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AUTHOR Sapp, David N.
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ABSTRACT

The consulting teacher program involving the use of special classes and resource rooms, which serves mildly to moderately handicapped students in Griggs, Steele, and Traill Counties in North Dakota, a rural school district, is described. Outlined is the service design model consisting of 11 steps: referral, observation, initial parent contact, referral conference, diagnostic teaching, planning conference, educational plan summary, teaching learning plan, implementation, classroom teacher evaluation, and program evaluation and recommendations. (IM)

DPT/CT: A REALISTIC ANSWER FOR PREVENTIVE SPECIAL EDUCATION SERVICES IN RURAL SCHOOL SETTING

Presented at Session 313 at the C.E.C. National Convention in Atlanta, Georgia, April 15, 1977, 8:45 to 12:00 noon.

The Special Education Department of Griggs, Steele and Traill Counties in North Dakota is located in the mid-eastern section of the State of North Dakota. The region comprising the GST Special Education Department has an area of 2,700 square miles and services twelve school districts with a total of 3,500 children, K-12. The average distance between the school districts is approximately twenty miles. Of the 3,500 enrolled students, the Special Education Department services approximately 9% of that population in all areas. Special Education services currently consist of six Consulting Teachers, five Speech Therapists, 4 Resource Rooms, and one TMH special class. Of the total population of the region, approximately .1% requires a special class setting with less than 50% integration into regular class settings.

The Special Education Department began its services in 1974 after the North Dakota Legislature passed a mandate requiring that students from age 0-21 who are handicapped be provided Special Education services, and that all such handicaps must be served by 1980. Therefore, it was the purpose of the Director to design a five-year educational plan by June of 1975 for the implementation of the State mandate. Coming from the Washington, D. C. area and being familiar with court cases desiring the least restrictive alternative to be used for the placement of children, initial planning of a non-categorical service model for learning disabled and mildly retarded students was determined to be the best procedure. Such a service now called the Consulting Teacher model began its service in the fall of 1975.

The service model is most appropriate for the following reasons:

1. Parents within the school districts having children with a handicapping condition, EMH and SLD, were resistive to the idea of transporting their children for significant distance to establish a class.

2. School district population bases K-12 range from as few as 120 students to approximately 700. The removal of mild to moderate learning handicapped students, i.e. EMH and SLD, would cause financial hardship due to the excess cost and the loss of regular education personnel.

3. With the advent of Public Law 93-380 and 94-142, the removal of students from school districts to Special Education classes becomes quite rare due to parent and children's rights being honored.

4. The fact that no large amounts of students had been segregated into special classes previous to the beginning of the Special Education Cooperative, teacher resistance in having such students not removed was lower. It may be said that the region was 20 years behind in developing Special Education services, but in developing services using the least restrictive alternative and non-categorical delivery, the systems within the three counties may be five to ten years ahead of the educational systems in implementing new Special Education laws.

The Consulting Teacher model constitutes the basis of a non-categorical service to mild to moderate handicapped students. The service design is an adaptation of the Diagnostic Prescriptive Teaching Model by Prouty & Prillaman. The model was adapted to meet the needs of a rural system. One adaptation was that the Diagnostic Teacher Model (DPT) in the original model served just one school building. In the Consulting Teacher model a staff person may serve two or three facilities within a school district or as many as three school districts. Thus, the CT becomes itinerant in nature.

The Consulting Teacher program as it currently operates in Griggs, Steele and Traill Counties in North Dakota, began in the fall of 1975 with a workshop conducted by Robert Prouty and Joan Landy from George Washington University regarding the Diagnostic Prescriptive Model. During the school year 1975-1976 the Special Education staff working in this particular model made modifications to encompass an eleven step sequence for the operation of the Diagnostic Prescriptive Teacher Model to meet the needs of our particular educational setting.

That model which is currently implemented as a Consulting Teacher model consists of eleven steps: Referral, Observation, Initial Parent Contact, Referral Conference, Diagnostic Teaching, Planning Conference, Educational Plan

Summary, Teaching Learning Plan, Implementation, Classroom Teacher Evaluation and Program Evaluation and Recommendations.

1. Referral - The first step in servicing a teacher or student in the CT model is the referral. At the beginning of the school year, the CT acquaints himself/herself with the school system by being visibly available during the first several weeks of the school year. At this time the CT is free before and after school and during lunch and coffee breaks to meet with regular class teachers. If the teacher is new to the system he/she may spend some of this time observing regular classes in order to be familiar with the classroom settings and teacher techniques. Students who have been referred from previous years must be re-referred for CT services. This is done due to the fact that different teachers may perceive different problems with a student who has learning difficulties and students do change between June and September. A teacher making a referral will answer the following questions:

   A. What is the problem?
   B. What methods have you tried to solve the problem?
   C. What do you see as the student's particular strengths?
   D. When can we talk?

   The referral form is a four section NCR form. Copies of the referral is given to the CT, the Director of Special Education and the Superintendent or Principal of the school district. When the CT receives the initial referral, he/she meets with the referring teacher to discuss the referral in-depth.

2. Observation - The Consulting Teacher arranges with the regular classroom teacher to observe the student at various times during the school day. The initial observation is made when the teacher sees the problem to be most visible. Several observations should be made to observe not only the student's behavior but his/her interaction with other students, the physical environment of the classroom, and the practice of the instruction given by the teacher. The CT should give feedback to the regular class teacher in a non-critical manner as soon as possible after each observation. Observation notes should be written after the observation but not within the classroom setting. Such notes are the personal data of the CT.

3. Initial Parent Contact - Upon the completion of observation sessions, the CT and the regular classroom teacher determine whether it is necessary for further evaluation or whether observation and interaction by the CT and regular classroom teacher at this time may have solved the problem. We have found in many cases that the first two steps along with the interaction between the CT and regular class teacher solves many problems that in other service settings would require specialized assistance. However, if both the CT and the regular class

teacher feel that more information is necessary, parent contact is made by the CT for parent permission for the CT to provide consultation and evaluation of the student. The permission letter does not indicate that the child has a problem. It simply requests permission to develop materials and programming to meet the student's specific educational needs along with permission to use evaluative instruments to determine needs and materials. The parents are made aware of their rights under Public Law 94-142 to be informed of the results of the evaluations, their right to an independent evaluation, if necessary, their right to review all records and the educational plan that will be developed for the particular student. The parent permission form is sent out by the CT and includes a location and phone for the parent to contact the CT if they have any questions. If the form is not returned within several days after it is mailed, the CT contacts the parent to determine if there were any questions regarding the permission.

4. Referral Conference - At this stage of the service, the CT and referring teacher get together to discuss in-depth the referred student. During this phase, the CT acts as a negotiator to develop with the teacher reasonable goals that flow from an objective and a mutually acceptable assessment of the problem in an educational setting. The CT may find it necessary to narrow down the original presenting problem, thus, pinpointing specific problems such as reducing the statement "Johnny is disruptive and frequently disturbs the class with his behavior" to a more specific problem "Johnny does not ask permission to speak or leave his desk". Tentative objectives should be stated in positive behavioral terms such as "Johnny will raise his hand when he wants permission to speak or leave his desk during the classroom procedure" at X% times by a specific date or time period. The CT discusses tentative strategies to be used and some possible instructional alternatives if the CT has developed such possible strategies and alternatives. The CT also at this time discusses the subsequent steps in the process of service delivery and coordinates other services if the child seems to have multiple problems requiring the use of other specialists. It should be noted that many of these activities within this step may have occurred during the 2nd step of the procedure. Thus, a referral conference may actually have occurred before parent permissions had been requested.

5. Diagnostic Teaching - During the referral conference, the CT will have made the initial plans for diagnostic teaching sessions with the referring teacher. The diagnostic teaching sessions are designed to allow the CT to develop techniques and materials based on the child's strength that will allow the child to be accomodated within the regular classroom setting. The CT in planning diagnostic sessions with the regular class teacher will have set up date, time, size of group, and location of the diagnostic sessions. The time of diagnostic sessions should not deprive the child of activities he/she really enjoys, unless a similar activity is planned in the diagnostic session.

A. Grouping of students for diagnostic sessions may occur with a group of children accompanying the referred child to a diagnostic session outside of the classroom.

B. If the child's problems are severe requiring careful analysis, the child may be worked with individually outside of the classroom setting.

C. The referred child may remain in the regular classroom with the classroom teacher or CT trying various techniques within the setting.

We have found that option C has worked for over 90% of our cases. In this type of setting the classroom teacher observes the activities of the CT and gradually takes over and integrates the activities into the regular classroom. Sessions should be outlined clearly by the CT with a clear picture of materials, methods and behavioral techniques that he/she will use with the child. Diagnostic sessions should not exceed one hour per day nor exceed ten sessions total.

6. Planning Conference - As a result of the diagnostic teaching sessions, the CT and regular class teacher meet in a decision-making process to formulate the educational plan that will be used to service the child within the regular class setting. The CT and the regular classroom teacher will therefore discuss what materials and techniques used in the diagnostic sessions will be undertaken by the regular class teacher in servicing the particular student within the regular classroom setting. Therefore, the educational plan for the child that will be presented to the parent is one that is agreed upon by both the regular class teacher and the CT. In developing the diagnostic sessions and the action and referral conference, the CT should integrate all knowledge he/she has of the classroom setting, teacher skills and peer interaction to insure a high probability of program success.

7. Educational Plan Summary - The CT, from notes and discussions made in the planning conference, develops an educational plan summary to be presented to the parents for approval for implementation in the child's educational program. The educational plan summary is identical to the requirement of an IEP as required by Public Law 94-142. The plan will consist of specific goals and objectives to be accomplished, strategies and materials to be used within the child's educational plan. The plan should also consist of specific involvement of personnel other than the classroom teacher, if such personnel are necessary. The educational plan along with a cover form explaining the plan and permissions by the parent are sent to the parent. If the parent wishes, a conference is then held to explain the plan in more detail before the parent signs permission for implementation. It is clear in the communication that the parent will be informed of any changes in the educational plan using the same procedure used in submitting the first plan.

8. Teaching Learning Plan - The educational plan presented to the parents is broad in nature and requires that the CT continue working with the regular class teacher in implementing the plan within the classroom

structure. The teaching learning plan therefore is a detailed step-by-step procedure of the educational plan approved by the parent. In implementing strategies and materials, the teaching learning plan may be as detailed as a day-by-day set of plans.

9. Implementation - In the development of the teaching learning plan, the CT works closely with the referring teacher in having the regular class teacher taking over the operation of the educational plan in the normal operation of the classroom. The CT begins by operating the plan with a group of students with the total class and gradually fades out having the regular class teacher taking over that operation. The CT may, during the transfer of activities, work with the remaining classroom groups, until the regular classroom teacher feels comfortable in handling the total classroom setting. The CT observes the action and provides the teacher with concrete feedback in pinpointing problem areas in the plan that may be brought up during the conferences. The CT works with the regular class teacher in deciding on modifications that may be necessary for the operation of the educational plan. Any major modificiation of the educational plan due to the fact that goals set in the original plan were completed or the emergement of new problems, will require the drafting of a new educational plan summary that will be implemented.

10. Classroom Teacher Evaluation - After the educational plan has been in progress for approximately four weeks, the CT gives the referring teacher an evaluation form. The form has four basic statements to be filled out:

    A. Restatement of Problems
    B. Restatement of Objectives
    C. How do you assess the child's progress at this point?
    D. What may the CT do to be of further assistance to you?

    Copies of this particular form, which is an NCR, is given to the Superintendent or Principal of the school, the Director of Special Education and the CT. The CT may, upon referring teacher request, assist in filling out A and B of the form. The referring teacher should fill out the remaining sections. If the referring teacher feels that he/she cannot adequately assess the status of the child's progress at the point of evaluation and/or is unsure as to what additional services he/she needs, the referring teacher may discuss these parts of the form with the CT.

From the procedure of diagnostic teaching sessions to the classroom teacher evaluation, we have found that cycling occurs due to change of conditions of the student being referred. Therefore, during a school year, a student referred at the beginning of that year may require that the procedures from diagnostic

teaching through teacher evaluation may re-occur several times. This is not unusual and should be expected since situations and child growth changes constantly.

11. Program Evaluation and Recommendations - A final step in the CT service model is that of program evaluation and recommendations. This particular step is done at the end of the school year for each referred student served by the CT. The CT along with the referring teacher and any other implementers of the programming meet to determine the activities of the total program during the year. The form spells out three specific areas of recommendations:

    A. The methods and materials that the involved staff feels is necessary to be used in the coming year.

    B. Specific management techniques that were successful during the current year and that may be recommended for the following year.

    C. The assessment of evaluation of goal achievement of the service is measured on a scale from -5 to +5; -5 meaning total negative movement and +5 meaning total achievement of objectives. This evaluation is submitted to the Director of Special Education and the administrator of the school district in order that they may determine the activities of the services and programs offered.

The CT model as described has provided a great deal of progress among regular class teachers in servicing mild to moderately handicapped children within the regular class setting. The program has been so successful during the past two years of operation that no child has been referred to Special Education classes that has received services of the CT. We, therefore, are contemplating within the next two years, the elimination of our special classes that have previously served children with severe learning disabilities and EMH problems. It is evident that there will be some children whose problems are so severe that special classes will be necessary. Such children are small in number and may require continuation or development of specific low incidence special classes.

This number would be less than 1% of our population as we view the oper-

ation of our special education services. We are also in the process of re-educating our regular class teacher population to accomodate a variety of children with differentiating learning needs.

The CT program has primarily been at the elementary level. The growth and interest carrying on the program at the secondary level has been the main emphasis for massive teacher re-education. Our current project in this area has involved the total school staff of two school districts, one of which intends to completely reorganize the educational structure of regular education from grades K-12. Teachers are now expressing the opinion that if CT services were available to them, they could accomodate any student with a mild to moderate learning handicap within their classroom setting in any grade from K-12.

Such educational direction will allow our school districts to comply with, if not exceed, Public Law 94-142, in providing the least restrictive alternative for handicapped children. Such service designs as a CT model should be seriously considered by not only rural education systems but also urban and suburban systems in providing real alternatives to the compliance of Public Law 94-142.

Accomodating children with learning handicaps in the regular classroom is a great stride forward for special education.

Note - For additional information, please contact David N. Sapp, Ed.D., Director of Special Education, Griggs-Steele-Traill Counties Special Education, P. O. Box K, Hillsboro, North Dakota 58045, phone #1-701-436-5860.