	___	___	___
19. Have you been contacted by the speech clinician concerning your child's speech problem?	___	___	___

20. If yes, how many times? _____

	Yes	No
21. Have you had a face-to-face meeting with the speech clinician?	___	___

22. If yes, how many times? _____

	Yes	No
23. Have the specifics of your child's speech problem been explained to you?	___	___
24. Do you know what your child does in speech class?	___	___
25. Has the speech clinician sent home speech homework for your child to work on?	___	___
26. Does your child do his speech homework?	___	___
27. Are you able to help him with his homework?	___	___

Comments:

Child's name _____

Speech Clinician Questionnaire

Speech Clinician Questionnaire

Dear Clinician:

In order to properly conduct an evaluation of your clinic program, we must gather data concerning clinicians and their opinions of the program. Please answer all of the following questions. Your responses will be held strictly confidential and no data will be identified with a specific school or clinician. Thank you very much.

1. Does a staff member in your speech program screen, for speech, every new pupil entering your school(s) during the pupil's first or second year of enrollment? Yes ___ No ___
   If no, please explain briefly.

2. On the average, what percentage of new pupils require enrollment into the speech program? ___

3. Are there pupils in your school(s) which you feel require enrollment into the speech program but who for some reason are not enrolled? Yes ___ No ___
   If yes, please explain briefly.

4. If yes, how many? ___

5. Do you consider the procedures for identification of speech defective pupils in your school(s) adequate? Yes ___ No ___
   If no, explain briefly.

6. Please list the standardized diagnostic test instruments which have been supplied for your use by the speech program. Please indicate also the frequency with which the instrument has been used.

Test Instrument	No. of times used this school year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

(use back of page if necessary)

	Yes	No
7. Are pupils diagnosed only at the beginning of the school year?	___	___
8. May new pupils be diagnosed during the school year. That is, at other times than only at the beginning of the school term?	___	___
9. On the average, how many diagnostic test instruments are used to diagnose a pupil who is finally accepted into the program?	___	
10. In your opinion, do you feel the diagnostic procedures employed by the speech program are adequate? If no, please explain briefly.	___	___
11. Would you consider your diagnostic procedures to be differential diagnostics or other than differential diagnostics? If other, please explain briefly.	___	___
12. On the average, how many professional opinions or diagnoses are compiled when making a diagnostic statement concerning a pupil?	___	

13. Please list the diagnostic consults that are available to you, those you have used and the frequency of use.

	Available	Used (check)	No. of times used
1.	_____	___	_____
2.	_____	___	_____
3.	_____	___	_____
4.	_____	___	_____
5.	_____	___	_____
6.	_____	___	_____
7.	_____	___	_____

(use back of page if necessary)

14. At the present time, for what percentage of pupils do you have information that you would consider reasonably complete diagnostic information? If no, please explain briefly.	___	
15. Are the test materials and supplies available (for your immediate use), for informal diagnostic testing, adequate?	___	___
16. Is there a procedure in the program for recording, in one place, all diagnostic information from speech teachers and other consults? If no, please explain.	___	___

	Yes	No
17. Is this information available to you for your immediate use? If no, please explain briefly.	___	___

18. Please list the therapeutic consults that are available to you, those you have used, and the frequency of use.

	Available	Used (check)	No. of times used
1.			
2.			
3.			
4.			
5.			
6.			
7.			

(use back of page if necessary)

19. Are referrals generally made by the clinician contacting the referral agency directly without consulting other personnel?	___	___
20. Are other personnel involved in making a referral? If yes, please explain briefly and list the personnel most usually involved and the frequency of involvement.	___	___

	Those Involved	No. of times involved
1.		
2.		
3.		
4.		
5.		
6.		
7.		

21. Do you consider the referral practices of the speech program adequate?	___	___
22. Do you consider the frequency with which pupils are referred to be adequate?	___	___
23. Do you consider the competency of the referral agencies you use to be adequate?	___	___
24. Do you have a choice of the referral agency you use or has a "list" of referral agencies to be used been developed by the program?	___	___
25. What is the average number of referrals made per pupil?	___	
26. Are reports received from referral agencies?	___	___
27. Do you see the reports from the referral agencies?	___	___
28. Do you consider the reporting to be adequate?	___	___

29. If you wished to change the way referrals were made and handled, what would you do?

30. In your opinion, generally, is the information received from referral sources useful as an aid to therapy or diagnosis? If no, please explain briefly. Yes ___ No ___

31. Do you think that referrals as they are now are are a waste of time? ___ ___

32. Do referrals require you to complete considerable paper work? ___ ___

33. Are you required to attend faculty conferences? ___ ___

34. During these faculty conferences is there an opportunity to discuss the specific speech problems of individual pupils? ___ ___

35. Do you set up faculty conferences with individual faculty to discuss the specifics of a pupil's speech problem? ___ ___

36. How often have you set up conferences with other faculty to discuss pupils' speech problems? ____

37. What would you consider to be the average number of consults you make with faculty per pupil? ____

38. In general, have the parents of your pupils been cooperative? ___ ___

39. How many face-to-face parent conferences have you had this year? ____

40. On the average, how many face-to-face parent conferences do you have per pupil? ____

41. What percentage of the parents of your speech pupils have been contacted by mail, telephone, or by visit? ____

42. Do you think that parent conferences tend to be effective? If no, please explain briefly. ___ ___

43. What percentage of the parents tend to be responsive to helping their children at home? ____

44. How many parents would you consider have been very actively engaged in the speech work of their children? ____

45. Considering the circumstances in your school, do you feel attempts to contact parents are worth while? If no, please explain briefly. Yes ___ No ___

46. Is it general practice of the speech program to insist that parents be contacted? ___ ___

47. What have been the general comments made to you by parents concerning the speech program?

48. Have you had conferences with the school guidance counselor and social worker concerning individual pupils? ___ ___

49. If yes, please indicate the frequency of contact.

guidance counselor ___
social worker ___

50. On the average, how many contacts per pupil do you have with:

the guidance counselor? ___
the social worker? ___

51. When you have conferences with other faculty in your school regarding a pupil enrolled in speech, what is the general content of the conference?

52. On the average, how many speech pupils do you see per week? ___

53. On the average, how many pupils do you see per session? ___

54. What is the number of your total case load? ___

55. In your opinion, what percentage of pupils have improved their speech to this date? date ___ ___

56. What is the age range of pupils you see? ___

57. Indicate how many in each age bracket.

5-6 ___
7-8 ___
8-9 ___
9-10 ___
11-12 ___
12-13 ___
other ___

58. Please list the speech disorders you are working with presently and the percentage of pupils in each group.

	Disorder	%
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

(use back of page if necessary)

Comments:

Classroom Teacher Questionnaire

Classroom Teacher Questionnaire

Dear Classroom Teacher:

The Title I Speech Therapy Program in your school is in the process of being evaluated. In order to properly conduct an evaluation of the program we must gather data from classroom teachers concerning their opinions of the program. It would be appreciated if you would fill out these questionnaires and thus help us collect the data. Your responses will be held in strict confidence and no data will be identified with a specific school. Thank you very much.

	Yes	No
1. Are any of the pupils enrolled in your classes being seen by the speech clinician?	___	___
2. If yes, how many?	____	
3. Are there pupils in your classes whom you would like to have seen by the speech clinician but who are presently not being seen?	___	___
4. If yes, how many?	____	
5. In general, do you think that the speech program in your school has successfully identified these pupils with speech and/or language problems?	___	___
6. Have you had an opportunity to discuss the speech problems of your pupils with the speech clinician?	___	___
7. How many conferences have you had with the speech clinician?	_____	
8. Do you think that these conferences have been fruitful?	___	___
9. Has the content of the conferences centered on the specific speech problems of your pupils?	___	___
10. Have you had the opportunity to participate in conferences involving the speech clinician, the guidance counselor, the social worker, and other faculty concerning the speech program?	___	___

Observer Site Visit Report

Observer Site Visit Report

School _____ Date _____ Clinician _____

Observer _____

I. Physical Conditions:

Type of room: Classroom ___ Office ___ Teacher's room ___
Coaching room ___ Other ___

Size of room: Adequate ___ Inadequate ___

Environment: Noisey ___ Quiet ___ Other _____

Is room used for all groups? Yes ___ No ___

Seating: Benches ___ Chairs ___ Fixed Seats ___
Movable Seats ___ Table ___

	Adequate	Inadequate
Ventilation	_____	_____
Lighting	_____	_____
Temperature	_____	_____
Blackboard	_____	_____
Charts	_____	_____
Mirrors	_____	_____
Other Aids	_____	_____
Decorations	_____	_____

II. Initial Information: Therapy

1. Group? Yes ___ No ___ If yes, number? ___ Age range _____
2. What observing? Diagnosis ___? Therapy ___?
3. Is there a lesson plan? Yes ___ No ___ Describe Briefly.

4. What are the overall goals of therapy?

5. What is the specific goal of this therapy session?

6. What was the clinician's reaction to the therapy session?

III. Clinician - Pupil Relationships:

	Yes	No
1. Has rapport been established?	___	___
2. Is there an ability to handle each child within the group?	___	___
3. Is there an ability to handle the group as a whole?	___	___

	Yes	No
4. Is there an ability to stimulate and hold the interest of each child within the group?	___	___
5. Is there equal opportunity for each child to participate?	___	___

IV. Therapy Session:

1. Is overall organization adequate?	___	___
2. Is aim of lesson appropriate for needs of children?	___	___
3. Is progress of lesson too fast for children?	___	___
4. Is there evidence of progression within the lesson?	___	___
5. Is there time given for review?	___	___
6. Is seating arrangement appropriate for lesson?	___	___
7. Is there sufficient quantity of material for lesson?	___	___
8. Is there sufficient flexibility for digression from the prepared lesson where appropriate?	___	___
9. Does session begin within a reasonable time?	___	___
10. Was explanation of activities adequate?	___	___
11. Were the activities suitable for the stated goals?	___	___
12. Did the session close at some logical ending point?	___	___

V. Materials Employed:

1. Are materials organized and readily available?	___	___
2. Are materials interesting and stimulating to the children?	___	___
3. Are materials appropriate for the age levels of the children?	___	___
4. Are materials creative and interesting and original?	___	___
5. List the materials actually used during the session.		
6. List the <u>diagnostic</u> materials that are immediately available to the clinician.		

VI. Records:

	Yes	No
1. Are case histories, which accompany each student adequate?	___	___
2. Are the following available as part of each record:		
Speech evaluation	___	___
Health record	___	___
Hearing test	___	___
Vision test	___	___
Intelligence test	___	___
Achievement test	___	___
Reading test	___	___
Cumulative record	___	___

	Yes	No
3. Do records note progress appropriately?	___	___
4. Does it appear from the records that a reasonable progression has been followed in the course of therapy?	___	___
5. Do records note referrals made, if any?	___	___
6. Do records note consultations with other professionals, if any?	___	___
7. Is there an indication of the student's status at the termination of each year or when clinicians change?	___	___
8. What are the clinician's comments regarding the follow-up of referral information?	___	___

VII. Comments:
Make any comment that will explain or clarify any observations previously reported.

VIII. Conference with school guidance counselor.
1. How many conferences has the guidance counselor had with the speech clinician? ___
2. What was the general content of these conferences?

3. Comments regarding your conference with the guidance counselor.

EVALUATION TEAM

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