Title of Session: Special Ed Forum - Exceptional Student Ed and Mental Health
Moderator: Paul Bohac
Title of File: 20090608spedese
Date: June 8, 2009

Room: Special Education Forum Group

PaulDB: Shall we start with introductions?

PaulDB: I am a retired Correctional Education teacher/Administrator with a background in Special Education.

JenniferOW: I live in Fredericksburg, Va. Seeking K-12 sped endorsement and M. ed at UMW.

BJB2: I'm a retired communication and art teacher living in Pennsylvania

BJB2 waits for Sharon and Jamie to introduce themselves

SharonE: I teach emotionally disturbed students grades, 3-5 (for 38 years now) and also teach special education technology graduate courses at a local university, I'm from Cupertino, CA

JamieB: I currently work in High School Special Education Inclusion, Redirection, and Credit Recovery. I am formerly from the Texas Education Agency department of Special Program Monitoring and Interventions. I work with 10, 11, and 12 at a local high school.

BJB2 . o O (I wonder if Sharon is going to soon join the ranks of the retired?!)

SharonE: maybe, but not for a few years

BJB2 nods

SharonE: love what I do, don't believe in throw away kids

PaulDB: Agree with you on that!!!

BJB2: Paul, do you want to bring us up to speed on the topic?

PaulDB: Okay. Last month we started talking about ESE kids and mental health issues.

SharonE: ESE

PaulDB: It is a topic that is not often discussed.

SharonE: define please

PaulDB: ESE is acronym for exceptional student education, Sharon.

JamieB: The acronym here in Texas is ED (Emotionally Disturbed), Sharon.

SharonE: here in CA it's the same as in Texas

JenniferOW: same in Va - ED

PaulDB: While we tend to identify special ed kids by the more common designations such as LD, ED, SED and so forth, we often find kids also have mental health issues.

JamieB: I have noticed that acronyms change from district to district, and agency to agency.

SharonE: We just use the federal categories

PaulDB: They do Jamie, and that is part of the mental health issue.

JamieB: For the teachers, or the students? *smiles*

PaulDB: For example, an emotionally disturbed kid is eligible for spec ed services because s/he is not succeeding in the classroom.

JamieB: Please explain.

SharonE: correct

SharonE: but the reason for the lack of success is stipulated

PaulDB: The lack of success in the classroom is often determined by poor academic performance.

SharonE: no LD, no socially maladjusted, ect.

SharonE: what about cross-categorical placements?

JamieB: Yes. And it is largely up to us in the classroom to determine how much of their lack of success is due to their emotional disturbance, and how much is due to other factors.

SharonE: not here, it's determined through a series of assessments

PaulDB: Dual diagnosis (a term common in mental health environments) is not as common in special education circles.

JamieB: We have the assessments too, but we use a large amount of data collection to assist the ARD committees in determining appropriate ways to address the situation.

SharonE: We do have that here, primary and secondary certifications

SharonE: correct Jamie

SharonE: I developed a therapeutic special day class 16 years ago. They are now 10 in all, from K-12

PaulDB: Yet, as you Sharon and Jamie have noted, there are situations when a child does experience two or more potential causative factors (risk factors?) that could contribute equally to the lack of academic success.

SharonE: each is staffed with a teacher, 2 paraprofessionals, a behavior specialist, a licensed therapist, with access to a psychiatrist

PaulDB: Please elaborate Sharon.

JamieB: Sounds like a very good program, Sharon.

SharonE: depending on the axis diagnosis, students are placed

SharonE: Thanks, the state 16 years ago had grant monies to help public schools develop therapeutic classrooms to bring students back from non-public schools with the same or better services, closer to home

SharonE: we were the pilot project for the grant

SharonE: What the data showed was that in fact services could be delivered in a better format, cheaper, and closer to home

PaulDB: What types of services for what types of kids?

JamieB: As an inclusion teacher, however, I have a problem with students in public education being placed based primarily on a diagnosis...there are too many other factors to address for the individual. (imho)

SharonE: Kids who have axis one diagnoses (DSM), who are not succeeding in school because of a diagnosed mental illness, and who could benefit from insight therapy

PaulDB: It would seem to depend on the definition of "diagnosis".

SharonE: I use the term mental illness because for the most part most of the kids have some kind of organicity or neurological component that needs to be addressed through

medication as well

JamieB: What is the primary goal of your program?

SharonE: the axes of the DSM are the criteria

PaulDB: So the issue is more of a medical or medically-related need?

SharonE: no

SharonE: a combination of medical, psychiatric, educational, behavioral

PaulDB: And the DSMIV is the primary tool?

SharonE: We get depressed kids, selective mutes, bipolar, ADHD with depression, you name it

PaulDB: How does the program connect with the state's high stakes testing such as for NCLB?

SharonE: no the DSM4R is only one of the tools, but a necessary component

SharonE: Students test with accommodations/modifications as needed

PaulDB: What other forms of evaluations are conducted?

SharonE: academic WIAT, Woodcock, WISC, Beery, the list is extensive depending on the kid (in CA black students may not be tested with IQ tests) bilingual testing, etc,

SharonE: then there are the observational assessments and teacher reports, Connors, etc.

SharonE: added to that are the assessment and team meetings for assistive technologies

JamieB: What are the long term goals of your program, Sharon?

SharonE: return to general education if possible with appropriate supports.

SharonE: if not, then LRE

PaulDB: And what types of support are offered?

JamieB: How long does the typical student remain in the program?

SharonE: we get kids straight out of hospitals, put kids straight into hospitals and everything in between. Supports include AT, speech, OT, APE, course alterations based on UDL, etc. depending on the individual needs of the student

SharonE: length of stay again depends on the kid's needs

SharonE: we use the SETT for team collective decisions and trials of supports too

PaulDB: So the program is self-contained for a period of time and then transitions into an itinerant operation and eventually a consultant program once the child is returned to his/her regular school?

SharonE: if that is what is best for the child, yes. Otherwise, they have the continuum available through 22

SharonE: we get girls mainly starting in middle school, seems cutters start then (or at least are noticed then)

PaulDB: And once they turn 22, do you arrange for continuations of services through voc rehab and ADA?

SharonE: my big issue is identification of the imploders and girls earlier so that we can get in and provide supports earlier.

PaulDB: Some of the research I have seen suggests that as early as 4th grade some indication may appear.

BJB2 wonders how the shaky economy is affecting the programs?

SharonE: voc. rehab. starts in middle school, we transition to adult services too, Catholic Charities had a MH program and also dual diagnosis services as we find MI populations tend to become drug/alcohol abusers too

JenniferOW: Stafford County (va) is creating a day school program- ED and MR- in one of the middle schools. I have limited knowledge about it but would like to learn more.

SharonE: because of the economy, we are getting lots of move in/move out stuff

SharonE: We get kinders with mental health issues

SharonE: diagnosed - PTSD, abuse, neurological issues

BJB2: what about parent involvement?

SharonE: starting to get a LOT of asperger

SharonE: parents are involved in family therapy as part of the program

JamieB: Do you work with autism, or downs syndrome, etc?

PaulDB: Glad to know the problems we are experiencing in Florida with the younger kids is not an anomaly.

SharonE: some autism (high functioning) and asperger syndrome, MR kids are served in other programs

PaulDB: To what extent are the kids of various ethnicities and cultures represented?

SharonE: again, they need to be able to benefit from insight therapy, so the MR kids don't really qualify

SharonE: we get the gamut - white, Asian, Hispanic, black, native American

JamieB: I'm still trying to understand if the diagnosis is a primary determining factor in participation in the program, or the level of support educationally needed by the individual student...

SharonE: we have 53 languages in our district, although as a regional program we get kids from many districts

SharonE: Jamie, it's all of that

JamieB: So a student with a, say, bi-polar diagnosis would not automatically be placed in your program?

PaulDB: The presumption is that if kids achieve, they will improve.

SharonE: what gets me is that the RTI model takes so long, then the SST process for pre referral that we get kids in 5th grade who should have been in LD classes in 1st or second grade and now they have emotional overlays to try to work with when all they needed was LD support

JamieB: Often, with the kids I have worked with, just knowing that there is someone who genuinely cares and will hold them accountable helps them to gain achievement...

SharonE: a kid who, even with a mental health diagnosis, who is succeeding in school would not be placed in the program

JamieB: Many districts hold off on initial assessments until the students are in 3rd grade because of normal developmental variances seen and documented.

JamieB: for LD

SharonE: well, when you have a kid who is in 3rd grade and doesn't know letters or sounds, can't remember the sequence of numbers but doesn't get identified until 5th

grade, something is wrong

PaulDB: Here in Florida, there is a Pre-K program in place that is aggressive in identifying students who may have potential problems in school.

SharonE: all districts have preschool programs per IDEA

SharonE: we have them at 4 sites in the district. About 11 percent of the sped population here in this district are on the spectrum

PaulDB: Key component in the Pre-K program is the role of the speech-language therapist.

SharonE: a neighboring district has an autism population of 25 percent of their sped.

JamieB: It seems like the late diagnosis could be an RTI issue...if it is not a lack of educational opportunity due to health or family issues.

PaulDB: Pre-K is in all 67 districts in the state at every elementary school.

SharonE: yes, SLP supports are in preschool, especially in the mild classes to help get the little ones ready for K. In the more severe classes, there is a heavy emphasis on AAC

SharonE: Jamie, it wasn't an issue of health or family. The school psych dragged his feet

JamieB: The neighboring district you described almost sounds like it needs some environmental studies done, to try to determine a causality for the high prevalence of autism.

PaulDB: What role do the regular class teachers play in the identification process?

PaulDB: No, the data suggests that 1 out of 150 students will be identified as autistic.

SharonE: No, it's a move in thing. We have various strands in the SELPA for low, medium, high functioning autism as well as inclusion programs for aspergers, so they move here from all over the world

SharonE: regular ed teachers are the first line through the SST and RTI processes

PaulDB: And the level of collaboration between regular teachers and the program you describe is strong?

PaulDB: For example there are shared training programs that both groups attend?

SharonE: Well, all of the kids in my program are mainstreamed for PE. Then kids are

mainstreamed for academics as they reach comfort and academic levels, otherwise they are included with modified academics as appropriate

SharonE: All special ed and general ed teachers are provided the same professional development through the district/SELPA

PaulDB: That suggests that the incidence of mis-referrals is kept to a minimum.

SharonE: correct

SharonE: but I am taking up too much time, Jeff, Jennifer what about you?

PaulDB: Is there something in writing that would provide guidance to a teacher who is considering a child for referral?

PaulDB: Actually Sharon, you are not. The topic just happens to be one with which you are familiar and so we all are learning from your contributions.

SharonE: again the RTI, SST, medical diagnoses, educational assessments, psych. assessments all combine to provide a referral

BJB2: Perhaps Jennifer can join this discussion in July (13) and tell us what she has found out about the VA program?

JenniferOW: I'll do that! The program begins in the fall.

PaulDB: I guess my question is one of the sequence that is followed in the referral process: who starts it, to whom is the referral submitted, who moves it along and so forth.

JamieB: That sounds very interesting. I have enjoyed learning about the CA programs. Thank you, Sharon.

BJB2 . o O (the strength of this group is that we can start a discussion and then continue it the following month and not have to start from zip.)

SharonE: you're welcome, Jamie, but remember, not all CA has these programs

SharonE: which is why we have move ins

JamieB: I understand, Sharon. However, one of my favorite pastimes is learning how others do what we do. I believe that we can all learn a great deal from one another, and as a result, improve education for our students.

SharonE: ok Paul, a kid is in regular ed, things are not going well (academically, behaviorally, emotionally)

SharonE: the teacher refers to SST, the SST team will make a variety of recommendations RTI levels 1, 2, and maybe even 3. The team will reconvene to see if the recommended interventions have worked. IF not, then a referral for sped assessment is done. That's the usual path

SharonE: however, if a kid is way out there (we have kids who are referred because they crouch on their desks like birds, fly pretend airplanes, you know), they get on the fast track

SharonE: also if a kid has been 5150

JamieB: What about referral to YOUR specific program?

SharonE: same process

PaulDB: Is it to be assumed that this begins when a child enters the school as a pre-K, Kindergarten, or 1st grade student?

SharonE: yes

BJB2 looks at the clock on the wall

SharonE: yes, BJB, btw, thanks for showing my grad students around

PaulDB: And what are the time limits for each step in the process?

SharonE: no time limits for RTI, IDEA kicks in once the parents sign a sped assessment

SharonE: unless it's a fast track thing

BJB2: This has been a stimulating discussion....and a refreshing positive look at SPED identification and treatment

SharonE: then much shorter

SharonE: bye folks

PaulDB: Thanks Sharon!

SharonE: sure

SharonE: I was going to be a lurker

JamieB: Thank you all, most especially Sharon.

JenniferOW: I was the lurker!

BJB2: Please return on July 13 for the next SPED discussion...

JenniferOW: Will do - thank you!

BJB2: we'll have all read the transcript by then and have lots to respond to

JamieB: I'll be watching your tweets, bjb!

PaulDB: Most assuredly!

BJB2 winks at Jamie. Thanks

SharonE: what do you search for in tweets

BJB2: I post the TI events, Sharon

BJB2 . o O (tappedinorg)

SharonE: thanks

JamieB: Open a twitter account, and select tappedin to follow.

SharonE: got one

SharonE: ok

SharonE: bye all

SharonE left the room (signed off).

BJB2: Thanks, Paul, for leading the discussion

JamieB: Have a great night.

BJB2 waves goodnight

PaulDB: I didn't do much!

BJB2: you were the moderator...important job!

PaulDB: Thanks though, it was certainly informative!

BJB2 agrees