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ABSTRACT

This final report discusses the outcomes of a project that gave outreach assistance to programs providing services to students (ages 3-16) with severe social, emotional, and behavioral disabilities. Programs receiving assistance from this project provided services to students in fully inclusive general education classrooms, in partially inclusive classrooms, in special education classes, in psychoeducational programs, and in day treatment community-based settings. The goals of the program were to: (1) increase the understanding of educators and families of students with severe disabilities about exemplary teaching and behavior management practices for facilitating social-emotional competence and responsible behavior; (2) increase the skills of educators in selecting, implementing, and demonstrating exemplary practices; (3) facilitate the effectiveness of state and local education agencies in implementing quality adoption sites and programs with personnel skilled in demonstrating exemplary practices; and (4) assist state and local agencies in providing technical assistance, information dissemination, and personnel development. At the end of the 3-year period, the project exceeded anticipated outcomes for each management objective. Details of each management activity and its accomplishments are provided in the report, as well as recommendations for effective outreach and technical assistance. (CR)

U.S. Office of Special Education Programs

FINAL PERFORMANCE REPORT

DEVELOPMENTAL THERAPY-DEVELOPMENTAL TEACHING:

An Outreach Project for Children with Severe Disabilities (CFDA No. 84.068U) October 1, 1996 - September 30, 1999

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Extent of Project Activities Across the States

= In-depth training

= Model dissemination activities

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EXECUTIVE SUMMARY

DEVELOPMENTAL THERAPY-DEVELOPMENTAL TEACHING: An Outreach Project For Children With Severe Disabilities (CFDA No. 84.068U) October 1, 1996 — September 30, 1999

Final Report

This project, *Developmental Therapy-Developmental Teaching: An Outreach Project for Children and Youth with Severe Disabilities* (CFDA No. 84.068U), provided outreach assistance to programs serving children and youth, ages 3 to 16 years, with severe social, emotional, and behavioral disabilities (and those with other disabilities including autism, when severe problem behavior was also a disability). Programs receiving assistance from this project were providing services to these children and youth in fully inclusive general education, in partially inclusive general education, in special education classes, in psychoeducational programs, and in day treatment community-based settings. The original goals remained unchanged during the three years of the project.

Project Goals

1. Increase the understanding of educators and families of children and youth with severe social, emotional, or behavioral disabilities in early intervention, preschool, elementary and middle school and in other community settings, about exemplary teaching and behavior management practices for facilitating social-emotional competence and responsible behavior.

2. Increase the skills of educators in selecting, implementing, and demonstrating exemplary practices based on their increased understanding of the special program needs of these students.

3. Facilitate the effectiveness of state and local education agencies in implementing quality adoption sites and programs with personnel skilled in demonstrating exemplary practices which enhance teaching-learning environments for these students.

4. Assist state and local agencies in providing technical assistance, information dissemination, and personnel development for coordination and replication of model components to meet the needs and requests across the states and nation.

Project Activities

Outreach services included ***dissemination*** of information about the model (management objective 1); ***consultation and planning*** for model implementation (management objective 2); inservice training

for ***model implementation*** through workshops, in-class tutorials and in-depth follow-up (management objective 3); ***coordination with state and national agencies*** (management objective 4); outreach assistance for ***professional development*** through workshops, distance learning, and teleconferencing (management objective 5); preparation of ***inservice instructional sequences and media*** for use with local programs (management objective 6); design of ***new outreach activities***, including a training-trainers program, and modification existing outreach strategies to meet changing needs of personnel in multiple settings (management objective 7); and ***evaluation*** of project accomplishments in meeting needs of programs and individuals at each site, with particular focus on improving the performance and effectiveness of the service providers (management objective 8).

On a year-by-year basis, the project worked with 9 programs during the first year of the grant; 10 programs the second year (5 continued plus 5 new programs), and 16 programs in the third project year (9 continued plus 7 new programs). Details of each management activity and its accomplishments are provided in following sections.

Project Outcomes

At the end of the three-year period, the project exceeded anticipated outcomes for each management objective. Through dissemination activities, the project reached a documented total of 5,480 individuals in 46 states, Virgin Islands, and 13 foreign countries seeking information about the model and/or outreach assistance. Through conferences and workshops, 1,037 individuals received inservice training. Local needs assessment and for planning model implementation was provided to 21 programs in 8 states. Of these, 18 programs, 179 individuals serving 423 children with special needs, received in-depth, extended outreach assistance for model implementation during the three-year period. **Figure 1** provides an overview of these project accomplishments.

Project Effectiveness

Project effectiveness was defined as (a) personnel with demonstrated proficiency in their own service settings for facilitating emotionally healthy development of children with severe disabilities, especially those with severe social-emotional-behavioral problems, (b) increased social-emotional-behavioral competence of these children during staff training for model replication, (c) satisfaction of participants with the instructional sequences and training materials, and (d) programs providing sufficient resources to support effective model implementation.

Figure 1. Overview of Performance Indicators, Final Performance Report, Oct. 1, 1996 - Sept. 30, 1999

Management Objective	*States Reached*	*Schools/Sites Served*	*Individuals Reached*	*Children Benefitting Directly*	*Other Outcomes*
1. DISSEMINATION*	46 states & virgin Islands; 13 other nations	NA	5,480 individuals	NA	1,903 awareness materials distributed to 1,952 individuals; 1,625 newsletters mailed; 109 requests for monographs
2. PLANNING FOR MODEL IMPLEMENTATION*	8 states	21 programs	371 individuals	5,581 children	21 training agreements
3. MODEL IMPLEMENTATION & REPLICATION	8 states	18 programs; 1,512 hours of direct on-site consultation & instruction	179 individuals with extended in-depth training	423 children with special needs	16 programs continuing with model components after training
4. INTERAGENCY COLLABORATION*	10 states	30 agencies and universities	NA	NA	Additional funding support received from Georgia and Washington State
5. PROFESSIONAL DEVELOPMENT*	National outreach	21 programs	1,037 individuals 39 workshops	NA	24 other professional activities (presentations/exhibits, publications)
6. PRODUCT DEVELOPMENT*	NA	NA	NA	NA	Web site; 2 videos introducing the model; FBA software; internet course modules
7. PILOTING TRAINING OF TRAINERS*	6 states	28 leadership trainees	28 schools & agencies	NA	2 leadership trainees; completed new certification program, 17 others in process
8. EVALUATION (See Tables 1 - 11)	NA	Model fidelity measured at 9 replication sites	Sample performance data analyzed for 79 direct service trainees	Sample performance of 199 children analyzed for social/emotional/ behavioral gains	Data storage/retrieval system established; satisfaction survey from participants; focus group feedback from leadership trainees

*During Project Years 2 & 3 costs and resources were shared with our Early Childhood Outreach Project.

Observational ratings of actual performance of a representative sample of direct service providers, indicated that 83% acquired a proficiency score of *Adequate* or better by demonstrating basic practices necessary for model implementation. Of these, 79% achieved higher proficiency scores at *Effective* or *Highly Effective* levels of proficiency. Among the 28 leadership trainees in the new pilot program for training trainers, 82% achieved the passing criterion for in-depth knowledge of the model. During the short time this pilot effort was initiated two of these program coordinators were able to complete proficiency requirements in all five competency areas and receive certification as a *Developmental Therapy-Developmental Regional Associate*. The remaining leadership participants continue to pursue their individual plans for acquiring certification.

Measures of satisfaction of participants with their training experiences indicate that project activities met their needs, and most respondents indicated considerable gains in understanding and skills. Almost all participants also indicated a need for further training or more time with project instructors on-site. Workshop effectiveness, assessed by 815 participants (including participating parents) received average ratings of 4.5 to 4.7 on a scale of 5 (*Highly Satisfied*) to 1 (*Not Satisfied*), indicating high degrees of satisfaction. Satisfaction of direct service teams, assessed through post-project anonymous questionnaires, indicates levels of satisfaction from above average (ratings >3.0) to highly satisfied (ratings of 5.0) on all four project training dimensions: workshops, observations in their classrooms, debriefings for feedback, and written feedback. Views of leadership trainees about their satisfaction and usefulness of their project experiences was assessed through a focus group discussion. The participants held high opinions of their experiences both professionally and personally.

Measures of social-emotional-behavioral development of a representative group of 199 children at 9 sites during the model implementation period indicate that the group made statistically significant progress ($p < .000$), indicating that model implementation activities had a positive effect in promoting social-emotional-behavioral development of the children.

A final measure of effectiveness was obtained by interviewing local coordinators to assess the extent to which participating programs acquired the basic elements for model replication. Of the 9 sites that participated in evaluation of child progress, all were rated at the *Basic Implementation* level or better, and two sites achieved the highest *Exemplary Model Demonstration* level.

Together, these evaluation results indicate that the overall project mission to improve service for children and youth with severe social-emotional-behavioral disabilities was achieved with distinct and measurable performance indicators.

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FINAL REPORT

DEVELOPMENTAL THERAPY-DEVELOPMENTAL TEACHING:

An Outreach Project For

Children With Severe Disabilities (CFDA No. 84.068U)

October 1, 1996 — September 30, 1999

THE INTERVENTION MODEL

The *Developmental Therapy-Teaching* curriculum provides a framework for guiding social-emotional development and responsible behavior in children and teens. It matches a child's current social, emotional, and behavioral status with specific goals, objectives, behavior management strategies, curriculum materials, activities, and evaluation procedures. It also defines specific roles for adults to facilitate a child's development. The curriculum sequentially spans social, emotional, and behavioral development for children and youth from birth to 16 years.

The curriculum has four areas: *Behavior, Communication, Socialization,* and *(Pre) Academics/Cognition*, to address four essential human activities — *doing, saying, caring,* and *thinking*. Within each of these four areas, specific teaching objectives follow developmental sequences for social-emotional competence and responsible behavior. Specific curriculum activities, management strategies, and adult roles define the ways the model is implemented for preschoolers, school-aged children, and teens.

Three measurement instruments provide the core evaluation measures for this curriculum. The *Developmental Teaching Objectives Rating Form-Revised* (DTORF-R) is a 171-item assessment instrument used to obtain a profile of a child's social-emotional-behavioral status. It identifies specific objectives for social-emotional competence in an Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Individual Transition Plan (ITP). The rating process is used also for a functional behavioral assessment, provides a profile of current strengths as well as areas of difficulty, and is used at repeated intervals to evaluate child progress.

The *Developmental Therapy Rating Inventory of Teacher Skills* (DTRITS) has four forms specifying the basic adaptations in practices for model implementation in four large age groups: infant/toddlers, preschool, elementary school-aged, and in middle/high school. The DTRITS provides an observational rating of an adult's current performance skills, serves as a needs assessment for

planning inservice training, is the basis for tutorial feedback, can be used as a self-guide for model implementation, and documents acquisition and maintenance of skills over time. DTRITS data also provide measures of replication fidelity at sites attempting model implementation. An *Administrative Support Checklist* contains 41 basic administrative elements associated with levels of program quality in model replication. Previous studies of model effectiveness have shown that certain minimal levels of administrative support were necessary to support successful performance by direct service teams in classroom settings as measured by the DTRITS during a school year.

The evaluation plan uses these three instruments to obtain measures of both qualitative and quantitative assessment of outreach activities and the optimal settings/conditions for achieving the greatest results. These measures of trainees, children, and programs were analyzed for evaluation of outcome effectiveness. The benefits from such analyses are these:

- Formative feedback to individual participants re-focuses training so that learning experiences can be redefined, reinforced, revised, and replicated.
- Summative feedback documents project accomplishments and permits staff to examine the quality of outcomes.

HOW THE PROJECT GOALS WERE ACCOMPLISHED

The Developmental Therapy-Teaching Programs is an outreach unit of the College of Family and Consumer Sciences at the University of Georgia, Athens, Georgia. The unit enjoys outstanding administrative support and working relationships with the Office of the Vice President for Services and Outreach, Dr. Eugene Younts; and in the college, with Dean Sharon Nickols and Associate Dean Christine Todd. The unit is comfortably housed off-campus due to a critical space shortage at the University, but is able to connect directly to all of the on-campus support systems. **Appendix A** illustrates the administrative organization of the unit within the University.

During the three years of this grant project, the unit received additional grant support for other outreach, training, and service activities from the Georgia Department of Education, U. S. Department of Education Office of Special Education Early Education Programs (CFDA 84.024C), State of Washington Department of Social and Health Services Division of Children and Family Services, and local public education and community service programs.

Project staffing went through several changes during the three grant years. The original Project Director, Karen R. Davis became ill during the first year and subsequently went on disability

status and died. Serving as part-time Project Director was Dr. Mary M. Wood, retired professor emeritus of special education and founder of the Developmental Therapy-Developmental Teaching model. Replacing Davis as senior trainer was Dr. Connie Quirk, an experienced and certified National Instructor for Developmental Therapy. Dr. Faye Swindle served as part-time Senior Training Associate for the entire three-years of the project. A second Training Associate, Julie Hendrick became ill also during the first few months of the project and was retired on disability. Her part-time position was filled by Diane Wahlers as Coordinator of Outreach and Distance Learning during the second and third grant years. The Coordinator for Dissemination, Betty DeLorme and Office Manager Debbie Huth served the project part-time throughout the three grant years. In addition to this core staff, the project was able to obtain the services of four highly experienced and certified National Instructors in Developmental Therapy as adjunct staff/consultants to assist with in-depth training at selected field sites. These were Dr. Bonnie McCarty, Dr. Susan Galis, Dr. Mary Leiter and Rosalie McKenzie, a specialist in services to young children with Autism Spectrum Disorders. In addition, Dr. William Swan and Dr. Douglas Flors provided services for project evaluation.

The success of the project and subsequently its mission lies with the fit between project goals and agency needs and commitment. Programs and agencies seeking to improve their services need all available information about resources and options. Keenly aware of this need, the project had extensive communications with each potential site during planning phases so that expectations of administrators and direct service providers were matched to the outreach assistance as nearly as possible. This overarching principle guided project activities, while keeping efforts focused on the specific project objectives and outcomes as specified in the original proposal.

Activities and accomplishments are reported below, according to project management objectives.

Management Objective 1, Dissemination: *To design and disseminate information about the model and available outreach assistance available through the project.*

Model information was disseminated upon request to 5,480 individuals in 46 states. (The original project proposal for this objective was to reach individuals and programs in at least 8 states.) Internationally, the project received requests for materials and information from the Virgin Islands, Australia, Canada, England, Germany, Indonesia, Israel, Lithuania, New Zealand, Russia, Scotland, Singapore, Taiwan, and Ukraine.

The disseminated print materials included "awareness" packets of information distributed to 1,903 individuals; brochures, flyers, and other informational materials to 1,952 individuals; and three issues of the newsletter, distributed to 1,625 individuals. A fourth newsletter is currently in press for distribution during Winter, 2000. Copies of the newsletters are included at the end of this report.

Additionally, 109 requests were received for two project monographs. The first, a 73-page monograph describes the 25-year history of the Developmental Therapy-Teaching model. This product was useful for potential sites which needed in-depth information about the development of the model, references for related publications, summary of research conducted in a variety of settings documenting student progress with this model, acquisition of skills by teachers, and adaptations of the model for inclusive and early childhood settings. The second monograph, a 33-page publication, *Documenting Effectiveness*, provides potential users with reports of research documenting model effectiveness in inclusive, partially inclusive, and special education settings. It also describes effectiveness of the model with children ages 3 to 16 years. The findings support use of the model with children who have severe social-emotional-behavioral disabilities and those with other disabilities who have additional social-emotional-behavioral disabilities. Also included are observational data of teaching teams and college interns rated on performance in demonstrating specified practices for model implementation when working directly with children and teens. These data provide measures of fidelity in model implementation.

Telephone and e-mail communications were additional forms of dissemination used extensively for exchange of information and consultation.

During Project Year 2, a redesign of materials was needed to include internet access for expanded dissemination and training activities. The project web page, www.uga.edu/dttp, provided resources and basic model information. An additional web-based course module for learning to use the model's procedure for assessment of a child's social-emotional-behavioral development was developed during Project Year 3. [For additional information on web-based outreach and training, see management objective 6.]

Management Objective 2, Site planning for model implementation: *To determine the training needs of participants and programs and to design outreach services which reflect participant needs with ensured follow-up and support activities.*

We called this phase of outreach, *Site Development Assistance*. Following a preliminary

request for outreach assistance, the planning focus was to identify the training needs at local program sites and the degree of commitment from staff, parents, and administrators to provide necessary resources and support for model replication. Criteria for accepting a site for model replication were:

- ✓ Evidence of administrative support and need for services to be provided for model implementation.
- ✓ Evidence of sufficient staff planning to demonstrate basic knowledge about the model and a willingness to attempt model implementation.
- ✓ One supervisory person from the site who agreed to participate in the Training Trainers Program while outreach services are provided to the direct service personnel. (New requirement, begun in Project Year 2.)
- ✓ A Training Agreement with content needs and training schedule collaboratively developed from a needs assessment developed by project staff, program administrators, direct service providers, and parents.
- ✓ A student evaluation schedule for the year, including a minimum of pre- post-measures to be submitted to the project without student names attached, including the Developmental Teaching Objectives Rating Form-Revised (DTORF-R) and other evaluation measures routinely used by the program. [See management objective 8, *Evaluation.]*
- ✓ Agreement to use the DTORF-R for IEP program planning and to provide family services and program evaluation consistent with the principles of the model.
- ✓ Commitment of staff time to training with the understanding that periodic performance measures would be collected by the project instructor with feedback to the participants.

Figure 2 lists the sites participating in planning for model implementation, showing the year a site initiated planning and the extent of carryover of training from year-to-year. As shown, 21 sites received planning assistance for model implementation. After the first project year, we received a second outreach grant focusing specifically on the needs of very young children with severe social-emotional-behavioral problems. With this new project, we transferred outreach services for four early childhood programs [sites 6, 7, 8, and 9 in Table 2] where model implementation activities were

Figure 2. Sites Participating in Planning for Model Implementation by Year (N = 21)

Year 1. 1996 - 1997 Site Planning	Year 2. 1997 - 1998 Initial Implementation	Year 3. 1998 - 1999 Replication Level
1. Fanin & Gilbert County School District, Mountainbrook Psychoeducational Program Blue Ridge, GA	Initial implementation	Model replication
2. Cherokee County School District, Mountainbrook Psychoeducational Program Canton, GA	Initial implementation	Model replication
3. Dalton School District. Mountainbrook Psychoeducational Program Dalton, GA	Initial implementation	Model replication
4. Cooperative Educational Services* Trumbull, CT	Initial implementation*	Model replication*
5. Laurens School District #55 Laurens, SC	Site planning continued	Discontinued
6. Gateway Therapeutic Preschool Bowmansville, NY	(Continued through Early Childhood Project)	- - - -
7. Learning Tree Therapeutic Preschool Bremerton, WA	(Continued through Early Childhood Project)	- - - -
8. Parents Early Intervention Program Positive Education Program Cleveland, OH	(Continued through Early Childhood Project)	- - - -
9. Monarch Therapeutic Preschool Lacy, WA	(Continued through Early Childhood Project)	- - - -
	Year 2. 1997 - 1998 **Site Planning and** **Initial Implementation**	**Year 3. 1998 - 1999** **Replication Level**
	10. Special Needs* Positive Education Program Cleveland, OH	Model replication*
	11. Day Treatment (2 locations) Positive Education Program Cleveland, OH	Model replication
	12. Warner Robins AFB Schools* Warner Robins, GA	Model replication*
	13. Maine School Administrative District #40 Waldoboro, ME	Partial replication
	14. Maine School Administrative District #72 Fryeburg, ME	Initial implementation

Figure 2 (continued)

Year 3,
Initial Implementation

15. Cobb-Douglas*
Psychoeducational Program
Marietta, GA

16. Behavioral Health Resources
Olympia, WA

17. Ash Street School*
SouthMetro Psychoeducational Program
Atlanta, GA

18. Flat Shoals School*
SouthMetro Psychoeducational Program
Atlanta, GA

Site Planning

19. Hopkins County School District*
Madisonville, KY

20. Presbyterian Child Welfare Agency
Louisville, KY

21. Child Study Treatment
Clover Park School District
Lakewood, WA

*Programs marked with an asterisk serve both early childhood and school age children and those with Autism Spectrum Disorders. At these sites, outreach assistance was a collaborative effort with our Early Childhood Outreach Project.

underway but serving only preschool children. Their data are included in this report for Year 1 only. Of the remaining 17 programs during Project Years 2 and 3, 6 programs served both preschool and school aged children with Autism Spectrum Disorders or related disabilities, ages 3 to 11 years [sites identified with an asterisk* in Table 2]. Outreach assistance to these particular programs was shared collaboratively with our Early Childhood Outreach Project because the identified needs encompassed a broad developmental and age range.

Each program differed in staff skills, needs, and resources. Planning for the training sequences and implementation processes at each program site was unique to the identified needs. Therefore, considerable resources were allocated to the planning phase of outreach, prior to actual training for model implementation.

In planning, needs assessment activities were conducted with potential sites to insure that there was sufficient commitment philosophically to provide necessary resources for implementing components of the model. The planning phase was completed when a formal training agreement was negotiated and signed by the program administrator. This agreement formalized mutual agreements about (a) amount of training and technical assistance the project would provide, (b) obligations of the local site for cost-sharing and released staff time, and (c) scheduled times for repeated evaluations of child progress during the training period. Each training agreement specified the implementation sequence but could be modified during the process as needed.

When a local program committed to model implementation, cost sharing was negotiated on the basis of the size of the program, the number of participating teams, extent of administrative support, and the initial skill levels of participants. Local programs were expected to contribute some resources to the effort. We used a minimum cost-sharing approach in which every participating program made some degree of commitment, both in cost and in released time for participating personnel. The fees were designed to minimize initial costs to local programs during this planning phase, with no charges except travel expenses for the project consultant. The project assumed costs for training materials and the project consultant. In contrast, there was a rather large proportional contribution expected when a program simply requested a single *Workshop by Topic* [reported in management objective 5 below]. We kept this type of assistance to a minimum, except for introductory presentations about the model because workshops alone, without follow-up, seem to have minimum long term benefits; that is, there is little carryover or skilled implementation. [A copy of the fee schedule is included in **Appendix B** at the end of this report.]

Management Objective 3, Model Implementation and Replication: *To conduct extended in-depth training and technical assistance for model implementation at local program sites.*

This management objective received the major portion of project resources and staff time because activities involved extended, in-depth training with repeated visits to each participant at each site. Overall, during the three project years, activities to implement the model provided approximately 1,512 hours of direct, on-site consultation and instruction through inservice, observations, feedback, and tutorials at 18 program sites with 179 participants working directly with 423 children with special needs. (The numbers participating exclude parents and additional local personnel that participated in introductory workshops and staff debriefings, but were not in positions to participate for extended periods of in-depth training; e.g., parents, social workers, program directors/principals, psychologists, general education, teachers. These individuals are described in management objective 5, *Professional Development.)*

While there was variability in amount of project assistance provided to each program, on average a site received 3 visits of three days duration at each visit during a school year [18 contact hours per visit x 3 visits = 54 in-depth instructional hours approximately per program per year]. While the sites had wide differences in staff experience and skill, they all requested continuing assistance after the first year of initial implementation.

Figure 3 contains a summary of types of programs provided and the age groups served by these 18 sites during the three-year period. Of the 21 sites that received assistance in planning for implementation, three sites began planning during the latter part of Project Year 3 and did not receive more than introductory training for implementation. All three of these new sites are continuing implementation activities under different funding sources.

Typically the implementation phase began with 2 to 3 days of workshops on the core content necessary for basic model implementation. **Appendix C** contains the "content map", developed

Figure 3. Summary Characteristics of 18 Sites Receiving In-depth Staff Training for Model Replication

Site	Number Staff Trained*	Type of Program	Number Children Served	Ages 3 - 5 Pre-K	Grades K - 3	Grades 4 - 5	Middle School	High School	Un-Graded
A	26	Inclusion	16	12	4	0	0	0	0
B	1-	Inclusion	32	32	0	0	0	0	0
C	4	Special classes	15	0		0	0	0	15
D	10	Special classes	39	0	0	7	12	20	0
E	8	Partial inclusion	7	0	4	3	0	0	0
F	12	Special classes	35	35	0	0	0	0	0
G	8	Special classes	35	0	12	2	9	12	0
H	18	Special classes	72	1	15	10	20	30	6
I	8	Special classes	21	0	3	2	11	5	0
J	20	Special classes	31	23	0	0	0	0	8
K	4	Special classes	10	0	0	0	0	0	10
L	14	Partial inclusion	20	20	0	0	0	0	0
M	8	Special classes	11	0	0	6	0	0	5
N	10	Partial inclusion	29	0	11	10	8	0	0
O	8	Partial inclusion & special classes	20	0	11	4	5	0	0
P	4	Special classes	10	1	4	1	4	0	0
Q	4	Special classes	14	3	6	5	0	0	0
R	4	Special classes	13	0	2	5	0	0	6
Total	179 trainees		430 children	127 3-5 yrs	72 K-3 gr.	55 4-5 gr.	59 Middle School	67 High School	50 Ungraded

*Participating staff worked in teams of 2 persons, minimum. Most programs had additional support staff working in the classrooms who were participating in training intermittently.

during Project Year 2, outlining the instructional content modules from which specific core sequences were selected, based on assessment of training needs.

A typical training sequence included:

- Initial workshops and seminars on-site, conducted by the project instructor and sometimes co-taught with a leadership person in the Training Trainers Program during Years 2 and 3.

- Observations of participants in their own programs working directly with students, followed by team debriefings and feedback about model practices they demonstrated successfully and those skills which needed further attention.

- Video consultation for feedback, when requested by a site, with written permission from parents and personnel being video-taped.

- Periodic observational ratings of participants, performance demonstrating their use of model practices followed by team debriefings and recommendations for improved practices.

- Written reports after each site visit reflecting recommendations and observations about progress of the site toward achieving the standards specified for designation as a replication site.

Management Objective 4, Interagency Collaboration for Model Replication: *To coordinate outreach activities with state and national agencies as they strive to improve services for children with severe disabilities, and to respond to comprehensive personnel development needs.*

The project collaborated with 4 state agencies responsible for personnel development networks to ensure consistency with personnel standards and plans. Correspondence with these agencies provided this project with the State plan for personnel development in Georgia and

assurances from the designated state agencies in Washington, Georgia, Ohio, Kentucky, and Maine that the project was consistent with State plans.

The project was approved by 8 universities in 5 states for staff development units (SDUs). The agencies for licensing child care providers approved the Developmental Therapy-Teaching Programs training under licensure standards in the State of Washington and in Georgia. Additionally, Continuing Education Units (CEU's) were provided to participants in the Black Hills Seminars in South Dakota through Augustana College; in Maine through the School Psychology Department of Southern Maine University; in Wisconsin through Silver Lake College Spring Tonic Conference; in Texas at the International CCBD Conference through University of North Texas; and in Georgia through Georgia State University and the University of Georgia Center for Continuing Education.

Project staff collaborated with 18 national and state professional associations and agencies to assist in planning and/or assisting in implementing the Developmental Therapy-Teaching model. These included CEC, CCBD, DEC, NEC*TAS, National Research Institute on Children's Mental Health, Head Start program of Audubon Area Community Services, Inc. in Kentucky, the Mental Health Center of North Central Alabama; Georgia Public Television; Northeast Georgia Regional Educational Services Agency; Georgia Department of Human Resources Early Intervention Program; Gateway Youth and Family Services in Williamsville, New York; EASTCONN in northeast Conneticut; Maine State Billing Services, Inc. for Medicaid planning.; and in the State of Washington EPIC in Yakima, Educational Services District #114, Educational Services District #113, and the Department of Social and Health Services, Mental Health Division and the Therapeutic Child Care Program in the Children's Administration.

Management Objective 5, Professional Development: *To provide topical workshops and other forms of professional resources for individuals, local programs, and professional organizations to extend outreach, training, and technical assistance in model implementation.*

While this objective originally was intended to provide topical workshops on request for professional development through inservice, our experience indicated that the greater benefits for professional development can accrue when participants have extended periods of intermittent training and follow-up with in-depth tutorial assistance directly in their classrooms. For this reason, single workshops and other forms of on-day training were minimized in the project, while extended, in-depth training was given a greater project priority [as described above in management objective

3, *Implementation*].

Topical workshops. Over the three-year period, 1,037 individuals participated in topical workshops. (The original proposal anticipated about 350 individuals would be served through workshops.) During Project Years 1 and 2, workshops were presented at 8 locations with 172 participants. About 41% were teachers, 22% were paraprofessional aides/educational technicians, and the remainder were coordinators/supervisors (9%), family service providers (8%), program administrators (6%),psychologists (5%), social workers (5%), speech/language therapists (2%), and others (4%). Many of these participants later became part of direct service teams at implementation sites [See management objective 3 above.] The topics requested typically included a day-long overview of the model and its basic components: *Behavior Management, Assessment of Students' Social-Emotional-Behavioral Development, Roles of Lead and Support Teachers, Building a Therapeutic Team, Functional Behavioral Assessments, Group Dynamics and Social Roles in Groups, Creative Arts for Therapeutic Gains,* and *Curriculum Practices that Address Emotional Needs.*

During Project Year 3, workshops and other forms of professional development activities expanded with a greater emphasis on actively including parents and foster parents in the training. In addition, as the new leadership trainees began to co-teach with project staff at sites where model implementation was beginning, the project was able to expand the number of sites receiving planning and implementation assistance. Between September 1998 and September 1999 in the last project year, 31 workshops were conducted for 865 participants (with 643 responding to the evaluation questionnaires). About 37% of the respondents were teachers, 16% were para-educators or educational technicians, and the remainder were administrators, coordinators/supervisors (14%), family service providers (8%), parents (6%), social workers (4%), psychologists (3%), and others (12%) including art, occupational, physical, educational, and behavioral specialists, students, bus drivers, nurses, mental health technicians and others not specified. The proportions and varieties of occupations represented at these professional development sessions seem to reflect changing trends toward a much more diverse group of individuals working with troubled children and youth.

Other professional activities. Project staff presentations, writings, collaboration, training and exhibits related to model dissemination and implementation for professional organizations, conferences, and seminars included the following:

Black Hills Seminars, Reclaiming Children and Youth, South Dakota, June, 1997

Keynote address, Washington State Re-Ed Conference, August, 1997

CCBD International Conference, Denton, TX, Oct., 1997

Collaborative research report and publication of pilot program in Winnipeg, Canada, Oct., 1997

OSEP Project Directors Meetings Jan., 1998, Washington: presentation "Using Evaluation to Build an Effective Outreach Program" (over 35 individuals)

Teleconferencing seminar with University of North Texas doctoral students - Feb. 17, 1998

Pre-conference and conference workshops, Black Hills Seminars, Reclaiming Children and Youth, "Voices for Change", South Dakota, June, 1998

Seminar, Healing Racism, Star Commonwealth, Michigan, Aug., 1998

Audio-taped lecture for University of Missouri-Columbia project, Nov., 1998

CEC Annual International Convention, Minneapolis: poster session "Managing the Ever-Changing Pulse of Classroom Dynamics" (over 90 individuals) April 15 - 18, 1998

Exhibit at conference on Autism: Enriching the Quality of Life, Emory University, Atlanta: June, 1998 (over 50 individuals)

Developmental Therapy-Teaching Leadership Conference, Athens, Georgia, April 1998 (22 participants).

Pre-conference and conference workshops, Black Hills Seminars, Reclaiming Children and Youth, Spearfish, South Dakota, June 1999

National Technical Assistance Center for Children's Mental Health, June 1998, Orlando:NEC*TAS-OSEP panel "Early Childhood Systems of Care" (over 50 individuals)

Interview for doctoral dissertation at University of North Texas, June, 1999

National Educational Service manuscript review, August 1999.

Planning with Buffalo State College for pre-service personnel preparation project, Sept., 1999.

Audio recording of lecture, "The Developmental Perspective", for University of Missouri-Columbia and Arkansas State University project, Enhancing Teacher Problem Solving skills in Early Childhood Behavioral Disorders, Nov., 1998

Silver Lake College Spring Tonic Conference, March 1999, Wisconsin: University students & faculty

Northeast Georgia Regional Educational Services, April, 1999, Athens, GA: Meeting the educational needs of students with severe emotional/behavioral disabilities.

CCBD International Conference, Sept.,-Oct. 1999, Austin, Texas: day-long, four-session strand on current and future directions for psychoeducation.

1999 CCBD Mini-Library Series monograph, *Psychoeducation: An Idea Whose Time Has Come*, with Larry Brendtro, Frank Fecser, and Polly Nichols

Among experienced program administrators, supervisors, and coordinators there were distinctly different kinds of professional development needs. With staff turnover annually, local leadership individuals find themselves in need of providing introductory level inservice training for new personnel while simultaneously offering advanced skill training for experienced staff. They also indicated a need for assistance with their own supervisory and program consultation skills. For this group, we initiated a pilot training-trainers program, *Regional Associates (RAs) for Developmental Therapy-Developmental Teaching* during Project Year 2. [This program is described below in management objective 7.]

Management Objective 6, Product Development:. *To develop new materials and revise existing training materials for greater effectiveness in meeting training needs of local service providers for model implementation in a changing educational climate.*

In order to reflect current needs and trends of the field, project staff worked continually to develop, disseminate, evaluate, and redesign the extensive products, materials, and instructional modules used in this outreach project. These new materials/products included (a) new video productions for introduction to the model, (b) computer-aided materials for meeting 1997 IDEA requirements for functional behavioral assessments, (c) new training materials for trainers-in-training, and (d) new training materials for skill practice by site personnel. These products are described below:

New video productions. In addition to new printed awareness materials and portfolios of model information, the project completed a series of introductory 20-minute videos in collaboration with the University of Georgia Center for Continuing Education, Media Production Department. (The original proposal projected a series of four videos.) The videos introduced principles of the Developmental Therapy-Developmental Teaching approach and illustrated exemplary practices to demonstrate developmentally appropriate strategies and environments which encourage social-emotional growth. These videos were designed for personnel and families of children in three age

groups: (a) Early Childhood and ECSE programs, (b) those in elementary school programs, and (c) those in middle and high school programs. The first, "Providing Developmental Therapy-Teaching Programs for Little Ones", was completed in March, 1998. The second, "Developmental Therapy-Developmental Teaching for Troubled Children in Elementary School", was completed in August, 1999. The third was re-designed into an interactive format with a newer technology – a CD-ROM. Additional funding was needed to accomplish this and was received from the U. S. Department of Education Office of Special Education Programs. This project in currently underway under separate funding. The fourth proposed video in this series, for training personnel to use the *Developmental Therapy-Teaching Objectives and Rating Form-Revised (DTORF-R)* with reliability, was also re-designed into newer technology using an internet course format, and is expected to be on-line before the end of 1999.

Computer-aided materials. The most recently completed material is a software version of the DTORF-R for use by participating sites. This program, available for either MAC or PC, enables a rating team to generate their results in printed format to attach to their local IEP forms. In response to the 1997 IDEA requirements for identifying specific social-emotional-behavioral objectives, (a) this software version provides a measure of current level of function, (b) identifies specific program objectives, (c) projects anticipated gains, (d) specifies positive management strategies based on the IEP, and (e) records repeated assessments periodically to document extent of child progress.

New training materials for trainers-in-training. In keeping with the increased focus on training trainers [the RA leadership program described in management objective 7 below] we compiled core instructional units most frequently requested by sites. These structured "lessons" were requested by the leadership trainees as a means to assist them as they began to conduct inservice workshops and training independently. With new grant funding the first draft is being compiled, field-tested, and revised as a *Manual for Instructors in Developmental Therapy-Teaching*.

New training materials for skill practice by site personnel. In addition to redesigning handouts and participant exercises to support existing training workshop modules during Project Year 2, we began to reshape this management objective to focus on distance learning and web-based communication. A strategic plan was developed for the expanded use of technology and distance learning through teleconferencing, consultation and training via the University satellite system, and the internet. [See **Appendix D.**] .

During the last year of the grant, many instructional modules were revised as a result of

evaluation feedback from participants at the local sites. In addition, efforts were made to obtain additional funding for continuation of our development of new technology — specifically interactive internet course work and CD-ROM instruction, offering useful tools for adults to learn and practice at their own learning rate.

Management Objective 7, Pilot Program for Training Trainers: *To design new outreach activities to meet expressed needs of personnel in multiple settings.*

In Project Year 2, we instituted a pilot program to field test a training- trainers program for leadership individuals to prepare them to (a) conduct awareness sessions and basic inservice training for new staff to use the basic model components, (b) guide their experienced staff in maintaining high quality performance, and (c) assist new local programs in planning and implementing the model. In this preliminary pilot effort we received 38 applications during Project Year 2 and accepted 28 individual in 6 states who met the prerequisite requirements. Not all were expected to complete this pilot training during the project funding period, and other funding sources were obtained to enable these initial participants to continue their training for certification as *a Regional Associate (RA) for Developmental Therapy-Developmental Teaching.*

Criteria for acceptance into the *RA* training- trainers program were:

- Hold a current supervisory/coordinating position with responsibilities for direct supervision in a program planning to implement the model.
- Submit a resume of prior experience related to work with children and teens who have severe social-emotional-behavioral disabilities.
- Provide a letter of recommendation about current work from a supervisor.
- Complete a preliminary needs assessment.
- Complete a pre-assessment test of basic knowledge about the model and how its theory is translated into "best practices" for the students to be served.
- Commit a follow-up with model outreach activities independently for at least one new site a year following certification.

Those accepted into the *RA* training -trainers program began by planning their individual training programs with a project instructor so that their training occurred simultaneously with co-teaching/supervision, of local program personnel began. **Appendix E** contains the names and

positions of these leadership individuals.

First year training requirements for participating RAs were these:

- ✓ Complete on-line independent study modules about the basics of the Developmental Therapy-Teaching model and the underlying principles.
- ✓ Participate and co-teach with the project instructor for on-site workshops.
- ✓ Observe with the project instructor as direct service teams learn to implement the model in their work with students.
- ✓ Complete three observational ratings of the teams with the instructor: a baseline rating at the 1st observation and two practice ratings during the 2nd & 3rd observations.
- ✓ Debrief with the instructor and the observed team following each observation to provide feedback about ways they are demonstrating model practices and ways to improve their performance.

Second year RA requirements included:

- ✓ Plan and implement (with instructor's assistance) introductory workshops for new staff members and additional workshops on essential model elements for all returning personnel.
- ✓ Observe teams with the project instructor during all site visits.
- ✓ Complete three observational ratings with the instructor: two practice ratings with feedback (1st & 2nd visits) and one "reliability" rating to measure degree of agreement with the instructor, item-by-item.
- ✓ Debrief with the project instructor and teams after each observation about ways they are demonstrating model practices and ways to improve their performance.
- ✓ Assist the project instructor in preparing written descriptions of workshop activities proven effective in staff development for implementing the model.
- ✓ Achieve specified performance standards in each competency area (see **Appendix F.**)

The workload and resources for this pilot effort were shared collaboratively with our new Early Childhood Outreach Project. Grant support for an additional project has also been received to expand and refine the *RA* program during the next three years; thus enabling *RAs* to complete their certification requirements and extend their own outreach activities. At the end of the final project year, two participants had completed all certification requirements, and seventeen others were actively

nearing completion of the requirements. (For details, see management objective 8, *Evaluation.*)

Management Objective 8, Evaluation: *To evaluate project effectiveness in meeting the original project goals on time and within budget.*

Accomplishments for each management objective were evaluated for timeliness and effectiveness. Figure 1, presented at the beginning of this report, summarized the scope of project accomplishments. Forms and instruments have been developed and field-tested in previous projects. They are included in the original proposals with descriptions of their development, reliability, validity, and uses. It is particularly important to note that the original reliability and validity studies about these instruments and subsequent research reports using these instruments were submitted to U.S. Department of Education, Program Effectiveness Panel. These studies were conducted with populations of students with identified social, emotional and behavioral disabilities. The performance measures in these studies resulted in documentation of program effectiveness and model validation three times – first as an effective model for children with severe social-emotional-behavioral disabilities; second, as an effective training program to increase performance competencies of those who work with these students; and third, as an effective model for use in inclusive, partial, or special education settings.

Simple descriptive statistics and written reports were used to summarize frequency data, describe extent of effort, and characterize the several groups of participants and service settings. [The evaluation plan, procedures for data collection, and measurement instruments were described in the original proposal, Evaluation Plan, p.37, and will not be repeated here. However, the Summary of Evaluation Plan from the original proposal, is reproduced in **Appendix G** for ease of reference.]

Timeliness was judged by on-going process evaluation activities described in each management objective. Overall, the project maintained the work schedule and budget for activities and accomplishments as anticipated in the original proposal. Changes in key personnel that resulted from illness and death during the first project year somewhat slowed the initial accomplishments in Project Year 1. However, the targeted activities and accomplishments were recovered and exceeded during the remaining two years.

Effectiveness of the project was assessed on four dimensions: (a) observational measures of participants' performance in using the specified practices; (b) progress of the children served by the participants during model implementation; (c) satisfaction of the participants with the training; and

(d) assessment of administrative support for model implementation. **Tables 1 - 11** located at the end of this report contain these effectiveness measures.

Reliable data collection at on-going service program sites is a well-documented challenge. It proved to be so for this project as well. In order to assure confidence in reliability of the data and in the accuracy of the findings, we had to accept smaller numbers in our samples. While this approach introduced a question of bias into the selection process, we chose samples which had reliable data, excluding those where data were incomplete or inaccurately collected. We believe the smaller samples are representative of the typical participants, children served, sites, and outcomes.

Evaluation question 1. *Do participants demonstrate understanding of the key roles of adults, as defined by the Developmental Therapy-Developmental Teaching model, for fostering healthy social-emotional-behavioral development of children and youth?*

The original evaluation plan involved administering a 50-item multiple choice knowledge test to answer this question. A decision was made at the end of the first year of the project that a knowledge test *per se* was not entirely suitable because of the intense focus of our technical assistance on actual performance and demonstrated skills of participants. The proposed test put some direct service participants at a distinct disadvantage and resulted in low scores when their actual performance demonstrated understanding of the content. We believe that effective performance requires understanding of the knowledge base. Therefore, observations of performance using the *Developmental Therapy-Teaching Rating Inventory of Teacher Skills (DTRITS)* was accepted as a sufficient proxy of knowledge on the part of the direct service teams. A representative sample of participants performance scores when working directly with children is presented below in evaluation question 2. These results show that 83% achieved DTRITS proficiency scores of adequate or better, indicating a working knowledge of basic practices needed for model implementation.

To further evaluate participants understanding of adult roles in model implementation, a group of 13 program directors and coordinators volunteered via teleconferencing to participate in a focus group to discuss their views of the training program. The in-depth, open-ended interview was conducted by the Project Evaluator and the Coordinator for Distance Learning in a one-hour, informal conversational format using video tape to record responses. Focus group guidelines suggested by M. Q. Patton in *How to Use Qualitative Methods in Evaluation* were followed for conducting the interview and analyzing responses. Here is a quote from one participant in the focus group that reflects their views about successful implementation:

> Our staff are much more accountable in identifying their adult roles in working with children. As opposed to *"Why is this kid doing this? What is wrong with them?"* [they now ask] *"What am I doing? What can I do differently?"* – those types of questions. So there is more accountability. There is this magic with DT that is really quite exciting when they ask, *"What can I try?"* – we decode and identify what is going on and come up with a solution. Then the staff person comes back and says *"Oh my God! It worked! It was so easy!"* – with a lot of these kids who have an abandonment issue we start meeting that need, then the child stops doing what was so highly destructive and disturbing in the classroom.

Evaluation question 2. *Do participants demonstrate effective performance skills in the service setting after participation in the training program to implement the model?*

Performance of direct service participants. Model implementation requires major emphasis on close teamwork among the direct service providers and the support/resource staff. When project staff made site visits for in-depth follow-up training, an attempt was made to observe all participating teams for a minimum of one hour in each classroom. Typically, an observation was then followed by a 30 - 60 minute debriefing for feedback with the team, focusing on skills and areas of performance that required improvement. At the time implementation activities began at a site, the project instructor observed each team to obtain a baseline DTRITS rating (Time 1). After the initial implementation activities were completed, DTRITS ratings were repeated (Time 2). This procedure was repeated each year that the site participated with the project in implementation.

Table 1 reports the DTRITS scores achieved by 28 teams (79 individuals) at 9 representative sites after initial model implementation, performance feedback, and tutorial assistance. Levels of proficiency established for DTRITS scores in previous studies are 90-100 = *Highly Effective*, 70-89 = *Effective*, 50 - 69 = *Adequate*, 30 - 49 = *Less than Adequate*, and 16 - 29 = *Poor*. The scores indicate that 22 teams (66 individuals, 83%) achieved DTRITS proficiency scores at the *Adequate* or better level, indicating demonstration of the basic practices necessary for model implementation. Of these, 16 teams (52 individuals, 79%) demonstrated *Effective* or *Highly Effective* skills.

Performance of leadership participants in the training-trainers pilot program. An expanded

evaluation design was added in Project Year 2 when the new pilot program was initiated for leadership individuals in the *Regional Associate (RA) Training Program*. Of the 28 people meeting the requirements and accepted into the program, 2 participants successfully completed all requirements in the five competency areas and received certification during the two-year pilot program. The pilot program was so well received by these leadership participants that 22 self-selected to continue active training under a new project, while 4 are currently inactive but indicate their interest in continuing in the future.

Table 2 summarizes the progress of these *RA* leadership participants toward achievement of the specified standards for each of the five competency areas. Results of the evaluation activities for this program component are summarized here:

Competency 1. Knowledge: The 50-item multiple-choice test of knowledge about Developmental Therapy-Developmental Teaching was taken by all but one of the *RAs* at the beginning of their training. Post-training knowledge tests were administered on an individual basis, when *RAs* requested the test after periods of self-study or as they came to the end of their individualized leadership training program. Of the 28 *RAs*, 11 requested taking the post-training knowledge test as they neared the end of their programs, and 9 (82%) achieved the passing criterion or greater. **Table 3** reports the pre-and post-training scores for these 11 individuals, ranging from 73 to 86. Note that 2 persons [#12 &17], with past experience using the model, achieved the criterion score on the knowledge test at the pre-training administration. The remaining *RAs* continue their independent progress toward certification as a *Developmental Therapy-Developmental Teaching Regional Associate.*

Competency 2. Reliability in using the 171-item DTORF-R assessment procedure: Leadership participants were expected to participate in team assessments of children in their programs and to review all DTORF-R ratings for accuracy. This procedures is a quality check on reliability of the assessment and requires extra proficiency in the use of the instrument on the part of the RA. Each rating was then reviewed by the project instructor for accuracy in the rating procedure and reliability of rater judgments. The instructor identified problem areas or inaccuracies in the rating procedure and provided feedback to the *RA* and the rating team. When DTORF-R ratings at a site were accepted as reliable and valid measures by the instructor, the *RA* was judged to have passed competency 2, DTORF-R reliability. Using this procedure, to date 11 of the 28 RAs received a "pass", indicating competency in supervising team ratings of social-emotional-behavioral development.

Competency 3. Reliability in using the 212-item DTRITS observational rating form: *RAs* were expected to observe with the project instructor as teaching teams worked directly with groups of children during implementation of model practices. These parallel observations were made during each return visit of the project instructor, and practice DTRITS ratings were made independently by the *RA* and the instructor. Follow-up discussion of rating differences on particular items following an observation served as tutorials for the *RAs*. This procedure was repeated with each visit until the DTRITS rating by a *RA* reached 80% agreement with the project instructor. Using this procedure, 4 *RAs* reached the performance criterion to date. [There is a further discussion below about the difficulties of leadership individuals in freeing an uninterrupted hour to complete an observation and DTRITS rating.]

Competency 4. Field supervision: Each *RA* was expected to provide on-going inservice assistance to their staff for model implementation during the periods between project instructors' visits. At the conclusion of the training agreement, or at the time when the *RA* and project instructor believe that implementation reached an acceptable replication level, the teams were asked to anonymously rate the quality and effectiveness of the *RA* in assisting them in effective implementation. Using this procedure, 4 *RAs* completed the requirement successfully by receiving average ratings of 4 or better on an 8-item form with a 5-point rating scale. As this outreach project ends, 13 others are actively in process of guiding their program staff in model implementation and 6 are inactive but indicate interest in continuing to use model components.

Competency 5. Group instruction in basic model elements: Three phases of training were used to assist the *RAs* in developing effective skills for leading staff workshops for model implementation. The first phase, completed by 20 of the *RAs*, involved co-teaching with a project instructor in which planning was a combined effort between the instructor and *RA*. [These sessions were evaluated by workshop participants and are reported below in *Participant Satisfaction*.] The second phase required independent presentations when there was no co-teaching but the project instructor assisted the *RA* in planning, selecting strategies, and designing effective workshop materials. This second phase was completed by 17 *RAs* [also evaluated by the workshop participants]. The third phase for *certification* was successfully accomplished by 9 *RAs*, in which they independently planned all aspects of the workshop, led the session, and were evaluated by a project instructor on an 18-item rating form with a 5-point scale of effectiveness as a session leader.

Evaluation question 3. *To what extent are participants satisfied with their training*

experiences?

Satisfaction with workshops. **Table 4** summarizes workshop evaluations from 172 participants at 8 locations during Project Years 1 and 2 for each of four questions. [It should be noted that not all of the participants at these workshops completed the anonymous evaluation forms.] Using a scale from 5 (*Highly Satisfied*) to 1 (*Not Satisfied*), the respondents indicated high degrees of satisfaction, with average ratings ranging from 4.69 to 4.73. **Table 5** contains consistently similar evaluations from 23 workshops conducted during Project Year 3 for 643 respondents. All but 9 of these workshops were co-taught by project staff with leadership participants in the *RA* training-trainers program. Using the same evaluation form, respondents expressed similar levels of satisfaction with the material, workshop organization, general impression of the workshops, and the extent to which their individual needs were met. These average ratings ranged from 4.51 to 4.74.

Satisfaction of leadership trainees (*RAs*). A focus group interview with 13 program directors and coordinators in the training trainers program was held around two general topics with six specific questions. The first discussion focused on the training that they had received, and the second topic concerned their perceptions of the training they were able to provide others. In general, the focus group held high opinions of their individual training experiences, both personally and professionally. **Appendix H** contains the questions and summary of responses. They identified experiences they valued the most (questions 1.1 & 1.2), citing the 3-day leadership retreat for in-depth immersion on the model, participating in presentations with project co-instructors, and observations of instructors as they provided consultation and feedback in classrooms. The group identified many new skills they had acquired (question 1.3), including understanding of the model and how to apply it in different situations, working with families to support children's healthy development, doing assessments, decoding feelings, and helping teachers and parents develop effective plans.

The group was less similar in their perceptions of their own professional and personal experiences during training (question 1.4). Several described their self-development as highly satisfying and exciting, while others expressed feeling pressure to perform at levels of difficulty resulting in feelings of inadequacy. (One individual viewed this pressure experience "unprofessionally handled".) Their observations of their effect on children, families, staff, and programs (question 1.5) were all highly positive.

Their recommendations for design of the leadership program (question 1.6) reflected satisfaction with effective aspects such as the notebooks of materials from others' training efforts, the

self-evaluation prescreening process to identify individual strengths and needs, opportunities to focus on aspects relevant to their daily work, and the system that responded to different learning needs.

Their recommendations included greater assistance with presentations, opportunities to practice presentations with peers for feedback, increased diversity of participating RAs, and increased time needed for preparation of presentations. They expressed some disappointment in the value of self-help/peer study groups where they attempted to learn from each other.

In discussion about the training they provided others (question 2.1), they were positive and confident of their present level of skill for supporting others in schools, consultation and informal training with parents, presenting workshops and training new staff in introductory and intermediate levels of model implementation, using the model for FBA and Positive Behavioral Intervention Plans, and informally supporting staff in consultation about individual children's needs. They generally felt that their work with the project and with their staff (questions 2.2 & 2.3) was well received but expressed concern that presentations offered only at the basic level fail to meet the needs of advanced participants.

Their plans for training others in the future (question 2.4) included foster parent training, continuing on-site staff training, consultation with other school districts, and training in positive behavior management for general and special educators, administrators, and mental health personnel. They had numerous future project plans using the model. These included finding grant funds for expanding the scope of their program's model implementation, using the assessment instruments at a statewide level, extending the model into regional school districts, and expanding the curriculum resources for the model.

They all also anticipated continuing their individual tutorial programs and completing certification requirements so that they would be able to train others in the future. They were articulate about their own strengths and weaknesses and were able to suggest very specific ways in which the project could assist them further in gaining the skills they needed (question 2.5). They requested project instructors to continue visiting and monitoring their activities and programs; assistance in setting up grant-funded pilot programs; assistance in obtaining resource materials, audio-visual aids in training for model implementation, and on-line training materials. They also requested an annual leadership conference bringing together *RAs* from across the country for in-depth immersion in leadership issues.

Satisfaction of team participants in training for model implementation. To obtain information

about the level of satisfaction among those who participated in on-site training for model implementation, a one-page questionnaire was mailed to 97 participants at 7 of the 9 sites agreeing to participate in project evaluation activities. Everyone at a site who had signed an attendance sheet at group training sessions received the questionnaire, including support staff, administrators, and direct service team members. Using a scale from *Very Helpful* (5) to *Not Helpful* (1), they were asked to rate four training activities anonymously: *workshops*, *observations* in their classrooms, *team debriefings* for feedback, and *written feedback*. The questionnaire also contained 5 additional open-ended questions about their perceptions of skills they had acquired as a result of training, positive aspects and weaknesses of the training they received, changes in their effect on children and families, and recommendations for future training.

Responses were received from 24 %. **Table 6** summarizes their ratings, indicating levels of satisfaction ranging from above average (ratings > 3.0) to highly satisfied (ratings of 5.0). Their responses to the open-ended questions reflected a wide range of individual differences in levels of training they received, from participants on direct service teams working year-long for model implementation to individuals such as support staff who had attended only the introductory staff development sessions. Responses to the question of newly acquired skills included understanding the social-emotional development of children better, skill in using the DTORF-R assessment instrument and applying the results in direct programming, using behavior management strategies effectively, working with parents and staff more effectively, and applying the model in adolescent programming.

Training activities they cited as strengths included all of the specific content areas in the core training. They reported satisfaction with the organization of these sessions, role play opportunities, relevant examples, small group exercises, and opportunities to discuss individual cases. They also mentioned knowledge levels, helpfulness, support, and skills of project instructors in providing practical applications as strengths in the training.

Their reports of weaknesses of the training focused almost entirely on issues of time. They felt a shortage in number of scheduled observations and feedback they received (time limitations on the part of the visiting instructor's schedule) and training after school when they were tired or scheduled to leave. They also reflected that they would have liked more direct suggestions for activities, curriculum ideas, follow-up case studies, and applications in the classroom for writing goals and objectives. One respondent expressed concern about the extent to which the DTORF-R met 97 IDEA requirements for alternate assessment and adequate goals. There was also a comment that the

comprehensiveness of the curriculum requires in-depth work beyond what can be done given all the other daily requirements.

In response to the question about positive changes in their effect on children and families as a result of the training, all but 3 respondents indicated YES, giving specific examples such as a common language among staff and families, changes in parents' awareness of their child's strengths and problems, increased ability to manage problem behavior more effectively, and increased staff team work.

Respondents made many helpful suggestions for our future training of others. Most suggestions reflected the need for more extended training during the school year and more time with the project instructor in their classrooms in focused training as they begin implementation. They reflected on the need for a slow, in-depth approach to assimilating the complex aspects of the model, and a need to have more in-class support during implementation. For group sessions, they suggested repeating basic constructs at each visit [to accommodate new staff and those who may have missed out on previous training sessions]. A suggestion was made that more background information of a general nature be provided prior to on-site training. They also suggested that group sessions be conducted on teacher planning days rather than after school. These detailed responses are included in **Appendix I.**

Evaluation question 4. *Did children show significant progress in social-emotional-behavioral competence during the model implementation period?*

To evaluate project impact on children served by the participants during model implementation, 9 sites agreed to assist us in collecting basic descriptive data and reliable assessments of social-emotional-behavioral status using the DTORF-R. All children served by the participants at these sites were included if their DTORF-R ratings for social-emotional-behavioral development were completed with accuracy and there was at least one repeated assessment at least 2 months but no greater than 11 months apart. There were 199 children in the sample.

Table 7 summarizes the characteristics of these children at each site at the time model implementation was initiated. They ranged in age from 2 months to 216 months (18 years), with an average age of 10.5 years. Boys comprised 85% of the sample and 74% were white. All had at least one recorded disability, 68% with a primary diagnosis of severe emotional/behavioral disability, 22% with a diagnosis of Autism Spectrum Disorders, and 34% with additional secondary disabilities. Most

of these children (78%) were being served in intensive special education programs, 2% were in full inclusion programs and 20% in partial inclusion. The severity of their disabilities, calculated from the extent of delay on their baseline DTORF-R ratings of social-emotional-behavioral development, ranged from 10% as severe, 56% as moderate, 30% mild, and 4% were in the range comparable to their age peers.

On average, the time lag from the initial baseline DTORF-R rating (Time 1) to a second DTORF-R rating (Time 2) was 7.8 months — approximately one school year. Statistical analysis of gains made by these 199 children using paired sample t-tests with a probability level of .05 and a 2-tailed test indicate that the group made significant progress ($p < .000$) during the time when their teachers received training for model implementation.

Analyses repeated for each site indicate that similar statistically significant gains ($p < .000$) were made by the children at 7 of the 9 sites. **Table 8** contains these mean DTORF-R ratings, standard deviations, standard errors, and months from baseline to the second rating, and **Table 9** contains results of the t-tests of gains. These findings indicate that the children made significant social-emotional-behavioral progress during the time of model implementation by participating teams.

To explore the extent to which implementation of the model may have contributed to these gains, comparisons were also made between the actual DTORF-R scores achieved and extrapolated scores assuming no intervention with this model. Extrapolated scores were obtained by calculating the average rate of item mastery prior to baseline (baseline DTORF-R score ÷ CA months at baseline = prior monthly rate of item mastery) times months in intervention to Time 2. **Table 10** summarizes these results. From baseline to Time 2, the 197 children made significantly greater gains during initial model implementation(average of 7.8 months) than could have been achieved had they progressed at their previous mastery rate prior to implementation. Similar findings occurred for 52 of these children who continued their programs during the subsequent 6.2 months and received a repeated assessment at Time 3. These findings indicate that model implementation by the participating teams had a positive effect in promoting increased social-emotional-behavioral development of the children that they served.

Evaluation question 5. *To what extent did local programs at participating sites acquire the basic elements specified for model replication?*

An administrative checklist containing 41 basic program elements desirable for effective model

replication was used by project instructors and site administrators/coordinators to determine the extent to which model components had been included in the implementation effort. If a component was rated as provided and being used consistently, the item was marked YES. If it was used inconsistently, the item was marked PARTIAL, and if it was not available or not implemented, it was marked NO. The total items marked YES provided an administrative support score for a site. Criterion levels established in previous research studies on model effectiveness are these: 26-41 items = *Exemplary Model Demonstration* (components consistently and effectively replicated); 16-25 items = *Model Adoption* (sufficient number of elements to consider model implementation achieved); and 10-15 items = *Basic Implementation (*indicating essential components were utilized*)*. **Table 11** reports the administrative support scores at each of the 9 implementation sites that participated in child progress data collection for the project. All of these sites were rated at the *Basic Implementation* level or better; indicating administrative planning that provided the essential elements for model implementation. Five sites were rated at the *Model Adoption* level, and two sites achieved the *Exemplary Model Demonstration* level.

Summary of Evaluation Results

The preceding review of evaluation data and outcomes indicates that each of the four project goals was effectively accomplished and exceeded anticipated outcomes in the original proposal. Outcome measures indicate:

- Increased understanding about how to promote healthy social-emotional-behavioral growth through exemplary teaching and behavior management practices among those who work with children and youth who have severe social-emotional-behavioral disabilities (SE/BD).

- Increased skill in using practices proven effective in enhancing teaching-learning environments for these students.

- Collaborative planning with state, regional, and local service providers to implement model programs for children and youth who have severe social-emotional-behavioral disabilities.

- ❖ Increased technical assistance, information dissemination and professional development opportunities for those who provide education and mental health services to these students, their teachers, and their families.

Together, these evaluation activities support the conclusion that the overall project mission to improve services for children and youth with SE/BD was achieved.

PROBLEMS ENCOUNTERED AND HOW THEY WERE SOLVED

There were several unanticipated problems which influenced the direction of grant activities over this three-year period. These problems reflect issues and challenges in the field of severe social-emotional-behavioral disabilities and how they impact on outreach assistance for model implementation rather than problems specific to this project. Conditions that gave rise to these problems and how the project responded are described below, by management objective.

Problems in Dissemination, and Project Response

The extremely large volume of requests for information about the model (and how to obtain assistance in implementing it) was not anticipated. Daily requests were received from individuals, program administrators, professionals, parents, or direct service providers nationally and internationally. The solutions were (a) an expansion and redesign of print materials into electronic media, (b) design of a web site with links to other resources, (c) sharing of materials and collaboration for translations in response to international requests for materials and guidance in model replication, and (d) extensive telecommunications to reduce actual staff travel for model dissemination purposes. To accomplish these new directions, it was necessary to redesign job descriptions for both key staff and for new personnel, primarily in use of advanced electronic communications and in computer graphics design.

Problems in Planning for Model Implementation, and Project Response

The project received many more requests for assistance in model implementation than could be provided. This was particularly true for large programs, some with as many as 25-30 teams (approximately 75 individuals at one site) seeking extended in-depth, year long training. It would have been impossible to meet this need using the outreach model of intermittent, in-depth training and

follow-up at participating site visits for observations and debriefings with every individual team. The solution was to carefully plan for specific needs at each program with the site administrators. This planning included identifying a limited number of teams who volunteered for a one or two year pilot effort to assess the goodness of fit between the model and the established program. Only one of the 21 sites was not able to continue implementation activities after initial training (this was due to turnover of both top administrators and teaching teams).

Another problem in planning involved local concerns about how much additional paper work and time would be required of participants. Already over-loaded with paper work and record keeping, this question was raised at every site. A parallel concern was the question of "fit" between the model's assessment instrument for developing IEPs, Functional Behavioral Assessments, Behavioral Intervention Plans and the site's district requirements. These issues of balance between model requirements, limitations in project staff, overload of staff at local sites, and their expressed needs for inservice assistance were addressed during planning with administrators at each site. In the initial inservice training with participating teams these issues were frequently revisited. Most, but not all of the sites were able to blend model implementation requirements with local requirements. In each instance where it did not occur, local administrators and participating teams made the decision to include the models instruments for social-emotional-behavioral assessment as an add-on to local requirements for IEPs, FBAs and BIPs.

Problems in Model Implementation, and Project Response

Turnover of staff is an on-going problem throughout the field. We encountered numerous instances of absenteeism, staff resignations during the school year, and extended illnesses both physical and mental, causing shifts in job assignments and changes in teams participating in project activities for in-depth model implementation. Site administrators expressed their concern over this dilemma, which left them with new, inexperienced or untrained replacement staff throughout the year. This situation gave rise to a need for repeated introductory training sessions on the basics of model implementation, while other team members were ready for advanced skill development.

To address this problem, a pilot initiative was designed to train local coordinators/supervisors at the implementation sites. The objectives were (a) to prepare these direct service leadership individuals to conduct introductory inservice training for their new staff and (b) to provide support to existing staff as they continued to acquire advanced skills for model implementation.

Additional problems encountered during on-site activities for model implementation were (a) staff absentee rate (with difficulty finding substitutes); (b) supervisors styles of crisis management, often resulting in their intensive involvement directly with children in crisis rather than in guiding staff to more effective solutions; (c) fragile or non-existing coordination between families and school personnel (characteristic for many programs in this field); and (d) lack of substitutes/released time for participants during inservice visits by project instructors. This latter problem curtailed the extent to which instructors could provide debriefings and individual feedback to teams at some sites following observations. Frequently instructors would be asked to demonstrate a more effective strategy, to advise staff about a particularly difficult problem, or to meet with parents of a particular child. Sometimes, project instructors would be asked to actually cover a teacher's group in a classroom while she/he was dealing with a serious crisis and had no other crisis backup. Instead of responding to these types of requests directly, project instructors provided coaching to the staff in solving these problems as a team.

With limited on-site time for project instructors to address these implementation problems, a re-shaping of our technical assistance was undertaken during Project Year 2. Staff from NEC*TAS helped us expand our long-distance communication links and instructional options to the implementation sites. The result was a web site, LIST-SERVE, teleconferencing, satellite hook-ups, and frequent phone consultation with site administrators and with participating teams.

Problems in Interagency Collaboration, and Project Response

This management objective received less proportional staff time than other activities yet the rapidly expanding need for close communication among agencies serving this population could have justified a full-time staff position. The special education/general education initiative for inclusion required considerable cross-agency work. Local and state level early childhood intervention programs also were facing the challenge of very young disruptive children with extremely difficult social-emotional-behavioral problems manifest in inclusive early childhood settings, child care, and foster care. The increasing incidence and severity of such problems served to further expand the need for interagency collaboration at local, regional, and state levels, including university and other state agency training programs. In addition, mental health agencies were beginning significant expansions into the schools with mental health services to troubled children and youth and their families. Payments for these services and coordination of treatment plans with educational plans became major interagency issues

at several sites.

Because the extent of this need was not anticipated in the original project proposal, it fell to core project staff to provide interagency collaboration in a limited way at state and regional levels, while our field-based instructors represented the project in coordination with local sites and agencies. They were asked frequently to attending meetings, participate in conferences, and make presentations. While these activities somewhat reduced the time project instructors spent in direct on-site assistance to participating teams, they were able to contribute to solutions for service delivery and personnel issues.

Problems in Product Development, and Project Response

The greatly increased number of requests for information and training for the Developmental Therapy-Developmental Teaching model, described above, required a considerable shift to electronic media to meet these needs. Without an increase in funding, product development and project resources for this management objective as originally proposed had to be redesigned. The original proposal anticipated production of three video tapes to introduce the model to audiences working with three age groups: early childhood, elementary school aged, and teens. We shifted resources to produce only two introductory videotapes, using the remaining resources to develop our first on-line course module to teach the basics for model implementation.

Problems in the Pilot Program for Training Trainers, and Project Response

Leadership individuals responsible for coordinating and supervising model implementation activities day-to-day expressed need for advanced skills and knowledge about the model. This was particularly evident to them between visits of the project instructor. Participating teams went to them for feedback, problem solving, support, and guidance as they worked to implement the model with children who had severe social-emotional-behavioral problems. With staff turnover, these leadership individuals also found themselves needing to repeat introductory level training for new personnel. To address this need, during the second year of the project we focused on identifying leadership personnel at participating sites who wanted extended training to become certified trainers. Standards for acceptance into the program and five rigorous performance standards for certification were established. [See description in previous section on accomplishments.] Individual training programs were designed to meet these standards, and training was implemented during the latter half of Project

Year 2. Leadership training included shared presentations with the project instructor at their own sites and at regional and state conferences. They also were required to observe and debrief with their own staff and the project instructor during site visits. Trainees expressed some concern that they would be unable to complete all of the requirements for certification during the project funding period, but were assured that they could progress through their training at their own rate. At the time, it was unclear how long it would take these individuals to accomplish the certification requirements. In spite of this uncertainty, they continued.

Problems in Project Evaluation, and Project Response

This management objective presented the greatest problems for the project, as we originally anticipated conducting evaluation activities with the rigor of a research project. The evaluation design proposed in the original proposal was used, but problems inherent in field based data gathering presented obstacles requiring modifications in several of the proposed evaluation activities. Because the evaluation plan had both formative and summative aspects, evaluation was a significant time-intensive, on-going project activity. It became necessary to shift position responsibilities among project staff when the collection and maintenance of accurate field records became increasingly demanding and time consuming.

The most difficult aspect of the design to fulfill was the assurance of reliability and validity of the observational performance data collected on participating teams and the children they served. At every site, project instructors reported the same types of difficulty in observing and rating the teams at work. For example, when an instructor arrived at a site to observe a team's performance, it was not unusual to find (a) the group on a field trip, (b) a high number of children absent, (c) a key member of the team absent, (d) a substitute for the lead teacher (e) a non-representative activity such as lunch or study hall, (f) new staff, and/or (g) some children following a part-time schedule in an inclusive general education class, necessitating a split in the team as one staff person went along to assure that the inclusive experience was successful.

Collection of reliable and valid data on the progress of children served during the project presented a different set of problems. One of the core requirements for model implementation is the accurate use of the DTORF-R rating procedures by the participating teams as they rate the social-emotional-behavioral development of every child in their group. The project staff did not do these ratings, but reviewed each team's completed ratings for accuracy. If discrepancies were evident, the

instructor and the team met to revise the ratings. This procedure required the project instructor to have sufficient time when on site to observe each child in the program. The original evaluation plan specified collection of both baseline and intermittent DTORF-R measures on each child. Valid baselines were sometimes difficult to obtain from some teams because (a) they lacked a sufficient understanding of the instrument even though they had participated in the preliminary workshops (a core content requirement), (b) difficulties for project staff to obtain the basic demographic information needed (such as file access) to describe the sample population, (c) carelessly completed ratings, (e) untrained staff participating in the rating, and/or (d) incomplete ratings. Collection of valid ratings repeated throughout the school year to document progress was also difficult as children (a) moved away, (b) were newly enrolled), (c) transferred to other programs, and/or (d) were absent during the rating periods.

To assure reliability and validity of the data and confidence in the accuracy of the findings for participating teams and children, we had to accept smaller numbers in our samples. While this approach may have introduced bias into the sample selection process, we chose to use samples which had reliable data, excluding those where data were incomplete or inaccurately collected. We believe the smaller samples are representative of the typical participants, children served, and sites.

Another, less significant change in the original evaluation plan involved the discontinuation of administering the pre- post- knowledge test for participating teams. A decision was made at the end of the first year of the project that a participant knowledge test *per se* was not entirely suitable because of the intense focus of our technical assistance on actual, demonstrated skills and performance of participants. The paper - pencil test put some team members at a distinct disadvantage and resulted in low scores when their actual performance demonstrated understanding of the content. We believe that effective performance on the DTRITS requires understanding of the Developmental Therapy-Developmental Teaching knowledge base, and is a sufficient proxy for knowledge. Only in the instance when participants seek credit for the inservice did we use the knowledge test.

IMPLICATIONS FOR POLICY, PRACTICES, AND RESEARCH

There is deep, widespread concern among school personnel and parents about troubled children and teens. While national statistics reflect drops in juvenile crime rates, dramatic acts of violence by children against themselves and other children, children against teachers, and children against their own parents have raised awareness of society's failure to met the social-emotional needs of its young

people. The explosion of violent acts in schools during the past three years caused a surge in requests for information about the Developmental Therapy-Developmental Teaching model. We believe that the volume of requests we received reflects the deep concerns of those who work and live with seriously troubled children and youth on a daily basis. They are simply unprepared for the levels of complexity presented by this group of young people. Not only parents, but even experienced professionals are faced daily with hurdles requiring skills and understanding beyond the ordinary scope of parenting, mental health, and educational interventions.

Recommendations for the Field

The complexity of troubled young people demands an equally sophisticated, multidimensional approach with shared values and standards that transcend races and cultures. Providing for complexities involved in effective special education for this group of children and young people should be a central principle in policy and practice. Here are several recommendations that would follow from such a central principle:

1. Program missions should be grounded in well established complementary theories about how children develop mentally healthy personalities, and include *learning, valuing, relating, behaving with responsible self-control,* and *basic thinking and problem-solving.*

2. Programs should be conducted with seamless components for mental health interventions, and include involvement with other major social institutions that shape children's lives – families, childcare, law, government, recreation, and spiritual life.

3. Assessments should be based on procedures shown to be reliable and valid for identifying child's current assets in each of the areas addressed in the scope of the intervention program.

4. In planning a child's intervention program, defined procedures should be used for gathering and analyzing past experiences to more fully understand the impact on a child's current status.

5. Advanced skill training with demonstrated proficiencies in developmentally and emotionally appropriate practices, human relationships, and sustained practice of mission standards should be required for anyone working in this field — including professionals and paraprofessionals in special education, mental health, and general education.

6. Criteria for child progress should be established with defined outcomes having practical and theoretical validity.

7. On-going inquiry into the presumed effectiveness of every practice with every student should be part of every program.

The field should be held to such basic standards for children and youth with severe social-emotional-behavioral disabilities.

Recommendations for Effective Outreach and Technical Assistance

Project experiences, problems encountered, and feedback from front-line practitioners over the past three years suggest numerous ways to assist individuals and programs at the local level in meeting the needs of this difficult-to-serve group of young people.

1. Family involvement in intervention programs. Family involvement was initially low at the participating sites, reflecting similar widespread problems in the field. We found that by putting a priority on this, we were able to make some change in attitudes and practices. Specifically, we found that parents, encouraged by the local staff and our project instructors to participate in the basic skills workshops along with program staff, were responsive and could utilize the training at home. We also found that this co-participation built greater understanding between staff and families. Feedback from some project participants noted that parents who participated with their child's team in rating social-emotional-behavioral development were increasingly positive about their child's abilities and potential for progress in the program.

> There is concrete shift in attitude based on how we are impacting our parents in that process. When we do DTORF assessments with parents we hear comments like *"I thought my child was really screwed up* (and that was the nicest comment). *I found that my child was really quite normal but that my expectations were to high."*

While such highly positive changes were not evident at all sites, we believe that by putting greater emphasis on parents as team members, outreach projects can contribute significantly to enhancing constructive family involvement for a child's benefit.

2. Skilled local leadership. The greatest benefits from model implementation accrue when local programs have their own supervisors/coordinators trained to high levels of proficiency and knowledge about the model. At sites where we had a leadership trainee actively participating in model implementation as a trainer-in-training, there was greater progress by the teams in demonstrating and sustaining effective model practices. There also appeared to be more confidence among the direct service teams to attempt new or improved practices when the coordinator was actively involved both during the instructor's site visit and during the interim between visits. Finally, assessment of child progress was more accurately completed at sites where there was an active leadership person in training.

3. On-going site evaluations. Each site should work to accumulate a database to build their own normative expectations about child progress in that program. However, teams in intervention programs are not typically enamored of data collection processes, justifiably, as additional paper work and accuracy are necessary. However on-going evaluation of each child's progress is essential if program quality is to be maintained. We observed that teams were able to modify their day-to-day practices with more precision at sites where more frequent child progress data were collected. They adjusted their practices as children made progress. In contrast, at sites where assessments were made only at the beginning and end of the year, program practices were not as readily changed as children

changed. When this occurs, children tend to plateau and a program could inadvertently contribute to a ceiling on greater social-emotional-behavioral development. We found that considerable outreach effort needs to be put into helping local administrators and coordinators put basic evaluation procedures in place. When local staff and parents (a) see evaluation results in formats easy-to-understand and interpret at a glance, (b) receive supportive assistance in using the results in practical ways to improve classroom conditions, and (c) are assured that their own value is not threatened by the results, there appears to be greater commitment to being a part of ongoing program evaluation.

Recommendations for Outreach

The degree of flexibility in current OSEP guidelines for conducting discretionary grant-funded projects is reasonable and helpful to outreach activities. With a field changing as rapidly as it did during the three years of this project, flexibility in modifying staffing patterns, staff assignments, tasks to be accomplished, and procedures was essential for successful accomplishment of the project goals. We found the meetings in Washington extremely helpful in keeping up with current trends and new innovations — especially those that focused on our area of severe social-emotional-behavioral disabilities and technical problems of documenting intervention effects. We also found that contact with the larger national technical assistance projects were of help, especially those that came from allied fields involved with mental health or technological issues. Greater contact with grant officers by allowing them to visit funded projects and implementation sites could also promote greater utilization of proven models and practices nationally.

Because the area of early childhood special education is distinctly different from general special education, especially in the area of severe emotional-behavioral disabilities and Autism Spectrum Disorders, we found it necessary to apply for a second outreach project to obtain additional resources for more targeted outreach to programs serving these very difficult-to-manage young children. That second outreach funding contributed immensely to the overall success of our outreach

effort by allowing us to provide a coordinated flow of assistance across age ranges, especially for programs that serve both early childhood and school aged students. Such multiple-grant funding assists outreach programs in maintaining a broad scope of expertness necessary to respond effectively to needs in the field.

At present funding levels, only core outreach services with intermittent assistance over a three-year period can be provided. Yet, requests for assistance far exceed capacity to respond both within specific sites where implementation is occurring and at new sites where entire school districts or mental health programs seek assistance. Expansion of federal funding for outreach, both in dollar amounts and in funding periods (preferably from three to five years) would enable outreach programs to expand, sustain on-going efforts, and increase the depth of skills at participating sites. Increased funding levels would also allow for increased FTE for greater project involvement in interagency planning at state, local, and regional levels. With educational reforms at high levels, it seems essential that model outreach programs contribute to planning for educational improvements.

Finally, our single greatest number of requests for on-site outreach assistance came from direct service providers who wanted to see model practices in action. They expressed a need to observe model practices demonstrated effective with children who had challenging behaviors similar to the ones they experience daily. Whenever possible, project instructors identified staff in local programs that were demonstrating proficiency and success with model practices. Yet, other teams at the same program seldom had released time to observe these practices and learn from them. We also made arrangements for a few direct service providers to visit other programs to see model practices. But these opportunities were few because direct service personnel can seldom be released.

Project instructors were also asked frequently to demonstrate specific strategies when making site visits. We did not encourage this because of project focus on staff training and not direct service delivery. However, we endorse the idea that skill acquisition is easier when there are opportunities to observe and model effective practices. A multiplier effect is created when local demonstration sites are available for observing and modeling effective practices. We believe that observations of

successful practices by direct service peers is among the most effective and cost efficient activities for a model outreach program. However, current OSEP ceilings on funding levels for model outreach projects make it difficult, if not impossible, to mount a project component to provide these opportunities. We recommend several policy standards for OSEP to consider:

- ✓ Expand maximum amount available for project proposals to include a specific component for direct service demonstration activities.

- ✓ Encourage outreach projects to offer extended regional summer institutes where direct service providers could participate in-depth as observers and team members in a successful demonstration program.

- ✓ Allow outreach projects to offer stipends and expenses for participating at in-depth training institutes for implementing model practices.

- ✓ Allow funds for partial payments to demonstration teachers at model sites and related program expenses such as transportation of children to the demonstration site.

- ✓ Encourage project FTE for project instructors to coordinate direct service programs for children and supervise learning experiences for direct service trainees at summer demonstration components of the outreach project.

- ✓ Allow funds, including travel and substitutes, for direct service providers to visit demonstration sites for short visits.

In summary, this project has shown that extended on-site, in-depth, extended outreach

assistance will result in improved program quality and skill acquisition by direct service providers, supervisors, coordinators, children, and their families. The lesson to be learned is that even more can be gained from these expenditures in the future if closer links are made available between an outreach project, local implementation programs, and high quality demonstration programs.

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Tables 1 - 11

Table 1. Observational Performance Ratings of 28 Direct Service Teams (79 Participants at 9 Sites After Initial Model Implementation)

Participant Team		**DTRITS Scores and Proficiency Levels Achieved**			
Team ID	*n individuals*	*Highly Effective 90-100%*	*Effective 70-89%*	*Adequate 50-69%*	*Below Passing <50%*
031	2		89		
032	2		85		
033	3		100		
041	2				38
042	3			56	
043	3			56	
051	2				19
052	3	100			
801	2			61	
802	5		79		
803	2			68	
804	2				43
901	2		80		
902	2				18
903	2		72		
904	2				26
1001	2			68	
1002	3		80		
1003	3				30
1101	3		88		
1102	3	91			
1103	5		82		
1104	5		71		
1105	3		79		
1107	5		89		
1108	3		86		
1701	2			67	
2201	3		79		
TOTAL 28 teams, 79 individuals		2 teams, 6 individuals	14 teams, 46 individuals	6 teams, 14 individuals	6 teams, 13 individuals

Table 2. Regional Associates in Training: Progress toward Certification (N = 28)

Regional Associate	competency 1 Knowledge Test	competency 2 DTORF-R Reliability	competency 3 DT/RITS Reliability	competency 4 Field Supervision	competency 5 Group Instruction in DT-T	Status
#1	pretest ✔ post test		in progress		co-presentations with staff ✔ independent presentations certification presentation	active
#2	pretest ✔ post test: not passed		in progress		co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#3*	pretest ✔ post test		in progress	in progress	co-presentations with staff independent presentations certification presentation	active
#4*	pretest ✔ post test	passed	passed	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#5	pretest ✔ post test	passed	passed	in progress	co-presentations with staff independent presentations ✔ certification presentation	active
#6*	pretest ✔ post test: passed	passed	in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#7*	pretest ✔ post test: passed	passed	passed	completed: EIC West, Positive Education Program (PEP)	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	certified
#8*	pretest ✔ post test		in progress		co-presentations with staff ✔ independent presentations certification presentation	active
#9*	pretest ✔ post test	passed	in progress		co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#10	pretest ✔ post test	passed	in progress	in progress	co-presentations with staff ✔ independent presentations certification presentation	active

Table 2. (continued)

Regional Associate	competency 1 Knowledge Test	competency 2 DTORT-R Reliability	competency 3 DT/RITS Reliability	competency 4 Field Supervision	competency 5 Group Instruction in DT-T	Status
#11	pretest ✔ post test: passed	passed	passed	completed: Greenview Day Treatment Center, PEP	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	certified
#12	pretest: passed		in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#13	pretest ✔ post test: passed		in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#14	pretest ✔ post test				co-presentations with staff independent presentations certification presentation	inactive
#15*	pretest ✔ post test: passed	passed	in progress	completed: Monarch Therapeutic Learning Center	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#16*	pretest ✔ post test: not passed	passed	in progress	completed: Monarch Therapeutic Learning Center	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#17	pretest: passed	passed	in progress		co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#18	pretest ✔ post test				co-presentations with staff independent presentations certification presentation	inactive
#19	pretest ✔ post test				co-presentations with staff independent presentations certification presentation	inactive
#20	pretest: not taken		in progress		co-presentations with staff ✔ independent presentations certification presentation	active

Table 2: (continued)

Regional Associate	competency 1 Knowledge Test	competency 2 DTORT-R Reliability	competency 3 DT/RITS Reliability	competency 4 Field Supervision	competency 5 Group Instruction in DT-T	Status
#21*	pretest ✔ post test		in progress	in progress	co-presentations with staff ✔ independent presentations certification presentation	active
#22*	pretest ✔ post test: not passed		in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#23	pretest ✔ post test		in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation ✔	active
#24*	pretest ✔ post test		in progress	in progress	co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#25	pretest ✔ post test		in progress		co-presentations with staff ✔ independent presentations ✔ certification presentation	active
#26	pretest ✔ post test	passed			co-presentations with staff independent presentations ✔ certification presentation	inactive
#27	pretest ✔ post test: not passed		in progress		co-presentations with staff independent presentations ✔ certification presentation	active
#28	pretest ✔ post test	passed	in progress		co-presentations with staff independent presentations certification presentation	active

* Training shared with our Early Childhood Outreach project

Table 3. Pre- Post- Knowledge Test Scores for 11 Leadership Trainees

Trainee	*Pre-test*	*Post-test*
#2	66	73
#6	73	83*
#7	71	86*
#11	66	83*
#12	81*	85*
#13	65	83*
#15	62	81*
#16	61	77
#17	80*	NA
#22	66	79
#27	67	73

*Performance criterion = >79

Table 4. Workshop Evaluation Summaries for Project Years 1 & 2 (N =172 respondents at 8 workshops)

Evaluation Statement	Average Rating (scale = 5 to 1)
1. The material presented has been ... *Very Beneficial (5) to No Benefit (1)*	4.73
2. The workshop was ... *Well Organized (5) to Disorganized (1)*	4.71
3. My general impression of the workshop is ... that it was *Excellent (5) to Poor (1)*	4.69
4. This workshop met my need ... *Very Well (5) to Not at All (1)*	4.56

Table 5. Workshop Evaluation Summaries for Project Year 3 (N = 643 respondents at 23 workshops)

Evaluation Statement	Average Rating (scale = 5 to 1)
1. The material presented has been ... *Very Beneficial (5) to No Benefit (1)*	4.67
2. The workshop was ... *Well Organized (5) to Disorganized (1)*	4.74
3. My general impression of the workshop is ... that it was *Excellent (5) to Poor (1)*	4.60
4. This workshop met my need ... *Very Well (5) to Not at All (1)*	4.51

Table 6. Follow-up Evaluation by Direct Service Teams at Model Implementation Sites (N = 23)

Training Activity	*n responses*	*Average Rating (5 - 1 scale)**	*Range*
Group Training Sessions	19	4.26	3 - 5
Instructor's Observations in Your Class	16	4.00	3 - 5
Feedback/Debriefings	16	3.87	3 - 5
Written Feedback	6	3.67	3 - 4
Other "Training at demonstration site"; "Staff development"; "Reading text"	3	4.50	4 - 5

*5 = *Very Helpful* to 1 = *Not Helpful*

Table 7. Characteristics of Children with Repeated Performance Measures at 9 Representative Sites Where In-depth Training for Model Implementation Occurred. (N = 199)

Site	C	D	E	G	H	I	J	M	N	Total
n	8	39	7	35	37	21	31	11	10	199
Average Baseline Age										
(months)	103	145	100	147	153	147	66	113	101	—
(years)	9	12	8	12	13	12	5.5	9	8	—
Age Range (yrs.)	7-10	7-16	6-11	5-20	0-18	7-18	3-9	6-11	5-12	
Gender										
Boys	7	37	7	28	29	18	27	8	9	170
Girls	1	2	0	7	8	3	4	3	1	29
Race										
White	4	21	6	33	33	17	18	4	10	146
Black	4	18	1	0	1	2	10	6	0	42
Asian	0	0	0	0	1	0	1	1	0	3
Hispanic	0	0	0	0	0	2	1	0	0	3
Mixed	0	0	0	2	2	0	1	0	0	5
Disability (primary)										
Emotional/behavioral	2	35	2	34	30	21	5	6	0	135
Developmental	0	1	0	0	1	0	2	0	1	5
Intellectual	0	1	0	1	3	0	0	0	3	8
Speech/language	3	0	0	0	0	0	0	0	1	4
Autism	3	1	5	0	2	0	23	5	4	43
Other	0	1	0	0	0	0	1	0	0	2
Secondary Disability										
Yes	6	24	0	9	18	0	3	3	5	68
No	2	15	7	26	19	21	28	8	5	131
Severity at Baseline										
None	0	1	0	1	2	2	0	1	1	8
Mild	0	13	2	13	14	12	3	2	0	63
Moderate	4	24	5	20	19	7	17	5	8	106
Severe	4	0	0	0	1	0	11	3	1	19
Missing data	0	1	0	1	1	0	0	0	0	3
Severity at Time 2										
None	0	4	0	2	2	3	2	1	1	15
Mild	0	12	4	19	19	11	5	3	2	75
Moderate	4	23	3	14	15	7	12	5	7	90
Severe	4	0	0	0	1	0	12	2	0	19
Missing data	0	0	0	0	0	0	0	0	0	0
Months:										
Base to Time 2	4.4	5.4	6.7	5.5	5.9	6.2	8.1	5.4	3.6	—

Table 8. Students' Performance Scores at Baseline and at Time 2 During Staff Training for Model Replication at 9 Sites

Site	N	Mean DTORF-R Baseline	S.D.	S.E.	Mean DTORF-R Time 2	S.D.	S.E.	Months: Base-line to Time 2	S.D.
C	8	38.9	24.9	8.8	44.2	24.0	8.5	4.4	.52
D	38	99.4	17.6	2.8	110.1	14.5	2.3	5.4	1.6
E	7	73.3	21.0	7.9	80.6	23.5	8.9	6.7	1.6
G	34	97.6	26.8	4.6	107.9	31.0	5.3	5.5	1.5
H	37	95.8	32.9	5.4	103.5	28.9	4.7	5.9	1.4
I	21	108.5	24.6	5.4	114.8	19.1	4.1	6.2	2.2
J	31	28.2	17.4	3.1	35.9	21.1	3.8	8.1	2.3
M	11	58.0	36.5	11.0	66.4	42.5	12.8	5.4	.52
N	10	67.8	19.7	6.2	74.4	16.3	5.2	3.6	.84
TOTAL	197								

Table 9. Paired Sample t-Tests for Children's Gains, Baseline to Time 2 at 9 Sites (N = 197).

Site	N	Months Base to Time 2	Mean DTORF-R Gains	S.D.	S.E.	95% Confidence Lower - Higher		t	df	Sig. (2-tail)
C	8	4.4	5.4	4.2	1.5	1.9	8.9	3.6	7	.009
D	38	5.4	107.1	11.8	1.9	6.8	14.6	5.6	37	.000
E	7	6.7	7.3	11.9	4.5	-3.8	18.3	1.6	6	.16
G	34	5.5	10.3	10.4	1.8	6.7	14.0	5.8	33	.000
H	37	5.9	7.6	14.2	2.3	2.9	12.4	3.2	36	.003
I	21	6.2	6.2	18.6	4.1	-2.2	14.8	1.5	20	.14
J	31	8.1	7.6	11.2	2.0	3.5	11.8	3.8	30	.001
M	11	5.4	8.4	8.2	2.5	2.9	14.0	3.4	10	.007
N	10	3.6	6.6	6.4	2.0	2.0	11.2	3.3	9	.01

Table 10. Comparison of Children's Actual DTORF-R Scores and Extrapolated Scores Assuming No Intervention.

DTORF-R Scores	*Baseline (n = 197)*	*After Initial Implementation, Time 2 (n = 197)*	*After Extended Implementation, Time 3 (n = 52)*
Actual Mean **SD**	80.14 37.74	88.69 37.78	105.73 37.50
Extrapolated Mean **SD**	80.14 38.57	83.91 38.57 (Note)	98.62 35.50
Paired Sample t-Value	___	5.10*	2.2**
Time Lags	___	7.8 months	6.2 months

*P .000
**P .027
Note: Extrapolated scores are obtained by calculating the average rate of item mastery per month prior to baseline (baseline DTORF-R score ÷ CA month at baseline = monthly rate of item mastery) X months in intervention.

Table 11. Level of Administrative Support for Replication at 9 Representative Sites Participating in Project Evaluation

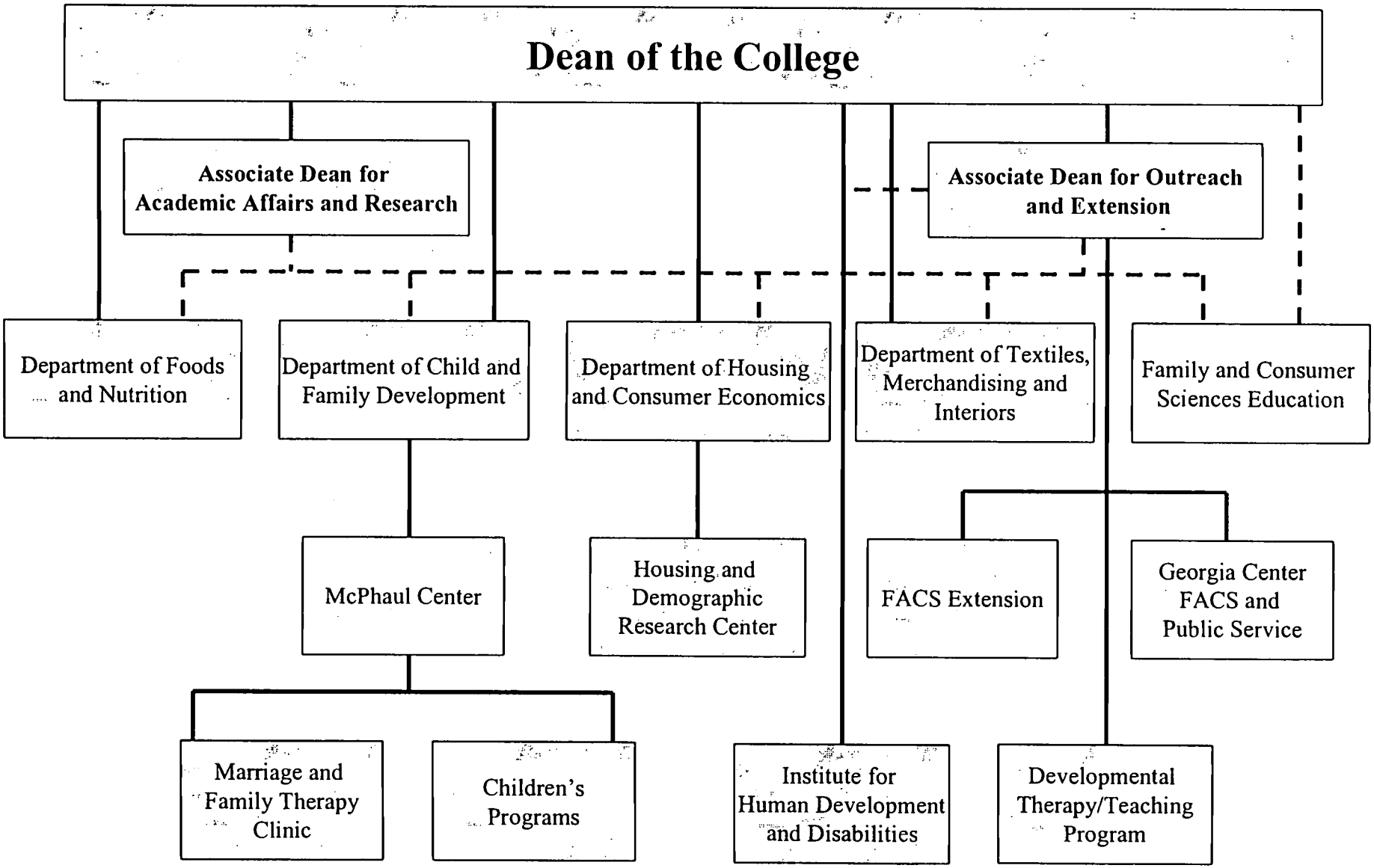
Site	*Score**	*Replication Level*
C	30	Exemplary Model Demonstration
D	17	Model Adoption
E	25	Model Adoption
G	13	Basic Elements Used
H	30	Exemplary Model Demonstration
I	12	Basic Elements Used
J	19	Model Adoption
M	13	Basic Elements Used
N	21	Model Adoption

*Score indicates number of administrative elements in place for model replication

APPENDIX A

Administrative Organization Unit
Within the University

Organization of the
COLLEGE OF FAMILY AND CONSUMER SCIENCES
Academic Programs, Research, and Service



APPENDIX B

Fee Schedules
Used with Local Sites
for
Cost Sharing

Appendix B.
Fee Schedules Used with Local Sites for Cost Sharing

Developmental Therapy-Teaching Programs

P.O. Box 5153
Athens, Georgia 30604-5153

Phone: 706-369-5689
Fax: 706-369-5690
e-mail: mmwood@arches.uga.edu

SCHEDULE OF FEES

Workshops, Site Development Assistance, or In-Service Training

	Fees and Expenses Paid by Local Program
Workshop by Topic..... *Limited to 1 or 2 full days* *Institute provides workshop materials.*	For 30 participants or less: $150.00 (one-time fee), plus 1 instructor's fee per day & travel expenses.* For more than 30 participants: $200 (one-time fee) plus 2 instructors' fees per day & their travel expenses.*
Site Development Assistance..... *Overview presentation, on-site needs assessment, program observations, consultation, and planning for model utilization.* *Institute provides consultant & materials.*	Travel expenses for 1 consultant. (Number of days to be negotiated.)
Extended Inservice for Implementation..... *Year-long assistance, including 3 or 4 full day in-depth workshops and on-site individual team follow-up visits.* *Site provides copies of curriculum materials and released time for teams participating.* *Institute provides two certified instructors & workshop materials.*	One-time fee negotiated according to number of teams participating: • 4 teams or less = $300 per site, • over 4 teams = $600 per site, plus travel expenses for 2 instructors. Number of days to be negotiated. About $100 per team for materials, including DTORF-R assessment kit & curriculum guide.

*All consultants and instructors have successfully completed the National Developmental Therapy Leadership Training Program and are certified as both Developmental Therapy-Teaching demonstration teachers and as staff instructors. The per instructor fee per day (plus travel expenses) paid by a local program for a topical workshop is $500 when the instructor has the doctorate and $250.00 without the doctorate. For other forms of technical assistance, consultation, and inservice training the Institute provides instructors' fees.

Travel expenses include travel, accommodations, and up to $35.00 per day for meals.

APPENDIX C

Content Map
for
Developmental Therapy-
Developmental Teaching

Appendix C
CONTENT MAP
For Developmental Therapy-Teaching

~~ Instructional Modules for Inservice Training ~~

PART 1
Introduction to This Approach

△Module 1[1]

Graphic: "Six Frequently Asked Questions About This Approach"
Q1: "What is the program focus?"
Q2: "Why are change and growth built into the program?"
Q3: "How does this approach promote success-producing behavior?"
Q4: "How does it motivate students to become involved?"
Q5: "What is required to use this approach?"
Q6: "How do you know the program is effective?"

- **Q1. Program Focus**
  Q: What fundamental beliefs about troubled children guide the program?
  Graphic: = "Behave, Speak, Feel, Relate, and Think"
  Graphic: = "Four Foundation Beliefs and Program Implications"
  {Or group cards for matching beliefs & implications}

- **Q2. Instructional Goals for Change and Growth**
  Q: "How are change and growth built into the program?"
  Graphic: = "The Broad Sequence of Instructional Goals, Stages One - Five" (Figure 1.3 on page 8)
  Q: "What curriculum content is included to achieve these goals?"
  Graphic: = Doing, Saying, Caring, and Thinking" (Figure 2.2 page 34)

- **Q3. Programmatic Changes for Success-Producing Behavior**
  Q: "How do changes in adult roles and intervention strategies promote social-emotional-behavioral successes?"
  Q: "How do changes in learning environments and experiences promote social-emotional-behavioral successes?"
  Graphic: = "Summary of Program Stages" (Figure 1.4 on page 10)
  Video: "Introduction to Developmental Therapy-Teaching - Little Kids to Teens" (use either preschool or school age version)
  Or, use **"Roles of Adults"** video to illustrate adults behavior and program activities, Stages One to Five

---

[1] △ = Modules typically included as basic content for initial and middle phases of acquiring skills for using Developmental Therapy-Teaching. Selection of modues and order of use in inservice is determined by the needs of participants at the beginning of training and may be modified as training progresses.

- **Q4. Motivating a Student to Become Involved**
  Q: "How do *self-esteem, identify,* and *personal responsibility* fit into this approach?"
  Graphic: = "Understanding a Student's Heart and Head" (List on page xii)

- **Q5. Program Implementation**
  Q: "Why combine 'Therapy' and 'Teaching'?"
  Q: "Where can this approach be used?"
  Q: "Which children benefit?"
  Q: "Who can learn this approach?"
  Q: "What special equipment and materials are needed?"
  Q: "How are parents involved?"
  Q: "How are cultural, age and family values addressed?"
  Q: "What place does academic instruction have?"
  Q: "How can other curriculum be included?"
  Graphic: = "More Questions"

- **Q6. Documenting Program Effectiveness**
  Q: "What place does evaluation have in the program?"
  Q: "Can social-emotional-behavioral growth be documented?"
  Q: "Can student gains be attributed to program intervention?"
  Graphic: = "The Criterion - Referenced Evaluation System" (Figure 3.5, p. 72)
  Graphic: = "The Example of a Field-Based Research Design"
  6 Graphics: = "Students A - F"

PART 1

Corresponding Readings: Note:

Preface, xii - xiii
Chapter 1, pages 7 - 16
Figures 1.3, 1.4, 1.5, 1.8
Chapter 3, pages 55 - 61, 70 - 78,
Figure 3.5

Note: All reading references are for *Developmental therapy-Developmental Teaching* (1996) unless otherwise indicated.

****

PART 2
Using the DTORF-R

△Module 2

- Uses of the Instrument
  Q: "What is the DTORF-R?"
  Graphic: = (pages 1 - 2*)

- Rating Procedure
  Q: "What is the procedure for using it with reliability?"
  Slide/audio, **"Instructions**
  "Review the Basics" (pages 18 - 25, 30*)
  Practice Cases (pages 26 - 29, 31 - 36*)

Module 3

- More Practice Cases
  Q: **"Rating from a written description: Charlie"** (pages 38 - 39*)
  "Frank" (pages 42 - 43*), **"Donna"** (pages 46 - 47*)

Module 4

- Content analysis of the Instrument Subscales
  Q: **"What content scope and item sequences are included?"** (Pages 2 - 8, 25**)

Module 5

- Documenting Student Progress, Part 1
  Q: "Is the student making desired gains, specified on the IEP?"
  Graphic: = (pages 11 -17*)
- Documenting Progress, Part 2
  Q: "Can gains be attributed to the intervention?"
  Graphic = (pages 10 - 13**)

PART 2
Corresponding Readings:
Chapter 3, pages, 61, 66 - 70
*In *Users Manual for the DTORF-R:*
**In *Technical Manual for the DTORF-R:*

****

PARTS 3 - 5
Introduce each part
using the transparency of the
Developmental Therapy-Teaching Logo

PART 3
Healthy Social-Emotional Development for Typically Developing Age Peers

△Module 6

- Central Concerns and Values of Each Age Group
  Q: "What's really important to me?"
  Q: "What do I need from adults?"
  Graphic: = "A Child's Expanding Spirit"

  Q: "What do children this age typically value as 'satisfactory'?
  Graphic: = "The Sequence of Values" pages 41 - 43 (Figure 2.3 on p. 42)

- Key Social-Emotional Processes for Each Age Group
  Q: "What typical social-emotional processes occur in each age group?"
  5 Graphics: = "Stage Charts" (pp. 180, 204, 233, 264, 294)
  [Also 5 laminated charts for group use]

△Module 7

- Developmental Anxieties of Each Age Group
  Q: "What central developmental anxiety is experienced by typically developing peers in each age group?"
  Graphic: = "How Typical Developmental Anxieties Emerge" (p. 47)

PART 3
Corresponding Readings:
Chapter 2, pages 32 - 38, 41 - 48
Chapter 3
Appendix 4, pages 349 - 354

****

PART 4
Decoding Behavior

△Module 8

- Review Underlying Social-Emotional Needs for a Student's Age Peers
  - Q: "What is this student's age?"
  - Q: "What are typically developing age peers experiencing?"

  Graphic: "Developmental Anxieties" (list on page 47)

  Or review **"How Typical Developmental Anxieties Emerge"** (page 47)

  Q: "What concerns, anxieties, and approach to problems are typical at each stage for social-emotional development?"

  5 Graphics: = "Student in Brief" for age and stage (pp. 177, 201, 232, 259, 289)

Module 9

- Identify Other Special Developmental and Emotional Needs of Each Student
  - Q: What special factors may be producing developmental anxieties and emotional needs in an individual? (Refer to history, clinical assessments, current interests, habits, and behavior)

  Practice Exercise: "Roger" (pages 62 - 66)

Module 10

- Identify Defense Mechanisms in Observed Behavior
  - Q: "Which defenses are being used by this student consistently?"
  - Q: "Which anxieties are being protected?"
  - Q: "How intensely are the defenses used to obtain emotional protection?"

  Graphic: = "The Process of Adjustment"

  Graphic: - "Defense Mechanisms" (pages 48 - 49)

  Practice Exercise: "Identify the Defense Mechanisms" (pages 50 - 51)

Module 11

- The "Existential Crisis"
  - Q: "How important is the 'existential crisis'?"
  - Q: "Are typically developing age peers going through the existential crisis?"
  - Q: "Has this student passed through it?"

  3 Graphics: ="A Preexistential Student Views Adults" (page 39)

  "A Student in the Existential Crisis Views Adults" (page 40)

  "A Postexistential Student Views Adults" (page 41)

PART 4
Corresponding Readings:
Chapter 2, pages 38 - 51
Chapter 3, pages 62 - 66

****

PART 5
Materials and Activities

△Module 12

- Emotionally Appropriate Materials and Activities

  Q: "What content will motivate each individual?"

  Graphic: = "How the Emotional Memory Bank Works (Figure 4.5, page 91)

  Q: "How is emotional content selected to motivate and alleviate anxieties and concerns?

  4 Graphics: = "Content Themes" (List on page 92)

△Module 13

- Developmentally Appropriate Materials and Activities

  Q: "What schedules, activities and materials will promote mastery of the selected Developmental Teaching Objectives?

  Graphic: = "Planning for Specific Objectives (Figure 4.2 on page 86)

  Graphic: = "How Materials Change with Development" (Figure 4.4 on p. 90)

△Module 14

- Putting Social-Emotional Content into a General Curriculum

  Q: "What activities and materials can promote mastery of Developmental Teaching Objectives within an existing program?

  Graphic: = "Examples of Content in Typical and Special Classes (Figure 4.3, page 88)

  Or **5 Graphics:** = (Lists on pages 195, 216 - 217, 251, 275, 303)

Module 15

- Examples in the Language Arts

  Graphic: = Developmental Sequences in Language Arts (List on page 98)

- Examples in Children's Literature

  Graphic: = "Criteria for Selecting a Storybook" (List from notes)

- Examples of Teacher-Made Story Books

  Graphic: = "Steps in Designing a Teaching-Made Storybook" (List from notes)

- Examples of Teens

  Graphic: = "Content themes for Teens" (Figure 12.2 on page 305)

PART 5

Corresponding Readings:

Chapter 4, pages 81 - 94, 98 - 100
Chapter 8, page 195
Chapter 9, pages 216 - 217
Chapter 10, page 251
Chapter 11, page 275
Chapter 12, pp. 303, 305 309

PART 6
Positive Behavior Management

△Module 16

- Effective Discipline and Behavior Management
  Q: "What basic guidelines apply for children and teens of all ages?"
  Graphic: = "Four Keys to Successful Behavior Management" (p. 128)

△Module 17

- Positive Rather Than Negative Behavioral Results
  Graphic: = "6 Steps in Designing a Positive Behavior Management Plan" (page 111)

△Module 18

- Positive Behavior Management Strategies Matched to Stage of Development
  Q: "What positive management strategies will be most effective?
  2 Graphics: = "Most Frequently Used Management Strategies" (Figure 6.1, p.129), **"Less Frequently Used Management Strategies"** (Figure 6.2, p. 130)
  [Also, *group activity cards* matching strategies with definitions and stages]

Module 19

- Students' Changing view of Authority and Responsibility
  Q: "How do students change from external control to personal responsible for behavior?
  Graphic: = "Who is Responsible?" (New)
  Q: "What adult behavior is needed to assist students take increasing personal responsibility?"
  Graphic: = "Elements in Building a Relationship" (Figure 7.1 on page 159)

Module 20

- Group Dynamics
  Q: "What forms of social power are used by students and adults alike?"
  Graphic: = "Social Power" (list & definitions on page 159)
  Q: "Which group role is held by each individual in the group?"
  Graphic: = "Roles of Individuals in Groups" (Figure on page 113)
  and **"Social Power in Groups"** (Figure 10.3 on page 248)
  Q: "What changes are needed in social power and group roles to foster positive behavior of group members?"
  2 Graphics: = "Chart of Behavioral Relationships Among Six Students" (Figure 10.4 on page 249 and "What is Evident?" (Accompanying questions)

PART 6
Corresponding Readings:
Stage Chapters, pp. 107 - 122, 125 - 149, 158 - 163, 246 - 250

APPENDIX D

Strategic Plan for
Extending Outreach
Via Distance Learning

Appendix D.
Strategic Plan for Extending Outreach Via Distance Learning

I. System Variables

- **Target Audiences**
  What groups do we want to reach?
  What are their needs?
  What are the conditions and constraints around their learning?

- **Content Domains, Goals, and Modules**
  What "awareness" information is needed?
  What basic content skills and knowledge are needed?
  What advanced content skills and knowledge are needed?

- **Delivery Options**
  What delivery options are currently available?
  What instructional characteristics and benefits does each offer?
  Which options are suitable for our target audiences?
  Which options fit our content domains, goals, and modules?

II. Design Variables

- **Accessibility and Program Capability**
  How accessible are delivery options for our program?
  How accessible are delivery options for our target audiences?
  What levels of staff skills in technology are needed for each option?

- **Relative Costs and Benefits Among Alternatives**
  What are the unit cost estimates for delivery options?
  Which options offer feasible alternatives?

- **The Strategic Plan**
  What are the priorities?
  What are the steps?
  What additional resources will we need (costs, personnel, TA)?
  What timelines are realistic for implementation?

III. Implementation Variables

- **Design of Instructional Strategies for Selected Options**
  What are the unique learning characteristics utilized by each option?
  How much interaction will be included?
  What technological materials will be used?
  What support resources will be provided?
  Who will facilitate the learning?
  Who will handle the technology?
  What instructional feedback will be provided to the learner?
  What instructional evaluation and follow-up will be provided?

- **Design of Outcome Measures**
  What are the expectations and outcomes wanted by participants?
  What are the expectations and outcomes wanted by our program?
  What measures will be used to evaluate the amount of these expectations?
  How effective and useful are the implemented options in accomplishing these expectations?
  What impact does the outcome have on services to children?

APPENDIX E

Names and Positions
of
Leadership Trainees

Appendix E.
Developmental Therapy - Teaching Training Trainers Program: Regional Associates
October 1, 1996 - September 30, 1999

Name	Position	Location
Paul Baker	Coordinator	Mountainbrook Psychoeducational Center, Canton GA
Larry Beye	Director	Behavioral Health Resources, Olympia WA
Judith Bondurant-Utz*	Professor, Exceptional Education Department	Buffalo State College, Buffalo NY
Jane Butler-Nix*	Therapeutic Preschool Educator	Adams Elementary School, Yakima WA
Charleen Cain	ED/BD Teacher	Maine School Administrative District #40, Waldoboro ME
Patricia Copeland*	Therapeutic Child Development Program Supervisor	Learning Tree, Bremerton WA
Cynthia Edwards*	Resource Consultant Early Intervention Center	Positive Education Program (PEP), Cleveland OH
Muazzez Eren	Director, Family Development Center	Healthy Families of Clallam County, Port Angeles WA
Pamela Fox*	Head Start Training and Resource Specialist	Audubon Area Community Services, Inc., Owensboro KY
Andrea Gillen	Consultant	Columbus GA
Barry Ginnis	Program Director, Group Homes	Positive Education Program, Cleveland OH
Amy Hepburn	Family Advocate	Shoreline School District, Seattle WA
LouAnn Hepp	Behavior Specialist	Issaquah School District, I ssaquah WA
Theresa Johnston	Program Development Coordinator	Center for Special Needs, PEP, Cleveland OH
Kelley Simmons Jones*	Executive Director and Therapist	Monarch Therapeutic Learning Center, Lacey WA
Scotty Jones*	Program Supervisor and Staff Trainer	Monarch Therapeutic Learning Center, Lacey WA
Dan Kettwig	Behavior Specialist	Port Orchard WA
Dennis Koenig	School Psychologist	West Shore Day Treatment Center, PEP, Cleveland OH
Ru Kirk	Clinical Social Worker	Port Townsend WA

Name	Position	Location
Pamela Massingale	Coordinator	Mounatainbrook Psychoeducational Center, Dalton GA
Linda Middleton*	Executive Director	Sunshine and Rainbows Child Development Center, Forks WA
Billie Navojosky*	Program Coordinator Early Intervention Center	Positive Education Program (PEP), Cleveland OH
Patty Orona	Foster Parent Trainer	Port Angeles WA
Mary Perkins*	Early Childhood Coordinator	Educational Service District 113, Olympia WA
Susie Sarachman	Education Plus Counselor	ATTN Special Services / McKinney Elementary School and Behavioral Health Resources, Olympia WA
Claudia Valore	Program Coordinator	Hopewell Day Treatment Center, PEP, Cleveland OH
Suzan Wambold	Family Development Specialist	The Casey Family Program, Tacoma WA
Nancy Wheeler	Speech/Language Pathologist	Clover Park Schools, Lakewood WA

* Training shared with our Early Childhood Outreach project

APPENDIX F

Performance Standards
for
Trainees
in
Training Trainers Program

Appendix F

DEVELOPMENTAL THERAPY-TEACHING PROGRAMS

TRAINING OF TRAINERS

Regional Associate Certification
Competency Evaluation Standards

Competencies	Evaluation Procedures	Performance Standards
Knowledge of developmental theory, research, and resulting curriculum practices	*Developmental Therapy Knowledge Test* (50 items)	88% (44 items) correct, or greater
Reliable use of a rating procedure to identify social-emotional-behavioral objectives for children's IEPs	*Developmental Teaching Objectives Rating Form-Revised (DTORF-R;* 171 items) scored against a rating by a nationally certified instructor	90% agreement, item-by-item, against the instructor's rating
Reliable use of an observational rating form for assessing teachers' classroom competencies	*Developmental Therapy Rating Inventory of Teacher Skills (DTRITS;* 212 performance items) scored against a nationally certified instructor scoring protocol during a paired observation	80% agreement, item-by-item, against the instructor's rating
Field supervision of a team beginning to use Developmental Therapy-Teaching	*Evaluation of Trainer's Field Skills* completed by participating teacher (8 items)	Average rating of 4 or better on a 5-point scale
Group instruction of staff participating in a Developmental Therapy-Teaching workshop	• *Workshop Evaluation Form (4 items)* • *Evaluation of Session Leader* rated by a nationally certified instructor in Developmental Therapy-Teaching (18 items)	Average of 4 or better on a 5-point scale

uestion 1.3: What can you do now that you could not do before?

Learning Outcome	Levels of Satisfaction			
	high	fairly satisfied	fairly unsatisfied	unsatisfied
Awareness				
Understanding and knowledge	1. Can take information from the text and relate it to real life 2. Discuss DT-DT and tie it to experiences with kids 3. Administer DTORF			
Application of skill	1. Able to adapt model in different settings in different circumstances 2. Able to help parents become aware of problems and teach ways to support child's development 3. Can recognize children's/teachers' dynamics to support their strengths, decode anxieties, and support child's growth. 4. Do assessments. 5. Teach teachers/parents appropriate expectations; target effective plans			
Development of attitudes and values	1. Have made DT-DT "my own." See kids and relationships through [the DT-DT] filter.			

4: How do you feel about your own professional (and personal) experiences during the training?

Experiences	Levels of Satisfaction			
	high	fairly satisfied	fairly unsatisfied	unsatisfied
Relationship with trainers				Personally handled in an unprofessional manner
Development of skills			Felt pressured to do many difficult things- resulting in feeling of inadequacy.	
Self-development	Very growth supporting and exciting - consider self as Developmental Therapist: just part of who I am.	Feel enriched by all components of training but one.		

5: What observations do you have about your effect (directly or indirectly) on the children, families, staff, and programs you work with?

Audience	Effect			
	very positive	fairly positive	somewhat negative	very negative
Children	1. Appropriate adult roles and strategies result in positive growth for kids.			
Families	1. Specific, direct objectives give families hope for success			
Staff	1. Interactions with staff more pleasant and enthusiastic. 2. Staff training more effective. 3. Staff has taken on RA's excitement			
Programs	1. Training trainers has made it possible for statewide education in child development - critical for children's services. 2. Having comprehensive, effective model leads to improved funding.			

5: What changes would you recommend in our future training of others, in similar leadership positions?

Design of Training Program	Recommendation: Would be...			
	Very effective	Somewhat effective	Not very effective	Ineffective
Required components	1. Notebook of materials from others' training, presentations	1. Assistance with presentations, e.g., templates, outlines 2. Opportunities to practice presentations with peers for feedback.		
Individualized approach	1. Prescreening process to identify strengths/needs 2. Self-evaluation to determine strengths/needs. 3. Opportunity to focus on aspects relevant to job. 4. Track/level system to ensure that different learning needs are addressed.	1. Diverse self-help/study group (at different levels of learning DT-DT): duplicates diversity in classroom.	1. Monthly self-help/study groups: attempt to help each other learn not very effective	
Guidance from trainer/mentor		Sufficient time for planning presentations		

1 What training did you conduct for others while in the RA program?

Training Activity	Levels of Satisfaction			
	very satisfied	fairly satisfied	fairly unsatisfied	unsatisfied
Presenting Workshops, Conferences	1. Independent teacher training at introductory and intermediate levels 2. Co-presentations with national trainers 3. Foster parents' conference			
Support/study group	1. Consultation with school district counselors			
On-site teacher/staff training	1. Training of new staff as support teachers (yearly training, daily interactions) 2.Informal meetings, one-one, about children's needs/ programming 3.Training to use DTORF as FBA 4. Development of positive behavior management plans for SEBD students (IDEA requirement)			
Parent Training	1. Consultation with parents 2. Informal training of parents.			

.2 How was the training received by the participants?

Training Experiences	Strengths	Weaknesses
Presentations/conferences	Second opportunities to hear basic information enables participants to process concepts.	Presentations offered only at basic level don't meet needs/interests of advanced participants.
On-site training	Working with site over time allows trainers to meet needs of participants	

3. What observations do you have about the affect of that training on the children, families, staff, and programs they worked in?

Audience	Effect			
	very positive	fairly positive	somewhat negative	very negative
Children	1. RA has more successful impact in classroom.			
Families	1. Families have become more nurturing. Relationships with children/home environments are more positive/pleasurable. 2. RA has more successful impact on families. 3. Parents understand children's developmental level and can adjust expectations, i.e., their attitude becomes more positive.			
Staff	1. Staff asks positive change questions, thinks about children's developmental level. 2. Staff has developed more positive attitude about children 3. Staff seeks RA's expertise/guidance, feels more supported. 4. Living DT-DT principles on a daily basis gives RA credibility. 5. Staff becames more proactive by assuming appropriate adult roles. 6. Staff manages behavior more effectively using knowledge of children's needs and anxieties.			
Programs				

4. What plans do you have for using your training to train others in the future?

Outreach activity	Continuation of current projects	Future projects
Conferences		
On-site/Agency training	1. Foster parent training 2. Continuation of current on-site training 3. Training and consultation for school districts and TCDs. serving foster children 4. Training for area special education/regular education teachers. 5. Training for school administrators in child development, positive behavior management 6. Train mental health personnel, therapeutic child care workers, etc. statewide 7. Bring agency to DT-DT demonstration status	Grant proposals to expand program using DT-DT research Increase consistency of statewide assessment and services for children. Extend DT-DT training to regional school districts
Material Development		Curriculum development

5. What can we do to assist you in your future work, training others for implementing Developmental herapy - Developmental Teaching practices?

Type of Assistance	$$$	$$	$
Personal - professional growth	1. National trainers continue to visit 2. National Leadership Conference		1.Practical guidelines for serving as Regional Associate Instructors 2. Assistance (monitoring) from DTTP to ensure future training by RAs remains true to model.
Program development		1. Assistance in setting up grant-funded pilot projects 2. Resource library of DT-DT multimedia training materials 3. Audiovisual materials to demonstrate DT-DT practices and activities.	1. Online training materials and dissemination of information. 2. Notebook of handouts/overheads for presentations

APPENDIX I

Open-Ended Responses
of
Direct Service Participants
to
Evaluation Survey

Appendix I.
EVALUATION OF TRAINING: SUMMARY BY DIRECT SERVICE PARTICIPANTS (N=23)

What can you do now that you could not do before? (N=21)

A. Understand the developmental stages of children/students
- Chart the stage of development of each student
- Tell what developmental stage students are in (5)

B. Assess social-emotional-behavioral competence
- Relate different age levels to the DTORF stages
- Now know how the DTORF works and how it will be used in our program
- Give the DTORF correctly (2)
- Fill out a DTORF without getting sweaty palms

C. Program more effectively
- Think about children in term of readiness for activities and skills.
- Plan activities and groups according to developmental levels (3) that move kids through developmental levels & skills
- Better integrate therapeutic interventions into academic lessons
- Develop plans that work with stages (2)
- Assume a wider "scope' of delivery to meet very specific objectives related to developmental milestones

D. Use management strategies effectively
- Deal with behavior problems better
- [Reading the book has given me the ability to] utilize which behavior modification and management programs need to be used in a stage III classroom
- Find the underlying conflict in a crisis more easily
- Avoid conflict cycle
- Understand kids' reactions to situations better

E. Other
- Help parents to see what level their child functions on in the different domains
- Supervise staff more effectively
- Reinforce to staff the use of the DTORF
- Feel supported in a strength-based approach to kids
- Refresher course in restraint was helpful (?)
- Only had the beginning class so it was not informative to me
- See use and benefit [of DT-DT] for adolescents

What were the strengths of the training you received? (N=21)

A. Material/Content

- Overview of DTORF
- visual of the "tree"
- themes, devising a lesson for a particular stage
- learning strategies to keep classroom safe and function in a positive healthy manner
- learning a universal assessment system
- learning some new strategies
- Good overview
- [received] help with lesson plans
- having levels explained for grouping students
- clearly defining growth in each stage necessary to cope with everyday life
- positive, structured material
- emphasis on conflict cycle
- good notebooks and overheads, quality of materials
- applicability to SEBD population
- comprehensiveness
- seeing where my kids were developmentally and how I needed to change the curriculum to meet their needs
- DTORF

B. Organization/presentation

- (DTORF) training well organized
- practice sessions for the DTORF
- informative and useful workshops
- small group exercises
- relevant examples
- chance to discuss specific cases
- role playing LSCI
- comments/feedback from trainer
- enjoyable sessions

C. Trainers/mentors

- supportive nature of the trainers
- knowledgeable trainer
- very personal and courteous instructors
- helpful input on individual situations
- presenters offered information on an understandable level, good examples and moral support
- helped with application
- trainer there to help - nonjudgmental
- trainer was extremely helpful, not just with ideas and theory - was involved with making concrete, specific changes in classroom. Role-modeled interventions. Could put her work into action.

What were the weaknesses of the training? (N=20)

A. Length of training and timing of training

- time-slots of observations
- need more time
- meetings lasting longer than 3:30 p.m. (Dismissal time)
- great deal of information packed into a short learning period (memorization for the sake of passing an exam.)
- training was after school when we were tired. It was hard to pay attention
- little chance for observations and feedback not due to the team's inefficiency; poor coordination of visitation from our district.
- Not enough time to cover everything we need help on. Sometimes I feel rushed in these workshops
- Never enough time
- too much info - too little time to absorb
- Not enough time with [the trainer]. My classroom joined the project late so that may have been part of the problem.

B. Content of training

- Feedback to staff not directive enough
- Few specific curriculum/activity ideas
- would have liked more time for DTORF case studies and practice
- not enough follow-up and practicing what was learned
- application in the classroom to write goals and objectives
- good suggestions but not enough follow-through
- would like to observe "pros" at work actually implementing in our setting. Does not really satisfy new IDEA '97 requirements for IEPs or provide adequate goals for alternate assessment. You've tried to objectify but they aren't really measurable in many instances
- Comprehensiveness. Requires in-depth training almost above and beyond that possible when put into relationship with other requirements..
- Not enough classroom feedback, not enough observation. Our program does not debrief the way we should. Also, the training should put more emphasis on non-confrontation[al] verbal techniques and body language. I see this as a problem in new staff and they need to hear this in the program. More emphasis is needed on reflection, interpretation and redirection. I also was surprised, belatedly, that the session was over. Thought we had so much more to learn that I wondered if a problem had occurred that hastened our training to its end. I could have used a lot more workshop or observation time. From my point of view, staff needs a lot more training in doing a DTORF, selecting materials, doing theme based units and feedback.

C. Whoops...

- hard to get a return call or email quickly if we really needed help

Have you notice positive changes in your effect on children and families as a result of the training? (N=21)

A. YES

- Yes. (5) Definitely. (1)
- I have noticed a more improved program focus with common language being spoken on a daily basis.
- Some parent are becoming more realistic about their child's functioning compared to typical peers.
- We were able to control the behavior problems much easier. We also understood that they may be 8 years old but their stage says "they're only 2;" therefore, their behavior may be normal.
- The staff involved are better able to plan for their students.
- Some of my groups are more effective - some children who are placed with their age/grade group are way behind their peers in their psychosocial development.
- I can see us promoting appropriate student interaction according to the students' developmental stage.
- I believe using the DTORF as an evaluation tool for the child has aided in parental awareness of the child's strengths and weaknesses.
- I am trying to develop a more tolerant attitude in working with kids and families.
- Positive on & with the kids. The weekly meetings are helpful to brainstorm/reflect.
- yes, but it is up and down.
- yes, in students. Reaction from parents - not sure, not really observable, but in students there is more trust, more information shared and students in some cases are supporting each other more often.
- I have seen indications that students may see a difference in staff.
- I'm not sure I would have made it through the year had it not been for [my trainer] and the project. Even though it add some additional demands - the payoff was well worth it!

B. No

- Not yet (2)
- I am no longer working with children I completed training with.

What changes would you recommend in our future training for others? (N=18)

A. Workshop/introductory training (n=18)

- More time for workshops
- Present information more in "laymen" terms for parapros.
- Prior to doing a workshop, do a survey to determine the needs of the group so that you could include this in the planning.
- Workshops on teacher workdays, not after school.
- Encourage [participants] to match information with relevant examples of student behavior
- More small group exercises emphasizing the developmental task of each stage.

- A general overview of Developmental Therapy at each training
- Providing the book and materials ahead of time and asking [participants] to read first. Without a psychological background many of the concepts are new to them. We have a lot of provisional teachers coming from different educational fields, e.g., criminal justice, counseling, etc.
- In trying to get teachers and other staff at a large program such as ours to buy into a "new" philosophy and way of relating to students, it would have been helpful for all staff to have had a brief hand-out about DTORF to read before the first training session (applies to both school years, as some staff were new to us this year.)
- a video of good developmental teaching of stage I and II kids with PDD/Autism would be wonderful.
- More concrete suggestions for ideas to implement in the classroom.

B. Extended training during school year

- a modified instructional delivery for staff training. Material is comprehensive and requires a slow, in-depth approach for staff to "buy-into" and put into action.
- Involve more classrooms and teachers - maybe even create an entire building with the levels as the programs and acquiring the skills to move up, then out and back to public school or community when [the student] is developmentally appropriate for grade/age.
- One-on-one help in the classroom to get these programs "user-friendly" - confidence to instit te and pass on to new staff the programs we have been mandated to use.
- More support to help implement program in my classroom.
- Spend more time with the teachers - when you meet with them after an observation
- More observations with direct feedback..
- More consultation on real life implementation.

C. Other

- I would love to see this as coursework offered to teachers. I think the information would prove valuable for any type of classroom
- Definitely update the DTORF notebook fold out with examples of skills. The are all, or seem to be, from children. It is sometimes difficult to assess adolescents by the present examples. The videos were good. I would add more good examples and contrast them(a few) with bad examples.
- none (2)
- Send out [evaluations] right after our training so I can remember better.

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