

Lewis Cass Intermediate School District Procedure Handbook Speech and Language Impairment

Guidelines for Identification and Service Provision for Eligible
Individuals

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Adapted from

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Preface

There has been growing variability in policy and procedure for speech and language services among and within local education agencies within Lewis Cass ISD. Inconsistencies exist in evaluation methods, criteria for identifying speech and/or language-impairment, criteria for determining special education eligibility, programs and services, and the dismissal or exit criteria of local districts.

Since 1990, the 65-page Michigan Speech-Language-Hearing Association's (MSHA) Suggestions for Identification, Delivery of Service, and Exit Criteria was the most commonly used reference for speech and language pathologists (SLPs) in Michigan. This document was significantly revised and expanded to nearly 400 pages in December 2006 as the Michigan Speech-Language-Hearing Association Guidelines (MSHA, 2006). The new MSHA Guidelines document encompasses suggestions for eligibility, service delivery, and exit criteria for speech-language pathologists in both the clinical and school settings, as well as, for general education and special education.

We hope that in the same manner these Guidelines provide a resource from representatives of our Lewis Cass ISD community of practitioners: (1) to help to guide local discussion of the critical issues impacting speech and language services across Lewis Cass ISD, and (2) to provide consistent Lewis Cass ISD policy and procedure statements in response to the policies and procedures suggested in the MSHA Guidelines. It is important to keep in mind that in case of discrepancies in discretionary practices between MSHA Guidelines and Lewis Cass ISD Guidelines, the Lewis Cass ISD Guidelines should, in the interest of consistency, generally prevail. Ultimately, all policies and procedures should be implemented with a keen regard for bottom-line impact on each individual student's level of academic achievement and functional performance.

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Introduction

Background

The MSHA Guidelines (2006) are an excellent resource for speech-language pathologists (SLPs). There are, nonetheless, several significant issues that concern speech-language pathologists working in the school setting which require further clarification by local districts. These are identified in the MSHA Guidelines document and include:

- Documenting indirect workload activities and scheduling of services (p. WC-7).
- Early intervening process (p. PL-2) and notification and permission of parents for early intervention (pp. L-9, F-6, V-4).
- Determining the presence of a speech and language disorder using multiple assessments, test selection guidelines, and score comparison guidelines (pp. SLI-4-6, L-27).
- Dual certification and related service (pp. SLRS-2-3, LD-12).
- When to certify a student as learning disabled in oral expression and/or listening comprehension rather than SLI (p. LD-18).
- How to document assistive technology needs in the IEP (pp. AT-8-9).
- Dismissal criteria (pp. SLI-9-10, SLRS-5).

Staskowski (2007) and Ehren (2007) in separate presentations have emphasized the changing role of speech-language pathologists as a result of changes in laws and the needs of students. Language is the foundation of literacy and speech-language pathologists are the experts in language. The role of the speech-language pathologist needs to be different, not more of the same. Staskowski and Ehren have emphasized the unique contribution that speech-language pathologists can make as members of educational teams.

Purpose

The purpose of the present document is to clarify local procedures and create consistent policies that will guide educators in meeting the individual needs of students within Lewis Cass Intermediate School District in the area of speech and language. Every student is unique and must be treated as an individual. However, there are research-based and legal parameters that we must all keep in mind and to which we must adhere. These include, but are not limited to:

- Michigan Speech-Language-Hearing Association Guidelines (2006)
- Federal law: Individuals with Disabilities Education Act (IDEA, 2004) and No Child Left Behind (NCLB, 2002)
- Code of Federal Regulations (CFR) implementing applicable federal laws
- American Speech-Language-Hearing Association (ASHA) resources
- MI Revised Administrative Rules for Special Education (Michigan, 2008) (see Appendix A)

- Education YES
- Lewis Cass Intermediate School District Policy
- Research and Promising Practices

Best practices and current trends in education, especially those successfully utilized within Lewis Cass Intermediate School District were researched and considered and are incorporated into this document.

The intent of these guidelines is to increase consistency across Lewis Cass Intermediate School District in early intervention, evaluation, special education qualification, service, and dismissal. The committee recognizes that there still may be some minor differences between some local districts. Keeping differences to a minimum and working towards more uniform practices by school personnel is a goal.

How to Use This Document

The present document was written for reference use by speech-language pathologists, administrators, teachers, and other professionals. It is divided into two parts. Part 1 addresses critical issues identified by MSHA Guidelines which need clarification by local districts. Part 2 is a response to the articulation, voice, fluency, and language sections of MSHA Guidelines. Part 2 also includes revised and expanded sections on infant-toddler speech and language and English Language Learners (ELL).

For individual student concerns a first response may be a consultation to determine the extent of speech-language concerns. The speech-language pathologist may be a participant in such consultations (with parent permission – see Appendix B). Hopefully, many student concerns will be effectively addressed before resorting to a formal special education evaluation.

The complete MSHA Guidelines document is an excellent comprehensive resource. It contains expanded and technical information specific to the speech-language pathologist profession. These two documents are intended to be used together since they contain different information.

Guidelines are always moving targets and need to be updated as laws change, as laws are interpreted, and new research emerges. This is a living document and as such will need to be revised and updated periodically. These guidelines and subsequent updates are available at www.lewiscassisd.org.

Part 1 – Critical Issues

Early Intervening Services Using Research-Based Curriculum Interventions

The concept of early intervening services for school-age students comes from IDEA 2004. The intent is to provide preventive services to children who have not been identified as needing special education and related services but may be experiencing academic difficulties. Early intervening services are designed to address grades K-12 with an emphasis on grades K-3. The most commonly used model is called MTSS (Multi-tiered Systems of Support). For the purposes of this document, research-based curriculum interventions will be referred to as MTSS or early intervening services.

The core principles of this integrated, research-based approach, aimed at enhancing educational outcomes for all children, include:

- Early identification of students not achieving at benchmark
- High-quality instruction and interventions matched to student need
- Frequent monitoring of student progress to make decisions about instruction or goals
- Use of child response data to make educational decisions, including professional development, curriculum, and individual intervention decisions. (MAASE, 2007)

While there are many MTSS models, the U.S. Department of Education does not endorse or mandate any particular model. At the time of this printing the Michigan Department of Education also has not developed policy regarding MTSS. However, the aforementioned components are generally accepted as required MTSS components. Early intervening services will look different in different districts. Lewis Cass Intermediate School District is a diverse intermediate school district and the needs of students in the four local districts will dictate how early intervening services are implemented. Students for whom speech-language concerns are noted would likely be identified through the Child Study (Intervention) process which may be termed differently in the various districts within Lewis Cass. This process may also vary between different districts and even among individual schools within the same district. Just as the child study team process is a general education initiative, so too are early intervening services. These services ideally occur prior to a special education referral.

Position Statement

Lewis Cass Intermediate School District supports the position of the American Speech-Language-Hearing Association that:

“Speech-language pathologists play a critical and direct role in the development of literacy for children and adolescents with communication disorders, including those with severe or multiple disabilities. Speech-language pathologists also make a contribution to the literacy efforts of a school district or community on behalf of other children and adolescents. These roles are implemented in collaboration with others who have expertise in the development of written language and vary with settings and experience of those involved.” (ASHA, 2001)

According to Ehren, Montgomery, Rudebusch, and Whitmire (2006) speech-language pathologists offer expertise in the following:

- language basis of literacy and learning,
- collaborative approaches to instruction, and
- understanding the use of student outcomes data when making instructional decisions.

Districts should be cautioned not to overlook the extensive resources available from speech-language pathologists as vital members of early intervening teams. Often, early intervening services include two or more levels of intervention. Please see Appendix B for examples of Speech Pathologist Activities within MTSS Tiers.

Evaluation

The Federal Register (v. 71, no. 156, August 14, 2006) contains regulations implementing changes necessitated by the reauthorization of IDEA (2004). The evaluation of children with disabilities is addressed in §300.122 . It states that students must be evaluated in accordance with §§300.300 through 300.311 of subpart D of part II. These sections include legal requirements for parental consent (§300.300), screening for instructional purpose which is not for evaluation (§300.302), evaluation procedures (§300.304), additional requirements for evaluations and reevaluations (§300.305), and the determination of eligibility (§300.306). Michigan Revised Administrative Rules for Special Education (2002) also addresses these requirements in Rules 340.1710, 340.1721, and 340.1745.

Universal Screening: Screening across general populations for instructional purpose is not an evaluation (such as “Kindergarten round-up”). Instructional purpose means determining appropriate instructional strategies for curriculum implementation. This type of screening does not require parental permission when the test or other evaluation tool is administered to ALL students, unless consent is required from all parents.

MTSS Process: When a classroom teacher expresses a concern regarding the communication skills of a student, the teacher is responsible for contacting the parents and referring the child to the school’s Student Assistance Team. If the SAT team is concerned that the child may be manifesting a disability and evaluation is initiated. Following an initial discussion with the SAT, Tier 1 Activities may be initiated within the general education classroom. The speech pathologist may make recommendations to the classroom teacher and parents and may participate in whole group activities with the target student for a limited amount of time. Following a period of data collecting no longer than 6-12 weeks, recommendations are summarized and reviewed by the SAT. If the student is not progressing Tier 2 activities may be initiated.

Tier 2 activities are conducted within targeted groups in the general education setting or groups of children pulled from the classroom to work on targeted skills. Parent consent must be obtained for Tier 2 Participation using the Consent for Tier 2 Participation Form. These activities are limited to 6-12 weeks. Following the intervention, data is reviewed by the SAT. If the student does not appear to be progressing an evaluation is initiated. This process is further described in the flowchart in Appendix C.

Referral:

A concern may develop into a formal referral when the Review of Existing Evaluation Data (REED) form is signed by the parent or guardian and is received by special education staff. The 30-school-day timeline for completion and IEP imposed by the State of Michigan begins when the referral is actually received by the district (R.340.1721(c)(2)).

School personnel may receive a written statement from a parent or guardian requesting an “evaluation” or “testing”. A written request is not the start of the formal evaluation with a 30-school-day timeline. However, it does start a process that requires a written response. Within ten days of receiving a written request for an evaluation, the parent must be notified using the Review of Existing Evaluation Data form in Illuminate (340.1721(1)).

Best practice indicates the local district should take an immediate proactive response and contact the person requesting the evaluation. The district representative should determine why the evaluation is sought and the nature of the evaluation. This information is required as part of R 340.1721(1)(a). At this time, the educator making the contact should respond to concerns and explain the process. Depending on the specific situation, the process might range from taking the concerns to the building’s Child Study Team for intervention to immediately preparing the paperwork for parental signature to start a formal evaluation. Ideally, a face-to-face meeting is best since communication may be better and time lines for referral notices and evaluation consents or written withdrawals of request can be taken care of at one time.

It is important all parties understand that no student can qualify for special education under IDEA (2004) unless it can be documented that prior to the referral, research-based interventions within the general education classroom have been provided and have been unsuccessful (§300.306(b)). These interventions are usually recommended and monitored as part of a general education building team process, sometimes called “Child Study Team.” All communication and responses should be documented. If the parent decides to withdraw a written request for an evaluation, that withdrawal must be in writing. When this happens the withdrawal is often contingent upon some other action and possible reconsideration of a referral later, which should also be in writing. If any parental communication is oral, school personnel should still document the verbal exchange in writing.

General Procedures for Evaluation:

A special education evaluation includes the use of a variety of assessment tools and strategies to gather relevant functional, developmental, adaptive and academic information about the child, including information provided by the parent (§§300.304 & 300.305). A REED form must be completed for re-evaluations. The REED form documents a review of the information available and any additional information needed to determine if a student continues to have a disability and whether the child continues to need special education services. Following parent/guardian signature, evaluations are completed and a Multidisciplinary Evaluation Team Report (MET) form is completed in the online IEP system. The MET form indicates the areas in which the student is eligible or ineligible.

General Education Intervention Information

Documentation from early intervening services using research-based curriculum interventions must be included as part of an evaluation (§300.306(b)). Detailed recommendations for Lewis Cass Intermediate School District constituent districts are given in Part 1 of this document. No student can qualify for special education services under IDEA regulations and Michigan rules without documentation of a special education evaluation. The term “pre-referral process” should not be used as it too often implies a pre-emptive decision about initiating a special education referral. There should be differentiated general education services available to all students with the goal of students benefiting appropriately from such services. A student cannot be determined as having a disability if the student has not been provided appropriate academic instruction or has limited English proficiency. Early intervening services are used to determine if appropriate instruction has been provided to meet the student’s needs and assist in documenting the need for specially designed instruction available only through special education. This is particularly important when working with ELL students (see the ELL section of this document). The lack of benefit and success in the general education curriculum even after research-based curriculum interventions have been tried indicates a need for a special education evaluation. Special education eligibility is discussed in the next section.

Evaluation Requirements

An evaluation to determine eligibility for special education as a student with a speech and language impairment must include the following information and documentation:

- Ability/developmental level
- Relevant behavior observations
- Speech/language level
- Spontaneous language sample
- Educationally relevant medical information, if any
- Information from parents
- Documentation from early intervening services if appropriate
- Adverse educational effect
- Consideration of all areas of need

Use of Tests

Tests are used to aid in determining ability/developmental level and the student’s speech/language level. There are two types of tests: standardized and non-standardized. Both play an important role in the evaluation procedure.

Standardized Tests are required as part of the evaluation if available for the area of concern. They cannot be the sole determining factor for determining eligibility, but aid in determining levels of:

- Ability as influenced by communication skills
- Achievement as influenced by communication skills
 - Development
 - Speech
 - Language

Non-standardized Tests and assessment procedures may and should be used to support and expand on standardized test results. They are useful in determining both strengths and weaknesses but cannot be used without standardized tests for determining eligibility. They aid in developing interventions, goals and objectives, and documenting progress over time. Non-standardized tests and assessment procedures include:

- Criterion referenced tests
- Standardized tests administered using nonstandard procedures
- Developmental scales
- Checklists
- Dynamic assessments (test-teach-retest)
- Play-based assessment
- Speech intelligibility measures
- Review of student records
- Spontaneous language samples

Any test or evaluation material must comply with §300.304(c)(1). Each public agency must ensure that assessments and other evaluation materials:

- i. are selected and administered so as not to be discriminatory or racially biased;
- ii. are provided and administered in the child's native language;
- iii. are used for the purposes for which the assessments or measures are valid and reliable;
- iv. are administered by trained and knowledgeable personnel; and
- v. are administered in accordance with any instructions provided by the producers of the assessments.

Additionally, ethical standards outlined in Standards for Educational and Psychological Testing (AERA, APA & NCME, 1999) need to be met. Anyone administering tests should be familiar with this publication.

Each test should have an accompanying manual. It should contain enough information to determine the appropriate use of the test and interpretation of scores obtained. Information and data on the normative sample, reliability, and validity should be provided.

The normative sample is the population with which the test was normed. In order to apply the test norms to the larger population the sample should:

- Represent the most recent census
- Be large enough to insure reliability and validity
- Be representative of the student to be tested in terms of racial-ethnic and geographic status and disability

Reliability refers to the consistency of scores over time/freedom from measurement error. There are several types of reliability, each determined using statistical procedures. Test-retest reliability is generally looked at as the best indicator of a test's reliability. This is determined by administering the same test to the same group after a period of time and correlating the scores.

Validity tries to answer the question, "Does the test measure what it purports to measure?" Validity cannot be measured like reliability. It is inferred using a variety of methods including accumulated evidence and theory supporting specific interpretations of the test.

Language is complex and difficult to measure, thus language tests tend to be less reliable and valid than is desirable. Each test should be considered by the standards set for that test to be a valid method of identification. A general rule is that a test-retest reliability of .9 or higher is best; .8 to .9 is okay; and less than .8 is unsuitable. For this topic a close reading of the MSHA Guidelines at pages SLI-1 through SLI-11 is strongly suggested.

Sensitivity and Specificity

ASHA and MSHA stress the importance of sensitivity and specificity for a test (.80 or better). If the test does not have acceptable levels of sensitivity and specificity, then one needs go no further in reviewing the acceptability of other psychometric standards such as population sample, reliability, and validity (Spaulding, Plante & Farenella, 2006). Sensitivity and specificity are terms that are not as familiar as validity and reliability to speech-language pathologists and others.

Sensitivity refers to the degree to which a test correctly identifies a language impaired student as language impaired.

Specificity refers to the degree to which a test correctly identifies a non-language impaired student as non-language impaired.

As the importance of these measures has become apparent, more publishers are including this information in their test manuals. This data is also becoming more available in the research literature.

Hutchinson (1996) provides a useful explanation and guidelines for looking at psychometric information. He outlines 20 questions test users should ask about any test they consider. Guidance is also provided

regarding what to look for when answering these questions. This article provides a foundation for speech-language pathologists to use in reviewing tests. This paper in conjunction with the Spaulding, Plante, Farinella (2006) research provides speech-language pathologists a foundation on which to assess the appropriateness of a specific test for a specific student.

Sensitivity and specificity are different for each test and affect the cut-off score. The goal is to have both sensitivity and specificity as high as possible yet balanced to keep the possibility of under- or over-identification as low as possible. In *Eligibility Criteria for Language Impairment: Is the Low End of Normal Always Appropriate?* Spaulding, et al (2006) present a research-based review of 43 commonly used tests. From these sensitivity and specificity were available for only ten. Of these only nine had acceptable sensitivity and specificity (80% or better). Reliability and validity is generally moderate for each of these. The point at which an appropriate identification rate is achieved is the cut-off score for that test. MSHA recommends using .80 or higher as the criterion when selecting tests.

Interpretation of Test Scores

Test scores are only one factor in determining eligibility. While arbitrary cut-off scores from 1.5 to 1.33 standard deviations (SD) from the mean have been historically used for eligibility decisions, **a close reading of the test administration manual is strongly suggested.** Even when valid and reliable, a test score in itself is not a sole determination of eligibility for special education. For example, a cut-off score one standard deviation (SD) below the mean (score of 85 for an SD of 15) will capture all students with disabilities, but may also over-identify a significant number of non-impaired students (particularly culturally-linguistically diverse students). A cut score at two standard deviations below the mean (score of 70 for an SD of 15) will greatly reduce over-identification, but may increase under-identification of students appropriate for speech-language pathologist services. Test scores are just one piece of information that must be considered with other types of information when assessing the impact of a suspected disability.

Each individual test needs to be considered by the standards for only that test (Plante, 2003). IDEA and Your Caseload (ASHA, 2003) indicates that using a uniform cut-off score across all tests may result in over- or under- identification. **One cut-off score is not applicable to all tests or subtests.**

A comprehensive list of tests most commonly used in Lewis Cass Intermediate School District is provided in Appendix J. Information is also included for each test on age span, publication date, and test-retest reliability for total test and subtests where available. Caution is advised when looking at subtest scores. They are generally less reliable than total test scores. Sensitivity and specificity are also different for subtests than they are for total tests, but data for total tests are all that are usually provided in the manuals.

This does not imply that there is no use for other tests or subtests. They play an important role in the total evaluation as noted above. Their usefulness includes identifying weaknesses in need of remediation, providing guidance in determining goals and objectives, and documenting progress over time.

Cognitive Referencing

The term “cognitive referencing” has been used frequently in the speech-language literature. MSHA Guidelines (2006) call cognitive referencing the practice of comparing a student’s language performance to their performance on cognitive measures. “Severe discrepancy” refers to the degree of discrepancy

between a standardized ability test and a standardized achievement test and is a term more frequently used by school psychologists for the same concept. The consensus is that neither cognitive referencing nor severe discrepancy should be used as the **sole** determining factor in determining special education eligibility. Legally, there should never be any one determinate for eligibility, such as a language-cognitive ability discrepancy or any other single factor (§300.304(b)(2)). As noted above, an evaluation consists of much more than one or two test scores.

There are times when the concept of cognitive referencing is useful and aids in the comprehensive evaluation. For example, in *Speech-Language Guidelines for Schools*, the Kansas State Department of Education (2005) endorses the use of a severe discrepancy between the performance of the student and his or her peer, or evidence of a severe discrepancy between the student's ability and performance in the area(s) of concern as part of the procedure for determining eligibility for special education speech and language services. This is not the sole criterion; it is part of the entire evaluation process. The severe discrepancy determination is made by examining interventions, school records, interviews, observations, and assessments, not just by comparing one test score to another.

Looking at a discrepancy using the Kansas method can be useful in determining reasonable language expectations. It helps in understanding the whole child. Is the student's speech-language performance within an expected range for that student based on the multiplicity of available information? A psychoeducational evaluation by the school psychologist may be needed when working with complex cases. The psychologist's input may help in determining reasonable language expectations. His/her evaluation may impact eligibility, type of service needed, service provider, and dismissal of services. Extreme caution should be used when considering reasonable language expectations for a very young child.

Informed Clinical Opinion

Although this term has been used and applied primarily to the birth to 36-month age group and is referred to in law (IDEA, Part C) the concept seems applicable across all ages. No one procedure, test, battery of tests, checklist, or observation alone is valid, reliable, or legal for special education identification. Professionals gathering various forms of data regarding a student must always interpret the data and include information from parents and others, then synthesize that information as a member of a team. There is less formal documented information available for younger children. As a student gets older there is more information such as standardized test scores, school records, and research-based early intervention data, and thus there is more concrete information on which to base an informed decision.

Final decisions regarding special education eligibility have generally included some degree of "professional opinion" or "professional judgment". Basing this part of the evaluation on information versus simple opinion is really making an informed clinical opinion. (Schackelford, 2002; Bagnato, Smith-Jones, Matesa & McKeating-Esterle, 2006). ASHA (2003) also discusses the role of professional judgment based on documentation. The term "informed clinical opinion" reflects how each professional and each team should interpret the data and information collected during the evaluation. Informed clinical opinion will be the term used in this document.

Eligibility

If the evaluation is an initial evaluation, or there is consideration of adding or removing a special education area of disability, it would be considered a Multidisciplinary Evaluation Team (MET) recommendation. The IEP Team reviews evaluation data and other information presented to them and then recommends eligibility. Following the comprehensive evaluation, the relevant Multidisciplinary Evaluation Team Report (MET) form(s) is/are completed in Illuminate as described previously (see pg. 12)

Diagnostic Assurance Statements

The Speech and Language Impairment Multidisciplinary Evaluation Team Report (MET) form specifies three diagnostic assurance statements which are based on IDEA regulations and Michigan rules. The needed information to complete these statements is derived from the documentation provided from both early intervening services **and** the comprehensive evaluation. This includes test (standardized and non-standardized) results, observations, relevant medical information, and information from parents.

- The educational performance of this student is **adversely affected** by a communication disorder;
- The suspected disability is not due to limited English proficiency nor lack of instruction in math or the essential components of reading, and
- This student requires specially designed instruction available only through special education.

These three statements must be true for the student to have a disability under special education (IDEA) law. The student may have a disability, but if it does not adversely affect his/her educational performance, is due to limited English proficiency or related to lack of instruction in math or reading, he/she is not eligible for special education. If these statements are true, but his/her individual needs can be met in the general education setting without special education programs/services, then he/she is not eligible.

Speech-Language Impaired as a Primary Disability

When the early intervention and evaluation procedures have been completed and indicate a disability, and the above assurance statements have been determined to be true, the student is eligible for special education as a child with a speech-language impairment. Then a MET/IEP must be held to determine the child eligible for services and detail what those services will look like.

Individualized Education Plan/Programs and Services

Introduction

The MET Team determines eligibility. Determination is based on the evaluation(s) and other relevant information presented by the team. Following a determination of eligibility, the team formulates an IEP to provide the services determined necessary by the MET/IEP team.

Present Level of Academic Achievement and Functional Performance

The present level of academic achievement and functional performance (PLAAFP) is the foundation on which the rest of the IEP is developed. When adding strength and needs information into Illuminate, the following information must be included (this information is what generates the PLAAFP).

1. Strengths in the area of eligibility for each area where there is a need (articulation, expressive language/receptive language).
2. Data for each area of need. Including a documentation of positive behavior supports if a student has behavior needs that impact the student's learning or the learning of others.

The IEP system includes pre-developed impact statements that describe the impact of a student's speech and language disability on their academic progress. Baseline data should include both strengths and needs, but must include data related to the area(s) of the disability. Data may be derived from tests, classroom performance (such as work samples, teacher-made tests, etc.), documented observation (written, systemic, ongoing), and/or state or district-wide assessments. Other data sources include provider logs, checklists, attendance records, and other sources. Areas in which the student requires specially designed instruction need to be identified. Each area must be addressed in at least one of the following:

- Annual goals and objectives
- Supplementary aids/services
- Transition plan/services
- Transportation

Transition Plan

According to state law, a transition must be completed when the student is 16. If the student is 15 and will be turning 16 within the IEP duration, a transition plan must be completed. A transition can be done sooner if the IEP Team deems this is necessary.

Annual Goals and Objectives

Well written and compliant goals are SMART:

- A SPECIFIC skill or behavior that the child will complete
- A criteria (level or degree of performance) and condition (under specific circumstances) the skill will be MEASURED and where progress will be reported
- ATTAINABLE within a year
- RELEVANT to the area of need
- TIMELY: A due date by when the goals should be attained

Example: By September 12, 2013, without assistance, the STUDENT will verbally identify a minimum of 80 words composed of 3 letters with an accuracy rate of 75% in 3 out of 4 trials, as documented in student's progress reports.

Supplementary Aids/Services

- Must be based on documented need.
- Must be clearly defined and specific.
- Must not use "as needed".

Placement

IDEA regulations require that students with disabilities must be educated in the least restrictive environment (LRE) (§300.550). This requires that they be educated with children who are not disabled to the maximum extent possible. The term placement refers to points along the continuum of service, not to the physical location. Special education service is determined by the IEP Team based on needs identified in the PLAAFP.

A continuum of alternative services must be available to meet the needs of students with disabilities (§300.551).. Some smaller districts may not have enough students with specific needs to have every alternative service available at a student's local school, or even within the district. In these cases, districts make appropriate services available through cooperative arrangements with other districts in Lewis Cass Intermediate School District. Placement decisions are made on an individual student's needs, not on what is available in a district.

Students eligible for special education who have a need for Speech and Language services should receive services that are:

- Curriculum-based
- Outcome-oriented
- Educationally relevant

- Designed to improve the student's ability to access and make progress in the general curriculum and, for preschoolers, in age-appropriate activities
- Centered around student need
- Research-based

Services may be provided in a variety of ways but must be specially designed to fulfill the requirements for the student to progress in the general curriculum. Possible model of speech services may include:

- Consultation with the classroom teacher
- SLI push in services within the general education classroom setting (do not indicate time away from typically developing peers)
- SLI services within the special education classroom setting (do not indicate time away from typically developing peers for the speech service-this is accounted for when the program is added)
- Small groups in a pull-out setting
- Individual sessions in a pull-out setting.

Some students with cognitive impairment, physical impairment, severe multiple impairment, or autism spectrum disorder may require categorical special education programs and/or alternate curriculums. Speech-language needs for these students can often be met by the special education teacher with or without a speech-language pathologist consultation. Depending on the curriculum, there may be some situations when small group or individual services may be necessary for varying periods of time. There may be RARE occasions when a student has such a severe speech-language impairment that the student may require special education services with a teacher consultant or a special education teacher, yet meets only the SLI criteria.

Speech-Language Impaired as a Primary Disability

If the student's primary eligibility is speech-language impairment, an IEP must be conducted. Within Lewis Cass ISD service times are typically written in monthly increments (eg: 90-120 minutes per month, 6-8 times per month for 10-15 minutes per session). The IEP system requires documentation of the total amount of time per month, minimum hours per week, maximum hours per week and average hours per week. If the student is being pulled from a general education classroom, the average hours per week should also be reflected as the time away from general education. Please consult Appendix D for a Time Conversion Chart.

Speech-Language Services as Ancillary/Related Service

Neither IDEA regulations nor the Michigan rules require a second disability label (SLI) for a student to receive services from a speech-language pathologist. To add speech-language services to an IEP for a student that is eligible under a different category, a REED and a diagnostic report must be completed and the service can be added through an amendment OR an IEP. Services should provide the necessary support for the student's area(s) of need. These needs are identified in the present level of academic achievement, functional performance, goals and objectives, and progress in the general curriculum.

Indirect Therapy Services/Consultation of Speech and Language Therapy:

When a child is nearing graduation from speech and language therapy services, or there is a mild need that may be adequately addressed through staff support and/or periodic monitoring of the student and the IEP team believes that the child may benefit from periodic contact with the speech pathologist, Indirect therapy services or Consultation of speech and language therapy services may be written into the student's IEP as long as the student is not qualified for special education services under §340.1710.

Indirect therapy services are listed under the Programs/Services section and noted as "Consult" in the IEP System. This service involves ongoing support to staff who are working with the student on various elements within the IEP. There may be periodic contact with the student for the purposes of assessment and monitoring. Goals and Objectives are written by the caseload provider and/or the service provider. Documentation of services must be maintained by the service provider including: Date, Time and Information relative to the service provided.

If the service provided by the speech pathologist is consultative and support is provided only to the staff working with the student, the service is documented in the IEP system as a Supplementary Aid/Service.

Dismissal from Speech and Language Services

Termination of SLI eligibility – If the student has an SLI eligibility, determination of ineligibility by an IEP Team requires a Review of Existing Data (REED) and a subsequent evaluation as needed. Dismissal does not require documentation in a REED and MET as to why the SLI is no longer appropriate. The Multidisciplinary Evaluation Team Report form for SLI must be completed and an IEP held to terminate services.

Termination of Speech Language services as an Ancillary/Related Service – When SLI is not a category of eligibility, dismissal from speech-language as an ancillary service can be made only when the student is determined by an IEP Team to no longer require direct speech-language services. The speech-language pathologist will provide information to support dismissal in the strengths and needs section of the IEP. Under these circumstances the discontinuation of ancillary service can be documented in either an IEP or with an IEP amendment.

Obligations to Nonpublic and Home Schools

An occasional speech-language pathologist service delivery issue in Lewis Cass Intermediate School District is provision of service to nonpublic schools. Michigan law states the term "nonpublic school" also applies to a registered home school. In Michigan's Auxiliary Services Act, public districts must provide auxiliary services to nonpublic elementary and secondary schools within its boundaries. All special education related services are included in the Act. A public school must provide the same auxiliary service on an equal basis to pupils in the elementary and secondary grades at the nonpublic school. This is completed through a Service Plan. Just as in any IEP, these special education related services must address needs related to student academic achievement and functional performance in a service plan. The core academic content area remains the responsibility of the nonpublic school.

Evaluation services for special education are also an auxiliary service. Public school speech-language pathologists may therefore be involved in evaluations of students attending local nonpublic schools. If the outcome of an evaluation results in special education eligibility, some likely Service Plan considerations are:

1. **A proposed Service Plan for only related services.**– The parent may decide to retain the student’s enrollment at the nonpublic school, and the related services may be provided by the public district at the nonpublic school or other IEP Team determined site.
2. **Dual Enrollment.**– Whether involved in special education or not, any student may simultaneously in both the resident public district and a nonpublic school. In dual enrollments, the public school is still restricted from providing instruction in core curriculum as described above.
3. **The Auxiliary Act does not apply to preschool children.**–Since the Auxiliary Services Act does not include preschool, questions about special education services should be directed to the student’s resident district. Consultation, evaluation, and special education programs/services are all the responsibility of the resident district.

The topic of public services to nonpublic schools is more complicated than presented in this brief summary. For example, issues often involve distinctions among programs/services and accommodations, and core versus non-core curriculum. For further information, contact your district administration or refer to policies in Information on Nonpublic and Home Schools published by the Michigan Department of Education.

Caseload, Workload, and Scheduling

Caseload and Workload

The term caseload refers to the students who are receiving direct services and have an Individualized Educational Program (IEP). The term workload includes not only the speech-language pathologist's caseload but also encompasses the many additional activities which speech-language pathologists perform in the school setting. Workload includes:

- Direct services to students including instruction, interventions, and evaluations
- Indirect services to support the implementation of the students' IEPs
- Indirect activities that support students in the least restrictive environment and in the general education curriculum
- Activities that support compliance with federal, state, and local mandates and activities that result from membership in a community of educators.

In *A Workload Analysis Approach for Establishing Speech-Language Caseload Standards in Schools: Guidelines* (ASHA, 2002) the activities included in each of the four areas are defined. It is clear that in the modern day school setting best practices include many activities outside of providing direct services to students with IEPs.

Often in Michigan, administrators simply manage speech-language pathologist caseloads by tracking maximum caseload size of 60 (per Michigan Rule 340.1745) with little regard to quality of service and impact on student literacy. However, schools are also mandated to monitor student performance on State Performance Plan (SPP) indicators required by the IDEA regulations. Unfavorable performance on SPP indicators may trigger state-level determinations, intervention and, in troublesome cases, financial sanctions. Deploying related service staff, including speech-language pathologists, is a valuable resource in meeting SPP targets. It is hoped that the speech-language pathologist is utilized as a language specialist who can "bring to the table" expertise for building teams working to address bottom-line student performance in the language-intensive activities of reading and language arts.

Successful implementation of new practices (such as MTSS) will require a change in perspective from speech-language pathologists, administrators, teachers and parents. Speech-language pathologists will have the opportunity to utilize their unique and varied expertise and contribute to student success. However, it is not realistic to expect speech-language pathologists to continue to provide MTSS interventions and still provide best practice/research-based services to caseloads that often exceed 60 students. The concept of a Workload Analysis Approach, which has been recommended by ASHA since 2002, is essential to successful MTSS implementation. For further information, please reference the Work Load Activity Clusters in Table 1.

Table 1 - WORKLOAD ACTIVITY CLUSTERS

Direct services to students

- Counsel Students
- Evaluate students for eligibility for special education
- Identify students with speech and language impairment
- Implement IEPs and IFSPs
- Provide direct intervention to students using a continuum of service-delivery options
- Reevaluate students

Indirect activities that support students in the least restrictive environment and general education curriculum

- Engage in dynamic assessment of students
- Connect standards for the learner to the IEP
- Consult with teachers to match student's learning style and teaching style
- Design and engage in pre-referral intervention activities
- Design/recommend adaptations to curriculum and delivery of instruction
- Design/recommend modifications to the curriculum to benefit students with special needs
- Participate in activities designed to help prevent academic and literacy problems
- Observe students in classrooms
- Consult with teachers/students for suspected problems with communication, learning, and literacy

Scheduling

The populations of students served vary across districts from students with severe multiple impairments, to students with autism spectrum disorder, to students with mild articulation impairments. IEPs should reflect individual student needs in every manner, including the model of service delivery.

3:1 Model – In this model three weeks of a four week cycle are dedicated to providing direct services to students as individual therapy, small group therapy, push in lessons and evaluations. The fourth week is reserved for indirect services such as consultation, collaboration, developing materials, completion of paperwork and including Medicaid billings. A variation of this model is a weekly version where four days include direct services and the fifth day is reserved for indirect services.

Flexible Scheduling – According to the MSHA Guidelines this model combines service delivery options and provides opportunities for individual, small group (no more than 8), classroom and indirect services while allowing the speech-language pathologist to schedule other job related responsibilities.

Creative Scheduling – This schedule involves varying times in a schedule to meet the specific needs of a group of students. Time is blocked in a week to meet the specific needs of the students, but the service provided to that group may differ by day. Some days may include direct service provision to the students in the therapy room. Some days may include push-in services in the classroom and some days may include individual sessions with the students. Several scheduling options that depart from traditional service must be considered to help better manage speech and language workload.

Speedy Speech/Five Minute Articulation –Speech services can be offered to students utilizing shorter sessions with higher intensity and/or frequency. The speech-language pathologist drills the student with mild to moderate articulation impairments in short, individual (5-minute), and frequent (daily, three times a week) sessions. Sessions may occur near the classroom to decrease transition time. Results reported anecdotally are said to be as good as, or better than more traditional articulation therapy.

Part 2 – Supplement to Sections of the Michigan Speech-Language-Hearing Association Guidelines

Articulation and Phonology

Introduction

Speech errors are classified as articulation, phonology and motor speech disorders. Errors in sound production are generally classified as motorically-based or cognitively/linguistically based (Bernthal and Bankson, 1988). Motorically-based errors are generally called articulation impairments and may be characterized by the omission, distortion, substitution, addition and/or sequencing of speech sounds. Cognitively/linguistically-based errors are referred to as impairments of phonological processes and may be characterized by final consonant deletion, fronting, cluster reduction, gliding, stopping, syllable reduction, etc. Motor speech disorders include dysarthria and apraxia. Dysarthria results from the disruption of muscular control. Apraxia results from an impaired ability to generate motor programming for speech movements.

Prevention

Speech-language pathologists have a role in educating school personnel and parents about normal articulation and phonological development. Teachers and parents may be interested in promoting articulation development by providing correct models, listening activities, and by discussing articulation placements during instruction. For example, a kindergarten or first grade teacher may discuss tongue placement when introducing sounds for each letter or during phonological awareness activities. Increasingly, speech-language pathologists are providing phonemic awareness instruction to children, both with and without identified communication impairments, in the classroom as part of prevention initiatives. Mass articulation screenings have not been in practice in Michigan for some time. There is some discussion in the literature of this practice being renewed within a response-to-intervention (MTSS) framework applied to articulation (Moore-Brown & Montgomery, 2004). Typically, children’s articulation and phonological disorders are identified through teacher and parent referral.

Early Intervening

When a teacher or parent has concerns about a student's articulation, s/he consults the speech-language pathologist. Given proper permissions the speech-language pathologist observes the student's speech, talks to the child's parents and teachers, and discusses how the student's articulation difficulties may be affecting educational performance. If, after consultation with the speech-language pathologist, it is determined that the errors in articulation may be resolved without speech intervention; the speech-language pathologist may suggest strategies and follow-up for the student, teacher, and parents to use.

No referral is necessary when there is adequate student progress in response to the interventions. If it is determined that the student is not making adequate progress based on data collected, the special education evaluation process should begin. The parent will be contacted to complete a Review of Existing Evaluation Data.

The Formal Special Education Process: Evaluation Review/Consent

Consent for Initial Special Education Evaluation – When concerns for a student's academic achievement and functional performance persist after interventions in general education, a special education referral may be warranted. The team completes the REED form in Illuminate, and obtains parental consent. Gathering information from teachers, parents and students is an important aspect of the evaluation process. This information may be gathered through a variety of checklists provided by the 2006 MSHA Guidelines on pages A-11 through 13 respectively.

Articulation and Phonology Testing – Formal assessment may include both articulation and phonology. Norm-referenced tests which are both valid and reliable should be administered. Caution should be used in the interpretation of standardized scores to determine the need for services. Although some assessments will reveal standardized scores below the average range for single sound errors, services may not be necessary if there is not adverse educational effect.

Summary of Adverse Educational Effect and Eligibility – Based on the information gathered, the team decides whether the student is experiencing an adverse educational effect as a result of articulation or phonological errors. If it is determined that these articulation or phonological errors and concerns negatively impact the student's ability to be successful in the general education environment, which includes nonacademic and academic communication and classroom participation, special education eligibility should be considered. If there is not an adverse educational effect, the student is not eligible for special education services even if the child demonstrates some articulation errors. **Both** (1) the presence of errors and (2) an adverse effect on education requiring specialized instruction must be present to be considered eligible.

Dismissal Criteria – Please refer to pages SLI-7, SLI-8 of the MSHA Guidelines. Speech-language pathologists should keep in mind that there is research suggesting that students who are dismissed at 75-85% accuracy in conversational speech often go on to fully correct, suggesting that this is an appropriate time for dismissal (Diedrich, 1980).

Articulation and Phonology Norms

Lewis Cass Intermediate School District recommends using the Iowa-Nebraska Articulation Norms (Appendix E), which are based on when 90% of the population achieve a specific sound. This recommendation is based on the replication of the results over time and the frequency with which states have adopted these norms as their standard for statewide guidelines for speech and language.

The most recent study of these norms was in 1990 (Smit, Hand, Freilinger, Bernthal, & Bird). This study was a replication of studies in 1957, 1967, 1975, 1976, 1986 and 1988. The findings of Smit, et al (1990) demonstrate that the ages of acquisition of tested consonant single sounds have generally remained constant or moved to earlier ages. Ages of acquisition for a few phoneme singles and for most clusters have either remained constant or have moved to slightly later ages. **No single piece of data should be used to identify a student with a disability.**

Fluency

Definition of Stuttering – Disfluency (stuttering) is an abnormally high frequency or duration of stoppages in the forward flow of speech that occurs in the form of repetitions of sounds or syllable prolongation of sounds, blocks of airflow or voicing. Often accompanied by awareness, embarrassment, signs of physical tension, or increased rate of speech (MSHA, 2006, F-2).

Cluttering is a disorder of speech and language processing resulting in rapid, dysrhythmic, sporadic, unorganized, and frequently unintelligible speech. Accelerated speech is not always present, but an impairment in formulating language almost always is (MSHA, 2006, F-2).

Early Intervening – Teachers and parents who have concerns regarding a student’s fluency should consult with a speech-language pathologist to determine if further assessment is necessary. The speech-language pathologist and others will collect information through observations, checklists, and parent and teacher input. Strategies and suggestions related to how a teacher and family respond to the child’s disfluency may be given.

If the team feels that with consultation from the speech-language pathologist, the disfluency may be resolved, the speech-language pathologist then suggests strategies for the student, teacher and parent to use. The speech-language pathologist then follows up periodically. The speech-language pathologist may also elect to use early intervening to document this process. If the difficulty persists, then a complete speech and language assessment may be necessary.

If there appears to be disfluency that adversely affects the child’s educational performance which needs direct intervention from the speech-language pathologist, an evaluation process will begin and parent consent for evaluation will be needed. An example of when to immediately use the formal assessment process might include a case where there is a family history of stuttering behavior, and the student shows multiple secondary characteristics and disfluencies, along with self-awareness of the disfluent behavior. (MSHA, 2006)

Input – Input from teachers, the student, and parents are all important components of the fluency assessment. Examples of checklists are found in the MSHA Guidelines (2006). Reviewing family history, student self-esteem, motivation/attitude, and self-assessment of communication as it relates to their fluency are all important information to be considered.

Risk Factors – There are several risk factors that increase the likelihood that a student will continue to stutter. Refer to **Table 2 - Fluency Risk Factors**:

Table 2 - Fluency Risk Factors (Ainsworth & Fraser, 2006; Yairi & Ambrose, 2005)

Risk Factors	Where Obtained	Present or Absent
<p>Male (stuttering affects males 3 – 4 times more than females.)</p> <p>Females likely to recover without intervention.</p>		
<p>Age of Onset</p> <p>Students who begin stuttering prior to the age of 3 ½ years are more likely to outgrow stuttering. Students who begin stuttering after age 3 ½ years may continue to demonstrate stuttering behaviors.</p> <ul style="list-style-type: none"> ● 75% of those who stutter are doing so by age 6 ● 100% are doing so by age by age 12 	Parent Input	
<p>Time Since Onset</p> <p>Stuttering typically begins before 3 years of age. (Begins when speech/language gets more complex).</p> <p>If a student has been stuttering longer than 6 months, they may be less likely to outgrow the behavior on their own. The likelihood to persist increases even more after 12 months.</p>	Parent Input	
<p>Family History</p> <p>Approximately 30 to 60% of people who stutter have a family member who stuttered.</p>	Parent Input	
<p>Presence Other Speech/Language Impairment</p> <p>Students with other speech/language disorders are at higher risk for stuttering (SFA, 2006).</p>	Parent Input	
<p>Pattern of Stuttering</p> <p>If the student is relatively unaware of their disfluencies, the risk of a fluency disorder is reduced compared to a student who is aware of their stuttering. Whole word repetition at the beginning of an utterance is more typical in development than blocks (when phonation is interrupted).</p> <ul style="list-style-type: none"> ● Stuttering often begins abruptly/suddenly. 	SLP Observation or Parent/Teacher Report	
<p>Sensitivity of Child</p> <p>Students who are emotionally more sensitive may respond to stressful situations with stuttering behaviors.</p>	Parent Input	

<p>Environment</p> <p>Family reaction, fast-paced family schedule, family dynamics such as high expectations, communication style of parents and/or teachers, significant life event (death, divorce, etc.) may contribute to disfluencies.</p>	<p>Parent Input</p>	
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Persistence and recovery of stuttering- Recovery appears very common (historically: 68-85% unassisted recovery rates). Illinois study noted that only a minority (approximately 20%) of young children continue to stutter five years after onset. The likelihood of children recovering after 5 years of stuttering significantly decreases. While onset of stuttering is often quick, recovery from stuttering is usually gradual. In the majority of cases, onset of recovery typically occurs in the first year and usually completes within 3 years but sometimes up to 4-5 years. (Yairi & Ambrose, 2005)

Predicting recovery is heavily dependent on the time and course of stuttering disfluencies. Look at the longitudinal trends in the first 12 - 18 months. In persistent children who stutter, Stuttering Like Disfluency (SLD) rates become stable during this time and seem to be predictive of SLD rates later. Therefore the pattern in the first year of stuttering may be a warning sign for persistence. The longer the child is stuttering, the more likely it will continue. Therefore, it is important to do your best to establish an accurate onset.

Primary factors which help determine prognosis for persistence include:

- Family History (family history of persistence predicts persistence).
- Gender (boys are more likely to experience persistence).
- Age at onset(persistence is associated with slightly higher age of onset).
- Trend in stuttering behavior (biggest predictor of persistence):
 - 1). Stable rates of SLDs over time, particularly in the first year.
 - 2). Continued presence of multi-unit repetitions over time.
 - 3).Continued heightened tempo in repetitions (short intervals between units).
 - 4). Increasing proportion of prolongations and blocks over time.

Test Administration or Analysis of Frequency and Duration of a Connected Speech Sample – The primary goal of the initial assessment is to both determine eligibility and to identify an appropriate treatment plan. The speech-language pathologist and team must determine whether a fluency impairment exists, how it adversely affects educational performance (academic, nonacademic, or extracurricular), and how intervention should be designed to help the student to progress in the general education curriculum. See the Stuttering Severity Instrument (MSHA, 2006, F-14).

Classroom Observations of Adverse Effect – Observe the student during a time of day when the teacher indicates student’s disfluencies interfere with participation. Collect further information regarding whether

the student's fluency is adequate for successful participation in that curricular task or whether the student lacks the fluency skills and/or strategies needed.

Cluttering – Analyze disfluencies for differential diagnosis of stuttering versus cluttering. Please refer to the cluttering checklist in MSHA, 2006, F-17,18.

Other Assessment Information – The speech-language pathologist should complete a broad-based screening of language, articulation, oral-motor, and voice to explore the possibility of additional impairments.

Summary of Eligibility in Fluency – If there is documented evidence of stuttering and/or cluttering **and** an adverse impact on educational performance, and absence of cultural/linguistic or environmental/economic differences, then the student should be considered eligible as speech and language impaired in the area of fluency. **Both** the presence of a disability **and** adverse educational effect must be documented to be considered eligible. Only one of these criteria does not justify eligibility as a student with a disability.

Voice

Definition – A voice impairment is defined as the abnormal production and or absence of vocal quality, pitch, loudness, resonance, and or duration which is appropriate for an individual's age and or sex (ASHA, 1993, p. 40). When this disorder adversely affects educational performance, then a voice impairment may be present as described in the Michigan rule.

Early Intervening– Teachers and parents with concerns regarding a student's vocal quality should consult with a speech-language pathologist to determine if further assessment is necessary. The speech-language pathologist and others will collect information through observations, checklists, and parent and teacher input. When students present with laryngitis or hyponasality, a brief conversation about the duration, symptoms and possible presence of a cold or allergies can alleviate concern. The speech-language pathologist listens to the student's voice, interviews the parents, and together with the classroom teacher determines how the student's voice adversely affects educational performance.

If the team feels that with consultation from the speech-language pathologist, the vocal quality may be resolved, the speech-language pathologist then suggests strategies for the student, teacher and parent to use. The speech-language pathologist then follows up periodically. The speech-language pathologist may also elect to use early intervening to document this process.

If there appears to be vocal quality that adversely affects the child's educational performance which needs direct intervention from the speech-language pathologist, then a referral or Review of Existing Evaluation Data (REED) process will begin and parent consent for evaluation will be obtained. A medical evaluation, such as a visit to an otolaryngologist (ENT), may occur during the early intervening or evaluation process.

Input – Ideally, the parent provides a written medical report from a laryngeal examination for the evaluation for voice structure and function. Input and interviews from teachers, the student, and parents are all important components of the vocal quality assessment. Interviews with non-classroom school personnel will help determine whether there is vocal abuse/misuse in a variety of settings. Parent interviews may reveal environmental factors such as second-hand smoke, food allergies, and medical

conditions, such as sinusitis, enlarged adenoid/tonsils, and bulimia. Examples of checklists are found in the MSHA Guidelines (2006).

Consideration of Cultural/Linguistic Differences (CLD) – It is important to investigate cultural and linguistic variables that may affect voice production. Cultural variations can influence variations in volume, pitch, and quality.

Consideration of Temporary Physical Factors – Voice difficulties as a result of temporary physical factors should not be considered as a voice impairment/disability. These might include factors such as allergies, sinusitis, gastro- esophageal reflux, colds, abnormal tonsils or adenoids.

Vocal Quality – Use observations, checklists, or interviews to assess the student’s vocal characteristics looking for difficulties such as breathiness, stridency, or hoarseness. Breath supply should be evaluated for the amount and efficiency of air to sustain speech. Phonatory efficiency should be evaluated to assess the student’s ability to sustain quality phonation. Muscle tension during speech production should also be evaluated looking for signs of hypertension, hypotension, and anxiety when speaking.

Pitch – Use observations, checklists, or interviews to assess the student’s use of pitch looking for difficulties such as extraordinarily high or low pitch, pitch breaks, or monotone.

Loudness – Use observations, checklists, or interviews to assess the student’s use of loudness, looking for difficulties such as excessive loudness, or softness.

Resonance – Resonance disorders are usually the result of a variety of structural abnormalities such as cleft palate, and velopharyngeal insufficiency (hypernasality) or nasal polyps and enlarged adenoids (hyponasality). Use observations, checklists or interviews to assess the student’s resonance. Look for difficulties such as hyponasality, hypernasality, nasal emissions, and/or assimilation nasality on vowels.

Additional Areas of Assessment for Planning Intervention – Use observations, checklists, or interviews to assess: breath rate, phonatory efficiency, muscle tension, intelligibility, and speech avoidance.

Summary of Eligibility in Voice – If there is evidence of a voice disorder, an adverse impact on educational performance, and the absence of cultural/linguistic or environmental/economic differences, then the student should be considered eligible as speech and language impaired in the area of Voice. Both the presence of a disability and adverse education effect must be addressed to be considered eligible. Only one of these criteria cannot justify eligibility as a student with a disability.

Language

Overview

According to the Michigan Speech-Language-Hearing Association, “The prevention, assessment and intervention for language impairments are the most common activities of the school-based speech-language pathologist” (MSHA, 2006). Participation, access, and progress in the general education curriculum are dependent upon a student’s skills in oral and written language.

Definition of a Language Disorder – ASHA (1993, p. 40) provides the following definition of a language disorder and its components:

“A language disorder is impaired comprehension and/or use of spoken, written and/or other symbol systems. The disorder may involve (1) the form of language (phonology, morphology, syntax), (2) the content of language (semantics), and/or (3) the function of language in communication (pragmatics) in any combination.

1. Form of Language

- a) Phonology is the sound system of language and the rules that govern sound combinations.
- b) Morphology is the system that governs the structure of words and the construction of word forms.
- c) Syntax is the system governing the order and combination of words to form sentences and the relationships among the elements within a sentence.

2. Content of Language

- a) Semantics is the system that governs the meanings of words and sentences.

3. Function of Language

- a) Pragmatics is the system that combines the above language components in functional and socially appropriate communication.”

Early Intervening – It is recommended that when students are suspected of having language concerns, the same process be used (child study team/student assistance team and early intervention strategies) as when districts consider the presence of other potential learning difficulties. If general education interventions have been implemented and progress does not occur, it may be decided to formally assess a student’s language skills.

When the decision is made to pursue a formal assessment of a student’s language skills, the primary goal of an initial assessment is to answer the following questions:

- Does a language impairment exist?
- Does the language impairment have an “adverse educational impact” on school performance in the academic, nonacademic, and/or extracurricular domains?
- Does the student require specialized instruction?

Determining Eligibility for Language Impairment – The following information and documentation is required to determine eligibility for special education as a student with a speech-language impairment:

- Ability/achievement/developmental level
- Relevant behavior observations
- Speech/language level
- Spontaneous language sample
- Educationally relevant medical information
- Information from parents

Sample forms are available in the MSHA Guidelines (2006), L-13, 15-17, et seq.

Ability/Achievement/Developmental Level – Assessment information regarding a student’s ability level, achievement level, or developmental level may be available from psycho-educational, school social work, physical therapy and/or occupational therapy evaluation reports. Information from progress monitoring procedures (such as DIBELS, MLPP), group standardized achievement tests (NWEA or M-STEP), writing rubrics, or content specific measures (e.g., integrated theme tests in reading, district- wide assessments of reading and mathematics) should also be gathered and considered as part of the assessment process.

A review of accommodations, modifications, and interventions that have been provided to the student through the child study process and the intervention model should be completed. These strategies and the student’s response to them need to be documented.

Sample forms are available in the MSHA Guidelines (2006) L-8.

Relevant Behavior Observations – Information regarding behavior in the school environment may be found in the student’s cumulative file, prior evaluations, reports by private providers and public and/or private agencies, as well as the teacher and the parent input forms. Curriculum-based language assessments should also be reviewed. These assessments measure whether the student’s “language behavior” is adequate to successfully participate in the curricular tasks at his/her grade level or whether the student has the needed skills or strategies to accomplish grade level tasks.

Speech-Language Level – Multiple forms of assessment are required by IDEA 2004. These forms may include parent input, teacher input, a file review, curriculum-based language assessment, language samples, standardized test results, and outside speech-language assessments if provided by the parents. The standardized test profile is only one factor to be considered in the assessment profile when determining eligibility. Standardized test(s) chosen for the assessment should be reliable and valid, and have adequate sensitivity and specificity. Information regarding the use of standardized tests may be found in the Evaluation section of this document.

As noted in the section of this document that discusses cognitive referencing, the following points are repeated:

- A cognitive-language discrepancy is not required for making an eligibility decision for SLI

- A cognitive-language discrepancy should never be the sole determining factor in making any eligibility decision, but it can be a vital piece of understanding the whole child's abilities and performance
- Cognitive referencing can be useful in determining reasonable language expectations
- A cognitive-language discrepancy should be used with extreme caution when determining eligibility for a very young child.

Spontaneous Language Sample – Best practice in language sampling includes collecting both an oral language sample and samples of the student's written language. Information should be collected for the word, sentence, and discourse levels for both oral and written forms of language.

Educationally Relevant Medical Information – Relevant medical information may be obtained from past or current assessments by medical professionals and from the parent. In the school setting, relevant information may include, but is not limited to, information about medical concerns that affect school performance (such as vision, hearing, or attention issues).

Information from Parents – Information from parents may be gathered through interviews, checklists, or questionnaires. Information that may be obtained includes birth history, developmental history, health history, medical history, and specific information about the development of speech-language skills.

Sample forms are available in the MSHA Guidelines (2006).

Results of Assessment – The speech-language pathologist and team then consider all information gathered during the assessment phase including the student's response to general education intervention(s), input from multiple sources, and standardized test results. Next, the team proceeds to summarize information related to the student's suspected disability.

Summary of Assessment Information – When all the relevant information has been collected and reviewed, the team considers whether the assessment results support the identification of a language impairment. The speech-language pathologist describes whether this impairment adversely affects the student's participation in the general curriculum.

Summary of Adverse Educational Impact – Based on the information gathered and reviewed, the IEP Team decides whether the child is experiencing an adverse educational impact as a result of language impairment. There are two possible outcomes:

- If the language impairment (including phonological, morphological, syntactic, semantic, or pragmatic use of aural/oral language) negatively impacts the student's ability to be successful in the general education environment (in academic, nonacademic, and/or extracurricular domains), special education eligibility as a student with language impairment would be considered.
- If the student has a language impairment which does not have an adverse educational effect, he/she would not be eligible for special education services.

It must also be established that the suspected disability is not due to lack of appropriate instruction in reading, including the essential components of reading instruction, lack of instruction in math, or limited English proficiency,

Summary and Recommendation for Eligibility as Language Impaired – When it has been determined that a language disability is present which adversely affects educational performance, eligibility for speech and language services must be considered by the IEP Team. A Lewis Cass Intermediate School District Multidisciplinary Evaluation Team (MET) / Eligibility Report Summary must be completed whether or not the student qualifies for language services.

Once eligibility has been recommended, the IEP Team must describe the Present Level, including parent input/concerns, as well as the strengths and needs of the student. . The description of needs must identify the evidence aligned with the need, and explain how each need affects the student’s ability to access and perform in the general education curriculum.

General Information – Birth through 5 Years of Age

Children in the infant to preschool age group present some unique issues. These children may qualify for and receive some form of speech-language services under Early On, special education, or Head Start. The differences between these can be confusing.

Early On – In Michigan, the State Department of Education has been designated as the “lead agency” for the coordination among school and non-school agencies for services to children ages birth through 2. Michigan’s program for children birth through 2 with developmental delay and/or an established condition is the Early On program. Early On may merely coordinate services or directly provide services. As children served by Early On near the age of 3, specific planning activities are provided for transitioning children to appropriate preschool settings for children ages 3 through 5 according to each child’s needs and family situation. All children ages birth through 2 in Lewis Cass Intermediate School District have access to Early On services, through Lewis Cass Intermediate School District.

Build Up Michigan - Build Up Michigan (formerly Project Find) is a program designed to provide access to free academic and developmental assessments for children who are ages 3-5 years old. This program is funded through IDEA. Build Up Michigan referrals are another avenue of special education qualification for students who did not qualify for Early On services prior to age 3. Build Up Michigan referrals are received from Parents, Physicians, Local preschool programs, Great-Start Readiness Programs, Headstarts and judicial systems. The referrals are routed to the Early Childhood Special Education Supervisor who then distributes them to the speech pathologists in the local districts or the speech pathologist servicing the center-based Early Childhood Special Education (ECSE) programs. Following the intake and evaluation process an IEP is held to qualify a child for special education services or to disqualify a child from special education services at the present time.

Head Start – Head Start provides services to children from families with income at or below the poverty line, children from families receiving public assistance, and foster children. The Head Start population must include up to 10% of children with disabilities, who have a written IEP.

Early Head Start is for children from birth to age three who qualify for speech and/or language services, are referred to Early On and are served under an IFSP, either by Early On or a Speech-Language Pathologist from the resident school district.

Children aged three to five in Head Start are screened by a Head Start Speech Specialist. If the speech and/or language concerns are significant or there appears to be other areas of significant concern, children are referred to the local resident school district for further evaluation and/or programming.

Great Start Readiness Program (GSRP) - GSRP is a 4 year old preschool program for students in Cass County. The focus of GSRP is to prepare children to make the most out of their time in school and to give parents the opportunity to actively encourage their children in school success.

The GSRP uses the Creative Curriculum to help children develop a strong interest in learning. Each classroom offers a developmentally appropriate setting for up to 16 children. Ages and Stages Questionnaires and Child Observation Records are used to keep track of each child's developmental progress.

Children are referred for speech and language concerns via the Build-Up Michigan referral process. Concerns are most often routed to the local school building speech pathologist, but if there appear to be more global concerns or more intense communication concerns, the referral is routed to the center-based speech pathologist and the diagnostic team at the Intermediate School District.

Services to Students in Preschool Programs

The preschool section of MSHA Guidelines (2006, PL) is fairly consistent with Lewis Cass Intermediate School District practice. Suggested checklists for teachers and parents are presented in Appendices P and Q. The rest of this section is comprised of a summary of the more important points presented by MSHA Guidelines.

This section provides information specific to children in their preschool years, ages 3 through 5 with language as their primary concern or disability. This section should be used in conjunction with the more detailed School Age Language section of this document. Service delivery varies depending on whether speech-language pathologists can collaborate with a preschool program or when a student is brought in by the parent for speech and language services. Following determination of eligibility, the continuum of placements is considered. The child may receive direct speech intervention through walk in services (ie. Parent provides transportation to facility) or it may be recommended they attend a special education preschool program and receive direct speech intervention.

Pre-Referral/Early Intervening/Referral Process – Typically, a parent/caregiver, preschool teacher, daycare provider, or pediatrician is the first person to become concerned about the preschooler's communicative development.

Parent/caregivers will often consult with a speech-language pathologist to decide whether a concern warrants further evaluation. Sometimes parent concerns are the result of a lack of understanding about the variances that occur in typically developing language proficiency. Therefore, an informal interview should be completed to determine if the concerns are typical of language development or if a comprehensive evaluation is warranted. If a formal evaluation is not necessary at the time of concern, speech-language pathologists may provide suggestions to be carried out at home or in the classroom to facilitate the continuation of language development. The team may decide to make a more formal plan for early intervening services.

Initial Eligibility Assessment – The primary goals of the initial assessment are to determine eligibility and to identify an appropriate treatment plan. This means that the speech-language pathologist and team must determine:

- Whether a language impairment exists,
- Whether the language impairment adversely affects educational performance (academic, nonacademic, or extracurricular), and
- How intervention should be designed and implemented in order to help the student to progress in age- appropriate activities and curriculum.

Play-Based Activities to Collect Further Assessment Information – Gathering and forming impressions regarding samples of the preschooler’s oral language is another essential component of the evaluation. An oral language sample can provide the speech-language pathologist with information regarding the preschooler’s language subsystems, frustration when communicating, and communication when scaffolding is provided. The speech-language pathologist usually plays with the child for 10 to 15 minutes using developmentally appropriate toys.

Observing Language Subsystems and Utilizing Dynamic Assessment through Play – During a play-based activity, the speech-language pathologist should take notes about all of the language subsystems (such as, phonology, syntax, morphology, semantics, and pragmatics). When evaluating phonology skills, the speech-language pathologist is noting the level of intelligibility as well as phonemes/speech sounds that the child can and cannot produce. In regards to syntax, the speech-language pathologist determines the preschooler’s mean length of utterance and complexity of the utterance. Morphological markers are another subsystem of interest. Observation of the child’s semantics can provide the speech-language pathologist with the types of words the child is using (such as, nouns, verbs, prepositions). It is just as important to collect information regarding pragmatic language including the ways the child communicates (such as, crying, pointing, intonation) and the functions the attempts serve (to request, protest, greet, name, comment). For some children, the goal is to determine whether the preschooler has intent to communicate. If intent is demonstrated, the speech-language pathologist should question how the preschooler communicates. If intent is not demonstrated, it is important to provide the preschooler with opportunities to protest, request, and name objects during play.

Evidence of Communicative Frustration – Play-based assessments can also give the speech-language pathologist information regarding the preschooler’s frustration level when trying to communicate. This can be a determining factor when qualifying a preschooler of this age for speech and language services.

Communication when Scaffolding is Provided - The speech-language pathologist should continue to provide support and accommodations to the preschooler to see if communication functioning improves. Often, communication improves with scaffolding, when picture symbols are introduced, or when language is made simpler and less complex. During this time, the speech-language pathologist documents if the preschooler’s language improved with such interventions or if the preschooler continued to have difficulty. Observing how the preschooler reacts to these scenarios is beneficial when treatment planning.

Observation of Parent-Preschooler Interactions – Many children display more or less language when they are with familiar people such as their parents/caregivers or siblings. Speech-language pathologists can observe these differences when the child is coming to and from the therapy room. They can also be

observed by providing 10 to 15 minutes of play between the child and parent. The observation also allows the speech-language pathologist an opportunity to suggest home intervention techniques.

Services to Students in Secondary Educational Settings

Assessment Considerations for Adolescents – Initial identification of an adolescent with a language impairment is rare at the secondary level and often involves a teacher or parent referral (Larson & McKinley, 2003).

1. It is recommended that the referral follow the student study procedures, which apply to all special education referrals. Make sure that appropriate intervention procedures have been tried and documented. The student study team reviews the comprehensive educational history from the cumulative file to explore patterns in the student's education that correspond to the initial concern.
2. During the student study phase, the speech-language pathologist should carefully consider the impact of teacher presentation style and classroom routines in a variety of the student's scheduled classes as they relate to language (Larson & McKinley, 2003). The speech-language pathologist should explore these areas further when gathering information about the student's language problems and determine if the communication breakdown occurs in the student's comprehension of the message or the teacher's presentation of the material. This information may also be useful when recommending classroom accommodations and modifications.
3. Following appropriate consultation and observations, additional information about the student's language abilities should be gathered. This could include (but is not limited to): accumulated curriculum-based language assessment, dynamic assessment, language samples and portfolio reviews.
4. Standardized testing should be used as part of the initial speech and language assessment to determine receptive or expressive language deficits.

Test Recommendations for Adolescents:

- Clinical Evaluation of Language Fundamentals–5 CELF-5
- Test of Adolescent Language–R TOAL
- Test of Language Competency TLC
- Comprehensive Assessment of Spoken Language CASL
- WORD Test–Adolescents

Intervention Considerations for Adolescents – As with any student diagnosed with a language impairment, intervention planning should be curriculum-based and goals should emphasize a strategies-based type of intervention rather than instruction of discrete skills. Therefore, it may be more appropriate for the speech-language pathologist to collaborate with the teacher on implementing strategies in the classroom every day, rather than employing direct or duplicate instruction. The speech-language

pathologist may monitor the student's use of strategies through the teacher's reporting on classroom instruction and performance.

Service Delivery Considerations for Adolescents – Service delivery models should reflect the type of intervention needed for the student based on the IEP. Wallach and Butler (1994) caution against “importing” traditional elementary pull-out models to the secondary level. Consultation or monitoring are important service delivery options in any secondary setting. It is essential that the speech-language pathologist schedule time for collaborating with other school professionals to discuss language instruction needs and monitoring of student progress, as well as development of materials.

Adolescent language development should be contextually-based so increasing language development is accomplished through the special education classroom learning opportunities. Language is learned in a pragmatic, experiential manner and can be expanded and reinforced throughout the student's program. Consultation with staff concerning student's needs and appropriate language skills may occur periodically or as requested. The choice of monitoring student progress or consulting with the student, including working on defined goals, are viable service delivery options.

Students who are placed in categorically special education classrooms should receive embedded language instruction through their curriculum, and may not require continued direct speech-language pathologist services. Resources and language enrichment lessons can be provided to teaching staff. The more that speech-language pathologist services are integrated into the student's daily routine and academic curriculum, the more effective learning will be. Direct service to adolescent-aged students should be limited to skills that can only be delivered through specialized therapy techniques provided by a speech-language pathologist.

Students in a resource room program are usually provided teacher instruction related to vocabulary. Understanding terms within the curriculum is more directly tied to their educational program. Instruction in this area may include vocabulary reinforcement through study guides or various modalities of learning, test-taking strategies, learning memorization techniques, visualizing and verbalizing information, and resources to draw on, and so on. The speech-language pathologist is available in a consultative role if specific problems arise. If there are pragmatic communication issues that are interfering during this stage of adolescence, then a more direct speech and language intervention may be appropriate.

For students who qualify as SLI only, direct services may be indicated for fluency, voice, or articulation difficulties. The intensity and determination of service will be dependent on the student's need for improvement, level of sustained progress, priority of service within the student's academic requirements, and support of involved evaluation team members, parents, staff, student, and speech-language pathologist.

Assessment Considerations for Redetermination – Students who are being reevaluated for SLI eligibility may fall into several categories listed below. The Review of Existing Evaluation Data (REED) will drive the evaluation requirements.

1. Students may have shown a consistent speech and language impairment through at least two comprehensive evaluations (or since preschool and early elementary), indicating a pervasive speech and language impairment throughout their educational experience. This group of students may require a review of past MET findings, input from staff and parents, and a careful

examination of present level of functioning within the curriculum. Formal standardized testing may not be required to define the eligibility due to consistent patterns over a number of evaluations. If so, a report reflecting previous MET reports, staff input and educational implications is sufficient.

2. Students may have demonstrated increased language skills in their pragmatic, semantic or syntactical skills, either through documented observation or through improvement within the curriculum. This progress may have positively impacted academics indicating a possible reduction of services or elimination of the SLI eligibility. In that instance, it would be advisable to conduct formal standardized testing to assess growth, as well as the other information gathered from involved staff, to help determine eligibility status.
3. Students may be receiving a duplication of services between the special education teacher and speech-language pathologist. If services pertinent to the language deficit are being delivered in the special education classroom, consultation or monitoring by the speech-language pathologist may be considered more appropriate for that student at this stage in his/her education.

Dismissal Requirement – Speech-language pathologists may find it helpful to utilize the Lewis Cass Intermediate School District Speech and Language Diagnostic Report (Appendix K) when recommending a change in SLI eligibility or service. Note that this report is not an evaluation report, but the “diagnostic report” pursuant to Michigan rule 340.1745 that requires a diagnostic report for the provision of speech-language service whether or not the student is SLI eligible.

Considerations for Dismissal from Speech

- Completion of all goals on the IEP; no longer a speech or language impairment
- Lack of benefit from services documented by speech-language pathologist
- Dual support is being provided within other services of special education
- ELL, cognitive impairment, autism spectrum disorder factors indicate language/communication skills meet expectations
- Speech and language abilities no longer interfere with academic and/or vocational functioning

Infant-Toddler Speech and Language

Speech-language pathologists using this section should also refer to the language section for general guidance including the definition of speech language impairment (Rule 340.1710) in the Michigan rules and Part C of IDEA. Part C, or Early On Michigan, specifically focuses on infants, toddlers and their families. Compliance with Part C of IDEA regulations are unique to speech-language pathologists working with children birth to 36 months of age. These regulations impact not only the evaluation and service delivery for these children, but also the referral and consent process.

There are several basic tenants affecting the speech-language pathologist working with this population:

- Evaluation of children from birth to 36 months of age must include all areas of development, (social-emotional functioning, cognitive skills, motor skills, and speech and language development) and relevant medical information such as hearing and vision status.
- A 20% delay in any one developmental area qualifies a child for Early On services in Michigan.
- Service delivery must be provided in the child's natural environment, defined as settings that are natural or normal for the child's age peers who have no disability (IDEA, 1997).
- Provisions must be made for year-round services.
- Parents and caregivers are defined as the primary "client" because they have the most naturally occurring opportunities to interact with the child throughout the day.
- After the initial evaluation process, a speech-language pathologist may or may not be the primary worker or service coordinator for the child and family. The Individual Family Service Plan (IFSP) process will determine the goals and outcomes for the child and family. The child's goals and outcomes will help determine the services to be provided.

Determining if a Formal Assessment is Needed – It is important to distinguish between a formal request for evaluation versus a parent or agency inquiry. Often, a parent or caregiver is simply looking for information about typical child development, community resources, or the referral process. The speech-language pathologist, or intake staff, may provide this information without beginning a formal evaluation. However, when a parent requests an evaluation for a suspected delay, Part C of federal special education rules require that an evaluation be completed.

The caregiver interview is often the first step in determining if a formal assessment by a speech-language pathologist is needed. Thorough knowledge of child development is required of the interviewer to discuss if a child is displaying typical developmental patterns and is expected to continue to develop appropriately within the context of the child's current environment. If the child's speech and language delay appears to be the primary area of delay, a speech-language pathologist is included in the evaluation team. The SLP does not necessarily have to complete a special education evaluation. He/she may simply serve on the multidisciplinary team for Early On eligibility.

Assessment Considerations – Often, communication concerns are recognized before other co-occurring impairments. Therefore, the speech-language pathologist may be the first professional to identify additional areas of concern regarding development.

Gather Input – Formal written consent to evaluate as well as an explanation of the referral process is required before the evaluation begins. A language assessment should begin with a comprehensive interview with parents/caregivers to explore concerns, gather familial history of communication disorders, and obtain the child’s medical and developmental history. Particular attention needs to be paid to how the infant/toddler uses language within the context of his or her everyday routines. The Early On Service Coordinator completes a developmental history form with each family.

Hearing screening is required as part of a birth to 3 evaluation, however, certain types of hearing loss may be missed through the screening process. A formal audiological evaluation may be required. The following are red flags for hearing loss (Appendix R: Early On Hearing Development Screening Checklist):

- Family history of hearing loss
- Lack of responsiveness to sounds/voices
- Limited babbling/vocal play
- Lack of calming by sound alone
- Delayed speech/language development
- Language development with poor articulation
- Developmental delays
- Parent/caregiver concerns

Observation of Parent-Child Interactive Play – As with all language evaluations, observe the child’s interaction skills in a naturalistic environment during play with the parent or caregiver and/or sibling. Observations of play between comfortable communicative partners can provide a speech-language pathologist with valuable information. This information will be important to compare to results on standardized instruments. For example, did the child use more or less words, make more or fewer communicative attempts, show increased or decreased eye contact, demonstrate increased or decreased direction following structured versus unstructured assessment situations? In addition, this observation can meet the requirement of Part C of IDEA for parent/child interaction to be observed and documented in the evaluation report.

Communication Information Gathered During Play-Based Evaluation – Throughout the play-based evaluation, the speech-language pathologist should provide support and accommodations with the infant/toddler to determine if communication functioning improves. Communication can improve when scaffolding, modeling, picture symbols, gestures or signs are introduced. During this time, the speech-language pathologist should document if the infant/toddler’s language improved with such interventions or if he/she continued to have difficulty.

Prelinguistic Communication and Pragmatics – During play activities and daily routines, it is vital to collect information regarding the way the child communicates (such as crying, pointing, intonation) and the functions that it serves (such as, requesting, protesting, greeting, naming, commenting). When evaluating infants and toddlers who are not yet at the word level, it is important to consider prelinguistic features of communication. Children begin communicating from birth through pre-intentional

communication acts (crying, eye gaze, sounds). Children then begin using those communication acts in an intentional way before a formal language system develops. An important milestone for this age group is the child's ability to establish joint attention with others by sharing attention and affective states with both eye gaze and facial expression. It is important to provide the child with opportunities to protest, request, and name objects while considering how the child's communication skills differ across environments and individuals (such as parents/caregivers, extended family, or others).

Vocabulary (Semantics) – The child's vocabulary should be assessed to determine if it is appropriate for the child's age. Receptive and expressive vocabulary can be assessed through standardized testing, parent interview, checklists and/or within a dynamic context. Examples of observations for receptive vocabulary may include: Does the child turn to his name, point to pictures in storybooks, or follow directions during daily routines or play activities? Examples of expressive vocabulary observations include: Does the child use different types of words (nouns, verbs, description words) during daily routines and play activities? Does the child use his/her vocabulary appropriately?

Form (Syntax) – Mean length of utterance (MLU) should be assessed to determine if it is appropriate for the child's age. The speech-language pathologist should also assess how well the infant/toddler understands when others talk.

Intelligibility (Articulation/Phonology) – When assessing the intelligibility of an infant/toddler, it is important to determine whether the child is understood by familiar listeners, in context, and if a referent is needed or not. If the infant/toddler is understood, it should be noted if contextual cues were needed. If an infant/toddler is described and/or is evidenced as being "frequently unintelligible" by a familiar listener, it would be beneficial to determine the percentage of intelligibility. If intelligibility is a concern, refer to the Articulation section for guidelines in this area (Appendix S: Early Childhood Developmental Milestones). If the child does not use words to communicate, an inventory of sounds (consonant and vowels) and syllable types used should be collected.

Motor Speech – During the evaluation process, oral motor structure and function should be assessed. An oral motor evaluation with young children may include observations of motor planning skills, mouth posture during play and rest, drooling, dentition, eating and swallowing skills, and articulator movements.

Test Profile – Standardized assessment is required when evaluating any child's speech and language skills. Information from comprehensive assessment tools can help determine language function compared to age-matched peers when using the author's guidelines for interpretation of test scores. It is also important to look for variations within the infant/toddler's language profile that may suggest deficits within a language subsystem which should be explored further. A list of commonly used tests standardized for the infant/toddler population is found at the end of this section.

Consideration of Cultural/Linguistic Differences – When an infant/toddler's native language is not English, it is important to consider that the language or cultural differences may be impacting his/her language development. Non-English speaking children at this age often are not exposed to more than one language and the evaluation should take this into account by attempting to administer the test in the child's native language. Refer to the English Language Learners section for guidelines in this area and Bilingual/Non-English Speaking Families Parent Interview for assistance with determining appropriate language for evaluation.

When internationally adopted infants and toddlers are evaluated for possible speech-language impairment, it is important to consider development specific to this population. Many variables need to be considered including the child's environment in their native country (placement in orphanage, home care, or other setting), amount of time spent in this country, age at adoption, and social-emotional factors related to a major life change for this child.

Summary of Adverse Educational Effect – A culmination of information gathered from all the above sources should be used to assist in the final determination of whether the infant/toddler's language delay has an adverse effect on educational performance. At this age level, adverse effect can be defined as the impact the delay has on participation in developmental activities, daily routines, and family life. When considering eligibility for speech-language services in the infant/toddler population, consider the following:

1. Results of standardized assessments demonstrating language skills below the level expected for the infant/toddler's age.
2. Child is unable or ineffective in their abilities to express wants and needs or exchange information effectively.
3. Child is unable or ineffective in demonstrating understanding of spoken language.

Considerations for Ineligible Children – At the conclusion of the evaluation process, children may be determined to not meet the guidelines for SLI but still display delays at least a 20% delay in their speech and language skills. Services through Lewis Cass Intermediate School District for these delays include Early On and community playgroups. The SLP may consult.

Intervention – Once a child has qualified for language intervention, services can be provided in a variety of ways. Thought must be given to service delivery within the child's natural environment, which usually is the home. Service delivery models may include direct services on an individual and/or small group basis, service coordination, and/or consultative services including a variety of possibilities, such as providing coaching to the parent/caregivers.

Intervention is based on a family-driven "coaching" model in which parents are empowered to provide intervention strategies within the context of their daily routines. By fostering a partnership between family and professionals, child outcomes are improved (Jung, 2003).

Dismissal Criteria – An infant/toddler should be dismissed from speech-language pathologist services once he/she has acquired speech and language skills within an age-appropriate range. Assessments, observations, and parent/caregiver input should all be gathered before dismissal of services is rendered. Dismissal may be considered if:

1. Results of language assessment indicate age-appropriate receptive, expressive, and pragmatic language skills;
2. With the Early On service providers the SLP meets weekly or bi-weekly to discuss Early On.
3. Phonological sound development is within an age-appropriate range; and
4. Child outcomes have been met and the child no longer has a 20% delay.

Commonly Used Standardized Assessments for the Infant/Toddler Population

Global Language Instruments:

Preschool Language Scale 5th Edition (PLS-5)

Preschool Language Scale Spanish – 4th Edition

Receptive Expressive Emergent Language Test 3rd Edition (REEL-3)

Expressive Language Instruments:

Expressive One Word Picture Vocabulary Test (EOWPT)

Preschool Language Scale-5th Edition (PLS 5)

Receptive Language Instruments:

Peabody Picture Vocabulary Test (PPVT-4)

Preschool Language Sale-5th Edition (PLS-5)

Articulation Instruments:

Goldman-Fristoe Test of Articulation (GFTA-2)

Clinical Assessment of Articulation and Phonology (normed ages 2-6 to 8-11)

Other Assessment Tools Helpful in Evaluation of Infant/Toddlers

Communication & Symbolic Behavior Scales

Communication & Symbolic Behavior Scale Checklist

Clinical Evaluation of Language Fundamentals – Preschool (CELF-P) Pragmatic Checklist

Hawaii Early Learning Profile (HELP)

Creative Curriculum

Evaluation and Therapy Considerations for Special Populations

Auditory Processing Disorder

An auditory processing disorder (APD in this document) is sometimes also referred to as Central Auditory Processing Disorder (CAPD). APD is not defined in IDEA regulations or the Michigan rules because it is not a special education eligibility category. Richard (2001, p. 8) states, “While most professionals can cite behavioral and academic examples of processing, few can clearly explain what processing entails.” ASHA (1995) says it is a difficulty in the perceptual processing of auditory information in the central nervous system.

APD is discussed in the MSHA Guidelines (APD-1). Although this section is brief, it provides a good foundation from which to build an understanding of this complex concept. The Source for Processing Disorders (Richard, 2001) is referenced and provides more comprehensive information. MSHA uses a

working definition of APD as what is done with what is heard. Language development can be affected when the auditory system is unable to appropriately respond to auditory input.

An APD is different from a language processing disorder (LPD). APDs involve the ability to perceive and assign meaning to sounds. LPDs involve processing verbal information that requires a verbal or nonverbal response. APD is generally associated with the medical field and is evaluated and diagnosed by an audiologist. LPD is an educational term, but is not a special education eligibility in and of itself. Richard (2001) explains that auditory processing and language processing lie on a continuum.

Richard (2001) states “processing is moving back and forth between auditory features of the signal and language features of meaning. In other words, processing occurs on a continuum beginning at a level of pure auditory processing, transitions to a mix of both auditory and language processing, and ultimately ends in pure language processing.”

Table 3 – Characteristics of Auditory Processing Disorder and Language Processing Disorder

Auditory Processing Disorder	Language Processing Disorder
<ul style="list-style-type: none"> ● History of otitis media ● Normal pure-tone hearing ● Poor short- and long-term memory ● Difficulty following oral directions, especially in noise ● Frequent requests for speaker to repeat themselves ● Poor attention span/daydreams ● Possible mild speech and language issues ● Possible problems with academics ● Possible behavioral problems ● Fatigues easily during auditory tasks ● Age-commensurate IQ ● Poor prosody 	<ul style="list-style-type: none"> ● Age-commensurate IQ and vocabulary with academic deficits ● Difficulty with word retrieval ● Use of neutral, generic, or less-specific labels ● Problems with pragmatics ● Misuse of words with a similar phonetic structure ● Incomplete sentences or thoughts ● Reauditorizes the stimulus (verbal repetition) ● Delayed response time (use of fillers, etc.) ● Frequently responds “I don’t know or “I forgot”

Auditory Processing Disorder	Language Processing Disorder
<ul style="list-style-type: none"> ● Poor rhyming and/or musical skills ● Reading and/or spelling difficulties ● Difficulty localizing 	

If a school is informed that a student has been diagnosed with an APD the early intervention team for that building should gather information to determine if the student is having difficulties in school. Questions should include asking if the teacher and/or family have to make any special modifications for the child to succeed. For example, if the child has to spend six hours per week so they can pass their spelling test and everyone else only needs one that should be a red flag. Does the teacher need to have an aide work with the child in order for them to get their work done?

If he/she isn't having academic difficulty, then nothing further needs to be done. If he/she is, then interventions as discussed in the early intervention section need to be implemented. Appendix L, Strategies to Improve Auditory Performance, from the MSHA Guidelines can be helpful in either situation.

If the student is having academic difficulties that cannot be resolved with these interventions and/or other research-based interventions, then the student may have a disability. This is uncommon when there are no co-morbid problems such as Attention Deficit-Hyperactivity disorder (ADHA), anxiety issues, LD, SLI, but when it exists and significantly impacts the educational progress of a student, it can be evident as a learning disability in listening comprehension. Both the speech-language pathologist and school psychologist must be involved in an evaluation of this type. For additional information, see the section in this document that addresses listening comprehension.

Listening Comprehension and Oral Expression

“There are many and varied interpretations as to when to certify a student as having a learning disability (LD) in oral expression and/or listening comprehension rather than speech and language impaired (SLI). As the terms oral expression/listening comprehension under learning disability, and the term SLI appears redundant with no clear guidelines defined in state/federal law as to how these certifications are qualitatively different, the speech-language pathologists should follow the policies set forth by their individual school district.” (MSHA, 2006, p. LD-18). As noted above, individual or local school district in this document means Lewis Cass Intermediate School District.

Neither listening comprehension nor oral expression is defined in IDEA regulations or the Michigan rules. These terms appear in the list of areas of eligibility for learning disability, but do not appear under SLI. The Lewis Cass ISD committee developed descriptors for use in this document.

Descriptors

Listening Comprehension – A disability in listening comprehension would be evident in the student's:

- Difficulty or inability to concentrate on, comprehend, and apply spoken language

- Difficulty with comprehension and interpretation of spoken language
- Problems with information received aurally
- Difficulty processing oral information in a timely manner in the educational setting

Many of these characteristics are also indicative of APD and/or LPD.

Oral Expression – Oral expression appears to be more difficult to identify. Some general characteristics include:

- Difficulty in expressing concepts orally they seem to understand
- Difficulty speaking grammatically correct English, even though English is their only or first language
- Difficulty following or having a conversation about an unfamiliar idea
- Trouble telling a story in the proper sequence
- Difficulty organizing thoughts for responsive language vs. spontaneous speech

As in all situations where a student is exhibiting difficulty in the education setting, the first involvement needs to be by the early intervention team. If the results of research-based interventions are unsuccessful, then a special education referral is appropriate.

Evaluation – A comprehensive evaluation by both the speech-language pathologist and school psychologist needs to be conducted when a learning disability in oral expression or listening comprehension is suspected. Sample checklists unique to these two areas are included in Appendices M and N. It may be premature to validly assess these areas before there has been sufficient exposure to systematic instruction, curriculum and interventions.

Care is needed to make sure the evaluator is not giving visual cues. Consequently the tests that deal with evaluating auditory information should not include pictures or objects as they can be used as a crutch to help the child remember what he/she has heard. Both the SLP and psychologist have to include timed tests as the speed of processing may be part of the issue.

Both the speech-language pathologist and school psychologist must conduct comprehensive evaluations when considering learning disability in listening comprehension or oral expression. These professionals need to work together and both evaluations should support any such determination. While consideration of these categories of eligibility are included in law, no one subcategory of learning disability eligibility should be used as a “catch-all” or prematurely eliminated from consideration.

The school psychologist’s evaluation is necessary to determine if the student meets the criteria for any traditional learning disability category, such as one in basic reading skills, or another area. When the learning disability label is considered, the evaluation and results should be consistent with the eligibility requirements. If a student’s listening comprehension or oral expression is impaired to the point it negatively impacts educational performance, then standardized achievement tests and additional evaluation information should reflect this. **Identification as learning disabled in listening comprehension or oral expression should be approached cautiously and rarely used.**

Eligibility – The eligibility of learning disability in listening comprehension or oral expression should be used conservatively and follow strict special education eligibility guidelines. When a parent or teacher has concerns or outside agency reports a Central Auditory Processing Disorder exists, school personnel need to remember that the disability must have a significant adverse impact on educational performance to require special education. A student with listening comprehension difficulties may demonstrate significantly lower scores on standardized tests in the area of auditory memory for sentences, recall of semantic information, following directions and listening to paragraphs. Other points to consider are listed below:

- Other areas of language, such as semantic understanding, syntax skills, and expressive language would typically fall within the average range.
- In addition, subtests administered by the school psychologist that assess auditory memory and recall, would confirm the difficulty in performing related auditory tasks.
- Traditional learning disability categories and attention deficit hyperactivity disorder (ADHD) should also be evaluated as areas of potential disability.
- There should be substantiated evidence from classroom teacher input and observations indicating significant misinterpretation or gaps in auditory information gathered by the student in processing the curriculum.

A comprehensive evaluation including documentation by the student intervention team and the evaluations by the speech-language pathologist and school psychologist is used in determining if a student has a disability in listening comprehension or oral expression. Documentation of a disability, its affect on educational performance, and the need for specialized instruction are required in determining eligibility for special education services. Informed clinical judgement becomes very important if the student does not meet traditional guidelines. But clinical judgement must still be based on information from a comprehensive evaluation including all data.

Students eligible under listening comprehension or oral expression need assistance in the development of compensatory skills. More manageable pacing for processing information is needed in order to progress within the curriculum. The needs of these students may require the frequency and intensity of instruction available through direct services. Consultation or monitoring can be sufficient to meet the needs of the student.

Summary of Listening Comprehension and Oral Expression – In conclusion, consideration of learning disability in listening comprehension or oral expression requires both the speech-language pathologist and the school psychologist to conduct very thorough and comprehensive evaluations. **Identification as a student with a learning disability in listening comprehension should be rare, and in oral expression extremely rare.**

English Language Learners

English Language Learners (ELL) is the term used in this document to refer to students who need special considerations due to cultural and/or linguistic differences. ELL is also the term adopted by the State of Michigan for use in reference to all students who are limited English proficient (LEP). MSHA Guidelines (2006) refer to these students as “culturally and linguistically diverse populations” and include this information in three sections: CLD-I, CLD-L, and CLD-A.

English language learners do not qualify for special education simply because of their limited English language or articulation. As a matter of fact, Federal law §300.306 (IDEA, 2004) and Michigan Rule 340.534 (MDE, 2006) specifically state that the student’s communication difficulties must not be due to limited English proficiency.

ELL students are entitled to considerations under other federal and state requirements (34 CFR Part 100). If a district has enough ELL students to warrant having its own ELL coordinator, he/she would be the first person to consult for information and assistance.

Anyone working with the ELL population should be familiar with the typical natural second language acquisition process. Acquisition of a second language can look like a SLI, but in fact is not. Typical stages include:

1. **Silent Period** – The student is focusing on comprehension of English. Lasting up to a year after initial exposure, this period is marked by responses to English which are non-verbal or limited to one or two words. Progress can be interrupted or slowed down if the student is required to perform too early in the acquisition process.
2. **Language Loss** – First language skills diminish from lack of use. This often occurs when students spend more time in all English-speaking classrooms. This is a transition period and can look like a SLI.
3. **Reduced Exposure** – Poor performance in either language may result from limited exposure to a rich vocabulary. This may result from someone else speaking for the student, poor attendance, or other factors. Underlying conceptual development may be underdeveloped due to reduced learning opportunities.
4. **Code-switching** – The student changes from one language to another in the same sentence or paragraph.
5. **Inter-language** – A temporary language system which fluctuates as the student tests hypotheses about language and modifies rules as a result of these trials. The student is integrating aspects of both languages.
6. **Interference** – As the student becomes more fluent in English, aspects of the first language such as syntax may occur when using English.
7. **Fossilization** – The student achieves good fluency in English, but continues to make certain specific mistakes in structure or vocabulary (such as endings left off or pronoun confusion).

Keep in mind the typical natural second language acquisition process when looking for indicators of a noncultural or language based disability. Differences in sentence structure, speech sound production,

vocabulary, and the pragmatic uses of language are to be expected when learning a new language. A student may have difficulty learning because of a lack of exposure to English language or because of cultural experiences that are not commensurate with the school's expectations.

Two levels of language proficiency are identified by Cummins (1992). The first is basic interpersonal communication skills (BICS) which refers to language learned and used when there are clues to aid in comprehension. The second level is cognitive academic language proficiency (CALP) which refers to language used in academic learning with few clues and generally involve abstract concepts. A student needs both BICS and CALP to be successful academically.

Possible indicators of a noncultural or language based disability in students who are ELL include (Kayser, 1998; MSHA, 2006; Roseberry-McKibbin, 2002):

- Short mean length of utterance (MLU)
- Difficulties affecting grammar and sentence structure
- Difficulty in learning language at a normal rate, even with special assistance in both languages
- Slow academic achievement despite adequate academic English proficiency
- Communication difficulties at home
- Communication difficulties when interacting with peers from a similar background
- Inappropriate responses when peers initiate interaction
- Difficulty being understood by peers
- Overall communication skills which are substantially poorer than those of peers
- Frequent inappropriate responses
- Failure to express basic needs adequately
- Communication that is disorganized, incoherent, and leaves the listener confused
- Speech and/or language difficulties generally evident in both English and the primary language
- See MSHA Guidelines pages CLC-L11 to L12 for a list of phonological and language features in dialects and languages in the United States.

Preventative, research-based early intervention is essential in working with ELL students. Scaffolding support for instruction and a dynamic assessment approach (test-teach-retest) works very well. ELL students benefit more from this process than many other students and the information gained is an essential part of determining if the student is speech or language impaired. The student's rate of learning over time under ideal conditions (research-based interventions) is invaluable in separating cultural or linguistic differences from a special education speech or language impairment. When the speech-language pathologist works under the workload versus caseload approach (outlined earlier in this document) he/she could be very helpful with the early intervention team's efforts.

School districts have different resources and personnel of varying skill levels to work with English language learners.

Print resources include:

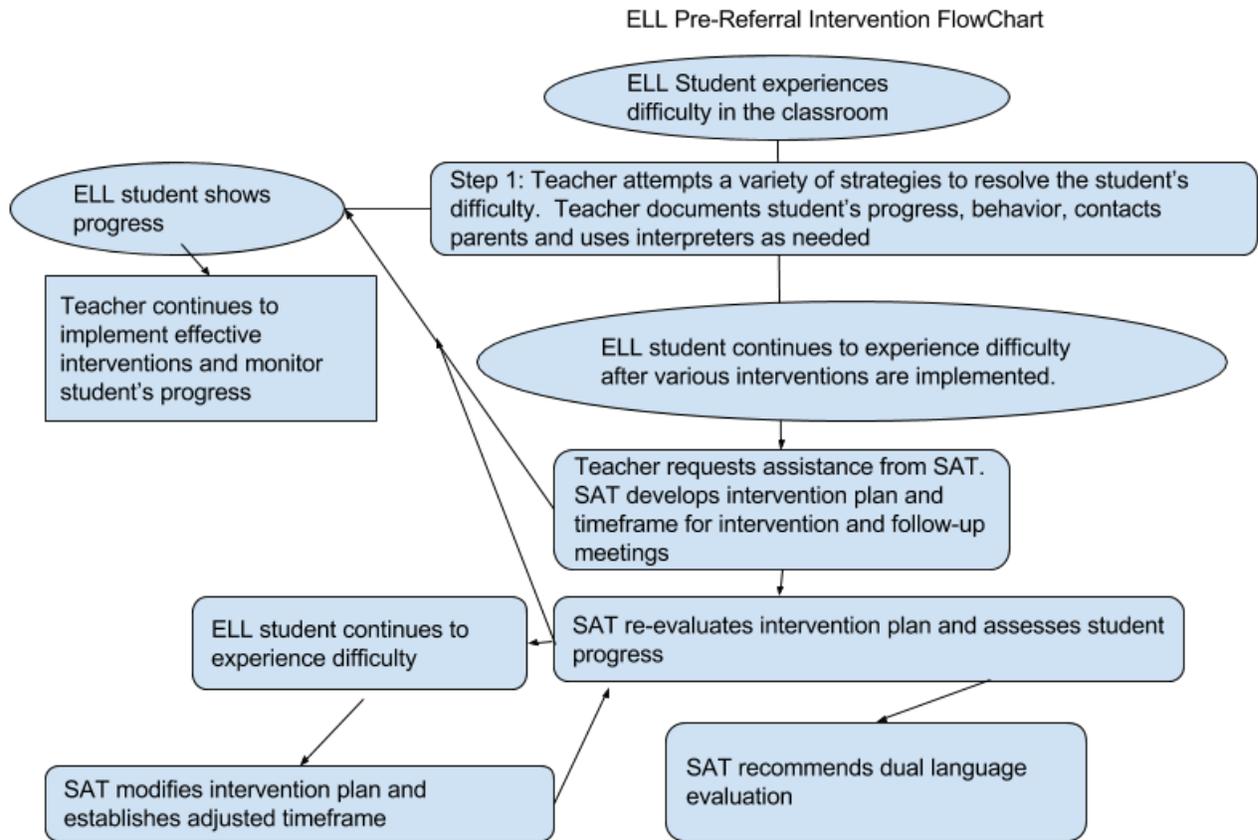
- *Assessment and Intervention Resource for Hispanic Children* (Kayser, H., 1998). Although written with a Hispanic focus, much of this applies to students with other cultural and linguistic differences.
- *Cultural and Linguistic Diversity Resource Guide for Speech-Language Pathologists* (Goldstein, B., 2002). A practical and easy to use book that "...bridges the gap between existing research and the use of that information in ...practice..." (p. xii).
- *Differentiated Literacy Instruction for English Language Learners* (Quiocho, A. L. & Ulanoff, S. H., 2009). Focuses on initial assessment and interventions for literacy instruction in English language development; also contains information on assisting ELL students who have been qualified for special education services.
- *Multicultural Students with Special Language Needs-Second Edition* (Rosberry-McKibben, 2002). An excellent resource for intervention and assessment strategies for working with students who come from a wide range of diverse cultural and linguistic backgrounds.
- *Special Education Considerations for English Language Learners: Delivering a Continuum of Services* (Hamayan, E., Marler, B., Sanchez-Lopez, C., & Damico, J., 2007). Discusses interventions to be utilized before, during, and after special education qualification as well as continuing integration of English language development.
- *Teaching English Language Learners: A Differentiated Approach* (Rothenberg & Fisher, 2007). Contains very specific strategies and activities for the practitioner.

Web-based resources as of January 2008 include:

- Colorin Colorado (www.colorincolorado.com) has Latino focus but also offers literacy and school tip sheets for parents in several languages.
- Kent ISD (www.kentisd.org) is a good first source for ELL information.
- Kent District Library (www.kdl.org). Resources are available in the Play, Grow and Learn area including developmental activities for early literacy and reading tips in eight languages.
- National Clearinghouse for English Language Acquisition and Language Instruction Educational Programs (www.ncela.gwu.edu). NCELA "...collects, analyzes, synthesizes and disseminates information about language instruction educational programs for English language learners and related programs." It is funded by the U.S. Department of Education under Title III of the No Child Left Behind (NCLB) Act of 2001.

The flowchart presented in Figure 2 is based on Garcia & Ortiz (1988) Preventing Inappropriate Referrals of Language Minority Students to Special Education which provides an overview of the process which should be followed prior to considering a special education referral. This model is designed to provide insights for classroom teachers and team members regarding potential sources of student difficulties by

raising a series of questions which must be addressed before a referral to special education is initiated.” (Garcia & Ortiz, 1988, p. 2) The original article gives a very detailed explanation of each step and should be consulted for complete information. If the eight- step series of questions, answers and recommendations are followed, it should be easier to make a determination if a student’s academic difficulties are the result of cultural or linguistic differences or might be related to a special education handicapping condition. See Figure 2 below:



These strategies as well as those contained in the resources previously mentioned should be helpful in determining if the observed difficulties are the result of cultural or linguistic differences.

Evaluating ELL students for special education as speech-language impaired or under any other category is complex. The goal of an evaluation is to determine if a student is SLI after any cultural or linguistic differences have been factored out.

After following the above procedures, if it is determined that a special education evaluation is appropriate, the same requirements under IDEA §300.304 for any other evaluation apply. However, special considerations need to be given to:

1. The cultural competence of the speech-language pathologist (MSHA, 2006, p CLD-I-1) and others working with the student

2. The use of interpreters throughout the process (MSHA, 2006, pp. CLD-I-2 & 3)
3. A comparison of any tests used with the Standards for Educational and Psychological Testing (AERA, APA, NCME, 1999) Chapter 9 "Testing Individuals of Diverse Linguistic Backgrounds". These standards include:
 - The student's language proficiency in both English and primary language
 - Validity and reliability of the test for this specific individual
 - Use of interpreters (pp. 95-96)
4. MSHA Guidelines (2006) emphasize when using "...an English standardized assessment tool with an interpreter or any other adaptations of the procedures, then the standardized score(s) cannot be used to make eligibility decisions." (p. CLD-I-3).
5. Any test used for determining eligibility should also be evaluated for use according to the prior Critical Issues section on the use of standardized tests.
6. At this time there are probably no "good" tests for determining eligibility for this population.
7. Additional requirements for an evaluation §300.304 (IDEA, 2004) take on a vital role in determining special education eligibility. More time and importance needs to be given to areas such as parent input, observations, review of existing data, results of research-based interventions, and other related data.

Obtaining parent information for this population necessitates establishing a rapport and ongoing working relationship over time. The question of how this child performs relative to other children in the family should be asked and the information utilized by the evaluator. Although this is not legally required, best practice in Lewis Cass Intermediate School District has shown that the student is a valuable source of information and his/her input should be solicited and utilized in the evaluation process. An informed clinical opinion as discussed in the Evaluation section of this document necessitates that any and all relevant information be considered in making a special education eligibility determination.

In summary, English language learners are a difficult and complex population with whom to work and to evaluate for special education. The questions and eight-step process outlined in Figure 2 can aid the student in learning and help separate cultural and linguistic differences from a speech-language impairment. Early intervention using research-based strategies should be utilized both prior to consideration for a special education referral and during the evaluation. The information obtained during early intervention can form a solid basis for a special education evaluation.

Assistive Technology

It is the mission of the Lewis Cass Intermediate School District to provide resources and expand the knowledge and use of assistive technology within our district so all students can learn in a manner which best meets their needs and abilities.

The Individuals with Disabilities Act (IDEA) requires that assistive technology (AT) be provided to all students with disabilities who require this support. The law states: "Each public agency shall ensure that **AT devices, AT services or both** are made available to a child with a disability, if required, as part of the child's special education, related services or supplementary aids and services.

Definitions:

Assistive technology device: any item, piece of equipment or product system, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain or improve functional capabilities of children with disabilities.

Assistive technology service: Any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device.

Assistive technology evaluation: The evaluation of the needs to a child with a disability, including a functional evaluation of a child in the child's customary environment.

Consideration: What does it mean to check the box?

IDEA requires that AT be considered for all students who are eligible for special education programs or services.

1. AT devices and services are considered for all students with disabilities regardless of type or severity of disability
2. During the development of the IEP, every IEP team consistently uses a collaborative decision making process that supports systematic consideration of each student's possible need for AT devices and services
3. Decisions regarding the need for AT devices and services are based on the student's IEP goals and objectives, access to the curricular and extracurricular activities, and progress in the general education curriculum.

When AT is responsibly considered there are four possible outcomes:

1. AT is not needed to support the attainment of the student's IEP goals and objectives.
2. AT currently being used is supporting the student's progress toward IEP goals and objectives and therefore should be continued and documented in the IEP.
3. AT is being used but it is not sufficiently supporting the student's progress toward IEP goals and objectives.
4. The student is not currently using AT and may benefit from its use.

Requirements:

Initial AT evaluations must follow the REED process:

Must obtain consent

Follow 30 day school timeline

Conduct and IEP and/or Amendment

If the IEP team is looking at obtaining existing data, then you do NOT have to conduct a REED and obtain consent.

Who is a part of the Assistive Technology Team?

The short answer is EVERYONE.

The Parents, the Student

The service providers working with the child:

General Education Teacher

Case Manager/SE Teacher

Paraprofessionals

Speech Pathologist

Occupational Therapist

Physical Therapist

Ancillary Staff:

School Psychologist

School Social Worker

Administration:

Supervisor, Principal, District Representative

SETT Evaluation

Once the IEP team has considered AT and determined that an AT evaluation is necessary, a SETT evaluation will be scheduled. The SETT framework was developed to guide IEP teams through the process of evaluating AT:

S=Student

E= Environment

T=Tasks

T= Tools needed to address the tasks

The team completes the LCISD AT Services Referral/Question Identification Guide in order to answer the question: "What task(s) does the student need to do that is/are currently impossible, and for which assistive technology may be an option?"

Based upon the referral question appropriate Student Information Guides should be completed by members of the team in order to guide the AT selection process. As a part of the SETT Evaluation, diagnostic staff may need to collect new data regarding motor, communication, cognitive or behavioral skills. A report is generated and shared with parents and team members. The AT Coordinator will use the Environmental Observation Guide to observe in the typical environment. After all of the data from all the participants on the team has been collected, the team will meet and use the LCISD AT Services Decision Making Guide to guide discussion about potential assistive technology to trial. The AT Coordinator will be responsible for securing and training in the use of the recommended assistive technology. Specific goals will be addressed to trial assistive technology options and the IEP team will collect data on the effectiveness of the AT trials. Following a trial period, the AT team will reconvene and a specific AT will be adopted. The IEP team will develop an AT plan which will then be referenced in the supplemental aids/services section of the IEP. The IEP team will continue to track the effectiveness of the AT and annually reconsider if it continues to be a necessary part of the child's IEP.

For more detailed information regarding the Assistive Technology Consideration and Implementation process, please see the Assistive Technology Guidelines available at www.lewiscassisd.org

Summary

Glossary

Apraxia – Impaired ability to generate the motor programming for speech movements. It is a planning/programming problem resulting from a central nervous system lesion.

Articulation – A speech disorder that affects the phonetic level; difficulty saying particular consonant and vowel sounds.

Assessment – The orderly process of gathering, analyzing, interpreting, and reporting student performance from multiple sources over a period of time.

Auditory Processing – Auditory processing is a term used to describe recognition and interpretation of sounds. Hearing occurs when sound travels through the ear and is changed into electrical information that can be interpreted by the brain. An auditory processing disorder means that something is adversely affecting the processing or interpretation of auditory information.

Basic Interpersonal Communication Skills (BICS) – Face-to-face conversational fluency, including mastery of pronunciation, vocabulary, and grammar.

Blocks – Inappropriate cessation of sound and air, often associated with freezing of the movement of the tongue, lips and/or vocal folds. Blocks often develop later, and can be associated with muscle tension and effort.

Cluster Reduction – The deletion through the lips or tongue; tight closure in the larynx (voice box); forceful repetitions or prolongation of sounds, usually at the beginning of words; difficulty in making voiced sounds (phonation); and/or silent blocks, in which no sound comes out at all on one or more consonants from a two or three consonant cluster.

Cluttering – A disorder of speech and language processing resulting in rapid, dysrhythmic, sporadic, unorganized, and frequently unintelligible speech. Accelerated speech is not always present, but cluttering is frequently accompanied by an impairment in formulating language.

Cognitive/Academic Language Proficiency (CALP) – Language proficiency associated with schooling, and the abstract language abilities required for academic work.

Code-switching – Moving from one language to another, inside a sentence or across sentences.

Culture – The customs, lifestyle, traditions, behavior, attitudes, and artifacts of a given people.

Diadochokinetic – Refers to the rapid production of alternating sounds. Diadochokinetic rate (DDK) refers to an assessment tool, that measures how quickly an individual can accurately produce a series of rapid, alternating sounds (tokens); may be one syllable such as "puh," two or three syllables such as "puh-tuh" or "puh-tuh-kuh," or familiar words such as "pattycake" or "buttercup." Other names for DDK rate include maximum repetition rate.

Dialect – The form of a language peculiar to a specific region; features a variation in vocabulary, grammar, and pronunciation.

Diplophonia – the production by the voice of two separate tones through abnormal variations in the vocal fold vibration.

Disfluency – (stuttering) is an abnormally high frequency or duration of stoppages in the forward flow of speech. See **Blocking**.

Dysarthria – Speech disorders that result from the disruption of muscular control due to lesions of either the central or peripheral nervous systems. It is classified as a neuromotor disorder.

Early Childhood Developmental Delay (ECDD) – A primary delay in a child through 7 years of age that cannot be differentiated through existing criteria for any other impairment, manifested by a delay in 1 or more areas of development equal to or greater than half of the expected development.

English Language Learner (ELL) – Children and adults who are learning English as a second or additional language; applies to learners across various levels of proficiency in English.

Evaluation – Judgments about students' learning made by interpretation and analysis of assessment data.

Expressive Language – For Speech-Language, the production of language to convey meaning to others. See **Receptive Language**.

Final Consonant Deletion – The deletion of the final consonant or consonant cluster in a syllable or word.

Fluency Disorder – An interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllable words, and phrases. This may be accompanied by excessive tension, struggles with behavior, and secondary mannerisms.

Fronting – The substitution of sounds in the front of the mouth.

Hypernasality – Too much resonance in the nasal cavity.

Hyponasality – Too little resonance in the nasal cavity which may sound similar to the speech of someone experiencing a head cold.

Limited English Proficient (LEP) – Refers to students with restricted understanding or use of written and spoken English.

Mean Length of Utterances (MLU) – Calculated by collecting 100 utterances spoken by a child and dividing the number of morphemes by the number of utterances. A higher MLU is taken to indicate a higher level of language proficiency.

Measurement Error – The difference between an observed score and the corresponding true score.

Morphology – The study of morphemes, which is the smallest linguistic unit that has semantic meaning. In spoken language, morphemes are composed of phonemes, the smallest linguistically distinctive units of sound. See **Phonology**.

Multilingualism – The ability to speak more than two languages; proficiency in more than two languages.

Native Language – An individual's first, primary, or home language.

Non-English Speaking (NES) – Individuals who are in an English-speaking environment but who have not acquired any English proficiency.

Normative Sample – A selection of a specified number of test takers from a larger population on which statistical data that summarize the test performance are determined.

Oral-motor – Refers to physical functioning and coordination related to the physiological production of speech.

Phonemic Awareness – The ability to hear and manipulate the sounds in words.

Phonetics – Organizing speech sounds into patterns of sound contrasts to create words.

Phonology – The study of phonemes, the smallest linguistically distinctive units of sound. See **Morphology**.

Prevocalic Voicing – The voicing of an initial voiceless consonant in a word.

Prelinguistics – The developmental stage of natural expression in newborn to young children that includes crying, cooing, babbling, and intonation; prior to intentional use of phonemes for initial word formation.

Pragmatics – The area of language function as it is used in social contexts.

Receptive Language – For Speech-Language, the discrimination, interpretation, and comprehension of meaning from received sounds produced by sources external to the listener. See **Expressive Language**.

Resonance Disorder – Disorders of speech sound quality, often characterized by physiological anomalies, such as hyper/hyponasality, nasal air escape, or malformed/malfunctioning functioning palate. Distinguished from **Voice** disorders caused by the actual production of speech in the larynx.

Scaffolding – Building on a person's existing repertoire of knowledge and understanding. Adult support for learning and student performance of the tasks through instruction, modeling, questioning, feedback, graphic organizers, or other techniques across successive meetings. These supports are gradually withdrawn.

Semantics – The aspect of language function that relates to understanding the meanings of words, phrases and sentences.

Standard Deviation (SD) – In statistics, a measure of how data points in a set (presumed to be distributed in a bell curve) are distributed around the mean. A low standard deviation means that the data are tightly clustered around the mean; a high standard deviation means scores are more scattered. Many tests use a scoring scale with mean of 100 and standard deviation of 15, meaning that about 68% of all scores across a broad sample will fall within +1 or -1 standard deviations (a score of 85 to 115).

Stopping – The substitution of a stop consonant for a fricative or affricate.

Stuttering – (Disfluency) is an abnormally high frequency or duration of stoppages in the forward flow of speech.

Subtractive Bilingualism – The learning of a new language at the expense of the primary language.

Syllable Reduction – The deletion of a syllable from a word containing two or more syllables.

Syntax – The structural sequence of language.

Transdisciplinary Approach – Professionals from different disciplines work together, with one of them serving as the primary contact with the family. The primary contact uses strategies that the other team members provide; the other team members have direct contact with the child and family only as necessary.

Reliability – The degree to which test scores for a group of test takers are consistent over repeated applications of a measurement procedure; the degree to which scores are free of errors of measurement for a given group.

Specificity – The degree to which a test accurately identifies speech-language impaired as speech-language impaired.

Sensitivity – The degree to which a test accurately identifies non-speech-language impaired as non-speech-language impaired.

Validity – The degree to which a test measures what it purports to measure; evidence that inferences from the evaluation are trustworthy.

Vocal Nodules – Added layers of tissue on the vibrating edge of the vocal folds that vary in size from pinpoint to the size of a peppercorn. They develop as the body attempts to protect itself against abuse and overuse of the voice.

Voice Disorder – Disorders caused by dysfunction of the larynx in the actual production of speech. Distinguished from sound quality **Resonance** disorders caused by other structural/functional issues.

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Appendix A – Michigan Revised Administrative Rules for Special Education Related to Speech-Language

R 340.1710 Speech and language impairment defined; determination.

Rule 10.

- (1) A “speech and language impairment” means a communication disorder that adversely affects educational performance, such as a language impairment, articulation impairment, fluency impairment, or voice impairment.
- (2) A communication disorder shall be determined through the manifestation of 1 or more of the following speech and language impairments that adversely affect educational performance:
 - a) A language impairment which interferes with the student’s ability to understand and use language effectively and which includes 1 or more of the following:
 - i. Phonology
 - ii. Morphology
 - iii. Syntax
 - iv. Semantics
 - v. Pragmatics
 - b) Articulation impairment, including omissions, substitutions, or distortions of sound, persisting beyond the age at which maturation alone might be expected to correct the deviation.
 - c) Fluency impairment, including an abnormal rate of speaking, speech interruptions, and repetition of sounds, words, phrases, or sentences, that interferes with effective communication.
 - d) Voice impairment, including inappropriate pitch, loudness, or voice quality.
- (3) Any impairment under sub rule (2) (a) of this rule shall be evidenced by both of the following:
 - a) A spontaneous language sample demonstrating inadequate language functioning.
 - b) Test results on not less than 2 standardized assessment instruments or 2 subtests designed to determine language functioning which indicate inappropriate language functioning for the student’s age.
- (4) A student who has a communication disorder, but whose primary disability is other than speech and language may be eligible for speech and language services under R 340.1745(a).
- (5) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a teacher of students with speech and language impairment under R 340.1796 or a speech and language pathologist qualified under R 340.1792.

R 340.1745 Services for students with speech and language impairment.

Rule 45. All of the following provisions are specific requirements for speech and language services:

- a) The speech and language services provided by an authorized provider of speech and language services shall be based on the needs of a student with a disability as determined by the individualized education program team after reviewing a diagnostic report provided by an authorized provider of speech and language services.

- b) The determination of caseload size for an authorized provider of speech and language services shall be made by the authorized provider of speech and language services in cooperation with the district director of special education, or his or her designee, and the building principal or principals of the school or schools in which the students are enrolled. (Caseload size shall be based upon the severity and multiplicity of the disabilities and the extent of the service defined in the collective individualized education programs of the students to be served, allowing time for all of the following):
 - i. Diagnostics
 - ii. Report writing
 - iii. Consulting with parents and teachers
 - iv. Individualized education program team meetings
 - v. Travel
- c) Individual caseloads of authorized providers of speech and language services shall not exceed 60 different persons and shall be adjusted based on factors identified in subdivision (b) of this rule. Students being evaluated shall be counted as part of the caseload.
- d) An authorized provider of speech and language impaired services shall be either a teacher of students with speech and language impairment under R 340.1781, R 340.1782, and R 340.1796, or a person with a master's degree, as qualified under R 340.1792.

Appendix B – The SLP and Multi-Tiered Systems of Support Activities within Tiers Tier One

With Teachers	With Students
<ul style="list-style-type: none"> ● Participation on planning and decision-making teams ● Professional development ● Parent education ● Analyzing student progress in relation to language underpinnings ● Assistance to teachers in differentiating instruction ● Assistance to teachers in making decisions about progress 	<p>Administration of emergent literacy screenings on selected students</p> <p>Demonstration of language-sensitive classroom techniques</p> <p>Observation of selected students in the classroom</p>

Tier Two

With Teachers (or other interventionists)	With Students
<ul style="list-style-type: none"> ▶ Participation on teacher assistance teams ▶ Participation in parent conferences for selected students ▶ Analyzing student progress ▶ Selecting additional interventions ▶ Making decisions about progress 	<p>Administration of prescriptive assessments on <i>selected</i> students</p> <p>Targeted diagnostic intervention for <i>a short time</i> for selected students</p> <p>Demonstration of targeted interventions</p>

Tier Three

With Teachers (or other interventionists)	With Students
<p>Participation on child study teams to establish need for comprehensive evaluation</p> <p>Analyzing student progress</p> <p>Coordinating interventions</p> <p>Making decisions about progress</p> <p>Development of an IEP</p> <p>Engaging teachers as partners in therapeutic intervention</p>	<p>Administration of normative diagnostic and dynamic assessments on <i>selected</i> students as part of a comprehensive evaluation</p> <p>Therapeutic intervention based on stages of therapy and literacy</p>

With Teachers (or other interventionists)	With Students
Reporting progress to parents Making accommodations to curriculum, assessment, and instruction for students with disabilities	