Handbook for Speech-Language Pathologists in Mississippi Schools

Revised May 2023

MISSISSIPPI DEPARTMENT OF EDUCATION

Mississippi Board of Education

Mrs. Rosemary G. Aultman, Chair

Mr. Glen East, Vice-Chair

Dr. Ronnie McGehee

Dr. Wendi Barrett

Mr. Matt Miller

Mrs. Mary Werner

Mr. Bill Jacobs

Charlie Frugé, Student Representative

Interim State Superintendent of Education

Mike Kent

Chief Academic Officer

Dr. Donna Boone

State Director of Special Education

Dr. Jennifer Boykin

Acknowledgments

The Mississippi Department of Education (MDE) would like to extend a special thanks to the Mississippi Speech-Language-Hearing Association (MSHA) for their contribution to and support of the process. Also, MDE would like to express its appreciation to the following people for their work on these guidelines:

Heather Boldin	Lauderdale School District
Stacey Garcia	Biloxi School District
Landon Wallis	Union County School District
Joanna Ozbirn	New Albany School District
Wendy Boyd	Coahoma County School District
Diane Freeman	Lauderdale School District
Rachel Powell	Brookhaven School District
Stacy Mathis	DeSoto School District

In addition, the following people at the MDE and Mississippi State University Research and Curriculum Unit (RCU) provided valuable assistance in the development and review of the document:

Teresa Laney	MDE
Ginger Koestler	MDE
Tara Thames	RCU
LaNell Kellum	RCU

This guidance document is designed to assist school-based speech-language pathologists (SLPs), administrators, teachers, and parents as they explore the role of the SLP in the school-based setting and work together to serve students in Mississippi Schools.

Table of Contents

Appendices

Purpose

Speech-language pathology services have significant impacts on children and their educational success in a variety of practices, including screening, testing, providing direct services, assisting students in accessing or making progress in the general education curriculum, supervising, and providing professional development growth opportunities. These services ultimately contribute to student success in their transition from school to work.

All speech-language pathology services in schools are guided by the MDE State Policies Regarding Children with Disabilities under the Individuals with Disabilities Education Act Amendments of 2004, or State Board Policy (SBP 74.19), available here: https://www.mdek12.org/OSE/PP

This document was developed to assist administrators, educators, parents, students and others in the knowledge of the roles and responsibilities of Speech-Language Pathologists (SLPs) and Speech Associates (SAs) in Mississippi schools in the areas of evaluation, determination of eligibility and implementation of the Individualized Education Program (IEP) of students with disabilities.

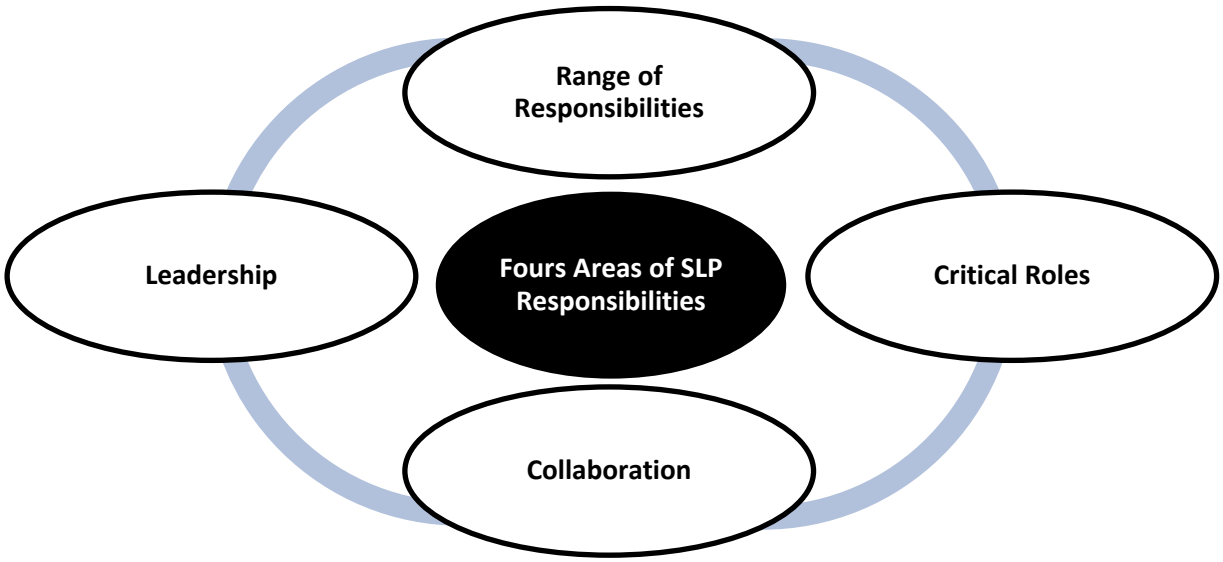
In order to provide a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), knowledge of the curriculum and Mississippi College- and Career-Readiness Standards is critical. The student's IEP should represent a prioritized set of skills and objectives, services, supports, and extensions (accommodations and specially designed instruction) that learners with diverse needs require in order to successfully master the Mississippi College- and Career-Readiness Standards and participate in curricular activities. A critical component to the provision of these services is the SA. They ensure the instructional alignment of goals and objectives with academic expectations, Mississippi College- and Career-Readiness Standards and school curricula.

CHAPTER I - Roles and Responsibilities and Scope of Practice of Speech-Language Pathologists and Speech Associates in Schools

In the school setting, the SLP is an individual qualified in the prevention, identification, diagnosis, and treatment of students with communication or educationally relevant swallowing deficits (for children with specific medical conditions). SLPs are individuals who hold a 215 AA license (issued by the MDE, Office of Educator Licensure) and a Certificate of Clinical Competency (CCC) issued by the American Speech-Language-Hearing Association (ASHA). ASHA is the guiding organization for standards of best practice in speech-language pathology, audiology, and speech and hearing sciences.

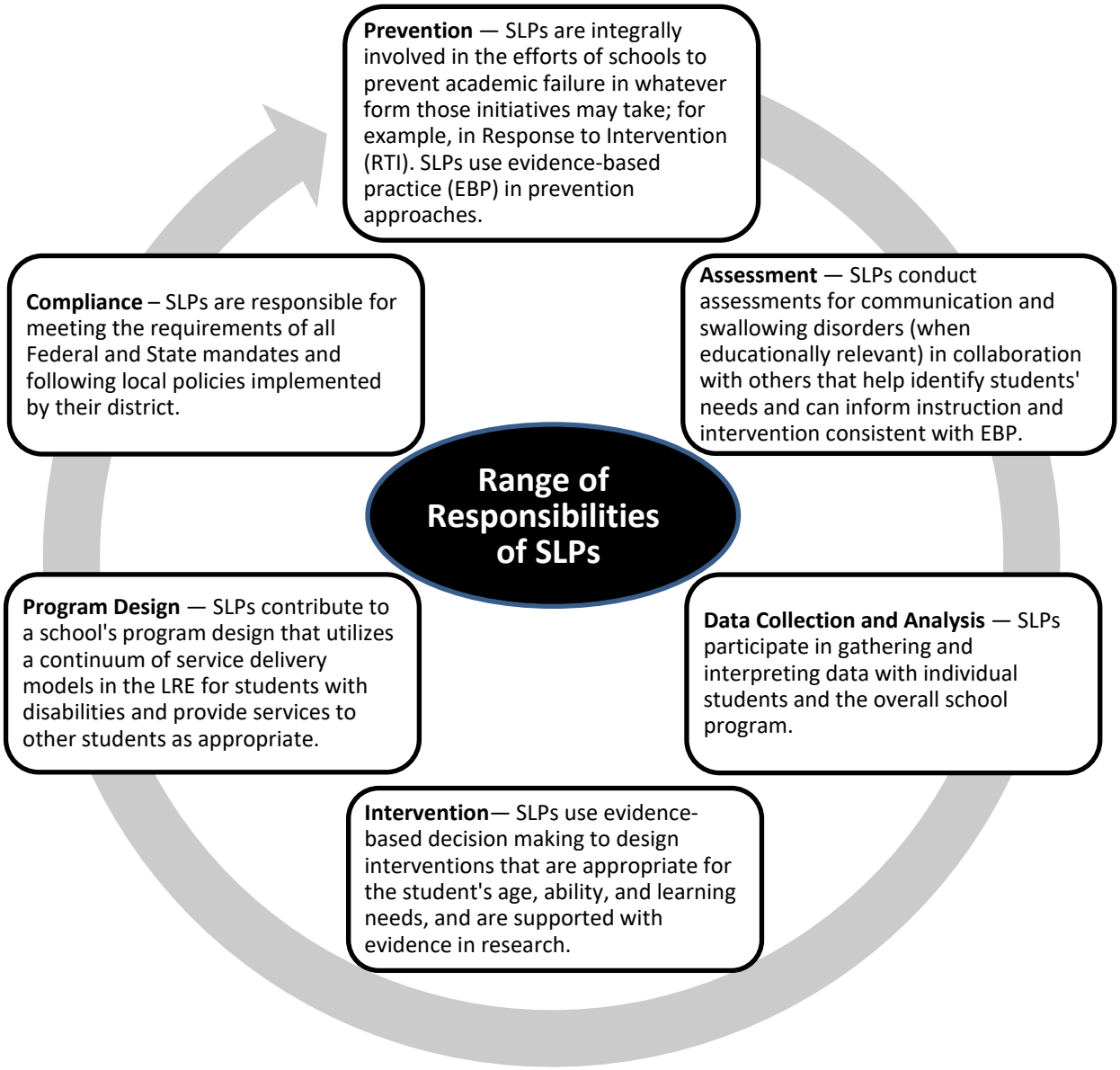
Four Areas of SLP Responsibilities

ASHA (2010) outlines four areas of SLP responsibilities in schools: (1) Range of Responsibilities; (2) Critical Roles; (3) Collaboration; and (4) Leadership.



Range of Responsibilities

SLPs have a range of responsibilities in schools that help students succeed by meeting performance standards in school (ASHA, 2010).



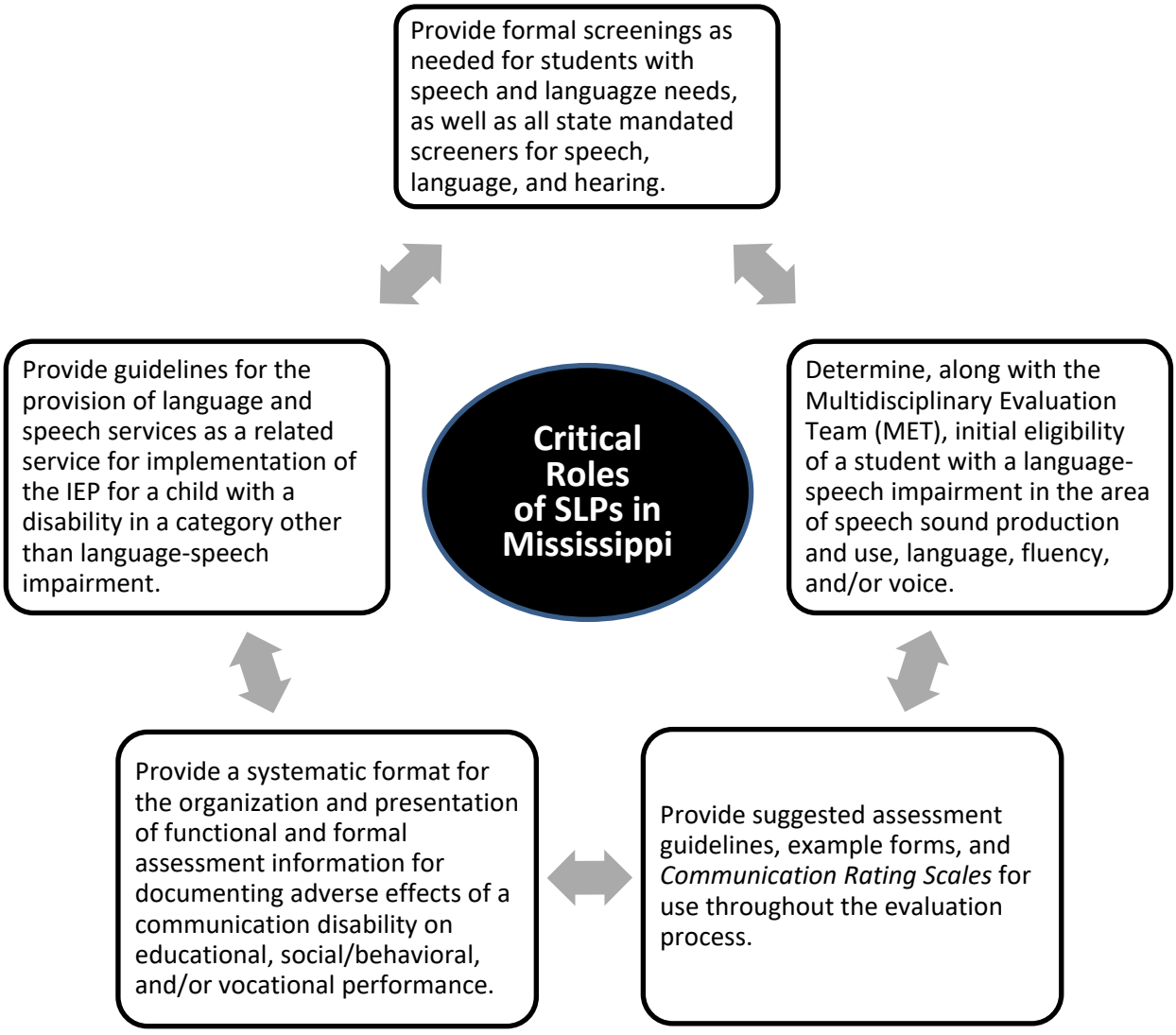
Mississippi State Board Policy (SBP 74.19) and 34 C.F.R. § 300.34 (15) define the services which are to be provided by a qualified SLP:

- Early identification of children with language-speech impairments;
- Diagnosis and appraisal of specific language-speech impairments;
- Referral for medical or other professional attention necessary for the habilitation or prevention of communicative impairments;

- Provision of speech and language services for the habilitation or prevention of communication impairments; and
- Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

Critical Roles

The **Critical Roles of SLPs** in education include working across all levels of school services (ASHA, 2010), which in Mississippi includes ages 3 through 21, with some districts meeting the needs of students younger than 3. SLPs responsibilities in Mississippi include:



SLPs serve a range of disorders, including language, voice/resonance, fluency, articulation (speech sound disorders), and swallowing and feeding (when educationally relevant). SLPs ensure educational relevance by determining if the communication or swallowing problem has an impact on the student's educational, social/behavioral, or vocational performance. SLPs provide unique contributions to curriculum to aid struggling learners and students with disabilities based on their expertise in language, linguistics, and metalinguistics. They highlight the language/literacy connection with their expertise on the interrelationships of listening, speaking, reading and writing, which aids in student literacy achievement. Finally, SLPs provide culturally competent services through their expertise of distinguishing a language disorder from other contributing factors, such as cultural/linguistic differences, socioeconomic factors, lack of adequate prior instruction, and the acquisition of the dialect of English used in the schools, as well as addressing the impact of language differences and English as a second language acquisition on student learning.

Collaboration

SLP's working in collaboration with other professionals is critical to meeting the needs of students (ASHA, 2010). In schools, SLPs work in conjunction with other staff members to contribute to the school's overall instructional program. SLPs work collaboratively with a variety of professionals.




General Education Teachers	Occupational Therapists	School Psychologists	Social Workers
Special Education Teachers	Physical Therapists	Audiologists	Behavior Specialists
Literacy Specialists	Psychometrists	Counselors	Others

Additionally, SLPs may work with both school and district administrators in the successful selection and implementation of the school's instructional program.

- SLPs collaborate with universities when serving in the capacity of teaching or supervising university students and conducting research.

- SLPs work with many community agencies (such as physicians, private practitioners, private schools, etc.) that provide services to children.
- SLPs collaborate with the families of students in training, planning, and implementing language-speech services to children.
- Most importantly, SLPs actively involve the students in successful planning, implementation, self-monitoring/awareness, and advocacy of communication goals.

Leadership

SLPs exhibit leadership to provide direction for defining their roles and responsibilities in schools and providing language-speech services to students (ASHA, 2010).

- **Advocacy** – SLPs must advocate for evidence-based practices and programs when providing service to children, such as workloads versus caseloads, professional development, and support for programs. SLPs have a responsibility to advocate for their roles to other professionals, families, and members of the community, and they must work to influence laws, regulations, and policies that promote the best practices in the field.
- **Supervision and mentorship** – SLPs have a responsibility to supervise student SLPs, clinical fellows, and SAs, as well as mentor new SLPs.
- **Professional Development** – SLPs can be utilized to design and conduct professional development that works to augment the performance of students in the general curriculum goals and objectives.
- **Parent Training** – SLPs can train parents in the processes of communication development, the characteristics of communication disorders, and the process of creating a language and literacy-rich environment.
- **Research** – SLPs must also participate in research of communication and swallowing and feeding disorders (as appropriate for students who have complex medical conditions) that supports the use of evidence-based assessment and interventions.

Work Environment

Adequate facilities for the many services provided by SLPs are necessary to meet the IEP requirements of students and to meet IDEA and Americans with Disabilities Act of 1990 regulations. In addition, specialized equipment and materials may be required to meet

the goals and objectives of students' IEPs. Table 1 contains recommendations to meet the need for adequate facilities and materials and equipment.

TABLE 1: Equipment, Materials, and Space for School-Based SLP Use in School Setting

Equipment	Materials	Space
Teacher's desk and chair; Student furniture of correct sizes and adequate number; File cabinets or drawers with locks; Adequate and secure storage for materials and equipment; Marker or chalk board, bulletin board, mirror; Computer, microphone, speakers, printer, and workstation for computer; Clock; and Access to: Penlight and otoscope; recording and playback equipment; assistive communication devices; audiometer (calibrated annually); phone for confidential conversations; and copy machine and paper shredder.	Computer software, including word processing, spreadsheet, database and creation software; clinical evaluation and instructional software; assistive technology software; Current norm-referenced assessment tools and protocols; Materials for informal assessment; Therapy and instructional materials and supplies; Access to instructional materials and textbooks used in the classrooms; File folders/pocket folders; Disposable gloves (latex-free); and Office supplies, including: Stapler/staples, scissors, pencil sharpener, paper clips, pens/pencils, correction fluid, post-its, hole punch, chalk, or dry erase markers.	Location: The room should be located away from noisy activities (gym, band room, cafeteria, etc.) and in an area that is readily accessible to non-ambulatory students. Size: The room should be of an adequate size to allow for small group activities. Generally, 180 square feet is recommended if the room also serves as an office for the SLP. Climate control: The room should have adequate ventilation and climate control. Lighting: Adequate lighting is necessary to allow for testing and observing. Internet access Wiring: A minimum of two 110-volt double outlets Availability: To provide privacy for assessment, conferences, and therapy. Acoustics: Acceptable acoustics optimize instruction.

Table 1 credited to Virginia Department of Education's *Speech-Language Pathology Services in Schools: Guidelines for Best Practice (Revised 2018)*.

Mississippi's Speech-Language Professional Growth System (PGS)

Speech-Language Growth Rubric

SLPs carry out formal and information assessments on students within the school, while making recommendations for students who need speech-language services. The purpose of the Speech-Language Growth Rubric is to:

- Guide the continuous professional growth of SLPs (215 SLP) and SAs (216 SA);
- Determine whether the SLP or SA is meeting professional standards, considering their specific roles and responsibilities;
- Highlight the speech-language professional's areas of strength and identify areas of growth;
- Serve as a guide for speech-language professionals as they reflect on their own practices;
- Provide shared understanding of priorities, goals, and expectations of quality practice.

The Speech-Language Professional Growth Rubric and all supporting observation documents may be found on the MDE website at www.mdek12.org/OEE/Speech.

SLP Requirements

- Minimum of three observation and feedback cycles during the school year with (two informal, one formal) required.
- High-quality feedback after each observation
- Observed by someone familiar with the roles and responsibilities of the school-based clinician
- Observed by someone familiar with due process and the documentation involved in the process, particularly artifact review
- SLP must be observed using the Speech-Language Growth Rubric
- Professional Growth scores are due no later than June 30 each year.

MDE Licensure Types

In Mississippi, the MDE issues two licenses for individuals practicing in the public schools in speech and language services. Regarding these licenses, individuals with a 215 AA license are able to:

- Provide services for articulation, language, voice, and fluency disorders, and any swallowing and feeding disorders that have a negative impact on educational progress;

- Provide direct and active mentoring, modeling, and feedback on all clinical duties and responsibilities of the 216 SA; and
- Mentor those who hold a valid 216 license (mentoring as described is not an administrative role).

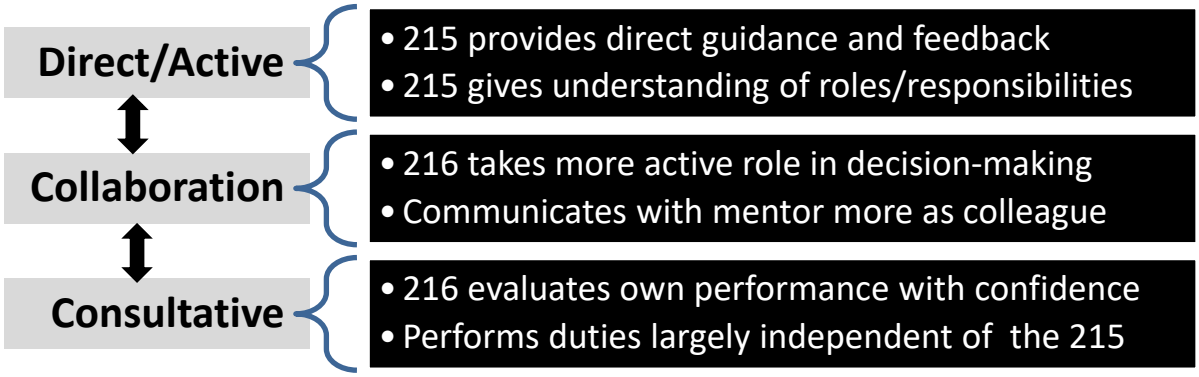
Individuals who hold a 216 A license issued by the MDE, Office of Educator Licensure, will be expected to:

- Provide ***only*** articulation therapy services to students identified with speech sound production impairments;
- Work under the mentoring and guidance of a 215 AA licenseholder;
- Participate in Child Find activities as assigned/directed by the district's director of special education and/or building principal;
- Conduct articulation assessments and develop reports;
- Participate in meetings, including, but not limited to Multi-Tiered System of Supports (MTSS), Multidisciplinary Evaluation Team (MET), Individualized Education Program (IEP), etc. and ***may not*** serve as the chairperson of the eligibility determination committee; and
- Maintain confidentiality of personal student information and educational records as required by State and Federal regulations.
- Participate in development of IEP.
- Communicate and collaborate with parents, general education teachers, special education teachers, and other related service providers.
- Develop therapy schedules.
- Provide therapy documentation: logs, notes, other data collection.

Mentoring

By utilizing a collaborative/mentoring model, public school districts will be able to maximize the skills of available licensed professionals to serve all eligible students with disabilities. The 216 licensed SA and the 215 licensed SLP will work together utilizing a collaborative model as described below.

- A continuum of direct observation, mentoring, collaboration, and consultation will be implemented.
- The experience, training, and education of the 216 SA will determine the amount of time needed for direction under the master's level SLP (215).



Transition to each stage is based on the mentoring 215 SLP's observation and judgment of the 216 SA's clinical performance and the 216 SA's input and confidence level.

Likewise, if a 216 SA is having difficulty at the collaborative or consultative level, then the 215 SLP may deem it necessary to step back to the previous mentoring stage until competence is achieved.

The Mentoring Documentation form developed by the MS Speech-Language-Hearing Association is located on the MDE website. Although this form is not required, it can be useful in facilitating conversations between the mentor and mentee and to provide documentation at the district level, if necessary.

CHAPTER II – Evaluation and Assessment

Child Find

Child Find requires all school districts to identify, locate and evaluate all children with disabilities, regardless of the severity of their disabilities. School districts are required to identify all children who may need special education services even if the school is not providing special education services to the child. **Schools are required to locate, identify and evaluate all children with disabilities from age 3 to age 21.** The Child Find mandate applies to all children who reside within the state, including children who attend private schools and public schools, highly mobile children, migrant children, homeless children, and children who are wards of the state.

Students suspected of having a disability that are identified through Child Find continue to receive high quality classroom instruction and supports for academics and behavior. All requests for comprehensive assessments for children suspected of having a disability should be submitted immediately to the district's special education director, school administrator or the MET. Written consent for the evaluation must be obtained from the parent prior to the assessment.

For students ages **three through 21,** the Local Education Agency (LEA) is responsible for identifying students who need Special Education Services through Child Find. For students enrolled in school, **ages five through 21,** within each individual school, students may also be referred for educational assessment through the Multi-Tiered System of Supports (MTSS) process. Complete definitions for Child Find can be located in the MDE State Policies Regarding Children with Disabilities under the Individuals with Disabilities Education Act Amendments of 2004 (IDEA 04), section 34 C.F.R. § 300.15.

Multidisciplinary Evaluation Team (MET)

The public agency must assemble a MET to respond to requests for comprehensive evaluations for children identified through Child Find activities, referrals from Part C Early Intervention Programs (First Steps), and requests from parents, teachers, Teacher Support Teams (TST), and other individuals knowledgeable about the child.

Each MET is responsible for:

- Determining if the child is in need of a comprehensive evaluation;

- Designing the comprehensive evaluation; and
- Determining if the child meets eligibility criteria for special education and related services.

The MET must include input from parents and collect, analyze, and interpret information to make an informed decision about the eligibility of a child for special education and related services. Depending upon the requirements of the specific evaluation and the nature of the child's suspected disability, many different people may be members of the MET. The MET must consist of the parents or guardians designated to make educational decisions for the child (unless they choose not to participate), qualified professionals from the list below who can administer individual diagnostic assessments and interpret the results, a general education teacher and/or care providers with direct knowledge of the child. It is recommended a MET Chairperson who can allocate school resources for the evaluation and resolve disagreements in eligibility determination decisions be included as needed.

Qualified Professionals Who Are a Part of the MET

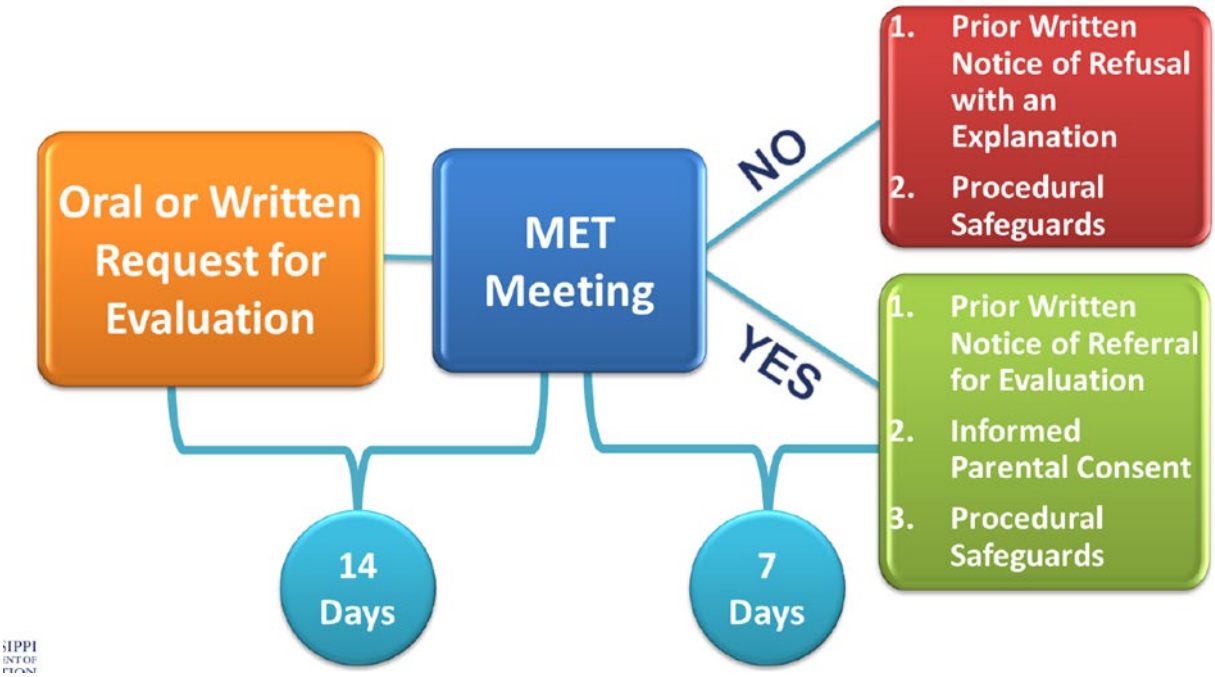
- Regular Education Teachers who have knowledge of the child, general curriculum, and Tiered Intervention supports;
- Special Education Teachers who have knowledge of disabilities, educational programming needs, and who can conduct educational assessments;
- SLPs who have knowledge of typical and atypical language and speech development and impairments who can conduct speech, language, fluency, and/or voice assessments;
- SAs who have knowledge of typical and atypical speech development and impairments and who can conduct speech assessments;
- School Psychologists who have knowledge of typical and atypical development, education, interventions, and disabilities and who can conduct cognitive, academic, adaptive, social-emotional, and behavioral assessments, interviews, and observations;
- Psychometrists who have knowledge of human development and the administration of formal assessments and, depending upon their specialized training, who can conduct cognitive, academic, adaptive, social-emotional, and behavioral assessments, interviews, and observations;
- School Health Nurses who have knowledge of physical development, health, and impairments and who can conduct health screenings and orofacial examinations;
- School Counselors who have knowledge of typical and atypical social-emotional and occupational development and, depending upon their

specialized training, who can conduct child and family interviews, educational/occupational assessments, and child observations;

- School Social Workers who have knowledge of typical and atypical social functioning and family systems and who can conduct child and family interviews, adaptive assessments and environmental observations; or
- Representatives of other agencies and/or additional examiners as needed, such as Audiologists, Physical Therapists, Physicians/Nurse Practitioners, Psychiatrists, Occupational Therapists, Ophthalmologist/Optometrists, or Rehabilitation Specialists.
- Behavior Specialists who have knowledge of and provide specialized behavioral assessments and treatment interventions.

MET membership must be configured based on the specific concerns of the referral. MET membership may change based on needs or concerns identified during the evaluation process.

Referral to the Assessment Process



When a parent, public agency representative, TST member, or other individual knowledgeable about the child makes a verbal or written request for an evaluation of a child, the public agency will assemble a MET to consider the request and determine the need for conducting a comprehensive evaluation. The public agency should have procedures for documenting verbal requests, as well as the process for handling any requests when school is not in session. The public agency must ensure

that requests for evaluations and responses to those requests are not limited by the number per year or the time of year the requests are received.

The MET must meet within 14 days of receiving the request to consider the request and review any pertinent documentation and existing data. The public agency must invite the parent and others knowledgeable of the child to participate in the meeting. Parental consent is not required for the review of existing data (e.g., existing teacher or related service provider observations, ongoing classroom assessments, criterion-referenced tests that are used to determine child progress, administration of tests or other assessments that are administered to all children, or screening by teachers or specialists to determine appropriate instructional strategies for curriculum implementation) to determine the need for a comprehensive evaluation.

Based on this review, the MET, including the parent, will either determine:

- There is sufficient evidence to suspect that the child may have a disability; or
- There is insufficient evidence to suspect that the child may have a disability.

NOTE: The standard of "suspecting a child may have a disability" is an intentionally low threshold to ensure that all children who may—but not necessarily will—qualify for special education services are provided a comprehensive evaluation. The intention is to prevent under-identification, as well as over-identification, of children with disabilities who need special education and related services. The MET should not attempt to pre-determine whether or not a child will be eligible for special education before conducting a comprehensive evaluation.

If the MET determines there is sufficient evidence to suspect that the child may have a disability and may need special education services, the MET must:

- Give the Prior Written Notice (PWN) or a similar form, to the parent within seven calendar days of the meeting to inform the parent the LEA is requesting an initial evaluation; and
- Give the Informed Parental Consent (found in State Board Policy 74.19 Appendix PS.F), or a similar form, to inform the parent of the evaluation process and to secure written consent for the initial evaluation; and
- Give a copy of Procedural Safeguards: Your Family's Special Education Rights (found in State Board Policy 74.19 Appendix PS.H) to the parent.
- Give a copy of Procedural Safeguards: Your Family Special Education Rights to the parent.

If the MET determines there is insufficient evidence to suspect that the child may have a disability, the MET must:

- Give PWN to the parent within seven calendar days of the meeting to inform the parent that the LEA is declining the request for an initial evaluation and the reasons for the decision; and
- Give a copy of Procedural Safeguards: Your Family Special Education Rights to the parent with an explanation of the due process procedures that the parent may use to dispute the MET's decision.

The MET must conduct an individualized comprehensive evaluation in accordance with IDEA regulations and MDE State Board Policy (SBP 74.19) before the provision of any special education services.

To determine whether a child is eligible for special education services, the MET ensures the comprehensive evaluation gathers information that:

- Consistently supports the presence of a disability; and
- Indicates the need for special education and related services for the child to participate in the general education curriculum or appropriate activities; and
- Identifies all of the child's educational needs to be addressed in the IEP whether or not those needs are typically linked to the disability category identified.

To be eligible for special education and related services, the MET must document an adverse educational impact (i.e., performance in academic, developmental, functional, social, behavioral, and vocational areas) due to the child's disability. To do so, the MET must ensure the determinant factor for the adverse educational impact is not a result of:

- A lack of appropriate instruction in math or reading, including the essential components of reading instruction as defined in the Elementary and Secondary Education Act (ESEA), i.e., phonemic awareness, phonics, vocabulary development, reading fluency, including oral reading skills, and reading comprehension strategies;
- Limited proficiency in understanding and/or speaking English; or
- Social or cultural differences of the child.

It is imperative that the SLP follow all of the MDE State Board Policies (SBP 74.19) Regarding Children with Disabilities under IDEA 04, specifically the "Evaluations,

Eligibility Determinations, Individualized Education Programs, and Educational Placements" sections, when conducting an evaluation.

After securing informed written parental consent to conduct an evaluation, the MET has a maximum of 60 calendar days in which to complete the evaluation, except for the following specific situations:

- The parent repeatedly fails or refuses to produce the child for evaluation.
- The child transfers to another public agency after the timeline has begun but before eligibility could be determined.
- The MET is using ongoing progress monitoring data collected to determine the child's Response to Intervention (RtI) as a method for identifying a Specific Learning Disability (SLD), the data do not clearly indicate the presence or absence of a disability at the end of the 60 daytime period, and the public agency and the parent mutually agree in writing to extend the time period.

Screenings

The school-based SLP may be required to complete screenings for hearing, speech sound production, language, fluency, and voice. Parental permission must be obtained before any individual screening of a child may take place. Appendix Y: Language-Speech Screening Permission Form may be used to document parental permission for screening. The SLP must follow state board policy (SBP 74.19), 34 C.F.R. § 300.8, § 300.39, C.F.R. 34 §§ 300.302-300.306, and C.F.R. 34 §§ 300307-300.311 when conducting screenings. Appendix A: Language-Speech Screening Form may be helpful when documenting screening results.

Hearing and vision screenings and, if necessary, follow-up examinations must be conducted in accordance with MDE OSE Procedures for State Board Policy (SBP 74.19). The results must be documented on the Appendix B Hearing and Vision Screening Report or on a similar form that contains all the required components. If the child fails the school-based hearing screenings, an audiologist holding MDE licensure, State Board licensure, or American Speech and Hearing Association (ASHA) CCC audiological certification or a physician with expertise in conducting audiological evaluations with appropriate audiological equipment must conduct a follow-up examination. If the child fails the school-based vision screenings, a licensed ophthalmologist or optometrist must conduct a follow-up examination. Existing hearing and vision screenings or examination reports conducted by a qualified examiner provided by the parent may be used if they provide the required information and are current. If the MET suspects the child may have a Hearing Impairment (HI) or be Deaf-Blind (DB), the child must have his/her

hearing evaluated by a qualified examiner and receive an assessment to determine his/her language and communication needs, including the need for instruction in alternative modes of communication. If the MET suspects the child may be Visually Impaired (VI) or Deaf-Blind (DB), the child must have her/his vision evaluated by a qualified examiner and receive an assessment to determine appropriate reading and writing media, including the current or future need for instruction in Braille or the use of Braille. See Special Assessments for Children who are Blind or Visually Impaired and Special Assessments for Children who are Deaf or Hearing Impaired for more information on evaluating children with sensory deficits.

Hearing Guidelines

Hearing Screening and Evaluation

Hearing screenings should be conducted by a licensed professional who has been clinically trained to administer hearing screenings, such as a school nurse or SLP.

To screen children for potential hearing difficulties, conduct a pure tone screening of the following required frequencies and levels, i.e., Speech Reception Thresholds (SRT), in a quiet room to reduce ambient noise:

	Optional	**Required**	**Required**	**Required**	*Optional*	*Optional*
Frequency (Hz)	500	**1000**	**2000**	**4000**	6000	8000
Level (dB)	30	**25**	**25**	**25**	30	30

Record the results of the hearing screening on Appendix B: Hearing/Vision Screening Report: Part I-A or on a similar form.

To administer an individual screening test, screen 1000, 2000, and 4000 Hz at a hearing level of 25 dB. The clinician may screen at 6000 and 8000 Hz at his or her discretion. A student may be rescheduled for a second individual screening within one week if failure to respond at the recommended screening levels at any frequency in either ear is noted. Procedures and criteria for the second screening are the same as those of the first.

Note: If a student fails or cannot be conditioned to respond to a hearing screening, a referral to a specialist is required. In this case, the quantitative measure on the Appendix B: MDE Hearing Vision Screening Report: Part II-A or a similar form containing the same type of information must be completed by an individual who works with the student or who has knowledge of the student's hearing.

The purpose is to determine if student can hear within normal range and to make appropriate referral for further evaluation if indicated.

Screen with Audiometer

The procedure as described here is a basic audiometric screening procedure.

- Instruct the student that he/she will hear a loud tone (or beep) and then some low or soft tones (or beeps). Instruct the student to respond every time a tone is heard by pointing to the ear or raising the hand. Remind the student to put his/her hand down after hearing the tone and listen for the next sound.
- With the student seated facing away from the examiner, the earphones should be placed on the ears appropriately. Hair should be pushed back and glasses removed so that the earphones adequately cover the student's ears.
- A "practice tone" should be given above the normal screening level. Set the frequency dial at 1000 Hz and the intensity dial at 40 dB. The practice tone above the normal screening level allows for quick and easy identification of the tone during the screening test.
- Set the frequency dial at 1000 Hz and the intensity dial at 25 dB. Present the tones in sequence for one to two seconds.
- Present the tone at 1000 Hz.
- Switch to 2000 Hz and present the tone.
- Switch to 4000 Hz and present the tone.
- Move the selector switch to the left ear and repeat the process.

Criteria for Failing Hearing Screening

Criteria for failure is the failure to respond to any one frequency in either ear at the recommended screening level.

At-risk children should be rescheduled within seven calendar days for a second screening. If a child fails the second screening (or cannot be conditioned to respond), the child shall be referred to a licensed or certified audiologist or otolaryngologist by the SLP for further evaluation Although it does not take the place of the formal evaluation, the quantitative description must be completed by:

- an individual who works with the child;
- has knowledge of the child's hearing; and
- is trained in recognizing developmentally appropriate hearing behavior.

Referrals should be made to the appropriate agency and the student seen within 14-21 days. Every effort should be made to expedite this process so the child can receive the necessary assistance.

An evaluation of a child's hearing by a licensed/certified audiologist/ otolaryngologist shall include all of the components of a complete hearing evaluation used to determine the eligibility of *Hearing Impairment* as defined in State Board Policy (SBP 74.19). For a child who fails the hearing screening at school, a statement of adequate hearing by a licensed/certified audiologist/otolaryngologist is sufficient. If the child's hearing ability cannot be formally determined by the licensed/certified audiologist/otolaryngologist and there is evidence that a disability exists, the MET can continue with the comprehensive assessment *and* eligibility determination while taking the results of the audiological assessment into consideration. If the child fails or cannot be conditioned for screening, you may refer out after the initial screening.

Other Hearing Evaluation Considerations

For a child who fails hearing screening at school, a statement of adequate hearing by a licensed or certified audiologist or otolaryngologist is sufficient after the child has been seen.

If a child's hearing ability cannot be formally determined by a licensed or certified audiologist or otolaryngologist, and there is evidence that a disability other than hearing loss exists, the MET can continue with the comprehensive assessment and eligibility determination while considering the results of the audiologic assessment. In this case, the MET must:

- Use appropriate assessment tools and methods.
- Report any deviations from standard assessment procedures.

Vision Guidelines

According to the Mississippi School Nurse Procedures & Standards of Care June 2018 Updated, October, 2019, vision screenings should be conducted by a licensed professional who has been trained to administer vision screenings and to use vision screening equipment and/or instruments appropriately, such as a school nurse. For complete information on how to administer a vision screening, consult the Mississippi School Nurse Procedures & Standards of Care June 2018 Updated, October, 2019.

To screen children for potential vision difficulties, conduct a screening with the right eye, left eye, and both eyes. If the child wears glasses, then the glasses should be worn during screening.

Grades	Appropriate Measures for Near-sightedness		Ages	Appropriate Measures for Far-sightedness
PreK to 4th Grade	• Snellen "E" • Hand Chart* • Other appropriate eye charts*		3-5 Years	• Near vision chart
5th Grade to 12th Grade	• Snellen "E" • Alphabet Chart*		6-20 Years	• +2.00 lens**

*Other instruments may be used, but the scores must be stated in Snellen equivalents.

**It is strongly recommended that no vision testing machine be used for screening children before the 5th grade.

Record the results of the vision screening on the form in Appendix B: Hearing/Vision Screening Report: Part I-B or a similar form.

NOTE: If a child fails or cannot be conditioned to respond to a vision screening, a developmentally appropriate quantitative description of the child's vision should be completed by an individual who (a) works with the child, (b) has knowledge of the child's vision, and (c) is trained in recognizing developmentally appropriate visual behavior. Use Appendix B: Hearing/Vision Screening Report: Part II-B or a similar form to record the quantitative description. If the student is not able to be conditioned for the vision screening after 2 attempts and Part II of the vision screening report is completed, the student must be referred to a qualified examiner for further evaluation before the comprehensive assessment can continue.

Results of first school-based vision screening

If the child demonstrates acceptable near vision for both eyes, and far vision in both eyes and each individual eye, record the child's far vision acuities in the corresponding boxes, indicate "PASS" on the screening form under the "1st Screening" heading, and record the examiner's name and the date of the screening.

- Near vision is screened with both eyes only. If the child can read the 20/20 line of the near vision chart with +2.00 lenses, or if a child cannot read the 20/20 line of a near vision chart at 13 inches unaided, indicate "FAIL" for near vision on the screening form under the "1st Screening" heading, and record the examiner's name and the date of the screening.

- If the child fails far vision in either eye or both eyes, record the child's visual acuities in the corresponding boxes, indicate "FAIL" on the screening form under the "1st Screening" heading, and record the examiner's name and the date of the screening.

Administration of second school-based vision screening. A child is considered "At-Risk" for having visual problems or impairments if the child demonstrates:

- Near-sightedness defined as vision worse than 20/40 using both eyes; or
- Far-sightedness defined as reading the 20/20 line with the +2.00 lens for children ages six (6) to twenty (20) or inability to read the 20/30 line on the near vision chart for children ages three (3) to five (5).

Criteria for failing vision screening.

- Worse than 20/40 using both eyes (near-sightedness); or
- There is a two-line difference between the left and right eye; or can read the 20/20 line with the +2.00 lens (far-sightedness).

Note: Other instruments may be used, but the scores must be stated in Snellen equivalents. It is strongly recommended that no vision testing machine be used for screening students before the fifth grade.

Children considered "at-risk" for visual impairments should have a second individual vision screening conducted within three to 10 calendar days of a failed first screening. Procedures and criteria for the second vision screening are the same as those of the first. When a child fails or cannot be conditioned to complete school-based vision screenings, the child must be evaluated by a licensed or certified ophthalmologist or optometrist. If a child's vision cannot be formally determined by a licensed or certified ophthalmologist or optometrist, and there is evidence that a disability other than vision loss exists, the MET can continue with the comprehensive assessment and eligibility determination while considering the results of the formal visual assessment. In this case, the MET must:

- Use appropriate assessment tools and methods.
- Report any deviations from standard assessment procedures.

Orofacial Examination

If the MET suspects the child may have an articulation Language/Speech Impairment, the child must have an orofacial examination conducted by a qualified examiner to determine if the orofacial mechanism is functioning appropriately. The examination

must evaluate the following structures: facial symmetry, dentition, hard and soft palate, uvula, fauces, pharynx and tongue.

If the MET determines a follow-up medical examination is necessary, a licensed physician or dentist must conduct an examination to determine the cause of the child's impairment and to provide a statement of adverse educational impact and recommendations, if any. The MET may use an existing medical report from a licensed physician or dentist provided by the parent in lieu of obtaining a new orofacial examination if the report includes the required information about the functioning of the orofacial mechanism and is considered current data according to procedures for Existing Records. See Appendix G: Orofacial Examination Form.

Existing Records

Existing current data may be used as part of the evaluation process to determine the presence of a disability, a need for special education and related services, and the educational needs of a child. Data that falls outside of the following time frames are of historical value but are no longer valid for making decisions about eligibility or educational programming:

Definition of Current	Types of Existing Records
No more than one (1) year old at the time the parent signs consent	• Intelligence measures • Hearing screening and follow-up evaluations • Vision screening and follow-up evaluations • Physical examinations
No more than six (6) months old at the time the parent signs consent	• Teacher Narrative found in SB 74.19, Appendix EE.I • Achievement measures • Social, behavioral, adaptive, and emotional measures • Language/speech assessments • Motor assessments • Curriculum-based assessments
No more than three (3) months old at the time the parent signs consent	• Developmental History found in SB 74.19, Appendix EE.H • Developmental instruments

Mass/Universal Screenings

SLPs can aid in analyzing data to identify student deficits. Parental permission is not required for universal screenings (any screening conducted on ALL children) per LEA policy and procedures but must be obtained when screening an individual child.

Nate Rogers Speech-Language Screening

According to Miss. Code § 37-175-15, the following process must occur:

1. Each local school district shall adopt a policy to ensure that students will be screened for speech, language, voice, and fluency disorders before the end of Grade 1.
2. If a student fails the screening, the parent or legal guardian will be notified of the results.
3. If a student fails the screening, the school district, in its discretion, may perform a comprehensive speech-language evaluation.
4. If a parent or a legal guardian of a student who fails the speech-language screening exercises the option to have a subsequent evaluation performed, such evaluation shall be administered by an SLP. The subsequent evaluation obtained by the parents shall be considered by the school district for eligibility in the area of speech-language in accordance with the procedures mandated by the federal Individuals with Disabilities Education Act (IDEA) for a placement in a speech-language program within the current school or to receive a Mississippi speech-language therapy scholarship for placement in a speech-language program in a nonpublic special purpose school.
5. A parent or legal guardian may provide written notification to the local school district opting out of the mandatory screening provided by the district.
6. The provisions of this section shall not apply to homeschooled students.

Although students must be screened before the end of Grade 1, it is best practice to wait until at least the second semester of kindergarten to universally screen students for speech-language deficits. Students bring a variety of backgrounds to kindergarten and early screening may result in overidentification of students who have never been exposed to academic language skills. The MDE does not suggest a particular screening instrument, but the LEA selection should be uniform across the district and must include all areas required by the policy (i.e., speech, language, voice, and fluency) via direct assessment or observation by the SLP. The LEA must have a follow-up procedure for any child who fails the screener. This may include a referral to the MET, a referral to the Teacher Support Team, or other means of monitoring the outcome of the screening.

***NOTE**: The required K-1 speech and language screening is a separate process from the kindergarten hearing, vision, and developmental screening that must take place in the first 45 days of kindergarten. Based on the results of the 45-day screening process, a child may be referred for further screening and/or a comprehensive evaluation.*

Language and Other Screenings

The SLP may conduct the following activities as part of a language-speech screening prior to assessment:

- Observation(s);
- Interview of teacher/parent
    - Appendix E: Teacher/Parent Interview - Speech Sound Production and Use
    - Appendix J: Teacher/Parent Interview - Language
    - Appendix O: Teacher/Parent Interview - Fluency
    - Appendix S: Teacher/Parent Interview - Voice
- Review of records, data, and all other information pertinent to the child to determine if further language-speech assessment is warranted; and
- Administer published and/or non-published screener(s) and other screening methods such as non-word repetition tasks, rapid word recall task, checklists, etc.

Parental permission must be obtained before an individual child is screened. The SLP or SA shall be included on the MET when further language-speech assessment is required.

The Evaluation Process

The SLP must follow State Board Policy (SBP 74.19) 34 C.F.R. § 300.8, § 300.39, C.F.R. 34 §§ 300.302-300.306, and C.F.R. 34 §§ 300307-300.311. When conducting evaluations, special consideration should be given to the *Special Education Eligibility Determination Guidelines* found on MDE Policy 74.19 pages 291-329. The guidelines specify the qualified professionals required for each disability category in assembling the initial MET; however, as a child's disability must not be pre-determined, the composition of the MET must be flexible to change over time as needed for conducting specific evaluations, assessments, observations and procedures necessary for determining the eligibility and the educational needs of the child. Additional resources are also provided by the American Speech-Language-Hearing Association - ASHA Practice Policy.

Assessment - Subgroups

Articulation/Phonological Processing Assessment

For articulation eligibility, normative data refers to articulation norms from standardized instruments, oral-peripheral examinations, and current research. Recent research has moved away from using formal norms for articulation and normative data is just one small component of a comprehensive assessment that includes the following:

- Articulation stimulability;
- Conversational speech intelligibility;
- Academic, social, emotional, behavioral, and vocational impact of an articulation disorder on the child's performance.

Speech Sound Production and Use

A speech sound disorder is a disorder of the phonological system and/or its articulatory aspect.

The disorder is characterized by speech that is difficult to understand or that calls attention to the speaker's production of speech and adversely impacts the child's educational, social, behavioral, and/or vocational performance. "Diverse impact" means that the progress of the child is impeded by the disability to the extent that the educational, vocational, and social or behavioral performance is significantly and consistently below the level of similar age peers.

An evaluation of speech sound production and use includes, but is not limited to:

- Administration of a standardized norm-referenced measure, and
- Functional procedures which assess use of speech sounds in conversation.

Speech sound disorders may be assessed and treated as:

- Phonetic or articulation disorders: Speech sound errors are motorically based (the ability to produce a target sound is not within the person's repertoire of motor skills).
- Phonemic or phonological disorders: speech sound errors are considered to be linguistically based and result from a rule system different from the adult model.
- Phonological processes include, but are not limited to:
    - Voicing Processes - processes in which the voicing of the phoneme(s) changes.

- Deletion Processes - processes in which a phoneme is deleted from a word.
- Fronting Processes - processes in which frontal consonants replace the correct phonemes.
- Syllable Processes - processes in which the syllable structure of a word is changed, such as deleting one syllable in a two-syllable word.
- Phoneme Processes - processes in which the distinctive features of a phoneme are changed, such as gliding processes (/w/ for /r/) and stopping processes (/p/ for /f/).

The suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form encompasses observations of phonetic/articulatory production and/or the phonological system to rate proficiency in speech sound production and use.

Students for whom this rating scale is appropriate are those who may have functional articulation disorders, or speech sound disorders with a neurological and/or structural origin, such as dysarthria, apraxia, etc.

The components that must be assessed to determine if a student has a speech sound disorder and is eligible for special education and related services, as listed in the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form are:

- Intelligibility of connected speech;
- Data from standardized test(s);
- Error types characterized on a range from common to atypical;
- Structure and function of the speech mechanism as it affects speech sound production (oral-peripheral examination); and
- Adverse impact of the speech sound disorder on educational, social/behavioral, and/or vocational performance.

Special Assessment Considerations: Judging Severity of Error Type in Speech Sound Production and Use

If speech sound productions are analyzed traditionally, (e.g., omissions, substitutions, distortions) most common errors generally involve substitutions of earlier developing sounds for similar, later developing sounds. These errors are usually considered less severe. Substitution errors most commonly involve a change in one distinctive feature, not two or more features. For example, when /t/ is substituted for /s/, only the manner feature is in error; when /ʃ/ is substituted for

/s/, only the place feature is in error. These common errors would typically indicate a less severe disorder. If, however, /b/ is substituted for /s/, the error would involve changes in 3 features: manner, place, and voicing. This error would indicate a more severe disorder. Omissions are generally considered more unusual than substitutions and are typical of more severe disorders. Distortions of an unusual nature (e.g., lateral air emission on /s/) often represent a more severe error type than more common, frontal distortions.

The information in the following table comes from *Articulatory and phonological impairments* and *Articulation and phonological disorders* lists the most frequent substitutions made by students with disorders of speech sound production and use.

Assimilation (Consonant Harmony) **One sound becomes the same or similar to another sound in the word**		
Process	**Description**	**Example**
Velar Assimilation	non-velar sound changes to a velar sound due to the presence of a neighboring velar sound	*kack* for *tack*
Nasal Assimilation	non-nasal sound changes to a nasal sound due to the presence of a neighboring nasal sound	*money* for *funny*
Substitution **One sound is substituted for another sound in a systematic way**		
Process	**Description**	**Example**
Fronting	sound made in the back of the mouth (velar) is replaced with a sound made in the front of the mouth (e.g., alveolar)	*tar* for *car*; *date* for *gate*
Stopping	fricative and/or affricate is replaced with a stop sound	*tee* for *see*; *chop* for *shop*
Gliding	liquid (/r/, /l/) is replaced with a glide (/w/, /j/)	*wabbit* for *rabbit*
Deaffrication	affricate is replaced with a fricative	*shop* for *ch*op
Syllable Structure **Sound changes that affect the syllable structure of a word**		
Process	**Description**	**Example**
Cluster Reduction	consonant cluster is simplified into a single consonant	*top* for *stop*
Weak Syllable Deletion	unstressed or weak syllable in a word is deleted	*nana* for *banana*
Final Consonant Deletion	deletion of the final consonant of a word	*bu* for *bus*

The substitutions listed above would likely be rated 3 for error types in the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form. Substitutions involving two or more feature changes would probably be rated 4 for error type. Numerous omissions resulting in a limited inventory of sounds would typically be rated 5 for error type. Additionally moderate or more severe articulation impairments may require an assessment of the phonological processes. Phonological processing

disorders can be assessed using standardized testing instruments. Those processes exhibited by the child should be identified, documented, and described in the language-speech evaluation to the IEP Committee.

***Note**: If a child presents with a phonological processing disorder, this may be an indicator of a language disorder and further assessment in language may be warranted. If a 216A-licensed examiner encounters a child with an apparent phonological processing disorder, a 215AA licensed SLP should be consulted on how to proceed.*

Exclusions

A student with a suspected disorder of speech sound production and use is not eligible for special education and related services when severity rating values fall within the normal range (non-disabling = 0), or speech sound differences are due to limited English proficiency or dialectal differences, *or* the speech sound errors do not interfere with educational, social, and/or vocational performance. *(Note: Such students may be eligible for language-speech services when a disorder exists in their native language or in their dialectal form of English. When tongue thrusts are unaccompanied by significant speech sound errors, other examples of educational impact must be provided.)*

Assessment Checklist for Speech Sound Production and Use Disorders

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s); for example, language, fluency and voice.
- Have the classroom teacher complete the Appendix H: Teacher Questionnaire Speech.
- Engage the student in conversational speech to assess intelligibility and phoneme production patterns in connected speech.
- Examine oral/motor structures and function. This includes examination of the facial characteristics (appearance, frontal view, and profile); intraoral characteristics (dentition, hard palate, soft palate, uvula, fauces, pharynx, and tongue); and function (lips, tongue tip, tongue based, and diadochokinesis).
- Administer a standardized test of articulation or phonology.
- ***Note:*** When the SLP completes the "Sound System" section of the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use

Form, it should be noted that not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section of the rating scale should only be marked after the standard score or percentile is compared to the standard deviation using the test manual for the specific test administered.

- Conduct behavior observations and/or other informal measures to validate test results, make intelligibility judgment, and assess adverse effect. Complete Appendix D: Communication Behavior Observation.
- For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational, social/behavioral, and/or vocational (developmental) performance. Complete Appendix C: Teacher/Parent Interview-Preschool.
- Complete the suggested Appendix F: Speech Sound Production and Use Assessment Summary.
- Complete the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form. Circle the appropriate scores within each component area to correspond with the assessment data.
- See Special Assessment Considerations: Judging Severity of Error Type in Speech Sound Production and Use.
- Do not include regional or dialectal differences.
- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Speech Sound Severity Rating of 0 - 3. *(Note:* All data from functional and standardized assessments are compiled and used to complete the suggested Appendix I: Communication Rating Scale: Speech Sound Production and Use Form. This constitutes the SLP's recommendation to the IEP Committee regarding whether there is a speech sound disorder and whether there is indication of an adverse impact on educational, social/behavioral, or vocational performance. The IEP Committee makes the final determination of eligibility or the MET if initial determination of eligibility.)

Essential Components for Evaluation/Reevaluation

Student assessment reports should include student demographic information; social history; reason for evaluation/reevaluation; results and recommendations; and formal and/or informal assessment of communication in conversational speech, including the adverse impact on educational, social, behavioral, or vocational performance. Reevaluation should also consist of a review of the current IEP and progress made toward annual goals and objectives, hearing and vision screening information when appropriate. For preschool children, the assessment report should state the impact the articulation, language, fluency, and/or voice impairment has on the child's participation in appropriate activities.

Language Assessment

A language disorder, defined broadly, includes an impaired ability to understand or use language as well as one's same-age peers of the same community. The disorder may involve:

- Form of language (phonology, morphology, syntax);
- Content of language (semantics); and/or
- Use of language in communication (pragmatics).

A comprehensive language assessment examines a child's skills in the areas of listening and speaking as related to a suspected language disorder across form, content, and use. The assessment determines the student's ability to:

- Understand and interpret language.
- Use appropriate language to successfully communicate in a variety of situations and for a variety of purposes, as well as documenting the type of language deficit, including, but not limited to:
    - Morphology,
    - Syntax,
    - Semantics,
    - Pragmatics, and/or
    - Phonology.

The suggested Appendix N: Communication Rating Scale: Language is appropriate for students who have specific language impairment, or who have a language disorder secondary to Autism, cognitive impairment, attention deficit disorder, auditory processing skill deficits, central auditory processing disorder, traumatic brain injury, hearing loss, or other related conditions. The components that must be assessed to

determine if a student has a language disorder and is eligible for special education and related services, as listed in the suggested Appendix N: Communication Rating Scale: Language are:

- Functional assessment measures across form, content, and use;
- Administration of standardized/norm-referenced test(s);
- Adverse effect of the language disorder on educational, social, and/or vocational performance.

If more data is needed to determine eligibility, a dynamic assessment approach should be undertaken during the **60-day** timeline.

When a parent, district personnel, another agency, or TST suspects that a student has a communication disability, a request should be made for an evaluation. **Interventions are not required for determining eligibility.** The SLP shall be a part of the MET and shall complete the language assessment. If a dynamic assessment is used, it shall be a part of the SLP's report and/or in the SLP's portion of the report which will assist the MET in making the eligibility determination. Students for whom English is a second language and who demonstrate dialectal variations may demonstrate impairment in their primary language. Collaboration with an interpreter or translator may be necessary when assessing students for whom English is a second language (§ 300.304 (c)(1)(ii)).

Functional Assessment

Observation and analysis of the student's language skills within his or her everyday contexts and environments provide essential information about language strengths and possible area(s) of weakness. Information gained within functional settings and contexts may be used not only as partial documentation of a language disorder, but also to learn more about the patterns and areas of the language disorder and to assist in intervention planning. Functional data should also be used to validate the results of standardized tests. While not inclusive of all possibilities within the school and home settings (especially for preschoolers), some examples of sources of functional assessment are listed below:

Language Sampling/Narratives

The informal language sample may be a key component of the functional assessment for preschool and/or students with severe language delays. Analysis of the language sample to validate standardized assessment data relies upon the use of developmental scales in the areas of phonology, morphology, syntax, semantics, and

pragmatics. For older students, an oral narrative may be an appropriate tool for functional analysis.

Classroom Observation

The SLP should observe how the student's language disorder affects his or her involvement and progress in the general curriculum. This informal assessment of the student's language skills may be used to validate the results of standardized tests. It may also help support a teacher's description of the student's communicative behaviors. The observation should assess how well the student is able to follow classroom routines, interact with his/her teachers and peers, respond to and participate in classroom discussion or other activities needed to progress in the general curriculum.

Teacher/Parent Interviews

- Information gathered from parents and/or teacher(s) about the student's language performance in familiar settings can be used by the SLP to verify the student's language performance.
- Outside assessments and other information from the parent(s)
- Teacher narratives including the Appendix L: Teacher Questionnaire for Expressive Language and/or the Appendix M: Teacher Questionnaire for Receptive Language.
- Developmental history
- Evidence of appropriate instruction in reading and math

Criterion-Referenced Activities (i.e., student telling a story)

Criterion-referenced measures indicate ability with respect to specific skills, such as curriculum-based language assessments and overall communication ability. Such measures aid in the understanding of a student's abilities and needs by complementing findings from norm-referenced measures, and by providing a means of describing the student's strengths and needs in terms of actual performance.

Review of Written Products (e.g., work samples, portfolio entries, etc.)

- Assessment of specific language skills within the context of academic tasks using the curriculum provides performance-based data to verify information gained from standardized instruments.
- Language tasks are used to probe for specific skills. Valuable assessment information may be gathered from clinician-generated activities using functional tasks with curricular materials.

Note: For preschoolers, or students in environments different from the traditional classroom, *additional information related to social interaction, behavior, and emotional development may be obtained through observation(s) of the student within a small group or age-appropriate setting (e.g., preschool program, daycare, community, vocational/technical program, and home).*

Special Assessment Considerations: Language

Exclusions

A student with a suspected language disorder is not eligible for special education and related services when:

- Language differences are due to:
  - Limited English proficiency
  - Dialectal differences
    Note: Such students may be eligible for language-speech services when a disorder exists in their native language or in their dialectal form of English.
- Language performance does not interfere with educational, social, behavioral, and/or vocational performance.

Assessment Checklist for Language Disorders

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, speech sound production and use, fluency, and voice.
- Gather data regarding the child's communication functioning in the educational/developmental setting. It is suggested that this be initiated prior to the standardized assessment to assist in the selection of appropriate test(s).
- Complete the Appendix J: Teacher/Parent Interview - Language and the Appendix L: Teacher Questionnaire for Expressive Language and/or the Appendix M: Teacher Questionnaire for Receptive Language.
- Administer relevant standardized/norm-referenced tests, which are both comprehensive and specific to identified areas of weakness.
  Note: When the SLP completes the "Standardized/Norm-Referenced Assessment" section of the suggested Appendix N: Communication Rating Scale - Language, it should be noted that not all standardized measures have a consistent correlation among standard deviations, standard scores,

and percentiles. This section should be marked only after the standard score or percentile is compared to the standard deviation using the test manual for the specific test administered.

- Collect any additional documentation needed to assess adverse effect of the language disorder on the student's educational, social, behavioral, and/or vocational performance.
- For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete the suggested Appendix K: Language Assessment Summary.
- Complete the suggested Appendix N: Communication Rating Scale - Language and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested Appendix N: Communication Rating Scale - Language. Circle the appropriate scores within each component area to correspond with the assessment data.
- See Special Assessment Considerations: Language.
- Do not include regional or dialectal differences.
- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Language Severity Rating of 0 - 3. *Note: All data from functional and standardized assessments are compiled and used to complete the suggested* Appendix N: Communication Rating Scale - Language. *This constitutes the SLP's recommendation to the IEP Committee regarding whether there is* a *language disorder and whether there is indication of an adverse effect on education. The IEP Committee makes final determination of eligibility or MET if an initial evaluation.*
- Complete a written report documenting assessment results and attach the suggested Appendix K: Language Assessment Summary and completed suggested Appendix N: Communication Rating Scale - Language.

Fluency Assessment

A fluency disorder is a disorder of the flow or smoothness of speech beyond what is considered typical. The disorder may be characterized by abnormalities in the behavioral dimensions of speech production (i.e., rate, rhythm, continuity, and effort used to produce speech). These abnormalities in speech production are often accompanied by affective (emotional) and cognitive symptoms that may have an adverse effect on successful student participation in educational, social, behavioral, and/or vocational activities.

Fluency disorders are identified by a process of differential diagnosis. An evaluation of fluency includes, but is not limited to:

- Assessment of observable behavioral components, including, but not limited to, repetitions, prolongations, sustained articulatory posturing, schwa replacement, physical concomitants, rhythm, rate, and physical effort.
- Assessment of any affective (emotional) components that may accompany the disorder, including fear, anxiety, frustration, embarrassment, guilt, shame, and helplessness related to communication.
- Assessment of any cognitive components that may accompany the disorder, including verbal avoidance, situational avoidance, and negative impact on self-confidence and/or self-image. The suggested Appendix R: Communication Rating Scale - Fluency encompasses observations of conversational fluency. Students for whom this rating scale is appropriate are those who may have abnormal timing and flow of conversational speech.

The components that must be assessed to determine if a student has a fluency disorder and is eligible for special education and related services, as listed in the suggested Appendix R: Communication Rating Scale - Fluency are:

- Frequency of dysfluencies;
- Type(s) of dysfluencies;
- Phonatory arrest or sustained articulatory posture;
- Speech sound prolongations;
- Schwa replacement for intended vowel;
- Physical concomitants (secondary characteristics/struggle behaviors);
- Awareness and emotional reaction to dysfluencies;
- Avoidance behaviors and peer reactions to dysfluencies;
- Adverse effect of the fluency disorder on educational, social, behavioral, and/or vocational performance.

Special Assessment Considerations: Fluency

Because fluency disorders are multidimensional in nature, more than just speech sampling and analysis must be used to diagnose a fluency disorder. A variety of assessment tools and strategies must be used to determine the presence or absence of behavioral, affective, and cognitive symptoms. A fluency evaluation must include observations of the student in communicative situations in which communicative stress is varied. Efforts must be made to determine whether behavioral, affective, or cognitive symptoms have an adverse effect on educational, social, behavioral,

and/or vocational performance. Behavioral components of the disorder may include presence of the following observable behaviors:

- Repetition of linguistic elements (listed from least to most disabling).
  - Whole multisyllabic word repetitions (e.g., "I want, I want to play.").
  - Whole monosyllabic word repetitions (e.g., "I can, can sing.").
  - Part-word syllable repetitions (e.g., "I eat spa-spaghetti.").
  - Part-word speech sound repetitions (e.g., "I can k-k-k-kick the ball.").
- Prolongation of speech sounds.
- Sustained articulatory posturing (i.e., position of the articulators may be correct for production of the speech sound, but posture is held for an abnormal length of time).
- Blockages or abnormal restriction of air or voicing, including phonatory arrest.
- Silent pauses.
- Broken words (e.g., "It was won *(pause)* derful.").
- Substitution of the schwa vowel for the intended vowel.
- Interjections.
- Pitch rise (typically present toward the end of a prolongation or linguistic sequence).
- Physical concomitants/struggle behaviors accompanying moments of stuttering (e.g., facial grimaces or tremors; leg, arm, or body movements; poor eye contact or eye blinking; production of extraneous distracting sounds such as sniffing or clicking sounds).
- Abnormal rhythm, continuity, physical effort, or rate of speech.
- Difficulty initiating, maintaining, or terminating vocalizations or verbalizations.

Affective components include communicative stress and negative emotional reactions that may accompany the disorder, for example:

- Fear
- Anxiety
- Frustration
- Embarrassment
- Guilt
- Shame
- Helplessness

Cognitive components that may accompany the disorder may include:

- Verbal avoidance (e.g., word substitutions, revisions, starters, postponements, circumlocution);
- Situational avoidance (e.g., avoidance of feared situations such as answering aloud in class, making class presentations, participating in class or group discussions); and
- Negative impact on self-confidence, and/or self-image that negatively affects academic performance or participation in vocational development or social activities.

Exclusions

Based on an IEP Committee (MET if it is an initial eligibility determination) decision, a student with a suspected disorder of fluency may not be eligible for special education and related services when:

- Severity rating values fall within the normal range (non-disabling= O);
- Fluency difference is related to normal development; and/or
- Dysfluencies do not interfere with educational, social/behavioral, and/or vocational performance.

Assessment Checklist for Fluency Disorders

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, articulation, language and voice.
- Collect and assess samples of communicative behavior in structured and unstructured communicative situations.
- Conduct behavior observations and/or other informal measures to validate the presence or absence of behavioral, emotional, and/or cognitive symptoms of a fluency disorder, and to assess adverse effect.
- For preschoolers, additional functional settings may be playtime or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete Appendix O: Teacher/Parent Interview - Fluency and the Appendix Q: Teacher Questionnaire Fluency.
- Complete the suggested Appendix P: Fluency Assessment Summary.
- Complete the suggested Appendix R: Communication Rating Scale - Fluency and assign a severity rating.

- Gather all assessment data and relate it to each of the components on the suggested Appendix R: Communication Rating Scale - Fluency. Circle the appropriate scores within each component area to correspond with the assessment data.
- See Special Assessment Considerations: Fluency.
- Total the values assigned to each component area, adding comments when appropriate.
- Assign a corresponding Fluency Rating of 0 - 3.
  Note: All data from functional assessments is compiled and used to complete the suggested Appendix R: Communication Rating Scale - Fluency. This constitutes the SLP's recommendation to the IEP Committee regarding whether there is a fluency disorder and whether there is indication of an adverse effect on education. The IEP Committee makes final determination of eligibility or MET, if it is an initial eligibility determination.
- Complete a written report and attach the suggested Appendix P: Fluency Assessment Summary and completed Appendix R: Communication Rating Scale - Fluency.

Voice Assessment

A voice disorder is characterized by the abnormal production and/or absence of vocal quality, pitch, loudness, resonance, and/or duration, which is inappropriate for an individual's age, sex, and/or culture. A comprehensive voice evaluation includes an analysis of the student's respiration, phonation, and resonance as well as data collected from observation, interview, and/or case history regarding the student's vocal quality and appropriate use of voice throughout the day. Informal data should be collected from the student, if appropriate, using the Appendix W: Vocal Self Perception - Student Questionnaire and/or the Appendix X: Voice Conservation Index Self-Rating. The evaluation must also include a physical examination of the oral structure and a medical exam conducted by an appropriate medical professional (e.g., otolaryngologist). The suggested Appendix U: Communication Rating Scale - Voice outlines the primary variables of voice production measured during an assessment for voice disorder. Students for whom this rating scale is appropriate are those who may have vocal nodules, vocal fold thickening, or other conditions of the laryngeal mechanism which cause noticeable differences in pitch, quality, loudness, and resonance.

The components that must be assessed to determine if a student has a voice disorder and is eligible for special education and related services, as listed on the suggested Appendix U: Communication Rating Scale - Voice are:

- Pitch
- Loudness
- Quality
- Resonance
- Vocal abuse/misuse
- Physical condition/medical findings (including documentation of an oral peripheral examination)
- Adverse effect of the voice disorder on educational, social/behavioral, and/or vocational performance.

The medical examination may include assessment of the vocal folds through indirect laryngoscopy, video endoscopy and/or video stroboscopy. The voice evaluation shall include an oral peripheral exam, documentation that a 10 calendar day interval between measures was observed (measure may be the same but must be approximately 10 days apart), formal/informal measures, including observation during or prior to the assessment process and documentation of a physical exam/voice assessment conducted by the appropriate medical specialist.

Special Assessment Considerations: Voice

When language-speech screening reveals vocal characteristics that are atypical for a student's age, gender and/or cultural background, the MET should convene to discuss comprehensive evaluation and referral to an appropriate medical specialist (e.g., otolaryngologist). A voice evaluation should include observations of the student's voice in a variety of communicative situations. The evaluation should also consider environmental and health factors which may contribute to the voice problem. The purpose of the medical referral is to evaluate the general status of the laryngeal mechanism. The results of the medical report should be used by the MET to determine whether voice therapy is an appropriate treatment. Some phonatory disorders do not respond to voice therapy, while other laryngeal conditions such as papilloma or carcinoma have serious contraindications to voice therapy. For these reasons, the SLP must not enroll a student in voice therapy unless current medical information is available. Voice disorders among school-age children are usually related to physical changes of the vocal folds, (e.g., vocal nodules); however, problems with vocal cord approximation can also cause dysphonia (hoarseness,

breathiness, harshness, huskiness, stridency, etc.). Listed below are common terms used in the diagnosis of laryngeal pathology:

- **Vocal cord thickening**: An actual tissue change that typically results from prolonged abuse/misuse of the voice or chronic infection of the vocal folds. This condition is common among school-aged children. Voice therapy specifically directed toward reducing abuse/misuse of voice production is often considered the best treatment for reducing vocal cord thickening.
- **Vocal Nodule**: A benign, callous-like nodule that typically occurs on the anterior glottal margin of the vocal fold. Vocal nodules are one of the most common disorders of the larynx and are primarily caused by prolonged hyperfunctional use of the vocal mechanism. Treatment often encompasses voice therapy, surgical removal of the nodule(s) or a combination of surgery followed by voice therapy.
- **Vocal Polyp**: A bulging enlargement that typically occurs in the same junction of the vocal fold as nodules. Vocal polyps are more likely to be unilateral than bilateral and typically develop as a result of prolonged vocal abuse. While polyps respond to voice therapy, surgical removal with follow-up vocal rest and voice therapy is often required.
- **Papilloma**: A wart-like benign tumor of the larynx that frequently occurs among young children. Small papillomas often vanish without therapeutic or surgical intervention; however, large papillomas may require surgical removal and/or close monitoring by a laryngologist. Students with papillomas are NOT candidates for voice therapy.
- **Contact Ulcer**: A benign ulceration of the vocal folds that is often caused by tissue irritation resulting from esophageal reflux and/or vocal abuse. Contact ulcers are rarely seen in children. Vocal rehabilitation is often the preferred treatment for contact ulcers, although large ulcerations may require surgery with follow-up voice therapy.
- **Leukoplakia**: A benign growth of whitish patches on the vocal folds, caused by chronic irritation (i.e., smoking) that causes vocal hoarseness and chronic cough. Typically, leukoplakia is treated by removing the cause of the irritation (e.g., quit smoking). This condition is not responsive to voice therapy.
- **Hyperkeratosis**: A benign mass of accumulated tissue, which may grow on the inner glottal margins of the vocal folds, causing hoarseness. This condition is not responsive to voice therapy but should be closely monitored by a laryngologist because it occasionally develops into a malignancy.
- **Granulomas or Hemangiomas**: Tissue lesions that are related to glottal trauma (e.g., intralaryngeal intubation during surgery) and result in a hoarse

vocal quality. Temporary vocal rest often reduces the lesion, and formal voice therapy is typically not required.

- **Vocal cord paralysis**: Lesions of the neural or muscular mechanism resulting in the inability of one or both cords to move. In adductor paralysis, the vocal fold(s) cannot move to the central position, while abductor paralysis causes an inability of the vocal fold(s) to move laterally.
- **Unilateral adductor paralysis**: Results in a breathy, hoarse vocal quality with poor intensity and range of pitch. Voice therapy may be somewhat helpful in achieving a stronger voice. Medical management, such as Teflon injection, is often recommended as well.
- **Bilateral adductor paralysis**: Results in almost aphonic speech, and voice therapy is seldom effective. Medical management, such as surgical repositioning of the vocal folds is sometimes helpful.
- **Unilateral abductor paralysis**: Seldom causes a significant speaking problem, but often results in shortness of breath due to the decreased size of the glottal opening.
- **Bilateral abductor paralysis**: Requires immediate surgical intervention (e.g., tracheotomy) followed by surgical repositioning of the vocal folds. Voice therapy may be prescribed to help the student learn to use the reconstructed phonatory mechanism.
- **Laryngeal web (synechia)**: A membranous tissue (webbing) that grows between the proximal vocal folds. Webbing may be congenital but is typically the result of severe laryngeal infections or laryngeal trauma. Laryngeal webbing may cause shortness of breath and dysphonia. Laryngeal webs are typically treated with surgical intervention followed by vocal rest.

Exclusions

Based on the decision made by the MET /IEP Committee, a student with a suspected voice disorder may not be eligible for special education and related services when:

- Severity rating values fall within the normal range (non-disabling=0).
- Vocal characteristics are the results of temporary physical factors, such as: allergies, colds, abnormal tonsils or adenoids, or transient vocal abuse/misuse.
- Prepubertal laryngeal changes in male students
- Regional or dialectical differences
- Disorder does not interfere with the educational, social, behavioral, and/or vocational performance of the student.

Note: The SLP should discuss any potential vocal harm with the student's parents and teachers to prevent acute or transient vocal patterns (e.g., transient abuse or allergy effects) from developing into chronic vocal problems.

Assessment Checklist for Voice

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, speech sound production and use, language, and fluency.
- Examine oral/motor structures and function (inclusive of an oral-peripheral examination).
- Complete Appendix S: Teacher/Parent Interview - Voice.
- Have the classroom teacher complete the Appendix T: Teacher Questionnaire - Voice.
- Collect and record appropriate samples of the student's voice, including samples of connected speech and sustained vowel phonations. Collect information regarding the student's vocal habits and the onset, duration and variability of the suspected voice disorder. Analyze the student's vocal characteristics.
- Secure medical findings from an appropriate physician for additional assessment of the structure and function of the laryngeal and/or velopharyngeal mechanism(s). Without this information, eligibility for voice therapy cannot be determined and therapy should not be initiated.
- Conduct behavior observations and/or other informal measures to validate assessment data related to the observed vocal characteristics and to assess adverse effect. For preschoolers, additional functional settings may be playtime or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete the suggested Appendix U: Communication Rating Scale - Voice and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested Appendix U: Communication Rating Scale - Voice. Circle the appropriate scores within each component area to correspond with the assessment data.
- See Special Assessment Considerations: Voice.
- Do not include regional or dialectal differences.

- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Voice Severity Rating of 0 - 3.
- *Note: All data from functional and medical evaluations are compiled and used to complete the suggested Appendix U: Communication Rating Scale - Voice. This constitutes the SLP's recommendation to the IEP Committee/MET regarding whether there is a voice disorder and whether there is indication of an adverse effect on education. The IEP Committee/MET makes final determination of eligibility.*
- Complete a written report and attach the completed suggested Appendix U: Communication Rating Scale - Voice.

Eligibility Determination

Eligibility for services is based on the presence of a disability that results in the student's need for special education and/or related services, not on the possible benefit from speech-language services. One of the most critical elements to be obtained from a student's evaluation information is the documentation of whether the student's disability adversely affects him/her within the educational, social, behavioral, and/or vocational setting. Specifically, adverse impact is the extent to which a student's disability affects the student's progress and involvement in the general curriculum as provided or, in the case of preschool students, how the disability affects the child's participation in appropriate developmental activities. Adverse impact is evident when a student's disability negatively impacts the student's:

- Involvement and advancement in the general education program (educational impact);
- Education and participation with other students with or without disabilities (social impact); or
- Participation in extracurricular and other non-academic activities (vocational impact).

Documentation of adverse impact is a critical element in the determination of eligibility for the provision of language-speech services when language-speech impairment is the primary disability. See Appendix AC: Eligibility Determination Checklist: Language/Speech Impairment (LS).

MET Eligibility Determination

Within 14 calendar days, upon completion of an evaluation, the MET team shall hold an eligibility determination meeting to determine whether or not the child is

eligible for one of the eligibility categories as defined by MDE. The eligible disability categories as defined by MDE are found in State Board Policy 74.19 pages 299-329 Disability Categories.

There are twelve categorical disabilities and one noncategorical designation (i.e., Developmentally Delayed) under Mississippi policies.

1. Autism (AU)
2. Deaf-Blind (DB)
3. Emotional Disability (EmD)
4. Hearing Impairment (HI)
5. Intellectual Disability (ID)
6. Language or Speech Impairment (LS)
7. Multiple Disabilities (MD)
8. Orthopedic Impairment (OI)
9. Other Health Impairment (OHI)
10. Specific Learning Disability (SLD)
11. Traumatic Brain Injury (TBI)
12. Visually Impaired (VI)
13. Developmentally Delayed (DD)*

*Developmentally Delayed is for non-categorical identification when the child has a disability and needs special education and related services but does not clearly fit one of the twelve eligibility categories.

The MET must include input from parents and collect, analyze, and interpret information to make an informed decision about the eligibility of a child for special education and related services. Depending upon the requirements of the specific evaluation and the nature of the child's suspected disability, many different people may be members of the MET. The MET must consist of the parents or guardians designated to make educational decisions for the child (unless they choose not to participate), qualified professionals from the list below who can administer individual diagnostic assessments and interpret the results, a general education teacher and/or care providers with direct knowledge of the child. It is recommended a MET Chairperson who can allocate school resources for the evaluation and resolve disagreements in eligibility determination decisions be included as needed. (See Qualified Professionals Who Are a Part of the MET.)

All members of the MET do not have to agree to the eligibility determination. If a member disagrees with eligibility, then that member should make a separate written statement presenting the member's conclusions.

The parent **MUST** give written consent for placement in Special Education for the student to be eligible to receive special education services.

Once the MET has made an eligibility determination, the IEP shall be developed by the IEP Committee within 30 calendar days of the eligibility determination.

The information gained through the evaluation process may be used by the MET to determine:

- Eligibility for language-speech services as a primary disability
- The need for language-speech therapy as a related service
- Continued eligibility for language-speech services

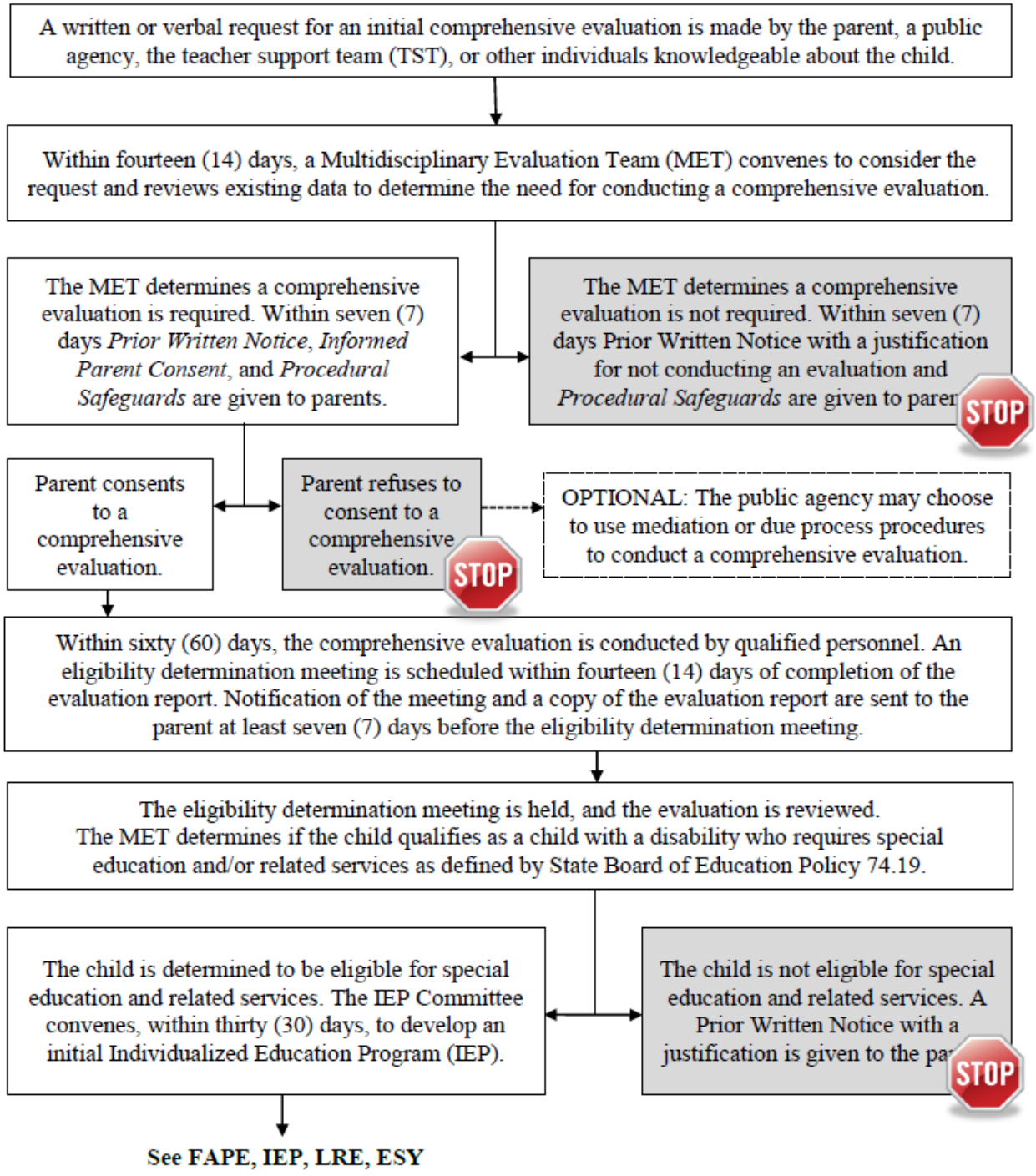
It also provides significant information for the MET and IEP Committee in identifying a student's instructional needs to be addressed in the IEP.

The MET may use the Eligibility Determination Report - Appendix EE.M from MDE Procedures for State Board Policy 74.19 Volume I or other methods of documentation to identify the basis for the MET's decision (i.e., data supporting the presence or absence of one or more disability categories). The MET may then document the agreement or disagreement of each team member on the Eligibility Determination Report - Appendix EE.M pages 127-128 from MDE Procedures for State Board Policy 74.19 Volume I or a similar form that contains all the required information.

For each criterion listed for each disability category, the MET should record the data source(s) used as the basis for determining whether the child meets or fails to meet the criterion. For example, when determining whether a child meets or fails to meet the eligibility criteria for the disability category of Autism, results from a standardized communication measure, a parent version of a rating scales measure, and an unstructured observation may support or fail to support the presence of the "significant delays in verbal and nonverbal communication" criterion, while parent reports on a developmental history and medical records may support or fail to support the "delays before the age of 3" criterion.

The required and recommended supporting evidence for each disability category noted on each eligibility determination checklist are found in State Board Policy 74.19 pages 299-329 Disability Categories.

Initial Evaluation and Eligibility Flowchart



MET Documentation Form

The MET Documentation Form found below is from the MDE Procedures for SB Policy 74.19-Appendix CF.H, pages 29-30 (a tool to guide public agencies in MET discussions, document the information discussed at MET meetings, and the determination of the MET. The MET Documentation Form, or a similar form, is recommended for use when conducting a MET meeting to ensure all data have been collected, reviewed, and considered in documenting a MET decision.

1. Collect all data necessary to make an informed decision about a particular child. The data will vary depending on the type of decision that will be determined.

2. Record the student's information (i.e., name, school, MSIS number, date of birth, grade, age, and gender). Also, document the referral source of the student to be discussed.

3. Record the date the public agency received the request; this is considered to be day one of the 14-day timeline for convening MET to respond to any Child Find requests. Also, record the date of the actual MET meeting. The date of MET should be within 14 days of the Child Find request.

4. Record the information that was available and reviewed during the MET meeting by checking the appropriate boxes. Not all of the data listed on the form may be required. If information is not available, but needed, the MET Chairperson should document what will be additionally collected and who is responsible for each piece of information. If the MET suspects that the student may be a child with a disability, the additional documentation should be collected as part of the evaluation process.

5. Record the recommendations of the MET and the actions taken or needed. Record additional recommendations if they are necessary.

6. Record the members present at the meeting and their positions. ALL required members should be in attendance with documentation provided that the parent was in attendance or invited.

7. Provide copies of the form to the parent along with the required documents determined by the committee's decision.

MET DOCUMENTATION FORM

Name:_____ School:_____

MSIS:_____ DOB:_____ Grade:_____ Age:_____ Gender:_____

Referral Source: Teacher____ TST Committee____ Parent____ Reevaluation____ Preschool____ Other:____

Date of Request:_____ Date of MET meeting:_____

The following information was reviewed by MET: **(Check only the documentation reviewed)**	
☐ Information/Reports provided by parent/guardian	☐ Current grades
☐ Universal Screening results student and class data	☐ Vision screening
☐ Required Tier I, II, and III forms	☐ Hearing screening
☐ Progress monitoring for academic objectives	☐ Teacher Narrative
☐ Progress monitoring for behavior objectives	☐ Behavior logs
☐ Student Data Form	☐ FBA/BIP
☐ Social/Emotional Worksheet	☐ Developmental History
☐ Copy of cumulative record insert	☐ Classroom observation
☐ Discipline reports from current and previous years	☐ Current or previous IEP with goals updated
☐ Attendance reports from current and previous years	☐ L/S Dismissal Narrative
	☐ Reevaluation Summary
	☐ Other/Specify:

Recommendation of Team for Initial Referrals:

____Comprehensive Assessment is recommended.

____Comprehensive Assessment is not recommended.

Recommendation of Team for Reevaluations:

____IEP Committee Decision – Comprehensive Assessment is recommended.

____Notice for Additional Assessment is completed at MET.

____School will complete Notice for Additional Assessment with parent.

____IEP Committee Decision – Comprehensive Assessment is not recommended at this time. Based on information reviewed, this student continues to need special education services and related services as indicated on the current IEP. The current eligibility should be continued.

____Notice for No Additional Assessment is completed at MET

____School will complete Notice for No Additional Assessment with parent.

____Language/Speech Dismissal: Committee recommends dismissal from speech services.

(If Parent does not attend meeting, Parent must be given written notice for decision within 7 days)

Other Recommendations:

MET Members Signatures/Positions:	

ELIGIBILITY DETERMINATION REPORT

PERSONAL DATA		
Child's Name:	**MSIS #:**	**DOB:**
District:	**School:**	**Grade:**

Based on the attached (re)evaluation report(s) completed, the Multidisciplinary Evaluation Team (MET) or Individual Education Program (IEP) Committee determines that:

☐ *The child meets the criteria for the presence of* _____

☐ *The child meets the criteria for the presence of a Language/Speech Impairment (LS) that is not the primary disability but requires language and/or speech services as a related service* _____.

☐ *The child does not meet the criteria for the presence a disability due to:*

- ☐ *failure to meet required criteria:* _____
- ☐ *exclusionary factors:* _____

Attach any applicable eligibility determination checklists and required statements from professionals.

Date of Meeting:

By signing below, I certify that this report DOES reflect my conclusions.		*By signing below, I certify that this report DOES NOT reflect my conclusions. I will submit a separate statement with my conclusions.*	
Signature	**Position**	**Signature**	**Position**
	MET Chairperson		MET Chairperson
	General Educator		General Educator
	Special Educator		Special Educator
	Parent/Guardian		Parent/Guardian
	Parent/Guardian		Parent/Guardian
	Child		Child
	Language/Speech Pathologist/Therapist		Language/Speech Pathologist/Therapist
	School Psychologist/Psychometrist		School Psychologist/Psychometrist
	Administrator		Other: _____
	Other: _____		Other: _____
	Other: _____		Other: _____
	Other: _____		Other: _____
	Other: _____		Other: _____

For children who meet the criteria for a Specific Learning Disability (SLD): The MET/IEP Committee must include the child's general education teacher who is knowlegeable of the child OR a general education teacher licensed to teach children the same age as the child; a special education teacher; and a diagnositic examiner such as a School Psychologist, a Psychometrist, a Speech/Language Pathologist.

For children who meet the criteria for an Emotional Disability (EmD): If the MET/IEP Committee concludes a child does not meet the criteria for EmD because all behavior patterns appear to be the result of social maladjustment, this eligibility determination report must indicate this conclusion and documentation must be included to support the conclusion that the behaviors are indicative of social maladjustment.

Eligibility for Language-Speech Service as a Primary Disability

Assessment data must provide information for two purposes: to determine whether a communication disorder or condition is present and determine whether the disorder or condition has an adverse effect on educational, social/behavioral, and/or vocational performance. *"Speech or language impairment*" means a communication disorder, including stuttering, impaired articulation, language impairment, voice impairment, delayed acquisition of language, or an absence of language, that adversely affects a child's educational, social/behavioral, and/or vocational performance. Assessment data must be comprehensive in order to provide information regarding a student's functioning across several parameters. Therefore, a variety of formal and functional assessment measures may be needed to provide the MET with sufficient information for an eligibility determination as well as program planning. Formal assessment (standardized testing) provides quantifiable data regarding the existence of language-speech impairment while functional assessments (e.g., observations, teacher and/or parent interviews) further verify the results of the formal assessment. Functional assessments also provide information regarding the student's ability to participate and progress in the general curriculum. Assessment tools and strategies shall be used that provide relevant information that directly assist and are used in the determination of the educational needs of the child. As part of an initial evaluation, if appropriate, or as part of any reevaluation, the MET or IEP Committee and other qualified professionals, if necessary, shall review existing evaluation data on the child including a) evaluations and information provided by the parents; b) current classroom-based assessments and observations; and c) observations by teachers and related services providers.

Using all evaluation information, the MET then must determine if the findings verify that there is an "adverse effect on educational, social/behavioral, and/or vocational performance" that requires specially designed instruction (SDI). This manual assists in documenting the degree and nature of the student's communication disorder and the extent to which it impedes the student's ability to participate and make progress in the general curriculum. After completing the evaluation process in each area of suspected communication disability, the scoring process gives SLPs a systematic format for presenting assessment information to the MET. The MET will then determine eligibility based on all data collected. Specially designed instruction means adapting as appropriate, content, methodology, or delivery of instruction to address the unique needs of the child with a disability and to ensure access of the child to the general curriculum. Adverse effect means that the progress of the child is impeded by the disability to the extent

that the educational, social, and/or vocational performance is significantly and consistently below the level of similar aged peers.

The Need for Language-Speech Therapy as a Related Service

Related services are services required to assist a child with a disability to benefit from special education. This assumes the child has already been determined to be eligible for special education services in one of the other categorical or non-categorical areas. Therefore, the evaluation process for the provision of language-speech therapy as a related service **does not** require determination of eligibility using the suggested *Communication Rating Scales*. It is important to note that although completion of the suggested rating scale(s) is not required when considering the need for language-speech services as a related service, it will provide valuable information for IEP development and program planning. Related services means transportation and such developmental, corrective, or supportive services as are required to assist a child with a disability to benefit from special education. It includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of disabilities in students, counseling services including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also means school health services, social work services in school, and parent counseling and training.

For students who are already deemed eligible to receive special education services under another area of disability (e.g., specific learning disability), the IEP Committee must determine if other services (e.g., language-speech therapy as a related service) are necessary to assist the child with a disability to benefit from special education. The MET, as part of the original evaluation process, should have identified areas of concern related to communication skills requiring further assessment. These areas of concern should be described under the Present Level of Academic Achievement and Functional Performance (PLAAFP) in the student's IEP. To verify the nature and extent of problems related to speech or language, the IEP Committee must use data from formal and functional assessments of communication skills. The IEP Committee will use this evaluation information to determine the type and amount of language-speech service needed to appropriately implement the student's IEP. For instance, if a child has been determined to have a mild intellectual disability, and the evaluation information also identifies problems in the area of speech sound production or use, then the IEP Committee must have sufficient information to determine if the speech sound production or use problems

are severe enough to prevent the child from benefiting from the other aspects of their special education program. If so, the IEP Committee must determine the nature and extent of the related language-speech services to be provided to support successful implementation of the IEP. See Appendix AC: Eligibility Determination Checklist: Language/Speech Impairment (LS)

Reevaluation

Continued Eligibility for Language-Speech Service

According to Mississippi State Board Policy (SBP 74.19) and 34 C.F.R. § 300.305**,** if for purposes of reevaluation, the IEP Committee determines that no additional data are needed to determine whether or not the child continues to be a child with a disability, the LEA shall notify the child's parents via PWN:

(a) of that determination and reasons for it; and
(b) the right of the parents to request an assessment to determine whether, for purposes of services, the child continues to be a child with a disability.

The IEP Committee must reconvene at least annually to review student progress and Present Level of Academic Achievement and Functional Performance information. During the annual review, the IEP Committee will determine whether a student needs continued provision of language-speech services and, if appropriate, will revise the Individual Education Program.

Every three years the IEP Committee must redetermine eligibility by assessing whether the student still has a disability that requires the continued provision of language-speech services either as a primary disability or as a related service. This means there still needs to be documentation of adverse effect on educational, social/behavioral, and/or vocational performance, if the student's language-speech impairment is the primary disability. If the student is receiving language-speech as a related service, the IEP Committee must document continued need for this service.

Procedures for reevaluation should include:

1. A review of the current IEP and progress made towards annual goals.
2. Review of current data to determine adverse educational impact.
3. Administration of formal assessments/evaluations when appropriate (Parental consent required). Administration of informal assessments, including curriculum-based assessments (parental consent not required). Interviews with teachers, parents, and therapists.
4. Observations across settings.

5. A review of the initial evaluation or last reevaluation report.
6. A review of the student's current academic status, including but not limited to absences, report cards, progress reports, discipline reports, etc.
7. A review of the eligibility criteria of disabilities.
8. Hearing and vision screening information when appropriate.

Reevaluation does not necessitate the administration of formal testing. A reevaluation can be completed based on current IEP data. The IEP team determines whether or not formal testing procedures arewarranted.

If testing is warranted, the parent must receive Prior Written Notice (PWN) of the IEP Committee decision and Procedural Safeguards and parental consent should be obtained in writing for further evaluation. If parental consent cannot be obtained, the district must fully document multiple attempts to contact the parent to obtain consent. (CFR 34, §300.300 (c). Once parental permission for testing is obtained or the IEP Committee decides to proceed, the reevaluation must be completed in a timely manner. If the IEP Committee determines that a change in services is needed (dismissal or other change), the IEP and Eligibility Determination Report must be revised to reflect the change.

A Change of Placement form must be given if the student's placement in special education changes.

If the IEP Committee suspects the child no longer has a disability, refer to the dismissal procedures and complete the reevaluation dismissal.

Continued Eligibility When Language-Speech Impairment is the Primary Disability

At least every three years, the IEP Committee must review current performance data and, if necessary, update the student's evaluation information to determine whether the student continues to meet eligibility guidelines for language-speech impairment. The IEP Committee may determine through a review of existing performance data (e.g., progress data on IEP goals and objectives) that the student continues to have a language-speech impairment that causes an adverse effect on educational, social/behavioral, and/or vocational performance and that no additional formal or informal assessment is required. If, however, the data is unclear or insufficient to make an eligibility determination, the MET may need to conduct additional assessments to determine whether the student still has language-speech impairment and needs continued services.

Continued Need for Language-Speech Therapy as a Related Service

The IEP Committee may review reevaluation data and determine that a student continues to have a disability in another categorical area (e.g., Intellectual Disability, Specific Learning Disability) or non-categorical area (e.g., Developmental Delay). The IEP Committee must review existing evaluation data to determine the need for the continued provision of any related services, such as language-speech therapy. If this decision cannot be made because existing data is insufficient or inconclusive, additional data from formal and/or functional assessments (e.g., specially designed tasks) must be collected. It is important to note that if the student's parent(s) request a formal assessment, the MET will comply. The LEA shall not be required to conduct an assessment if, after review of the existing data, the IEP Committee determines no additional information is necessary to determine whether the child continues to be a child with a disability, unless the parent requests an assessment. An LEA shall ensure a reevaluation, which may consist of the review described above and is conducted at least every three years to determine: a) the present levels of performance and educational needs of the child; b) whether the child continues to need special education and related services; and c) whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the IEP and to participate, as appropriate, in the general education curriculum.

Use of Dynamic Assessment

Dynamic assessments measure how a student responds to intervention and the difference between what the student can learn unaided and what he or she can learn with assistance. These methods can help identify learning potential and eliminate bias for students with cultural and linguistic differences or socio-economic risk factors. The student's behavior is reported as a frequency count, an amount of time, a rate of occurrence, etc.

"Narratives are stories about real or imagined events that are constructed by weaving together sentences about situational contexts, characters, actions, motivations, emotions, and outcomes" (Petersen, Gillam, & Gillam, 2008). Difficulties with narrative comprehension and production may have serious negative effects on students' educational and social achievement (Nation, Clarke, & Marshall, 2004). Narratives are sensitive indicators of language impairment in students; children and adolescents with compromised language skills typically produce shorter, less complete, and less elaborate narratives than their same age peers. Therefore, assessment of students' narrative

abilities is an essential part of a comprehensive speech-language assessment and results should regularly be reported as part of eligibility meetings.

To judge the adequacy of a student's narrative structure, an SLP must take into consideration the student's cultural and linguistic background and understand the nature of narratives produced within the culture. The second caution is that in some cultures, children are not encouraged or permitted to tell stories because narration is a privilege and responsibility reserved for adults. Consequently, some students may not have experience in storytelling or may be uncomfortable with—and even reluctant to engage in—storytelling if asked.

Dynamic assessment and observation approaches are particularly important with these children to determine if a student's different narrative structure is a result of cultural-linguistic differences, language impairment, or both.

Dynamic assessment:

- Provides systematic assessment of a student's ability to improve speech-language performance as a result of mediated learning;
- Provides evidence to distinguish speech-language impairments from speech-language differences (ESL/ELL, nonmainstream dialect, at-risk populations); and
- Yield data-based recommendations for use in classrooms and intervention plans.

Some disadvantages of dynamic assessment are:

- No statistical comparison with grade- or age-level peers;
- Limited availability of standardized data collection formats

Other Considerations

The SLP should be a part of MET when a child exhibits language difficulties as a result of any of these suspected areas of disabilities:

- Autism
- Developmentally Delayed: Communication
- Hearing Impairment (if applicable)
- Language-Speech: Language Impairment
- Specific Learning Disability
    - Listening Comprehension
    - Oral Expression
- Traumatic Brain Injury

Because language difficulty is inherent to these six eligibility categories, Language/Speech: Language Impaired should not be listed as a secondary eligibility on the Eligibility Determination Report. When a student is identified as eligible in one of these six categories, the IEP Committee may choose to add or remove language-speech as a related service without a secondary eligibility. This only applies to the subcategory of Language Impaired; if the student is eligible for related services for articulation, voice, and/or fluency, language-speech should be added as a secondary eligibility.

Dismissal/No Longer Eligible

When determining whether or not a student is a candidate for release or dismissal from language-speech services, the IEP Committee must determine if the student is no longer in need of specially designed instruction and related services. While current and comprehensive evaluation and performance data need to be available for review by the IEP Committee to make this decision, this does not mean that a full and formal assessment is always needed. Current data must be sufficient to determine whether the student no longer has a language-speech disability that causes an adverse effect on his/her educational, social/behavioral, and/or vocational performance, or his/her ability to benefit from special education. The IEP Committee may decide that current performance or assessment data and IEP progress data provide enough information to make that decision. If this information does not clearly indicate that there is no longer an adverse effect on educational, social/behavioral, and/or vocational performance, or the need for language-speech services as a related service, a more extensive and formal assessment may be needed to make a conclusive decision. It is important to note that the IEP Committee must accommodate parental requests for additional assessment prior to determining that a student no longer has a language-speech disability or no longer requires language-speech therapy as a related service. A reevaluation is not required if the student is graduating with a standard high school diploma or if the student has exceeded the age limit for FAPE (20) under State law.

Students may be dismissed from language-speech therapy when one of the following criteria is met:

- they no longer have a disability; or
- they no longer require language-speech services due to their disability.

Procedures should include:

- A review of the IEP
- Review of current data to determine adverse educational impact

- Administration of assessments/evaluations when appropriate
- Interviews with teachers, parents, and therapists
- Observations across settings

Appendix Z: Language-Speech Dismissal Form may be used to document the IEP Committee decision that language-speech services are no longer warranted due to:

a) The student no longer meets the eligibility criteria for language-speech services.
   - The student has mastered IEP goals/objectives.
   - The student's language-speech skills are within the normal range.

b) The student's progress has plateaued or has shown a lack of progress, and the student no longer benefits from language-speech services.
   - Documentation of lack of progress should be shown on the IEP's report of progress.
     - A summary of the data that supports the student's lack of progress should be included in the reevaluation for dismissal and shall include all of the components of a comprehensive evaluation (parent input, general education teacher, academic performance levels, etc.).
     - Students demonstrate lack of progress due to:
       1) Limited physical, mental, or emotional ability to self-monitor communication
       2) Poor attendance
       3) Lack of motivation
       4) Limited potential for a significant change in communication skills.

c) The student's communication no longer has an adverse educational impact on educational, social/behavioral, or vocational performance.

d) The student no longer requires language-speech services due to their disability.
   - Skills are being monitored and maintained in the student's environment.
   - Skills are being addressed by others in the student's environment (i.e., special education teacher, general education teacher, etc.).

CHAPTER III – Service Delivery

IEP Development & Implementation

Mississippi State Board Policy (SBP 74.19) and C.F.R.34 §§ 300.320-300.324 describes what the IEP is and who is responsible for the development and implementation of the "written statement for which each child with a disability is developed". It is at the IEP Committee/MET meeting where eligibility is determined. The IEP may be drafted at the eligibility meeting but in no case longer than thirty days from the date of eligibility. IEPs for all students must include a statement of measurable annual goals. Benchmarks or short-term instructional objectives must be included in the IEP for a student with significant cognitive disabilities.

Statements developed should address these areas/components:

- How the student's disability affects involvement and progress in the general curriculum
- Detailed description of the student's current performance in reading and math
- Results of the initial or most recent evaluation of the student
- Strengths of the student
- Concerns of the parent/guardian for enhancing the education of the student
- Description of the student's social, behavioral, and/or emotional skills

*For preschool children, how the child's disability affects participation in appropriate developmental activities.

The Present Level of Academic Achievement and Functional Performance (PLAAFP) provides the informational basis for generating goals, objectives, supports, accommodations, and services that are specifically designed to meet the student's *individual* needs. This area must describe what the student does (strengths) and does not do (weaknesses) in objective measurable terms. When appropriate, the present levels must reference the student's performance on district-level benchmarks and progress from the previous IEP. The PLAAFP should establish the foundation on which the rest of the IEP is developed, identify the impact of the disability on participation in the general education curriculum, and align the student's information with the content standards and benchmarks, annual goals, supplementary aids/services/supports, and secondary transition services.

Measurability

The IEP must list measurable annual goals consistent with the student's needs and abilities as identified in the Present Level of Academic Achievement and Functional Performance. They are the statements that identify what knowledge skills and/or behaviors a student is expected to be able to demonstrate during the school year the IEP will be in effect. They are directly related to the student's PLAAFP.

The goals on a student's IEP should relate to the student's need for specially designed instruction (SDI) to address the student's area of deficit(s) and how the deficit(s) interferes with the student's ability to participate and make progress in the general curriculum. **Measurable annual goals** are academic and/or functional goals that are written to meet the child's needs that result from the child's disability to enable the child to be involved in and progress in the general education curriculum and meet each of the child's other educational needs that result from the child's disability (§300.320(a)(2)).

- *They must be meaningful, understandable, and able to be accomplished within one year.*

This measurable goal will also yield the same result if measured or as measured by several individuals, allowing for a calculation of how much progress it represents and can be understood without additional information.

The following elements should be included in measurable goals: behavior, conditions, and criterion. It should also include the following: *1) the student (who). 2) will do what (behavior), 3) to what level or degree (criterion), and 4) under what conditions or timeframe (conditions)*. The behavior reflects the actions the student must do or exhibit, criterion, referencing explicitly how well the student will be expected to perform, and the conditions describing the circumstances or the assistance that will be given while the student performs the behavior.

Connecting Goals to the Curriculum

IDEA 1997 said of SLPs "[…] the changes in focus provide tremendous opportunities for SLPs to collaborate with regular and special educators as well as other service providers to explain the *language-learning connection* and to assist in developing strategies that account for the linguistic underpinning inherent in the *general curriculum*."

IDEA 2004 preserves and extends the 1997 language regarding research and access to the general curriculum, stating, "Almost 30 years of research and experience have

demonstrated that the education of students with disabilities can be made **more effective** by having high expectations for such children and **ensuring their access to the general education curriculum in the regular classroom, to the maximum extent possible"** (20 U.S.C. § 1400(c)(5)(A) (2004).

SLPs should assess performance and design instruction that links the student's goals/objectives to the **general education curriculum** whenever possible.

Measurable annual IEP goals must have 4 components:

- **Condition**: Situation, setting, or given material under which behavior will be performed
- **Behavior**: Specific action student will be expected to perform
- **Criteria**: Level of mastery student must demonstrate and/or number of times child must demonstrate the skill or behavior
- **Timeframe**: Start and end date for each goal

The following table displays examples of how IEP goals may be written.

Timeframe	Condition	Behavior	Criteria
In 36 weeks	when given 10 two-step word problems	Ashley will set up an equation to solve the problem using letters or unknown quantities	with at least 70% accuracy
By the end of the school year	when given independent seat work	Tevin will remain on task	for 30 minutes with minimal prompting (1 verbal reminder)
By the end of the 4th 9 weeks	when given a grade-level paragraph	Jordan will retell a sequence of events from a paragraph or short story in his own words in clear sentences (containing a subject and verb)	with 80% accuracy on 3 separate attempts (L.6.4)

Considerations when determining measurability:

- A measurable goal allows the IEP Committee to determine progress since last measured performance.
- A measurable goal can be measured as written without additional information.

- A measurable goal identifies how to measure progress and mastery of desired skill.
- A measurable goal yields the same outcome if measured by several people.
- Avoid using vague, unobservable terms that do not target specific skill or behavior, such as appropriate, improve, increase/decrease, participate, etc.

Language/Communication needs must be addressed in the Consideration of Special Factors section of the IEP. It is important to consider not only the communication needs of students who are nonverbal but also of those students who have receptive and expressive language deficits that make communicating difficult. A student who does not understand multi-step directions or academic vocabulary will have difficulty both accessing the curriculum and demonstrating knowledge. This should be fully explained in the PLAAFP, including effective ways to support the student in the classroom.

Also, consideration of Supplementary Aids and Services must be reviewed as well. What device or provision of help or activity does the student need to enhance the student's ability to access and make progress in the general education curriculum? Key questions to consider are:

1) What aids and services are needed to enable the student to succeed?

2) What specific aspects of the child's education cannot be implemented in the general education setting? Why not? and

3) What supports are needed to assist the teacher inimplementing the child's IEP (accommodations/modifications)?

When deciding on the student's services, the focus is to provide a Free Appropriate Public Education (FAPE) for the student, including the implementation of aids and services and the duration and frequency of services provided by school personnel. Least Restrictive Environment (LRE) is also the consideration in the provision of services. Learning takes place across all educational settings; therefore, in considering settings and the objective in mind, the goals are to assist the student in accessing and making progress in the general education curriculum—not in a solo, one-on-one setting. Goals should also provide training to other personnel on strategies related to the deficit the student is experiencing in communication (language-speech), and provide ways to aid the student in making the appropriate adjustments to assist them in accessing and making progress in the general education curriculum. The educator's acceptance and support of the student is important to facilitate communication and manage the language-speech disorder.

For example, if an oral presentation is required, the educator should discuss alternatives in advance with the student when applicable.

Continuum of Service Provision

Consider the continuum of services below to help determine whether the SLP is needed for direct services or if someone else in the child's environment may provide the support that the child needs. (Adopted from the California Department of Education)

The IEP Committee should consider the level of expertise needed to address educational goals. Consider the following questions:

1. Can the goals be addressed with adaptations and modifications to the classroom environment or curriculum?
2. Can the goals be addressed by classroom instructional staff using typical educational strategies with a reasonable expectation of success?
3. Can the goals be addressed with consultation and guidance from the therapist?
4. Can the classroom instructional staff conduct activities designed by the therapist with a reasonable expectation of success?
5. Can activities designed to address educational goals be delivered to the student only by a licensed professional therapist?

Teacher Support Team

If a student is struggling in school, the Teacher Support Team meets to determine if interventions should be designed to meet the student's needs, or if/when referral to MET for special education assessment is warranted. The process of referring students to MTSS is known as Response to Intervention (RtI), and there are 3 tiers of RtI.

Tier 1 is for all students and is quality classroom instruction in the general education classroom.

Tier 2 is strategic and targeted intervention and supplemental instruction designed to meet the student's individual needs.

Tier 3 is intensive intervention in the student's area(s) of need.

If a student's needs cannot be met through the RtI process, then referral to MET may be warranted. Complete regulations for MTSS can be found in the MDE Multi-Tiered System of Supports (MTSS) Guidance Document (2020). RtI is not required for students experiencing communication (language) deficits, but may be beneficial for some students.

Service Delivery Options

Keep in mind that all IEPs should be different and relevant to the student with whom you are working. All students may not require 30 minutes of therapy twice a week for a year. The place of service should be contingent on where the student is, what the goals and objectives are for the student, how the goals and objectives will assist the student in accessing and making progress in the general education curriculum and the LRE. An alternative delivery model guided by the SLP in inclusive settings could be helpful for addressing deficits in students whose language-speech difficulties have no adverse impact on their educational, social/behavioral, and/or vocational performance. *Training is imperative not only for SLPs, but also for general educators, special educators, and administrators, not to exclude parents*. SLPs can design and train appropriate stakeholders in strategies for intervention and for improving language-speech skills. Most helpful to student engagement and progress is a paradigm shift from a "caseload" approach to a "workload" approach, focusing not just on the number of students served, but also what each student needs in order to be successful in accessing and making progress in the general education curriculum. As particular skills are acquired, changes may be necessary in location, type, frequency and/or duration of therapy. Additional information may be found in Special Topics: Service Delivery Options and RtI.

Missed Visits

The Letter to Clarke (2007) from the Office of Special Education Programs (OSEP) gives written guidance on the need to use substitutes and to schedule make-up sessions when speech-language pathology sessions are missed due to a child's absence from school, cancelation for a class or school activity, or absence of the SLP. IDEA and the regulations do not address these issues. States and LEAs are required to ensure that all children with disabilities have available to them FAPE, consistent with the child's IEP (See 34 CFR 300.101). LEAs are encouraged to consider the impact of a provider's absence or a child's absence on the child's progress and performance and determine how to ensure the continued provision of FAPE in order for the child to continue to progress and meet the annual goals in his or her

IEP. Whether an interruption in services constitutes a denial of FAPE is an individual determination that must be made on a case-by-case basis.

Home Delivery of Services

When the IEP Committee determines that the student's home is the LRE, the committee must fully document in the IEP the location, duration, and frequency of services. Transitioning services from onsite to in-home brings with it unique challenges. It is important to consider and create policies to address questions about engagement, absences, and refusals. Logistical planning in advance for in-home services will help avoid difficulties later.

Integrating Teletherapy into Your Service Delivery Model

Teletherapy in schools is used to deliver a wide range of therapy services. Typically, teletherapy utilizes webcams, audio headsets, and videoconferencing to facilitate synchronous interaction between clinicians and students. Leading professional organizations such as ASHA recognize teletherapy as an appropriate model for service delivery for speech-language therapy and behavioral and mental health therapy for many students. Teletherapy in the United States has been developing as a field since the 1990s.

Schools and school districts use teletherapy to deliver a wide range of services. In rural areas facing a shortage of qualified clinicians, teletherapy provides access to timely evaluations and therapy. In large urban districts where the need for SLP services can place unreasonable demands on onsite staff, teletherapy provides a means to supplement onsite clinicians and help with caseload management.

Here are a few questions you should ask when considering a platform for teletherapy and teleassessment:

- What was the platform built for originally?
- Is it secure? (HIPAA and FERPA compliance are essential.)
- Is the platform interactive?
- Does it include an activity library and the ability to save activities?
- Does it allow second camera integration?
- Does it have features that support administration of online assessments?

Here are a few questions to help guide data collection on student resources and equipment for teletherapy:

- Do students have the internet bandwidth necessary for synchronous teletherapy?

- What options do you have to provide solutions for students without the internet at home?
- Is all necessary equipment available in the correct quantities?
- How can you prioritize equipment if there is short supply?
- Do you have a plan to track who receives equipment?
- Where would the service take place? (environment)
- Who is with the student? Who is available for support if needed?
- Can coaching or guidance documents be created to help the parent/caregiver prepare a location conducive for therapy?
- Will translation services be needed for setup and/or support of teletherapy?

Here are a few questions to help with staff contingency planning for teletherapy:

- Will therapy need to change from groups to 1:1?
- Will onsite staff need to take on duties that will prevent them from doing their traditional duties?
- If support staff are unavailable, how will therapy be conducted??
- How will staff mental health support be addressed?

When planning for teletherapy and tele-assessment, it is important for administrators to help staff think through what they know about teaching and doing therapy in person and consider how to transition those skills online, both functionally and logistically. Providing actual hands-on time using the online tools of choice will ensure staff are not just confident in how to use the tools, but how to work with students in a new environment.

Online assessment is appropriate for most students but there will always be some situations where in-person assessment is required, either due to the function level of the student or because the appropriate in-person support is not available. Preparing in advance for what you will do in these scenarios is important. If teletherapy is in place due to safety concerns for staff and students, you may need to set up a special station in the school in order to do in-person assessment, employing sanitizing protocols and utilizing social distancing which presents unique challenges in the testing environment. Any changes to the test protocol environment, etc., must be addressed in the final report and considered in any decisions made by the IEP Committee regarding services or eligibility.

Combined Direct and Indirect Services Using a 3.1 Model

The 3:1 model combines three weeks of direct intervention with students and one week of indirect services. With this model, three weeks out of each month are designated for direct intervention with students, and one week for indirect services, such as meeting with teachers, parents, and other specialists; planning, and developing treatment materials. During the time designated for indirect intervention for students, the SLP provides services that address individual student needs. These services may include:

- Conducting and attending meetings
- Performing evaluations
- Conducting training and consultations with staff and parents
- Visiting classrooms and conducting systematic observations
- Developing and adapting classroom and intervention materials

The 3:1 model provides opportunities for SLPs to consult with teachers about students' needs in the classroom, address curriculum pacing, and integrate speech-language goals and classroom curriculum. This service delivery model is supported by the American Speech-Language-Hearing Association (ASHA).

Service Delivery Options and Response to Intervention

There are a variety of service delivery options the SLP can choose to implement with a student in order to meet that student's individualized instructional needs. While SLPs are typically assigned a caseload (a set number of students), a workload approach can be implemented to ensure academic success for all students.

By beginning to utilize workload instead of caseload, you can ascertain the amount of work required per student. For example, while a student's IEP may be 30 minutes, 2 times per week, the amount of time to consult with the teacher, plan therapy, communicate with the parents, etc. may be an additional 30 minutes per week, so the workload for that student is 90 minutes per week.

Students' IEPs should be individualized to meet their needs. This can be done by using non-traditional therapy methods, including push-in classroom therapy, consultation with teachers, collaboration with teachers, and co-teaching.

For the Workload Approach, a variety of Service Delivery Models should be considered:

- Traditional Pull-out – Services are provided in a setting separate from nondisabled peers. This may be appropriate for some but does not meet the needs of all students.
- Push-in Therapy – Services are provided in the classroom setting individually or in a small group and provide more optimal conditions for classroom collaboration between SLPs and teachers.
- Consultation – For students who do not need the direct services of the SLP (as determined by the IEP Committee), an alternative delivery model guided by the SLP in inclusive settings could be utilized.
- Collaborative/team teaching – SLPs work with the general education and/or special education teachers to plan lessons and instruction.
- Environmental contexts – Services are delivered in a natural environment, such as the home, social context (i.e., on the playground), or employment contexts.

In addition, SLPs can use the workload approach to design interventions for children with mild language-speech deficits, and train others in strategies for improving language-speech skills.

- Flex/Block Scheduling – instead of scheduling in 30-minute therapy slots, scheduling is based on individual needs and directly collaborated with the general education instructional time.
- Schedule a "Kindergarten" block, where services are provided to students in kindergarten during the small group instructional time in the classroom. This allows for direct collaboration between the classroom teacher and the SLP on targeted weekly skills.
- Articulation Drill Block – schedule a block of time every day where students with minor articulation deficits can receive a 5-10 minute "drill" of the targeted speech sounds that does not interfere with the academic instruction.

This paradigm shift from caseload to workload means the amount of service delivery time should be made on an individual basis. As particular skills are acquired, changes may be needed in the location, type, frequency, or duration of the therapy services. More information on scheduling options in schools can be found on ASHA's website (asha.org).

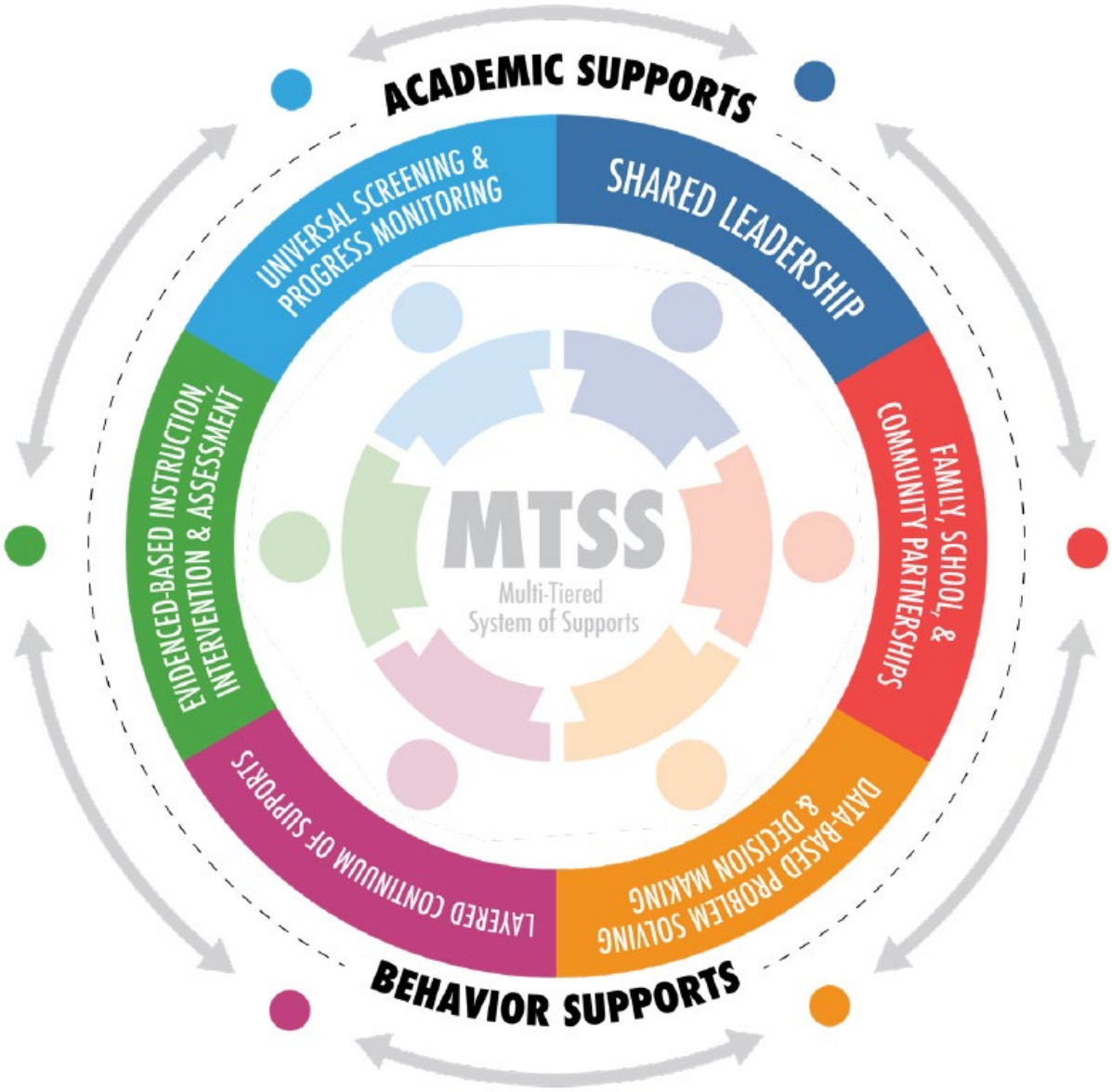
Multitiered System of Supports (MTSS)

MTSS is a method of organization of supports which ensures optimal educational outcomes for students, pre-K-12th grade. It aligns the entire system of supports, encompasses RtI and Positive Behavioral Interventions and Supports, and ensures

effective team-based problem solving that is data-informed and evidence-based. Mississippi's model for MTSS consists of six essential components:

- Shared Leadership
- Family, School, and Community Partnerships
- Data-Based Problem Solving and Decision Making
- Layered Continuum of Supports (Tier I, Tier II, Tier III)
- Evidence-Based Instruction, Intervention, and Assessment
- Universal Screening and Progress Monitoring

The essential components of an MTSS allow for a continuum of supports, working together endlessly, to improve student academic and behavioral outcomes by design, and redesign, of appropriate services through promotion of equitable practices.



Students with a special education eligibility receive services as outlined on their IEP. The IEP Committee is responsible for determining and documenting what services the student requires in order to be successful and that he/she be provided a free appropriate public education. Students with a special education eligibility in language/speech in the areas of articulation, voice, and fluency would not typically need additional academic or behavioral supports in the classroom. However, it is common for a student with an eligibility of Language/Speech: Language Impaired to need additional supports. The IEP Committee may decide to add goals to the IEP to address the student's deficits or place the student in Tier II or Tier III in order to receive supplemental instruction. It is important to remember that the student's

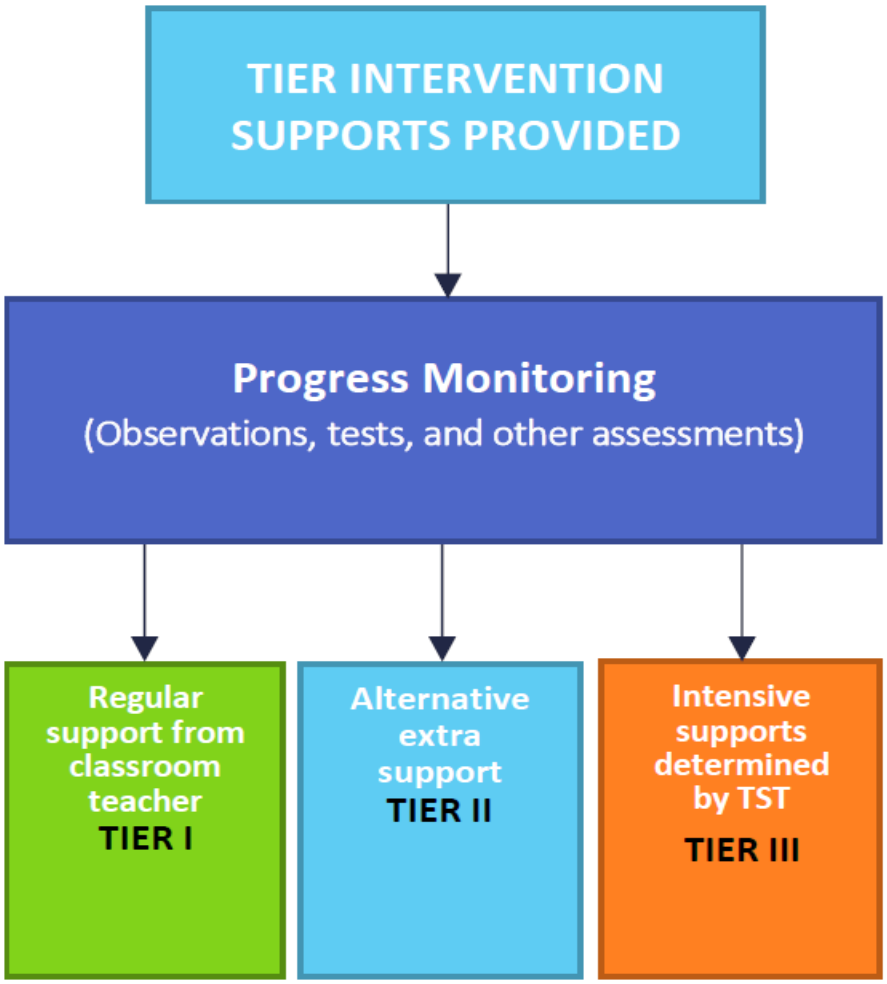
deficit skills, not the eligibility determination, dictate the services needed to provide a FAPE.

The speech/language pathologist may conduct interventions with students who have articulation, voice, fluency, or language deficits before they are identified as a student with a disability. There are ways to fund this activity that would allow the SLP to provide both prevention and rehabilitation services, including using Coordinated Early Intervening Service funds or partially funding with MAEP teacher units.

The SLP's role in MTSS may also come from consultation, collaboration, and as support as a member of the TST. As an expert in language development, and the language influences on literacy acquisition and instruction, the SLP serves as a valuable resource to school and district instructional leaders. Research has shown that students demonstrate gains when SLPs collaborate with teachers on early literacy instruction, such as phonemic awareness (Koutsoftas et al., 2009; McCallister & Trumbo, 2009).

As a member of the MTSS Teacher Support Team (TST), an SLP can lend diagnostic knowledge to the assessment of a student's academic weaknesses. Using the knowledge of language development, an SLP can identify the area of language that is causing a student's deficits, such as:

- Spelling errors
  - “cub” for “club” – phonological error, cluster reduction
  - “nis” for “nice” – phonics error, student does not know rules for long vowels
  - “anwise” for “unwise” - morphological awareness error, student does not understand prefix: example - (un-)



Universal Screening Data – SLPs can aid in analyzing data to identify student deficits. This may be identifying the area of reading that is the student's deficit, such as phonics vs. phonological awareness vs. fluency.

Once a student's academic deficit is identified, the SLP's expertise in language and literacy provides a valuable resource for the classroom teacher and all providers of services for students experiencing academic difficulties. The SLP can help the TST in prescribing targeted and focused instructional intervention that meet the student's' needs, including:

- Phonological Awareness – This pre-literacy skill is a required component of reading success. If students do not receive adequate instruction in phonological awareness, then there will be a missing foundational ability to break words into syllables and subsequently sounds, which impacts spelling and decoding abilities in otherwise fluent readers. The SLP's expertise in the fundamentals of speech phonemes, phoneme acquisition, and phoneme instruction allows him/her to serve as an expert consultant in effective phonological awareness instruction.

- Linguistic Principles of Language, Reading, and Writing – Reading is founded in language, and without the understanding of language structure and function, students will not achieve reading success. The SLP can share the knowledge of language structure, function, development, and acquisition to help teachers effectively understand and subsequently teach the linguistic principles of reading. This knowledge can be found in grammar instruction (morphology/morphological awareness) and sentence structure (syntax).
- Story Elements and Structure – The fundamentals in this skill are found in a student's ability to participate in oral narratives and discourse. The SLP can consult and collaborate with teachers in how to effectively teach discourse strategies, which carries over to the written component.
- Vocabulary – A student's ability to understand vocabulary related to the curriculum is a critical skill in academic success. By utilizing the strategies that SLPs use to teach and build oral vocabulary, the SLP can work with the teacher on effective strategies for teaching more complex academic vocabulary, such as synonyms, antonyms, prefixes, affixes, etc.

Students with cultural differences may benefit from language enhancement in the classroom by the teacher, teacher assistant, or other provider under the direction of and with consultation from the SLP. This is known as a dynamic assessment approach and is particularly applicable to students from culturally deprived backgrounds because the academic deficit may be due to lack of adequate exposure to a language enriched environment, and not a true language disorder. The SLP may use a screening method, such as a curriculum-based assessment, to determine a student's area of strengths and weaknesses.

A dynamic assessment approach to language enhancements is sometimes needed to adequately discern a student's overall language ability, and not penalize students for a lack of exposure to language.

Because MTSS is not traditionally viewed as an area in which SLPs can work, barriers may be encountered when trying to implement change. The process is most effective when all team members recognize the knowledge and role that the SLP can play. ASHA has information and research on the value of SLPs in MTSS and gives support to SLPs in sharing their role with teachers, principals, and administrators. With the implementation of the Mississippi College- and Career-Readiness Standards, all personnel will be held accountable for student growth, and it is part of the SLP's job to provide teachers with the support they need for students to be successful in the general curriculum.

CHAPTER IV - SLP and Literacy

Language and Literacy

Literacy is an essential element of practice for SLPs who work in school settings (ASHA, 2001). For Mississippi students, the Literacy-Based Promotion Act requires students to meet a performance level of 3 on the Mississippi Academic Assessment Program (MAAP) to be promoted from third grade. To graduate with a high school diploma, students must meet a proficiency level of 3 on the English, Biology, and US History. It is critical that SLPs in school settings have knowledge of the connection between language and literacy in order for students with language/speech disorders to be successful in their academic outcomes.

Language is a rule-governed system that applies to spoken language listening comprehension (receptive language), spoken language use (expressive language), written language comprehension (reading), and written language use (writing). Spoken language is not only a prerequisite skill to written language (i.e., literacy), but also continues to develop along with written language throughout childhood as the demands and tasks for language comprehension and use grow in complexity. Language demands of reading/writing differ from spoken language, as written text has higher level vocabulary and syntax than spoken language. Language should be a focus during reading/writing instruction, and reading is also affected by knowledge of spoken language.

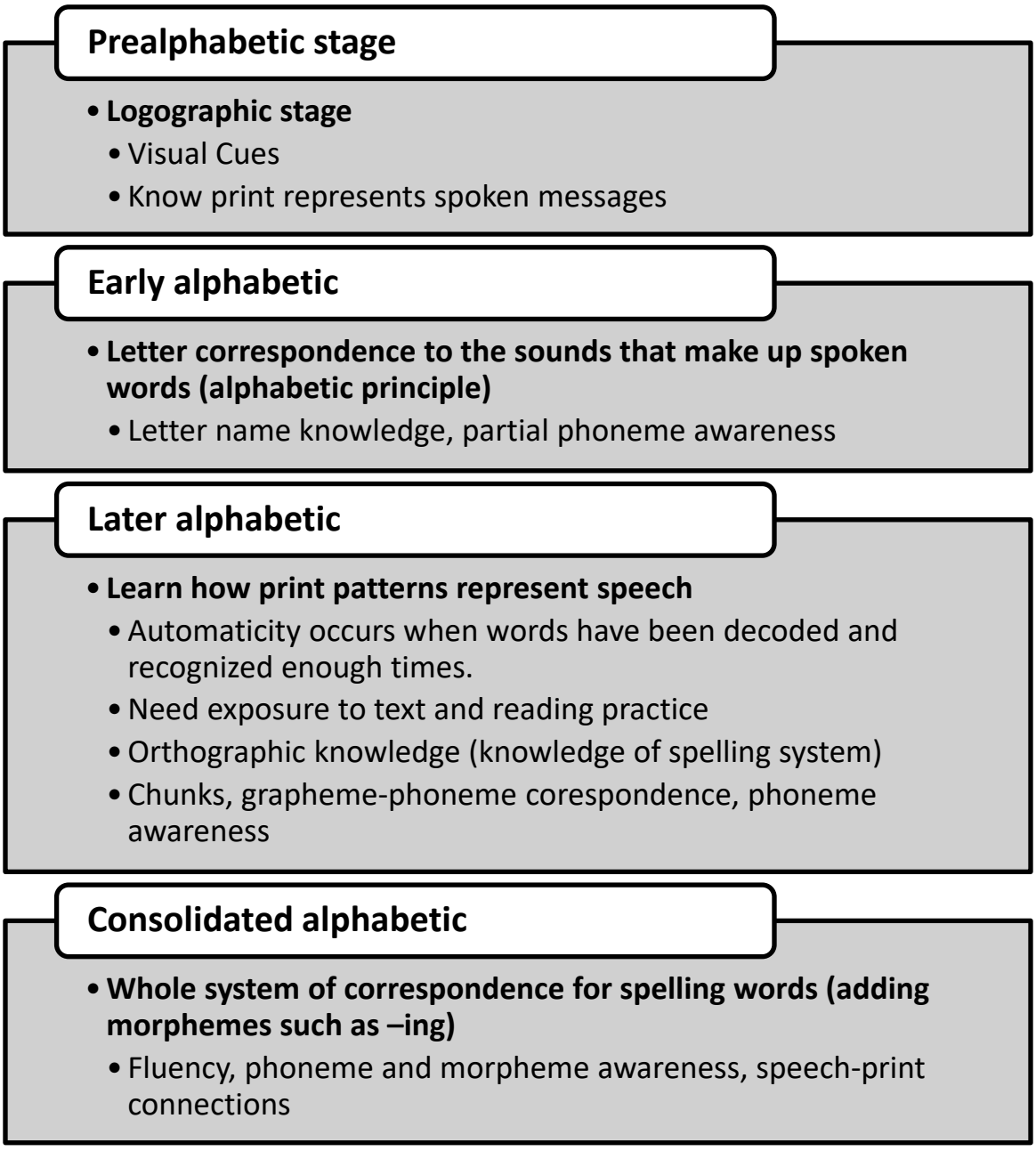
Spoken language lays the foundation for reading acquisition, therefore limited spoken comprehension equals limited comprehension of written text. Intact, well developed spoken language skills in syntax, semantics, and pragmatics are necessary to comprehend written texts. If a student presents problems in both spoken and written language, then interventions should be targeted by the SLP and general education teacher.

Spoken language is a biologically based system with a developmental progression that is similar across cultures, specialized neural structures adapted specifically for its functions, and universal appearance in individuals with normal development. Contrastingly, the process and use of written language is not necessarily biological. There is great variability in age and degree of proficiency of literacy acquisition, and visual-perceptual problems play a minor role in reading disorders. The primary deficits involved in reading disabilities are linguistic. The process of reading is a *metalinguistic skill* which focuses on language itself. To develop the literacy skills of decoding, spelling, reading, and writing, students are required to think about words abstractly in relation to

structure and not meaning. The English language follows an alphabetic cipher system, in which each symbol (i.e., letter) represents a phoneme (i.e., sound), and to have knowledge of this system, a student is required to have phonological awareness.

Learning to spell and read words is not a rote process of memorizing letter strings of increasing length. Reading progresses through four stages:

Four Stages of Reading Progression



Five Domains of Language

Language can be categorized in five domains, and these five domains are applicable across both spoken and written language modalities. Table 1.1 shows how each language domain is manifested in spoken and written language.

Table 1.1 Language in Brief (ASHA, n.d.)

Language Area	Spoken Language		Written Language	
	Listening	Speaking	Reading	Writing
Phonology	Ability to identify/distinguish phonemes (phonological awareness)	Appropriate use of phonemes in speech	Understanding letters/sound correspondence (decoding – phonics)	Accurate spelling of words (encoding)
Morphology	Understanding morphemes	Using morphemes	Understanding grammar in reading	Using grammar in writing
Syntax	Understanding sentence structure	Using correct sentence structure	Understanding sentence structure in reading	Using correct sentence structure in writing
Semantics	Listening vocabulary	Speaking vocabulary	Reading vocabulary	Writing vocabulary
Pragmatics	Understanding social aspects of language (conversational exchange)	Social use of spoken language (cohesion and relevant message in conversation)	Understanding point of view, needs of audience, etc.	Conveying point of view, intended message, cohesion, etc.

Phonology

Phonology is the system of rules governing the organization, use, and combination of sounds (*phonemes*) in speech in a given language. In English, there are specific sounds that may or may not be combined to form meaningful word units. The skill of *phonological awareness* is a metalinguistic skill with spoken word analysis; the ability to identify, think about, and mentally manipulate the parts of words, including spoken syllables, onsets, rimes, and phonemes, as well as rhyming skills. Words can be analyzed at three levels: syllable, onset/rime, and phoneme.

Phoneme (or *phonemic*) *awareness* is any spoken language task that requires attending to, thinking about, or intentionally manipulating the individual phonemes in spoken words and syllables, and does NOT involve print. Phonemic awareness develops gradually and hierarchically. Good spellers have good phonemic awareness, poor spellers do not. Development of phonological awareness progresses in this manner: Rhyming, alliteration, blending, segmenting, deletion, and manipulation. To perceive phonemes, our brain must translate an unsegmented acoustic signal into segments that are perceived categorically, a consequence of central linguistic processing.

Morphology

Morphology is the rule-governing system for how morphemes, the smallest meaningful units of language, are used. Morphemes can be free, in which they stand alone a minimal meaningful unit, or bound, in which they carry and change meaning in words and must be attached to a free morpheme (i.e., prefixes and suffixes). Instruction in morphology is critical to student success for both spoken and written language outcomes. When considering word selection for instruction, it is best to consider three principles: 1. Transparency – use words where meaning is transparent; 2. Generativity – introduce morphemes used in most words; 3. Complexity – introduce derived forms that do not change pronunciation of spelling first. Instruction should progress from most common to least common morphemes, and from less complex to more complex. Instruction should also be taught explicitly in both spoken and written language. The goals of instruction should include pronouncing words orally, and attending to sound, spelling, meaning, and etymology. Words need to be learned in lists and context of connected language, and lessons need to contain word construction and dissection. Finally, teach words in relation to other words with the same morphemes, such as multiple words with the same affix (i.e., “un”).

Morphological knowledge instructional activities should target base words with prefixes, suffixes, and suffix ending rules beginning in first grades. Activities can include listening for suffixes, prefixes, or base words, combining single words into compound words, sorting past tense/plural by the sounds of their endings, combining base words, prefixes, and suffixes, and using the new words. In upper elementary, students can successfully analyze 250 new printed words per year through morphological analysis with proper instruction. Children learn several hundred to 5,000 new words per year, with most new words being learned from print. The greatest benefit from vocabulary and spelling instruction may be gained from exploring aspects of word structure that can be generalized or used independently when students encounter new words. Emphasis should be on learning real words with derivations and connotations. Words should be taught and used in spoken and written language. In upper grade levels, instructional activities can include teaching about schwa, identifying prefixes, roots, and

suffixes, defining affixed words, practicing word building with one root, and building word webs or diagrams that show families of words built from a root. Mastery of derivational morphemes is influenced by the frequency words are encountered in text, the complexity of the derivational relationships that characterize words, and whether spelling is a clue to a word's structure, meaning, and origin.

Syntax

Syntax is the rules that govern the ways in which words are combined into phrases and sentences to form meaningful language. A strong syntactical structure is critical to understanding the advanced and complex language encountered in reading texts. Understanding of complex sentence structure is directly linked to reading comprehension and targeting complex sentence structure can be a powerful intervention tool. The goal is to build students' awareness of incomplete sentences, run-on sentences, awkward expressions, ambiguity, unclear or poorly expressed meaning, and conventions of grammar. Sentence awareness can be developed with sentence manipulation exercises such as unscrambling sentences, completing the subject or predicate, and generating questions from statements. Students can combine sentences in writing or dissect sentences in reading. In both spoken and written language, students can begin a sentence with a subordinate clause, or expand a simple sentence by adding information about who, what, when, where, why, or how. Another intervention can be joining two independent clauses with a coordinating conjunction and identifying the subject and predicate.

Semantics

Semantics is the meaning of words and combinations of words in a language (ASHA, n.d.). Variance in reading comprehension is attributable to knowing the meanings of individual words. Semantic knowledge is necessary to spelling as well, such as knowing when to choose "you're/your." For instruction, choose words for direct teaching that are central in a semantic field. Choose vocabulary from classroom curriculum; words are learned within a network of related ideas pertinent to a topic, theme, or text. Teach word meanings in relation to other words that are known; introduce words as part of a network of ideas. Effective vocabulary instructional strategies include using graphic techniques, which help facilitate semantic maps in the neurological network. Use linguistic and situational context to develop word knowledge, as most words are learned from reading. Teach vocabulary in relation to denotative and connotative meaning. For homonyms and homophones, instruction should teach multiple meanings for the same word, which deepens and broadens students' vocabulary knowledge and may facilitate word recognition, retrieval, and comprehension. Vocabulary instruction should teach idioms, metaphors, and other figures of speech. Additionally, identifying the referents

for nouns, pronouns, and phrases can facilitate both comprehension of word meaning and text comprehension. Qualities of effective vocabulary instruction include integration, repetition, and meaningful use.

Explicit and direct instruction should teach synonyms of common words with less common words (e.g., happy, elated) and instruction in antonyms of words. Students also need multiple representations of words, so act out or demonstrate a concept so the student has visual image, and use multisensory strategies, such as pictures.

Finally, vocabulary can help facilitate text comprehension, and SLPs can use classroom-based storybook lessons with integrated vocabulary. Instruction includes identifying unfamiliar vocabulary prior to lesson (i.e., *famished)* with pre-selected Tier 2 and Tier 3 vocabulary words. Tier 2 words are words that occur in literature and academic context but are not frequently used in spoken language. Tier 3 vocabulary words are content-specific, and do not frequently occur outside the context of the subject (i.e., photosynthesis). Vocabulary instruction should target Tier 2 words. The SLP and/or teacher should discuss meaning prior to story, identify word(s) during story, discuss words after story, and integrate words throughout the day (e.g., "Are you ready for lunch? I'm just famished!"). Students should be given opportunities to demonstrate understanding of word meaning through defining words and using words in context.

Pragmatics

Pragmatics are the rules associated with language use in conversation and in social contexts. In reading, pragmatics directly relate to reading comprehension skills for students. Students are required to understand the author's intent and meaning when reading a text, which ties directly to point of view. In writing, students are required to convey the intended meaning through text and understand that the author's intended meaning must be clearly conveyed to the reader. Reading and writing also require cohesion through text, with authors staying on topic, only giving relevant information, and ensuring clear antecedents to pronouns. Comprehension strategies include summarizing, clarifying, questioning, and visualizing modeled explicitly by teachers and practiced.

Orthography

Orthography is the written language system, and orthographic knowledge is the understanding of how spoken language is represented in writing. To develop full orthographic knowledge, a reader comes to understand that the English spelling system is morphophonemic in nature, being influenced by word meaning, origins, and the phonology rule system. English orthography can be explained if history and other factors are considered. In English, word origins come primarily from Anglo-Saxon, French, and Latin layers with Greek influences.

Phoneme-grapheme correspondence is the letter representation of (graphemes) of speech sounds (phonemes). In the English spelling system, word spelling is influenced by phonological position constraints. For example, the "floss" rule is that letters must be doubled at the ends of words or in the middle of words for the vowel to remain a short vowel and for the consonants to remain unvoiced. Additionally, orthographic rules govern that certain grapheme representations can only occur in certain positions of words. The "ck" grapheme representation for /k/ can only be used at the end of a syllable, just as the "ch" sound will never be spelled with "tch" (unless you go to Tchoupitoulas Street in New Orleans, which is influenced by the Indigenous origins). Finally, the spelling system is influenced by the morphological rule system. While the word "horses" ends with the /z/ phoneme, it will always be represented by the 's' grapheme because that is the letter representation of the morphological plural -s/-es rule.

When given all of these influences on spelling in English, 50% of English words are spelled accurately by sound-symbol correspondence rule alone, 36% more are spelled with only one error, and 10% more are spelled accurately if word meaning, origin, and morphology are considered. Fewer than 4% are true oddities in English spelling.

When a reader reaches a point of automaticity (automatically recognizing a word without decoding), that reader has a *mental graphemic representation* (MGR) or *mental orthographic image* (MOI) of that word (ASHA, n.d.). MGRs are stored in in the mental orthographic lexicon, and a reader does not have to use additional cognitive load for decoding. Teachers are familiar with the concept of MGRs with the terminology of sight words, but any word that is read with automaticity is recognized "on sight."

Discourse

Discourse is the type of structure of a text that is dependent on the content. Comprehension of reading texts relies on understanding of different types of text structure, including narratives, cause-effect, temporal, descriptive, persuasive, poetry, etc. Differentiating instruction means creating multiple paths so that students of different abilities, interests, or learning needs experience equally appropriate ways to absorb, use, develop, and present concepts as a part of the daily learning process. SLPs can identify what is required in the learning task; determine students' strengths and weaknesses; develop differentiated lesson objectives; and describe strategies for teachers and SLPs to use to differentiate instruction. Instruction can be differentiated by content of topic, such as:

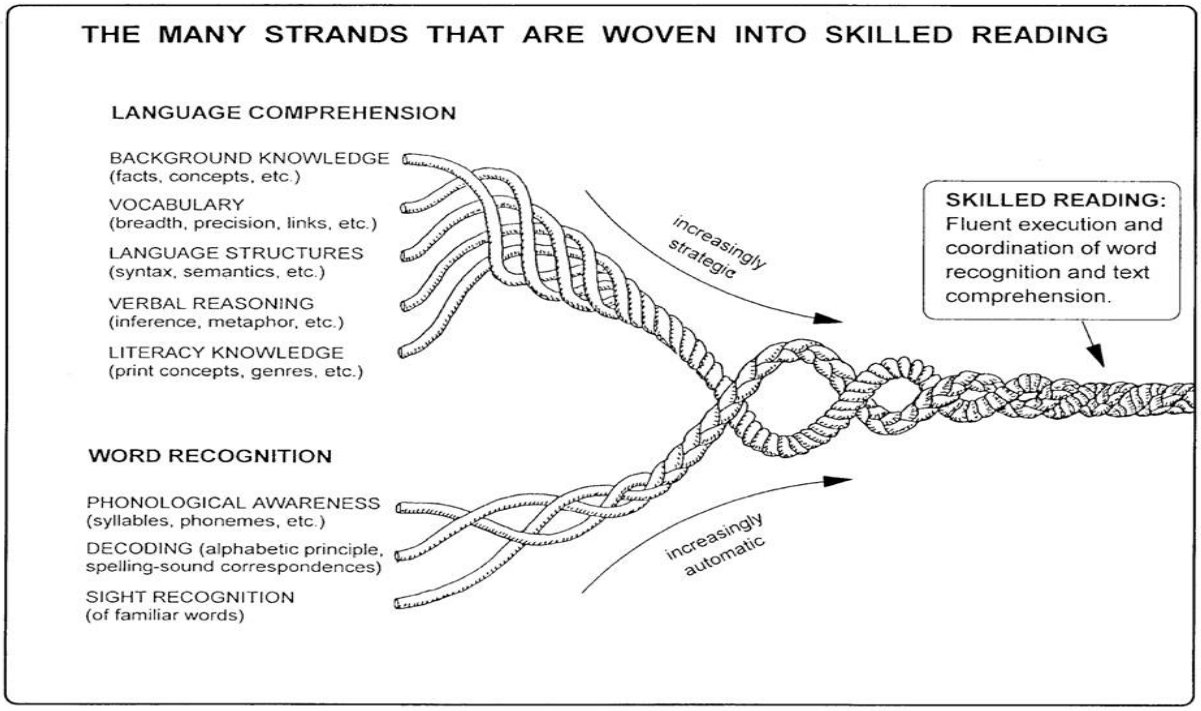
- What information should the students learn?
- By what process or through what activities?

- What is the product or evidence of learning? (Students may be given multiple options for expressing what they know and understand.)

Strategies for facilitating comprehension include: using multisensory strategies, such as graphic organizers, to teach story structure; parsing out the story into its parts (characters, setting, problem, attempt, solution, etc.); and writing personal stories with questions and answers for student to practice.

The Strands of Reading Comprehension

All of the areas of spoken and written language work together for individuals to fluently read and comprehend text. As illustrated in Figure 1.1, the Reading Rope (Scarborough, 2001) visualizes how each domain of language is connected to reading comprehension. While no reading skill works in isolation, the areas of skilled reading can be categorized by two areas: 1. Sound-, syllable-, and word-level recognition; and 2. Sentence- and discourse-level comprehension.



For sound-, syllable-, and word-level recognition to occur, a reader must have the foundational skills in spoken language phonological awareness, written language knowledge in orthographic awareness and phonics, and the spoken and written language knowledge in morphological awareness. For sentence- and discourse-level comprehension, a reader uses semantic awareness (background knowledge and vocabulary), syntactic awareness (sentence structure), and knowledge of text discourse structure (narrative vs. expository text) to facilitate understanding.

The SLP's Role in Dyslexia Assessment and Treatment

Screening Students for Dyslexia

The purpose of the screening is to locate students who are "at risk" for reading difficulty as early as possible. Effective July 1, 2017, MS Code § 37-173-15 mandates that each local school district screen students for dyslexia in the spring of kindergarten and the fall of Grade 1 using a State Board of Education approved screener. The components of the screening must include:

- Phonological awareness and phonemic awareness
- Sound symbol recognition
- Alphabet knowledge
- Decoding skills
- Encoding skills
- Rapid naming

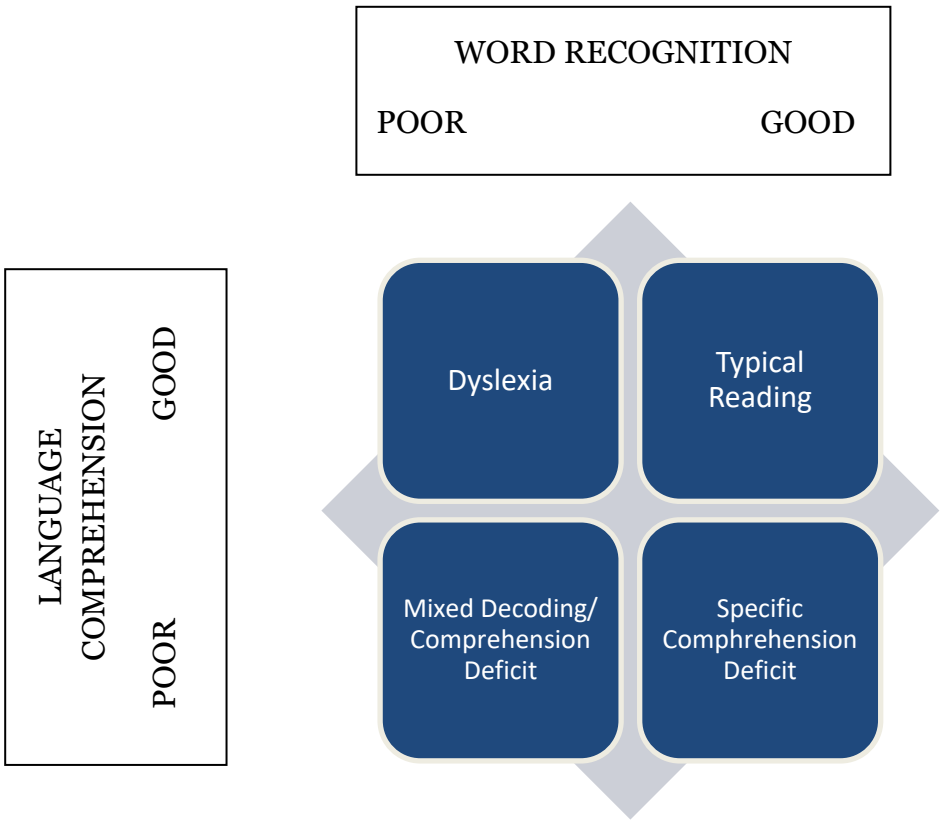
The MDE Approved Screener List and a Sample Parent Letter for Students Who Do Not Pass the Dyslexia Screener can be found on the MDE Dyslexia Website.

If a student fails the screener, the parent must be notified of the results and informed that this is not a diagnosis of dyslexia. The school may use the information from the screener to develop interventions appropriate for the child's needs. However, the school district may perform a comprehensive dyslexia evaluation or subsequent dyslexia evaluations if they deem necessary. Subsequent dyslexia evaluations may be administered by licensed professionals including:

- Psychologists, licensed under Chapter 31, Title 73, Mississippi Code of 1972;
- Psychometrists, licensed by the MDE, and in accordance with Chapter 31, Title 73, Section 27, Mississippi Code of 1972;
- Speech-Language Pathologists, licensed under Chapter 38, Title 73, Mississippi Code of 1972.

A dyslexia assessment must include all the components of the screening, as well as a cognitive measure and, ideally, a language assessment. A diagnosis of dyslexia is made based on a pattern of strengths and weaknesses and should never be made based on a discrepancy in cognitive ability and academic achievement. Typically, a student with dyslexia who is referred for a comprehensive assessment will present with unexpected academic difficulty in light of their cognitive ability.

The Simple View of Reading theory (Kamhi & Catts, 2012) demonstrates how language is the foundation of reading and writing. Following the simple view, reading can be categorized by word recognition (decoding) and language comprehension:



Accommodations

When providing classroom accommodations and modifications, it is crucial that the intent of the standard remains intact. The MDE Access for ALL Guide 2.0 provides guidance to teachers and administrators that will help promote equal access to grade-level content for both general education students and students with disabilities who receive instruction in the general education classroom.

The SLP's Role in Reading Instruction

SLPs can serve as valuable team members at the school building or district level on curriculum and instruction teams. For example, not all reading programs teach spelling explicitly or systematically, and the assumption cannot be made that if a reading program includes phonics, then the phonological awareness instruction is adequate and appropriate. The SLP's knowledge of phoneme development is a

valuable resource to curriculum teams determining the adequacy and effectiveness of a school's reading instruction.

Ways the SLP can serve in a leadership role to analyze the overall effectiveness of reading instruction include:

- Working with the grade-level curriculum committee on developing systematic spelling instruction (i.e., silent e pattern) *[Consultation]*
- Working with classroom teachers to teach whole class or small group spelling instruction using multi-sensory and visual strategies *[Collaboration]*
- Training teachers in how to teach phonological awareness principles (i.e., the phonological awareness hierarchy) *[Consultation]*
- Based on universal assessment data (i.e., DIBELS Initial Sound Fluency and Phoneme Segmentation Fluency), selecting classrooms with deficient phonological awareness scores (majority of the class is *Some Risk* or *At Risk)* to train teachers on effective phonological awareness instruction or present a lesson to the class *[Collaboration/Intervention]*
- Providing small group classroom instruction in phonological awareness skills to students *[Intervention]*
- Co-teaching comprehension strategies in the classroom *[Collaboration]*
- Using multisensory strategies, such as graphic organizers, to teach story structure *[Collaboration/Intervention]*
- Training teachers on the principles of morphological awareness and the benefits of teaching students this concept *[Consultation]*
- Team-teaching instruction on morphological awareness *[Collaboration]*
- During the weekly spelling lesson, identifying the morphemes in words and teaching their relevance to spelling (i.e., -y, -ion, -ed, -s, etc.) *[Intervention]*
- Participating in or leading professional learning communities (PLCs) on language and foundational literacy skills *[Consultation]*

CHAPTER V – Strategies for Deaf/Hard of Hearing Students

The MDE Access for ALL Guide 2.0 provides guidance to teachers and administrators that will help promote equal access to grade-level content for both general education students and students with disabilities who receive instruction in the general education classroom. Because hearing loss can impact the student in such a negative manner, the proper identification of children with hearing loss is critical. Therefore, hearing screening programs need to be well-planned and effective in meeting their goal of timely identification and intervention.

The SLP's Role in the Classroom with Hearing Impaired Students

Identify Your Student's Type of Amplification

Due to the advancements in technology surrounding hearing aids and cochlear implants, more children are entering school with these types of assisted hearing equipment and requiring different services from their peers who use sign language. These students will need assistance from the school-based SLPs to develop their auditory-oral skills. SLPs who are not up to date in their skills in this area should participate in professional development to renew their skills. School-based SLPs should work collaboratively with any private clinician, including auditory-verbal therapists, to assure use of consistent strategies and prompts. School-based SLPs have greater opportunities than private providers to integrate the skills into the classroom and other school settings. It will be your responsibility to educate and train your teachers on how to use the student's assistive listening devices from hearing aids to cochlear implants and FM systems.

Classroom Strategies for Educators

As the school SLP, you will need to make sure teachers are trained on how to use students' assistive listening devices. Also, make them aware of students' needs and strategies to implement in the classroom for improved listening. Some things for them to consider and monitor are listed in the following chart.

Be aware of light source	Don't stand directly under a light source it could cause a glare on the teacher's face and make it difficult for the student to see his/her mouth.
Monitor classroom noise	Make sure the classroom is quiet when the teacher is speaking.
Use visual aids	Use visual aids whenever possible.
Face students when talking	Remember to face the students when teaching, then turn to demonstrate on the board. Don't speak when facing away from the students.
Be aware of student proximity	Place deaf and hard of hearing students in the best listening area, close to the teacher and/or where the student can take advantage of visual cues from other students.
Use close captioning	When using videos or read aloud options, be sure to have closed captioning available.
Monitor background noise	Be aware of background noises.

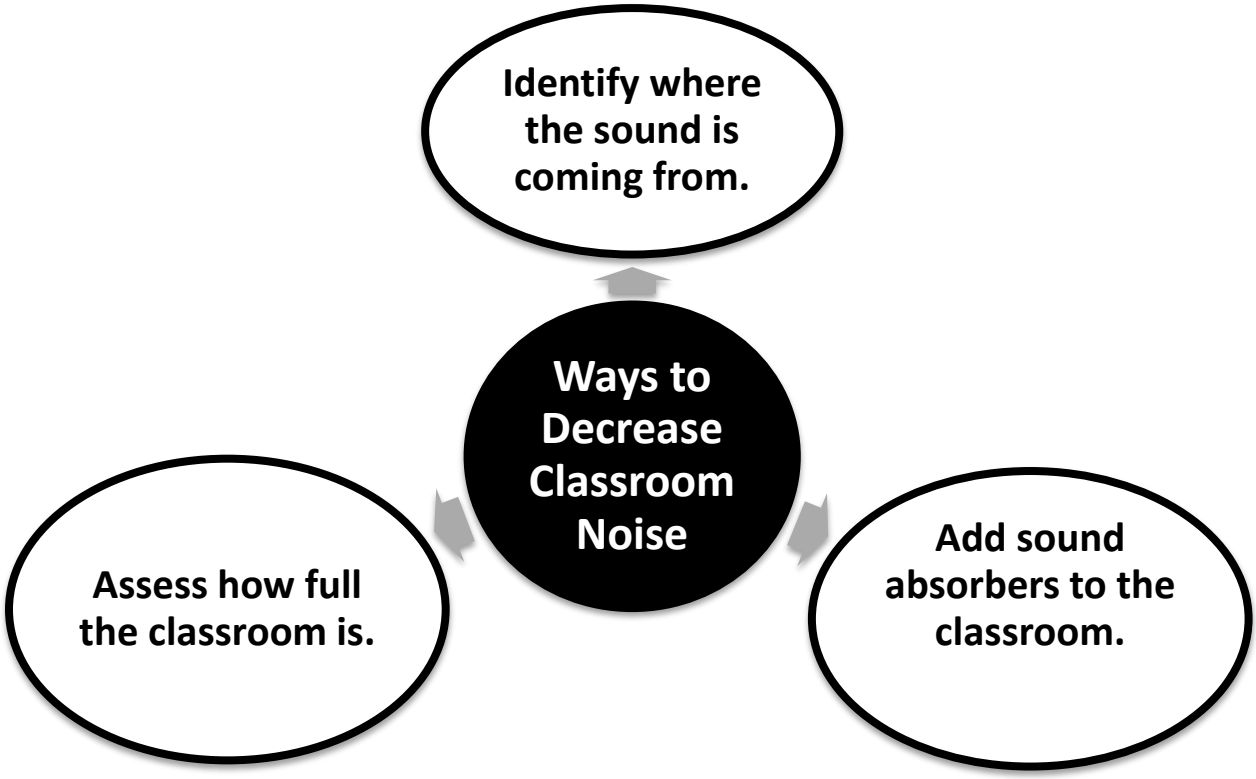
Classroom Acoustics

The architectural design of a classroom includes room size, room shape, and surface treatments. Suitable acoustical design in classrooms and other learning spaces enhances speech clarity and limits background noise to protect speech quality for both students and teachers. Poor acoustical design can result in excessive noise that is disruptive to the learning process and may negatively affect speech perception, student behavior, and educational outcomes (Klatte, Hellbrück, Seidel, & Leistner, 2010; Klatte, Lachmann, & Meis, 2010; Shield & Dockrell, 2008). Poor acoustics can affect all students, not just those with hearing loss.

Classroom noise includes any auditory disturbance that interferes with what a listener wants and/or needs to hear, including:

Noise from outside the building	Highway traffic, lawnmowers, playground noise, jets, etc. heard through the suilding structure
Noise from within the building	Students walking and talking in the halls, class bells, noise from other classrooms
Noise from within the classroom	Student's voices, mechanical noise from the heating, ventilation, and air conditioning system, technology used in the classroom

As the school SLP, you will need to be able to assess the student's classrooms and make recommendations for classroom accommodations/modifications that will help with decreasing noise levels for a more preferred listening environment. Start with measuring the sound in the classroom. You can use a sound level meter app for this, similar to the Decibel X app. The best listening environments will present with a background noise level of under 45dB.



Some ways to decrease classroom noise include:

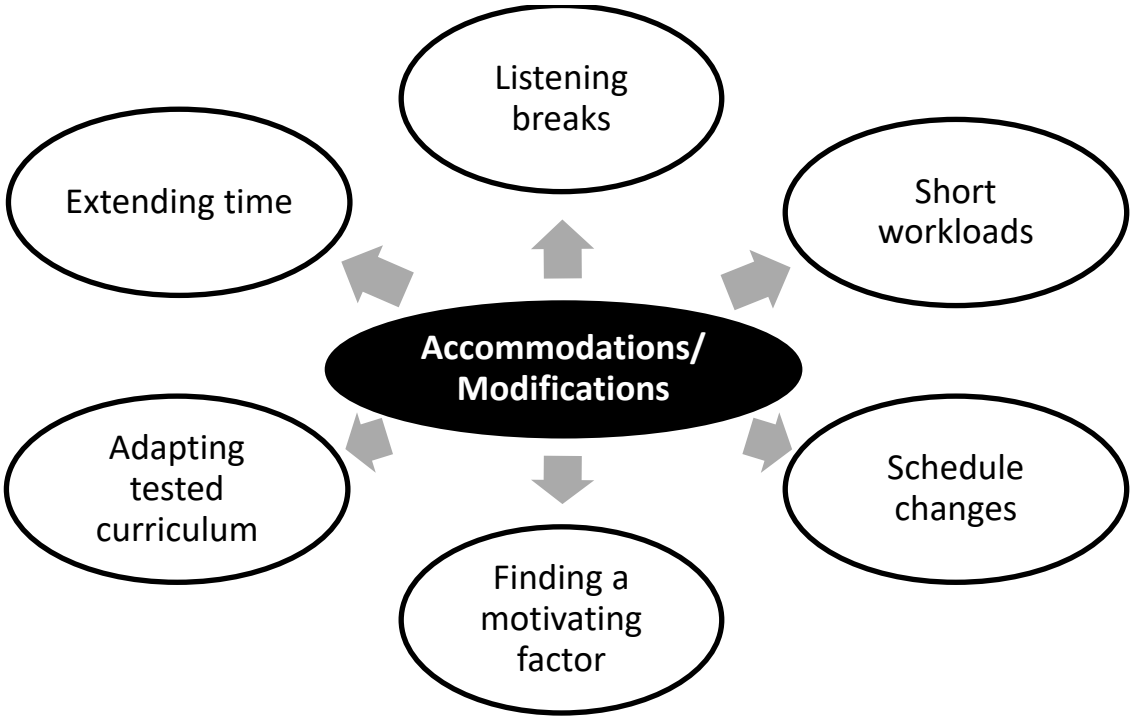
- Identifying where the sound is coming from: students, air conditioners, outside noises from hallway, street, etc.
- Assessing how full the classroom is: Do you see bulletin boards, curtains, books in bookcases, or items covering the walls or ceilings?
- Adding sound absorbers to the room, using fabrics such as rugs, window coverings, soft furniture, seat sacks, or backpacks; adding wall coverings similar to bookshelves, cork boards, bulletin boards, tapestries, painted canvas, or classroom visual charts; adding ceiling tiles to the walls; covering the ceiling with items like dropped ceiling tiles, draped fabrics, tissue paper, or hanging décor.

Some simple ways to make a classroom quieter include:

- Placing rugs or carpet in the room
- Hanging curtains or blinds in the windows
- Hanging soft materials such as felt or corkboard on the walls
- Placing tables at an angle around the room instead of in rows
- Turning off noisy equipment when it is not in use
- Replacing noisy light fixtures
- Showing students how hard it can be to hear when many children talk at the same time
- Placing soft tips on the bottom of chairs and tables
- Adding sound absorbers to the room. These can be fabrics such as rugs, window coverings, soft furniture, seat sacks, or backpacks; wall coverings similar to bookshelves, cork boards, bulletin boards, tapestries, or painted canvas; classroom visual charts; ceiling tiles added to the walls; ceiling coverings like dropped ceiling tiles, draped fabrics, or tissue paper or hanging décor.

Identify the Student's Listening Breakdowns

What does your student look like when there is a listening breakdown? It could look like a student who is disinterested, defiant, tired, or confused.



When you are able to identify the breakdown, you can determine the reason why and add accommodations or modifications to assist the student. Some possible accommodations or modifications might include listening breaks, shortened workloads, schedule changes, extended time for completing work, adapting tested curriculum to exclude items that the student cannot hear (phonics, rhyming, etc.), or finding a motivating factor.

Guidelines for Hearing Screening and Evaluation

Both Federal and State legislation mandate hearing screening in schools. Through IDEA, hearing screening for children is authorized in their Child Find clause, while both the MDE and the nursing guidelines of Mississippi call for school hearing screening programs to be established. The purpose of hearing screening is to identify children who may have a hearing impairment, whether permanent or fluctuating, that adversely affects a child's educational, social/behavioral, and/or vocational performance (MDE, 2009). Hearing loss can have a tremendously negative impact on a student's language-speech development as well as on his/her academic career if it is not identified and treated in a timely manner. This chapter addresses establishing and implementing hearing screening programs in schools.

Recommendations for Comprehensive Hearing Screening Programs in the Mississippi Schools

The American Academy of Audiology (AAA) Childhood Hearing Screening Guidelines (2011) outlines several components of a hearing screening program that schools should consider in establishing their own program. Johnson, Benson, and Seaton, in their widely cited *Educational Audiology Handbook* (1997), also recommend that school hearing screening programs include specific obligatory components. Combining Johnson, Benson, and Seaton's with AAA's components, the following elements are considered "best practices" for school hearing screening programs.

- The identification and training of screening personnel
- Equipment selection and maintenance
- Infection control
- Room set-up
- Protocol recommendations for screening for hearing loss
- Protocol recommendations for screening for middle ear problems
- Referral and follow-up procedures
- Recordkeeping and reporting
- Hearing screening program evaluation

The intent of this section is to address each of these components in order to equip the SLP in schools with the knowledge to establish an effective hearing screening program. The ultimate goal is to identify and treat children with hearing loss in a timely manner, thereby lessening the impact that the hearing loss may have on their educational development.

The Identification and Training of Screening Personnel

The MDE specifies that any of the personnel who do the screenings should be "a health care professional" (2009). Typically, those health care professionals are school nurses and SLPs. LEAs may also arrange for outside qualified agencies to conduct hearing screenings.

Equipment Selection and Maintenance

There are pre-set screening audiometers which screen only a limited number of frequencies at fixed decibel levels. The MDE guidelines require screening for frequencies **1000 Hz**, **2000 Hz**, and **4000 Hz at 25 dB HL**, but the tester can also choose to screen **500 Hz** at **30 dB HL** as well as **6000 Hz** and **8000 Hz at**

3025 dB HL. Thus, there is merit in having a basic portable audiometer that produces a range of frequencies from **250 Hz to 8000 Hz** at levels from **0 dB to 90 dB HL.** The greater capability and flexibility of a portable audiometer hold distinct advantages over a dedicated screening device, making it a good choice for purchase.

For a screening program to be trustworthy, screening equipment must be checked and calibrated electronically every year. The school's equipment provider can arrange for such service. In addition to annual electronic calibrations, biologic listening checks should be made of screening equipment at the start of each screening day (Johnson, Benson, & Seaton, 1997). These listening checks help assure that the audiometer is producing an accurate decibel level at each frequency in each earphone without crackling or intermittent signal from damaged cords. See Appendix AD: Calibration and Mechanical Check of Audiometer for tips on how to perform a listening calibration check.

Data for both the annual calibrations and the listening checks should be kept for each audiometer.

Infection Control

Both AAA (2011) and Johnson, Benson, and Seaton (1997) emphasize the importance of asepsis during screening. Surfaces of supra-aural headphones (headphones that are seated over the ear) should be cleaned after each use before the next student is tested. Screening stations should be equipped with disinfectant wipes and hand sanitizer for use throughout the day. Testers should wash their hands frequently or use disinfectant lotion. Tables and toys used in play audiometry should be wiped down with disinfectant wipes periodically throughout the day. Lastly, the tester should check with the school authorities prior to screening to find out if there has been an outbreak of head lice in the school. If so, screening should be rescheduled for another day.

Room Set-Up

The quietest room possible should be used for hearing screening for the obvious reason that tones can be masked by ambient noise. Rooms that are close to hallways, bathrooms, cafeterias, band rooms, and playgrounds should be avoided, or the screening should be scheduled around their use. Rooms with carpeting and/or acoustic tiling have better sound absorption, making them quieter.

To verify that a room is quiet enough for hearing screening, AAA (2011) suggests checking whether or not a person with normal hearing can hear the test tones at **10**

dB below the screening level. For a **25 dB HL** hearing screening, the tester should set the dial at **15 dB HL.** If the person can hear all the tones at 15 dB HL, then the room should be sufficiently quiet to perform the screenings.

After selecting the most appropriate room, placement of the screening station within the room is an important consideration. The equipment should be set up in a corner or near a wall away from florescent lights and air condition/heating units. The child should be seated as close to the wall as possible while still not being able to see the screener during the actual screening.

Referral And Follow-Up Procedures

Referrals and follow-up for children who failed the pure tone screening twice:

MDE requires that a child needing audiologic evaluation be referred either to an audiologist who holds a Mississippi license, or ASHA or AAA certification, or to a physician with expertise in conducting audiologic evaluations using appropriate equipment. Prior to conducting the screenings, the person in charge of the program should obtain a list of qualified people in the surrounding area to give to parents of the students who need audiologic evaluation. MDE lists the following elements that the audiometric evaluation report must include and that must be part of the multidisciplinary team report:

1. Type of loss;
2. Age of onset, if known;
3. Severity of loss;
4. Speech reception or speech awareness thresholds, if obtainable;
5. Speech discrimination scores, if applicable;
6. Recommendations regarding amplification; and
7. Other recommended interventions, if any, including the need for assistive technology.

The multidisciplinary report must also include acoustic immittance measures, an audiogram or other measure that would define a hearing loss, how the hearing loss impacts educational performance, and communication needs, if any. A description of the follow-up examination and results, including:

1. How the conditions noted during the examination might interfere with educational testing and performance; and

2. Recommendations for accommodations, modifications, and educational programming.

As these items are required to be in the multidisciplinary report, it would be helpful if the clinician would provide this list to the audiologist or physician to address in their report to the school.

Every effort should be made to expedite this process so that the child can receive the necessary assistance. Preferably, the referral process should take **14** to **21 days** so that the child can receive timely services if needed.

Record Keeping and Reporting

Johnson, Benson, and Seaton (1997) emphasize the importance of keeping accurate records of each child screened and the results obtained. In Appendix B: Hearing and Vision Screening Report you may record the pass/fail results of the first and second screening.

In addition to keeping data on each student's results, schools should have a reporting mechanism in place for the following individuals who are involved with the student:

A) **Parents:** Parents should be notified about (a) passing the screening, (b) the need to rescreen their child, and (c) the need to take the child for further evaluation. The local school district may include in this last letter a list of local audiologists to whom the parent can take their child.
B) **School personnel who are involved with the student:** During the time that the child is at-risk and going through the referral process, it would benefit the child greatly to receive simple assistance in the classroom.
C) **Agencies from which follow-up results need to be obtained:** In order for assessment to proceed and appropriate services to be implemented, it is vital to obtain the results from the outside agency to which the child is referred. The agency should convey this information back to the school in an expeditious manner with full explanations of all the test results. In addition to obtaining the results of the audiologic evaluation, if the child was found to have a hearing loss, the following questions should also be addressed by the audiologist performing the evaluation, then sent to the schools:
    1. How might the conditions noted during the examination interfere with educational testing and performance?
    2. How might the hearing loss affect educational, social/behavioral, and/or vocational performance?
    3. What are the recommendations for accommodations, modifications, and educational programming?

4. What are the communication needs and abilities of the child? (Mississippi Department of Education, 2009).

With these questions answered, the school will know how best to assist the child with the necessary services to maximize educational, social/behavioral, and/or vocational performance. There is an Appendix AA: Sample Parent Letter to Refer Students for Further Evaluation. There is also an Appendix AE: Sample Referring Agency Reporting Form which the school can send to the outside agency in order to facilitate receiving the follow-up recommendations necessary to best assist the child. Comprehensive testing may proceed based on these recommendations.

Reporting Forms

(A) Appendix AA: Sample Parent Letter to Refer Students for Further Evaluation
(B) Appendix AE: Sample Referring Agency Reporting Form
(C) Appendix B: Hearing and Vision Screening Report

For additional information see the Access for All Guide 2.0 and the Family Guide to Special Education Services: Hearing Impairment, Volume 5

Chapter VI Special Topics

Dysphagia

School-based SLPs play a significant role in the management of feeding and swallowing disorders. SLPs provide assessment and treatment to the student as well as education to parents, teachers, and other professionals who work with the student daily. SLPs develop and typically lead the school-based feeding and swallowing team.

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004) protects the rights of students with disabilities, ensures free appropriate public education, and mandates services for students who may have health-related disorders that impact their ability to fully participate in the educational curriculum. Feeding, swallowing, and dysphagia are not specifically mentioned in IDEA; however, school districts must protect the health and safety of students with disabilities in the schools, including those with feeding and swallowing disorders. According to IDEA, students with disabilities may receive school health and nursing as related services to address safe mealtimes regardless of their special education classification.

Although feeding, swallowing, and dysphagia are not specifically mentioned in IDEA, the U.S. Department of Education acknowledges that chronic health conditions could deem a student eligible for special education and related services under the disability category "Other Health Impairment," if the disorder interferes with the student's strength, vitality, or alertness and limits the student's ability to access the educational curriculum.

Students who do not qualify for IDEA services and have swallowing and feeding disorders may receive services through the Rehabilitation Act of 1973, Section 504, under the provision that it substantially limits one or more of life's major activities.

School districts that participate in the U.S. Department of Agriculture Food and Nutrition Service Program in the schools, known as the National School Lunch Program, must follow regulations [see 7 C.F.R. § 210.10(m)(1)] to provide substitutions or modifications in meals for children who are considered disabled and whose disabilities restrict their diet (Meal Requirements for Lunches and Requirements for Afterschool Snacks, 2021).[1]

For more information, see also Accommodating Children with Disabilities in the School Meal Programs: Guidance for School Food Service Professionals [PDF] (U.S.

Department of Agriculture, 2017). For more information see: Pediatric Feeding and Swallowing (asha.org)

Educational Relevance

IDEA protects the rights of students with disabilities and ensures free appropriate public education. Feeding and swallowing disorders may be considered educationally relevant and part of the school system's responsibility to ensure:

- Safety while eating in school, including having access to appropriate personnel, food, and procedures to minimize risks of choking and aspiration while eating;
- Adequate nourishment and hydration so that students can attend to and fully access the school curriculum;
- Student health and well-being (e.g., free from aspiration pneumonia or other illnesses related to malnutrition or dehydration) to maximize their attendance and academic ability/achievement at school; and
- Skill development for eating and drinking efficiently during meals and snack times so that students can complete these activities with their peers safely and in a timely manner.

Treatment in the School Setting

Management of students with feeding and swallowing disorders in the schools addresses the impact of the disorder on the student's educational performance and promotes the student's safe swallow in order to avoid choking and/or aspiration pneumonia. Students with recurrent pneumonia may miss numerous school days, which has a direct impact on their ability to access the educational curriculum.

IEP

Information from the referral, parent interview/case history, and clinical evaluation of the student is used to develop IEP goals and objectives for improved feeding and swallowing, if appropriate.

Feeding and Swallowing Plan

A feeding and swallowing plan addresses diet and environmental modifications and procedures to minimize aspiration risk and optimize nutrition and hydration. Ongoing staff and family education is essential to student safety. The plan should be reviewed annually along with the IEP goals and objectives or as needed if significant changes occur or if it is found to be ineffective.

A feeding and swallowing plan may include but not be limited to:

- Student demographic information;
- Appropriate positioning of the student for a safe swallow;
- Specialized equipment indicated for positioning, as needed;
- Environmental modifications to minimize distractions;
- Adapted utensils for mealtimes (e.g., low flow cup, curved spoon/fork);
- Recommended diet consistency, including food and liquid preparation/modification;
- Sensory modifications, including temperature, taste, or texture;
- Food presentation techniques, including wait time and amount;
- The level of assistance required for eating and drinking; and/or
- Cues or prompts for eating and drinking.

Guidelines for Culturally and Linguistically Diverse School-Aged Children

Background

As the population of Mississippi continues to become more culturally and linguistically diverse, school based SLPs are more likely to encounter students who are developing English proficiency or speak English dialects other than Mainstream American English (MAE; also commonly known as Standard American English; the dialect used in government communications, printing, national television newscasts, and many businesses; Roseberry-McKibbin & Hedge, 2011). These dialects are often referred to as non-mainstream dialects of English and include African American English (AAE) and Southern White English (SWE). Non-mainstream dialects of English are typically characterized by linguistic features that differ from MAE. Syntactic features include, but are not limited to, variable use of morphemes such as past tense *-ed,* auxiliary *be* and *do* forms, third person singular *-s,* and possessive *-s*. Selected phonological features include */t/* for voiceless *th, /d* for voiced *th,* final consonant deletion, devoicing of final consonant sounds and consonant cluster reduction. Linguistically based research has shown that each of these features and others that characterize nonmainstream dialects of English are pattern-based and are used systematically in speakers' spontaneous speech. Further, these dialects have been shown to be rule-governed, legitimate linguistic systems of communication and not slang or substandard forms of MAE. (For review of common features of AAE and SWE, see Oetting & McDonald, 2002; Roseberry-McKibbin & Hedge, 2011; Stockman, 1996. For review of the rule- governed nature

of AAE and SWE, see Green, 2002, 2011; Garrity & Oetting, 2010; Oetting & Newkirk, 2011; Wyatt, 1996.)

School-aged children who are English Learners (EL) of non-mainstream dialects of English present a unique assessment challenge to SLPs who do not have a solid understanding of non-mainstream dialects. This is because many of the features of non-mainstream dialects of English, appear to be identical to symptoms of childhood language impairment (Seymour, Bland-Stewart, & Green, 1998). What may appear to be a symptom of impairment may actually be a legitimate linguistic feature of AAE or SWE. The inverse is true as well; what may appear to be a linguistic feature of AAE or SWE may in fact be a symptom of impairment. This presents a diagnostic conundrum for many SLPs and those who are unfamiliar with linguistic systems of non-mainstream dialects such as AAE or SWE will likely have a challenge during the assessment process and with ultimately answering the question of problem/no problem.

What further adds to the challenge of assessing culturally and linguistically diverse school-aged children is limited access to or availability of appropriate assessment tools to adequately assess the communication skills of school-aged children who speak non-mainstream dialects of English. To date, very few culturally and linguistically appropriate commercial assessment tools are available for use with speakers of non-mainstream dialects of English. This requires SLPs to rely even more on their linguistic knowledge and their understanding of the universal principles of typical language development than they would when assessing speakers of MAE.

Disorder vs. Difference (or Dialect)

When SLPs are confronted with a culturally and linguistically diverse student whose speech and language skills may be contributing to his or her struggle in school, the first question that they usually ask is, “Is the student’s speech and language reflective of a language difference or a language disorder?” Disorder has a clinical connotation and in general, refers to speech and language skills that deviate from what one would expect for peers of the same age and grade. In contrast, a difference refers to a rule- governed linguistic variety or dialect that is shared by a group of speakers and differs in some ways from other dialects, like MAE, due to factors such as geographic region, socioeconomic status, and subgroup membership (Battle, 2002; Wolfram & Schilling-Estes, 2006).

Although the term dialect often carries a negative connotation and thought of by many as corrupt English, a dialect or linguistic difference is not disordered speech

or language. In fact, from a linguistic perspective, a non-mainstream dialect is just as rule-governed, systematic and regular across all linguistic parameters (i.e., phonology, morphology, syntax, semantics, and pragmatics) as any other dialect of English, including MAE. Since 1983, it has been the position of the ASHA that "no dialectal variety of English is a disorder or pathological form of speech or language." Further, the Association asserts that "each dialect is adequate as a functional and effective variety of American English" (p. 2).

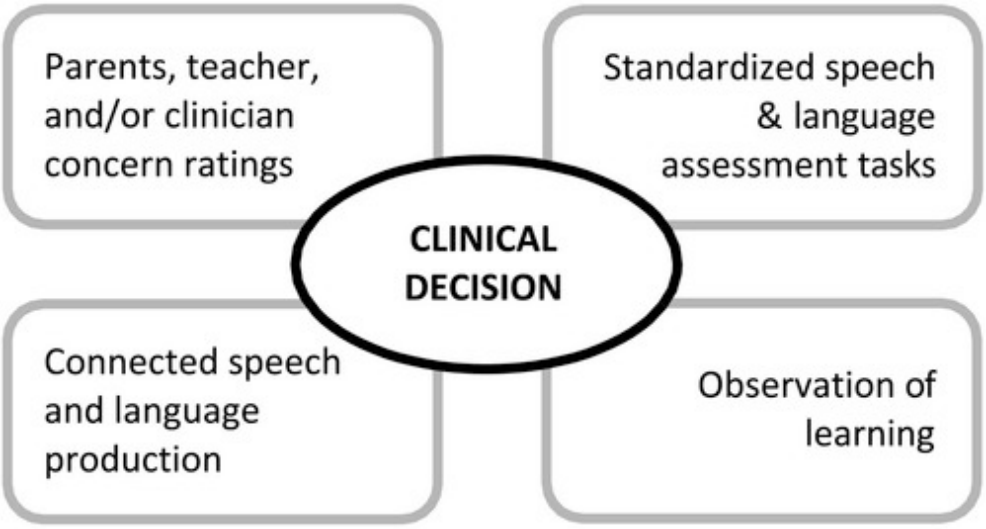
Dual Language Learner Assessment

Diversity of U.S. classrooms continues to increase with many different languages spoken (e.g., Spanish, Arabic, Vietnamese). It is estimated that by 2025 almost 30% of US school children will be Latino who may speak a language other than ENG at home (Kena et al., 2016). Factors that influence dual language learners progress included, but are not limited to:

- Length of time in the U.S.
- Age of first exposure to English
- Socio-economic status
- Environment (home vs. school)
- Caregiver expectations

Both ASHA guidelines (2019) for professional practice and the Individuals with Disabilities Education Act support the use of converging evidence for the assessment and diagnosis of dual language learners. Converging evidence refers to the idea that multiple pieces of assessment data must come together and trend in the same direction to make a diagnostic decision. Castilla-Earls, et al, 2020, recommends gathering assessment data using language experience questionnaires, bilingual language and speech sample analysis using large-scale reference databases (RDBs) when available, evaluation of learning potential, and standardized testing. These four assessment methods allow clinicians to examine the child in different contexts to determine their strengths and weakness in communication abilities.

Converging Evidence Framework



To use a converging evidence approach, a clinician first administers and collects a variety of assessment data. Second, the clinician weights all the available data equally because all the data suggested in this tutorial are valid for the identification of language and speech disorders in DLLs. To illustrate, although standardized testing is one of the components in the converging evidence approach, it does not by itself dictate the final diagnostic decision. Instead, standardized testing may be one of the pieces of available data, just as language experience questionnaires may comprise another one of the pieces of available data. It is important to note that it is possible to use a convergent evidence approach without a standardized test. In many cases, standardized tests are not appropriate for DLLs. It is also possible to reach a diagnosis of language/speech disorder, even when a standardized testing yields a score that could be considered within normal limits if the other evidence suggests a disorder. Finally, a clinician reaches converging evidence to make a diagnostic decision when the majority of the evidence suggests either a language disorder or typical language skills (Castilla-Earls, et al, 2020).

Required Competencies for SLPs

The ASHA (2003) has identified required competencies for SLPs who serve culturally and linguistically diverse students. These competencies are required to distinguish between dialectal differences and communicative disorders. They include:

1. Recognizing all American English dialects as rule-governed linguistic systems
2. Understanding the rules and linguistic features of American English dialect(s) represented by their clientele

3. Being familiar with nondiscriminatory testing and dynamic assessment procedures, such as the following:
    a. Identifying potential sources of test bias,
    b. Administering and scoring standardized test in alternative manners,
    c. Using observation, nontraditional interviews, and language sampling techniques, and
    d. Analyzing test results in light of existing information regarding dialect use.

In addition to these, we would add completion of an attitudinal self-examination to reflect upon and address one's own attitudes toward culturally and linguistically diverse speakers. Cultural competence checklists can be found on the webpage of the American Speech-Language Hearing Association.

Important Federal Regulations to Consider

The speech and language assessment of any student should be guided by current Federal regulations. However, some regulations of the Individuals with Disabilities Education Act (2004) Section 300.304 are particularly relevant for students who are culturally and linguistically diverse. These regulations pertain to evaluation procedures and they mandate the following:

1. A variety of assessment tools and strategies must be used to gather relevant functional, developmental, and academic information about the children, including information by the parent, that may assist in determining whether the child has a disability and the content of the child's IEP [Sec. 300.304(b)(1)(i, ii)].
2. No single measure or assessment can be used as the sole criterion for determining whether a child is a child with a disability, and for determining an appropriate educational program for the child [Sec. 300.304(b)(2)].
3. In an evaluation, technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors, must be used [Sec. 300.304(b)(3)].
4. In an evaluation, assessments and other evaluation materials must be selected and administered so as not to be discriminatory on a racial or cultural basis [Sec. 300.304(3)(c)(1)(i)].
5. In an evaluation, assessments and other evaluation materials must be provided and administered in the child's native language or other mode of communication and in the form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to so provide or administer [Sec. 300.304(3)(c)(1)(ii)].

6. In an evaluation, assessments and other evaluation materials must be used for the purposes for which the assessments or measures are valid and reliable [Sec.300.304(3)(c)(1)(iii)].
7. Assessments and other evaluation materials must be administered by trained and knowledgeable personnel [Sec. 300.304(3)(c)(1)(iv)].
8. Assessments and other evaluation materials must include those tailored to assess specific areas of educational need and not merely to provide a single general intelligence quotient [Sec. 300.304(3)(c)(2)].
9. No child is eligible for special education services if the determinate factor for eligibility is lack of appropriate instruction in reading, math or limited English proficiency [Sec.300.306(1)(i, ii, iii)].

Guidelines for Assessing Culturally and Linguistically Diverse Students

With consideration of the position of the ASHA regarding dialects and the aforementioned regulations of the Individuals with Disabilities Education Act (2004), the following practice guidelines are suggested when assessing culturally and linguistically diverse school-aged children:

1. **Plan a well-balanced, culturally sensitive assessment which includes ethnographic methods (i.e., methods that obtain information from the point of view of the student's culture).** Speech-language assessments of culturally and linguistically diverse students should always include non-standardized, informal procedures and instruments such as language-speech sampling, portfolio assessments, parent and teacher reports, criterion-referenced testing procedures, curriculum-based language assessments, and dynamic assessment. Processing-based assessment methods such as nonword repetition should also be used. These methods are thought to minimize biases related to prior world knowledge and experience.
2. **Identify standardized tests with appropriate psychometric properties**. SLPs should aim to use tests that have acceptable psychometric properties (e.g., sensitivity, specificity, validity, and reliability) and that have culturally and linguistically diverse students well represented in the standardization sample.
3. **Review standardized tests for possible bias.** Before using a particular standardized test in an evaluation, the SLP should examine the test items, picture stimuli, administration procedures, and oral instructions for evidence of bias. Three types of biases that are probable in standardized speech and

language tests have been identified: content bias, linguistic bias, and disproportionate representation in normative samples (Laing & Kamhi, 2003). Content bias occurs when test stimuli, methods, or procedures reflect the assumption that all students have been exposed to the same concepts and vocabulary or have had similar life experiences. SLPs who are assessing students who are from culturally and linguistically diverse backgrounds should closely evaluate standardized tests for items that assume that all students have been exposed to the same concepts and vocabulary or have had similar life experiences.

Linguistic bias occurs when there is a disparity between the language/dialect of the examiner, the language/dialect of the student, or the language/dialect that is expected in the student's response (Laing & Kamhi, 2003). Roseberry-McKibben (2011) highlight five types of test items on standardized speech and language tests that are most susceptible to linguistic bias. These include grammatical judgment items, sentence repetition items, grammatical closure tasks, receptive grammatical closure tasks, and articulation and phonological tasks.

SLPs who use standardized tests that contain these types of items should be careful not to identify a student as needing special education solely on the basis of test scores. Also, items that are linguistically biased should not be used solely as the basis for goals and objectives.

The final common type of bias associated with standardized tests is the disproportionate representation of culturally and linguistically diverse students in the normative samples of tests (Laing & Kamhi, 2003). This occurs when culturally and linguistically diverse students are not included or underrepresented in the normative sample. SLPs should examine the manuals of standardized test to ensure that the normative sample adequately includes children from diverse backgrounds.

4. **Consider Altering Standardized Tests.** If least-biased standardized tests are not available, the SLP may consider altering the administration of the test so that culturally and linguistically diverse students will perform optimally in ways that reflect their true speech and language abilities (Roseberry-McKibben & Hedge, 2011). Ways to alter tests include:

    - Omit items that reflect content and/or linguistic bias.
    - Reword directions.
    - Give extra examples and practice items.
    - Give the student extra time to respond.

- Repeat items if necessary.
- Give instructions in MAE and in the child's dialect.
- If a student gives a “wrong” answer, ask them to explain their answer. For answers that are correct according to the student's culture, give credit.

Be sure to report any alterations in standardized testing procedures in the language-speech report.

5. **Consider all assessment data in decision-making.** When analyzing the assessment data of culturally and linguistically diverse students, SLPs should consider all assessment data—not just the standardized test data. Data analysis should focus on the universal aspects of speech and language development for identifying signs of a disorder and not dialect-specific aspects of speech and language. That is, SLPs should look for speech and language patterns that are not typical in various dialects of English. Importantly, decisions of eligibility should never be made solely on standardized tests or on test items that reflect dialect-specific aspects of speech and language.
6. **Report assessment findings in a least biased fashion.** A report of assessment findings should always include a comprehensive review of the student's strengths and weaknesses. Cultural dialects should always be referred to in non-derogatory ways (i.e., as legitimate linguistic systems of communication) and with appropriate terminology and labels (e.g., *dialect* not *slang)*. When writing the assessment report, be sure to report any departure from standardized testing procedures. Also, the SLP should express caution or disclaimers when reporting standard scores generated from tests that are biased.

Comparison of Children with Limited English Proficiency with and without Disabilities

Characteristics	Child with limited English proficiency	Child with limited English proficiency and a disability
Communication Skills	Normal language learning potential. Communicative use of English is reduced and easily noted by native English speakers. English phonological errors common to culture. No fluency or voice impairment. Can be communicatively proficient to function in society.	May exhibit speech and language disorders in the areas of articulation (atypical phonology or prosody), voice, fluency, or receptive and expressive language; may not always achieve communicative competence in either first or second language. May exhibit communication behaviors that call attention to himself/herself in L1.
Language Skills	Skills are appropriate for age level prior to exposure to L2. The nonverbal communication skills are culturally appropriate for age level (e.g., eye contact, response to speaker, clarification of response, turn taking). Vocabulary deficit and word-finding difficulties in L2 only. Student may go through a silent period. Code switching common.	May have deficits in vocabulary and word finding, following directions, sentence formulation, and pragmatics in either L1 or L2. Atypical syntactic and morphological errors. Persistent errors in L2. Low mean length of utterance (MLU) in both languages. Difficulties in first language and English cannot be attributed to length of time in English-speaking schools. Stronger performance on tests assessing single word vocabulary than on tests assessing understanding of sentences or paragraphs.
Academic Functioning	Normal language learning potential. Apparent problems due to culturally determined learning style, different perceptual strategies, or limited or interrupted/inconsistent education.	May observe limited progress in second language acquisition, difficulty retaining academic information, difficulty in schoolwork of home country, or difficulty in acquiring the first language.
Progress	Progress in home language is contingent upon adequacy and continuation of first language instruction. Academic progress in English should be steady but will depend on the quality and quantity of English instruction.	May show less than expected progress in English acquisition and development of academic skills compared to similar EL students (i.e., from the same language background and with similar time in US schools and programs). May show a marked or extreme discrepancy between different areas (e.g., oral skills and writing skills) that cannot be attributed to lack of sufficient time or appropriate interventions.
Social Abilities	No social problems in L1. May have some social problems due to lack of familiarity with American customs, language, expected behaviors, etc. Student may experience social isolation and may be likely to be a follower rather than a leader in a group of English speakers.	May exhibit persistent social and behavioral problems that are in L1 and his/her native culture and not attributable to adjustment and acculturation.

Virginia Department of Education, Revised 8/15/2006.
Adapted from the Fairfax County, CLiDES Handbook Team (2003).

An Additional Consideration: Socioeconomic Status

An additional factor to consider while assessing students who are culturally and linguistically diverse is socioeconomic status. A large proportion of school children in America's schools have been reared in poverty. In Mississippi for the 2022-2023 academic year, more than 70% of public-school students qualified for and received free or reduced lunch (Mississippi Department of Education, 2022).

Children reared in poverty frequently enter school at a disadvantage due to decreased language exposure, decreased opportunities to interact with books, and they may present differences in perception and expectations related to the classroom context (Croll, 2002; Hart & Risley, 1995; Haverman & Wolfe, 1995; Washington & Craig, 1999). The literature suggests that children from low socioeconomic backgrounds:

- Hear fewer words spoken in the home than children reared in higher socioeconomic homes (Hart & Risley, 1995).
- Are exposed to more directive language and verbal discouragement than children reared in higher socioeconomic homes (Hart & Risley, 1995).
- Have a slower vocabulary growth rate (Hart & Risley, 1995).
- Perform lower on standardized language tests (Qi, Kaiser, Milan & Hancock, 2006).
- Have less literacy socialization experiences than children reared in higher socioeconomic homes (Smith, Brooks-Gunn & Klebanov, 1997).

These findings have important implications for SLPs. When assessing students who are reared in poverty (who may also be culturally and linguistically diverse), it is important for SLPs to recognize that the depressed English language skills (often vocabulary skills) may be due to limited experiences, limited exposure or different cultural practices. An SLP's assessment should take these factors into consideration to determine if lower test scores are indicative of a true disorder or a result of experiences that are different from middle-class mainstream American culture.

To that end, one assessment procedure that is particularly recommended for students who are from low-income backgrounds is dynamic assessment.

Dynamic assessment is a procedure that involves three phases: a test phase, a teach phase, and another test phase. This three-phase procedure allows the SLP to assess the students' learning *process* and his/her language-learning *potential*.

The important point to make is that being reared in poverty does not guarantee a disorder; however, poverty places children at a higher risk for developing deficits in language, literacy, and academic achievement. Due to the negative effects that poverty may have on children's language, literacy, and academic achievement, there has been a push for SLPs to work with families and early childhood educators from impoverished backgrounds using a prevention model (ASHA, 1998; 1991; Morris, 2010) to:

- Provide opportunities for children to read quietly or read to younger pupils in non-threatening environments.
- Provide instruction in classrooms so that all children may benefit from SLP instruction.
- Include literacy activities in after-school programs.
- Motivate children to read.
- Train parents to support their children's literacy development. This could be done during parent-teacher conferences or through "building literacy weekly tips" sent home in folders.

Considerations for Intervention

If after completing a culturally and linguistically appropriate assessment, the SLP determines that a disorder exists and that the disorder is adversely affecting academic performance, the following considerations are suggested. Prior to implementing the intervention process, therapists should consider their own values and belief systems and adapt approaches to service delivery to accommodate the needs of all students. We would suggest utilizing the following guidelines in order to provide culturally sensitive intervention.

- Know the culture of individual students. Every culture has a set of pragmatic rules that guide communicative behaviors. Becoming familiar with these rules will allow you to engage in interactions with clients and caregivers in a culturally sensitive manner.
- Ensure that your treatment methods and procedures do not violate the beliefs and values of your clients.
- Understand differences in nonverbal communication rules across cultures.
- Learn to pronounce the names of your students, and do not attempt to shorten the names or use nicknames unless it is requested by your student. Avoid commenting on unusual names or spelling of names.

- Ensure that the goals of intervention are consistent with expected outcomes of parents and involve parents in the intervention.

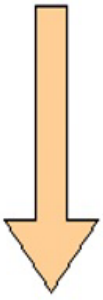
Preschool Considerations

Least Restrictive Environment Continuum

At least annually, the IEP Committee must consider the placement of the child based on:

- The child's IEP
- The location of the school the child would attend if s/he were not disabled
- Any potential or long-term harmful effects on the child
- Access to age-appropriate nondisabled peers
- The provision of supplementary aids and services

The continuum of placement for preschoolers is slightly different than that of school-aged children. Remember that the child's LRE is determined on an individual basis and the IEP Committee may not unilaterally exclude any option on the continuum. The chart below indicates placement options from least to most restrictive.

PI – REG ED PROG ≥ 10 hours/ SERVED IN REG ED PROG **OR** PK – REG ED PROG < 10 hours/ SERVED IN REG ED PROG	Services are provided in the regular education program.	**Least Restrictive**  **Most Restrictive**
PJ – REG ED PROG ≥ 10 hours/ SERVED IN OTHER LOCATION **OR** PL – REG ED PROG <10 hours/ SERVED IN OTHER LOCATION	Services are NOT provided in the regular education program.	
PC – HOME	The child does NOT attend any program and services are provided in the home.	
PH – SERVICE PROVIDER LOCATION	The child does NOT attend any program and services are NOT provided in the home.	
PG– SPEC ED PROGRAM	Served in a separate class	
PF– SPEC ED PROGRAM	Served in a separate school	
PE– SPEC ED PROGRAM	Served in a residential facility	

PI and PK – Services provided in the regular education program.

- Example: The child attends a daycare center class, and the service is provided in the room with nondisabled peers.

PJ and PL – Services are NOT provided in the regular education program.

- Example: The child attends a daycare center class, and the service is provided on the premises but not inside the general education setting.

PC – Child does not attend any program and services are provided in the home.

PH – Child does not attend any program and services are NOT provided in the home.

- Example: The parent brings the child to the school to receive services.

PG – Served in a separate class.

- Example: The child attends a self-contained class for students with disabilities.

PF – Served in a separate school.

- Example: The child attends a special school to address his/her specific needs (e.g., Magnolia Speech School).

PE – Served in a residential facility.

- Example: The child is placed in a facility such as Mill Creek or CARES to address severe needs.

The following placement options are considered general education settings for data collection purposes:

1. Head Start
2. Childcare centers
3. Public preschool programs provided by the LEA
4. Early Learning Collaborative programs
5. Community-based early learning programs

Because Mississippi does not have universal PreK, all preschoolers have the right to a FAPE. In most instances, a preschool child will have an IEP. However, if an LEA offers a public (free) placement and the parent rejects that option, the child will then typically have a Services Plan. When in doubt, the IEP Committee should document the child's services on an IEP to assure that FAPE is provided.

Child Outcomes Summary (COS) Process

The vision for the Child Outcomes Summary (COS) process is that every district that serves preschool students will accurately report outcomes data for each child with disabilities ages 3-5. MDE provides training and technical assistance to help districts improve the quality of these data, the quality of services, and ultimately improve outcomes for children. While the main purpose of the COS process is to meet federal requirements, these outcomes data have other valuable uses. These data should be used by districts to improve programs and services for preschool children. Additionally, this information can help programs improve communication with families about their child's functioning. These data also are useful for public reporting, including providing statewide and LEA information around preschool to the legislature and other stakeholders. Although the same assessment data may be used to determine a COS rating, the process is completely separate from eligibility determination under IDEA. Once the eligibility determination is made, the IEP Committee chooses a COS rating for the child based on all data collected.

The Childhood Outcomes Summary Manual provides special education preschool personnel an overview of the functions and processes that must be used to collect and enter required early childhood outcome data on all preschool children receiving special education services. As of July 1, 2021, Mississippi has been collecting data on child outcomes using the COS process. This process goes beyond basing the child's functioning on any one assessment tool or in any one situation. In the COS process, teams use information from multiple sources and synthesize all that is known about a child's functioning to identify a rating that best captures the child's functioning relative to what is expected for a child of that chronological age. The COS process was selected for several reasons, including:

- It does not mandate use of one particular assessment tool;
- It allows selection of various and multiple assessment tools based on the specific strengths, skills, cultural and linguistic background of the child;
- It capitalizes on all that is understood from all members of the IEP team, including families, to use the richest understanding of the child's functioning much like a portfolio;
- It is consistent with the Division for Early Childhood (DEC) Recommended Practices on assessment (ECTA Practice Improvement Tools for Assessment);
- It was designed to measure the child's functioning in the three outcome areas and not focus exclusively on developmental domains.

For a complete explanation of Indicator 7: Preschool Outcomes and the COS process, visit the MDE Early Childhood website.

Private School vs. Public School Services

The Every Student Succeed Act (ESSA), requires LEAs to provide for the equitable participation of private school students, teachers and, in some cases, parents and other education personnel in some of the ESSA's major programs.

It is the policy of the MDE to ensure that LEAs meet the private school requirements in §§300.130 through 300.148 (Children with Disabilities Enrolled by Their Parents in Private Schools).

Children with Disabilities Enrolled by Their Parents in Private Schools

Parentally placed private school children with disabilities means children with disabilities enrolled by their parents in private, including religious, schools or facilities that meet the definition of elementary school or secondary school. The Child Find process requires that each LEA must locate, identify, and evaluate all children with disabilities who are enrolled by their parents in private schools located in the school district served by the LEA, just as they would for students enrolled in the public school district (CFR §300.130-131).

The reauthorization of IDEA in 1997 and 2004 significantly altered the rights of children placed in private schools by their parents when there is no disagreement about special education services. These are students whose parents prefer private education to public education, often placing their children in parochial or other private schools. In Mississippi, children who are home-schooled are treated as children who attend private schools. (This section does not address children placed in private schools by the school district or children placed there by their parents when they disagree with the school district about the provision of a free appropriate public education for their children. The SLP should refer to school district policies for addressing such situations.)

The Regulations Governing Special Education Programs for Children with Disabilities in Mississippi require each school district to locate, identify, and evaluate private school children enrolled in private schools located in the district who are suspected of having a disability. Upon completion of the evaluation, the eligibility committee determines whether the child is a child with a disability. If the determination is made that the student has a disability and requires special education, the student may be entitled to receive certain services from the school district.

To maintain best practice, the MDE recommends that, once a parentally placed private school student has been found eligible for special education and related services, the school district of residence develops and proposes an IEP. The proposed IEP provides documentation that the school district stands ready, willing, and available to provide a free appropriate public education if the parent elects to enroll the student in the public school. However, if the parent chooses to reject the IEP and enroll the student in the private school, the rights of these children to receive special education services are limited. A services plan should be written for those children. Each school district must develop an agreement with each private school for within the district for how it will serve these children according to a federal funding formula. This agreement will address the type of service, location of the service, and transportation (if applicable) the school district will provide the student. Regardless of the type of service needs that are identified by the evaluation, the child is only entitled to receive those services identified in the school district's agreement with the private school, meaning that the child does not have an entitlement to a free appropriate public education.

The services plan does not require the same amount or type of services provided to public school students. It may exclude those sections that are not relevant based on the district's agreement for serving private school children. For example, if the district's agreement with the private school does not include a particular related service, such as occupational therapy, the district is not obligated to include that particular service in the student's services plan.

Workload/Caseload

Caseload refers to the number of students with IEPs, Individualized Family Service Plans (IFSPs), and 504 plans served by school-based SLPs and other professionals through direct and/or indirect service delivery options. In some school districts, caseloads may also include students who receive intervention and other services within general education designed to help prevent future difficulties with speech, language learning, and literacy. Caseloads can also be quantified in terms of the number of intervention sessions in a given time frame. The SLP's caseload includes all students eligible for special education and related services. Federal law does not mandate caseload size, but Mississippi's has established a current cap on the caseload for fulltime SLPs at 48.

Workload refers to all activities required and performed by school based SLPs. Workload includes the time spent providing face-to-face direct services to students as well as the time spent performing other activities necessary to support students' education programs, implement best practices for school speech-language services, and

ensure compliance with the Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004) and other mandates.

Traditionally, a school based SLP's workload has been conceptualized as almost exclusively synonymous with caseload; the reality is that caseload is only one part of the picture. When a student is added to a caseload for direct services, significant amounts of time within the school day, week, or month must be allocated for additional important and necessary workload activities.

The total number of workload activities required and performed by school based SLPs should be considered when establishing caseloads. ASHA recommends taking a workload analysis approach to setting caseloads to ensure that students receive the services they need to support their educational programs (ASHA, 2002).

Although Mississippi has established a caseload cap of 48 students, ASHA no longer recommends a specific caseload number for the following reasons:

- There is no research to support a specific caseload size.
- The needs of students receiving speech-language services vary greatly, and a specific caseload number does not consider this variation. For example, a caseload of 40 students with very mild communication disorders could be manageable, whereas a caseload of 40 students with severe disabilities is not likely to support the provision of a FAPE.

For these reasons, ASHA encourages assignment of SLPs based on workload rather than caseload. ASHA has designed a webpage to help SLP's identify their workload responsibilities in relation to their contractually obligated employment hours and focus on workload factors specific to their caseload. Visit the following website for more information regarding ASHA's Workload Calculator.

SLPs in schools are encouraged to be actively involved in seeking strategies to manage their caseload. (Power-deFur, 2001b) Strategies include:

- Prevention activities at the school site
- Collaboration with teachers and administrators
- Strategic scheduling and groups
- Participation in problem solving
- Effective utilization of paraprofessionals
- Regular meetings to review caseload size and severity to make adjustments as needed

- Review of student data to determine if children have met their goals and should be referred to the IEP team to determine if they are no longer eligible (Power-deFur, 2001a; American Speech-Language-Hearing Association, 2002).

Assistive Technology

An augmentative communication evaluation shall always be considered and documented as a part of a comprehensive language-speech assessment for students with minimal to limited functional communication skills.

All eligible students receiving SDI through an IEP must be considered for assistive technology. While parameters of "consideration" are not specifically defined in the law, it is considered best practice to address this issue through the incorporation of an IEP Committee/MET member with knowledge or experience in the field of assistive technology. An assistive technology device is defined as any item, piece of equipment, or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability. It does not include a medical device that is surgically implanted, or the replacement of such device.

An assistive technology service is any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. It also includes the evaluation of the needs of the child with a disability, including functional evaluation of the child in the child's customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices such as those associated with existing education or rehabilitation plans and programs; training and/or technical assistance for a child with a disability or his/her family, if appropriate. In addition, it includes training and/or technical assistance for professionals (including individuals providing education or rehabilitations services), employers, or other individuals who provide service to, employ, or are substantially involved in the major functions of that child.

Assistive technology is not only a communication device. It includes, but is not limited to:

- Access and environmental controls – devices that allow increased control of the environment or that open up access to things in the environment. This includes electronic controls like switches, special keyboards or mice, and remote

controls, as well as things that help people get around the community, like ramps, automatic door openers, and Braille signs.

- Aids to daily living – Special tools for daily activities, like brushing teeth, dressing, or eating. This includes adapted utensils, plates and cups, non-skid surfaces, and specially designed toilet seats and shower stalls.
- Assistive listening – Supports that help a student who is either deaf or has a hearing loss. This includes hearing aids, amplifiers, captions on TV, and typing telephones.
- Computer-based instruction – Software to help students with learning difficulties in reading, writing, math, and other subject areas.
- Mobility – Equipment that allows a student with a physical or visual disability to move independently and safely through the community. This includes wheelchairs, walkers, and adapted bicycles.
- Positioning – Supports that help a student with a physical disability remain in a good position for learning without becoming tired. This includes adjustable chairs, tables, standers, wedges, and straps.
- Visual aids – Supports that give a student with visual difficulties access to information. This includes large-print books, books on tape, magnifiers, talking computer software, and Braillers.
- Augmentative/alternative communication – supports that allow a child who cannot speak, or whose speech is not understood by others, to communicate. This includes, but is not limited to, picture boards, voice output communication devices, communication software, and computers.

Assessment of the student's communication abilities requires the inclusion of this communication modality in the assessment process. In order to effectively assess a student's abilities, adaptation of testing materials may be needed to allow the student to respond through non-standardized methods such as eye gaze, gesture or manual sign, symbol or text-based communication, a speech generating device, etc.

References

American Speech-Language-Hearing Association. (2012). ASHA Roles and Responsibilities of Speech-Language Pathologists (SLPs) in Schools DO's and DON'T's - Roles and Responsibilities of SLPs in Schools Working Group. Retrievents.pdf

American Speech-Language-Hearing Association. (2021). Demographic Profile of ASHA Members Providing Multilingual Services. Retrieved from asha.org/siteassets/surveys/demographic-profile-bilingual-spanish-service-members.pdf

American Speech-Language-Hearing Association. (n.d.). IDEA Early Intervening Services. Retrieved from: asha.org/advocacy/idea/04-law-early-services/

American Speech-Language-Hearing Association. (n.d.). Language in Brief. (Practice Portal). Retrieved from.asha.org/practice-portal/clinical-topics/spoken-language-disorders/language-in-brief/

American Speech-Language-Hearing Association. (2006). New roles in response to intervention: Creating success for schools and children. Retrieved from: asha.org/siteassets/uploadedfiles/slp/schools/rtiroledefinitions.pdf

American Speech-Language-Hearing Association. (1988). Prevention of communication disorders: Position statement. Retrieved from asha.org/policy/ps1988-00228/

American Speech-Language-Hearing Association. (1991). Prevention of communication disorders tutorial. *ASHA*, Vol. 33 (suppl. 6), 15-41.Battle, D.E. (2002). Retrieved from pubmed.ncbi.nlm.nih.gov/1684110/

American Speech-Language-Hearing Association. (2010). Roles and Responsibilities of Speech-Language Pathologists in Schools [Professional Issues Statement]. Retrieved from asha.org/policy/pi2010-00317/

American Speech-Language-Hearing Association. (2001). Roles and responsibilities of speech-language pathologists with respect to reading and writing in children and adolescents [Position Statement]. Retrieved from asha.org/policy/ps2001-00104/

American Speech-Language-Hearing Association. (n.d.). The Policy and Procedure Manual: Managing "by the Book". Retrieved from asha.org/slp/healthcare/policy_procedures

American Speech-Language-Hearing Association. (n.d.). Written Language Disorders. (Practice Portal). Retrieved from asha.org/Practice-Portal/Clinical-Topics/Written-Language-Disorders/

Bauman-Waengler, J. A. (2012). Articulatory and phonological impairments. New York, NY: Pearson.

Bernthal, J., Bankson, N. W., & Flipsen, P., Jr. (2013). Articulation and phonological disorders. New York, NY: Pearson.

Communication disorders in multicultural populations. (3rd ed.). Boston: Butterworth-Heinemann.

Croll, P. (2002). Social deprivation, school-level achievement and special education needs. *Educational Research,* Vol. 44*,* 43-53. Retrieved from eric.ed.gov/?id=EJ644455

Foster, W.A., & Miller, M. (2007). Development of the literacy achievement gap: A longitudinal study of kindergarten through third grade. *Language, Speech, and Hearing Services in School,* Vol. 38*,* 173-181. Retrieved from asha.org/doi/10.1044/0161-1461%282007/018%29

Garrity, A.W., & Oetting, J.B. (2010). Auxiliary BE production by African-American English speaking children with and without specific language impairment. *Journal of Speech, Language, and Hearing Research, 53,*1307-1320. Retrieved from pubs.asha.org/doi/abs/10.1044/1092-4388%282010/09-0016%29

Gillam, R. & Pearson, N (2004). *Test of Narrative Language*. Austin, TX: Pro-Ed.

Goldstein, B. (2000). *Cultural and linguistic diversity resource guide for speech-language pathologists*. Clifton Park, NY: Delmar, Cengage Learning.

Green, L. J. (2002). *African American English: A linguistic introduction*. Cambridge, England: Cambridge University Press.

Green, L. J. (2012). *Language and the African-American child*. New York, NY: Cambridge University Press.

Hart, B., & Risley, T.R. (1995). *Meaningful differences in the everyday experience of young American children*. Baltimore: Paul H. Brookes.

Haverman, R. & Wolfe, B. (1995). The determinants of children's attainments: A review of methods and findings. *Journal of Economic Literature,* Vol. 33, No. 4 (Dec., 1995), pp. 1829-1878. Retrieved from msuweb.montclair.edu/~lebelp/HavemanChildAttainJEL1995.pdf

Kamhi, A. G. & Catts, H. W. (2012). Language and Reading Disabilities, Third Edition. Boston, MA: Pearson.

Koutsoftas, A. D., Harmon, M. T., & Gray, S. (2009). The effect of tier 2 intervention for phonemic awareness in a response to intervention model in low-income preschool classrooms. *Language, Speech, and Hearing Services in Schools,* Vol. *40,* 116-130. Retrieved from pubs.asha.org/doi/10.1044/0161-1461%282008/07-0101%29

Laing, S. P., & Kamhi, A. (2003). Alternative assessment of language and literacy in culturally and linguistically diverse populations. *Language, Speech, and Hearing Services in Schools,* Vol. 34, 44-55. Retrieved from pubs.asha.org/doi/10.1044/0161-1461%282003/005%29

Langdon, H.W. (2007). *Assessment and intervention for communication disorders in culturally and linguistically diverse populations*. Clifton Park, NY: Thomson Delmar Learning.

Morris, L. R. (2010). *Behaviors and beliefs of African-American caregivers as related to their children's language-literacy development*. Dissertation. Louisiana State University, Baton Rouge. Retrieved from digitalcommons.lsu.edu/gradschool_dissertations/2950/

Oetting, J.B., & McDonald, J. (2002). Methods for characterizing participants' nonmainstream dialect use within studies of child language. *Journal of Speech Language Hearing Research,* Vol.45,505-518. Retrieved from eric.ed.gov/?id=EJ648815

Oetting, J.B. & Newkirk, B.L. (2011). Children's relative clause markers in two nonmainstream dialects of English. *Clinical Linguistics and Phonetics,* Vol. *25* (8), 725-740. Retrieved from eric.ed.gov/?id=EJ962441

Pena, E. D., & Bedore, L. M. (2011, November 01). It takes two: Improving assessment accuracy in bilingual children. *The ASHA Leader*. Retrieved from leader.pubs.asha.org/doi/10.1044/leader.FTR3.16132011.20

Plante, E., & Vance, R. (1994). Selection of preschool language tests: A data-based approach. *Language, Speech, and Hearing Services in Schools,* Vol. 25, 15-24. Retrieved from pubs.asha.org/doi/10.1044/0161-1461.2501.15

Qi CH, Kaiser AP, Milan S, Hancock T. Language performance of low-income African American and European American preschool children on the PPVT-III. *Language, Speech, Hearing Services in Schools*.(2006),Vol. 37, 5-16. Retrieve/002%29

Rice, M. L., Wexler, K. (2001). *Rice/Wexler Test of Early Grammatical Impairment*. San Antonio, TX: The Psychological Corporation.

RtI Action Network (2010). Ask the experts. Retrieved from: rtinetwork.org/connect/askexperts

Roseberry-McKibbin, C. (2007). Assessment and intervention guidelines for service delivery to low-SES children. *Perspectives on School-Based Issues,*

Vol. 8, 4-9. Retrieved from pubs.asha.org/doi/abs/10.1044/sbi8.3.4

Roseberry-McKibbin, C., & Hedge, M.N. (2011). *An advanced review of speech-language pathology: Preparation for PRAXIS and comprehensive examination (3rd ed.)*. Austin, TX: Pro-Ed.

Scarborough, H. S. (2001). Connecting early language and literacy to later reading (dis)abilities: Evidence, theory, and practice. In S. Neuman & D. Dickinson (Eds.), Handbook for research in early literacy (pp. 97–110). New York, NY: Guilford Press.

Semel, E., Wiig, E. H., & Secord, W. A. (2003). *Clinical Evaluation of Language Fundamentals-Fourth Edition*. San Antonio, TX: The Psychological Cooperation.

Seymour, H.N., Bland-Stewart, L., & Green, L. (1998). Difference versus deficit in child African American English. *Language, Speech, and Hearing Services in Schools,* Vol. 29, 96-108. Retrieved from pubs.asha.org/doi/10.1044/0161-1461.2902.96

Smith, J. R., Brooks-Gunn, J., & Klebanov, P.K. (1997). The consequences of living in poverty for young children's cognitive and verbal ability and early school achievement. In G.J. Duncan & J. Brooks-Gunn (Eds.). *Consequences of growing up poor* (pp. 132-189). New York, NY: Russell Sage.

Spaulding, T. J., Plante, E., & Farinella, K. A. (2006). Eligibility criteria for language impairment: Is the low end of normal always appropriate? *Language, Speech, and Hearing Services in Schools,* Vol 37, 61-72. Retrieved from pubs.asha.org/doi/10.1044/0161-1461%282006/007%29

Stockman, I. J. (1996). Phonological development and disorders in African-American children. In A. Kamhi, K. Pollack, & J. Harris (Eds.). *Communication development and disorders in African American children* (pp. 117-153). Baltimore, MD: Paul H. Brooks.

Ukrainetz, T. A. (2006). The implications of RtI and EBP for SLPs: Commentary on L.M. Justice. *Language, Speech, and Hearing Services in Schools,* Vol. 37, 298-303. Retrieved from pubs.asha.org/doi/10.1044/0161-1461%282006/034%29

Washington, J.A., & Craig, H.K. (1999). Performances of at-risk, African-American preschoolers on the Peabody Picture Vocabulary Tests-III. *Language, Speech, and Hearing Services in Schools*, Vol. 30, 75-82. Retrieve3001.75

Wiig, E. H., & Secord, W. (1989). *Test of Language Competence-Expanded Edition*. San Antonio, TX: The Psychological Corporation.

Wolfram, W., & Schilling-Estes, N. (2006). *American English: Dialects and variation (2nd ed.)*. Malden, MA: Blackwell Publishing.

Wyatt, T. (1996). *Acquisition of the African-American English copula*. In A.G. Kamhi, K. E. Pollack, & J. L. Harris (Eds.). *Communication development and disorders in African American children: Research, assessment and intervention* (pp. 73- 94). Baltimore, MD: Brookes Publishing.

Zimmerman, I.L, Steiner, V.G., & Pond, R.E. (2002). *Preschool Language Scale-Fourth Edition*. San Antonio, TX: The Psychological Cooperation.

Contributing Participants (these are individual's works that were paraphrased within the document)

Brandi L. Newkirk-Turner, PhD, CCC-SLP, Jackson State University; Lekeitha R. Morris, PhD, CCC-SLP, Delta State University—information paraphrased from *Mississippi Speech-Language Pathologist Handbook (2013) "Practice Guidelines for the Assessment of Culturally and Linguistically Diverse School-Aged Children"*

Rebecca Lowe, AuD, CCC-A, University of Mississippi, James E. Peck, PhD—information paraphrased from *Mississippi Speech-Language Pathologist Handbook (2013) "Practice Guidelines for Hearing Screening and Evaluation"*

Rachel K. Powell, PhD, CCC-SLP, BCS-CL, Brookhaven School District —Information paraphrased from *Mississippi Speech-Language Pathologist Handbook (2013) "Service Delivery Options and Response to Intervention"*

Documents used to develop various sections of this SLP Handbook

North Carolina Department of Public Instruction, Exceptional Children Division, *North Carolina Guidelines for Speech-Language Pathology Services in Schools (9-19-2006)*

Virginia Department of Education, Office of Special Education and Student Services *Speech-Language Pathology Services in Schools: Guidelines for Best Practice (Revised 2018)*.

Acronyms

AAC	Augmentative and Alternative Communication
ASHA	American Speech-Language-Hearing Association
AU	Autism
BIP	Behavior Intervention Plan
CCC	Certificate of Clinical Competence
DB	Deaf-Blind
DD	Developmentally Delayed
EBP	Evidenced-Based Practice
ESY	Extended School Year
FAPE	Free and Appropriate Public Education
FBA	Functional Behavior Assessment
HI	Hearing Impaired
ID	Intellectual Disability
IEP	Individualized Education Program
IDEA 2004	Individuals with Disabilities Education Act Amendments of 2004
LEA	Local Education Agency
LRE	Least Restrictive Environment
L/S	Language-Speech
MCCRS	Mississippi College- and Career-Readiness Standards
MD	Multiple Disabilities
MDE	Mississippi Department of Education
MET	Multidisciplinary Evaluation Team
MSIS	Mississippi Student Identification System
NOM	Notice of Committee Meeting
OI	Orthopedic Impairment
OHI	Other Health Impairment
OT	Occupational Therapy
PLAAFP	Present Levels of Academic Achievement and Functional Performance
PT	Physical Therapy
PWN	Prior Written Notice

RtI	Response to Intervention
SA	Speech Associate
SCD	Significant Cognitive Disability
SDI	Specially Designed Instruction
SLD	Specific Learning Disability
SLP	Speech-Language Pathologist
TBI	Traumatic Brain Injury
MTSS	Multi-Tiered System of Supports
VI	Visually Impaired