

Schools for All Children

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LOS ANGELES UNIFIED SCHOOL DISTRICT

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The Los Angeles Unified School District Position Paper *Speech-Language Pathology Program From Prevention to Service Delivery*

BACKGROUND

Speech and Language services are provided in public schools as a **related service** defined by the federal government in the Individuals with Disabilities Education Act (IDEA). Related services are described as “such developmental, corrective and other supportive services as may be required to assist a child with a disability to benefit from special education...” Speech and language services specifically address communication disorders such as stuttering, articulation, language or voice impairment that adversely affect a child’s educational performance.

Speech and language services are defined as:

- i. Identification of children with speech or language impairments;
- ii. Diagnosis and appraisal of specific speech and language impairments;
- iii. Referral for medical or other professional attention necessary for the habilitation of speech or language impairments;
- iv. Provision of speech and language services for the habilitation or prevention of communicative impairments; and
- v. Counseling and guidance of parents, children, and teachers regarding speech and language impairments. (34 C.F.R. 300.24 [14].

Speech and language services can also be identified as **special education** service if they are considered so under state guidelines (34 C.F.R. 300.26[1] [2] [I]). The California Education Code, Section 56333, states “A pupil shall be assessed as having a language or speech disorder which makes him or her eligible for special education and related services when he or she demonstrates difficulty understanding or using spoken language to such an extent that it adversely affects his or her educational performance and cannot be corrected without special education and related services.”

The American Speech and Hearing Association (ASHA 2000) has issued guidelines for the roles and responsibilities of school-based speech and language providers as well as *Preferred Practices for the Profession of Speech-Language Pathology* (1997). Recommendations for the nature, type, or location of service delivery are “based on the need to provide a free appropriate

public education for each student in the least restrictive environment and consistent with the student's individual needs..." In addition, ASHA's position on inclusive practices is consistent with a report from the U.S. Department of Education (CEC Today, 1996) when it states that "an array of speech ... (and language)...services should be available in educational settings to support children and youths with communication disorders."

PURPOSE

The purpose of this position paper is to define the roles, and delineate the responsibilities, of the speech-language therapist within the Los Angeles Unified School District. Specifically, service delivery models for speech and language will be described and aligned with a three-tiered model of prevention and intervention already adopted by the District in three Position Papers (2, 3, and 4) published during the summer of 2004. Service delivery models will emphasize an integration of speech and language services with classroom goals and curriculum. This three-tiered approach is designed to maximize the progress in curricular goals for students with speech and language disabilities. In addition, this paper will describe the development of educationally relevant goals and expectations for service completion.

This position paper addresses the following three aspects of service delivery:

Section I: Prevention-Early Intervention

This section addresses prevention issues in a three-tiered approach which is implemented in the general education classroom. The role of the speech-language therapist in the prevention phase is to serve as a consultant or resource to the school staff regarding normal communication development prior to referral for special education (speech and language) assessment.

Section II: Intervention

This section addresses intervention (after the student is enrolled in special education) through an array of service delivery models, also using the three-tiered approach. The role of the speech-language therapist during the intervention phase is varied and dependent on the needs of the individual student.

Section III: Service Completion Guidelines

This section describes various considerations which should be made by an IEP team prior to dismissal from speech and language services. Suggestions are made specifically with regard to articulation/phonology, fluency, language, and voice disorders.

ELEMENTS of SERVICE

The Speech and Language program provides services to all students in the Los Angeles Unified School District between the ages 3-22 years. The program is staffed by over 300 credentialed and/or licensed speech-language therapists. Services may include direct and indirect therapy on an individual basis or in small groups; collaborative and consultative services with the classroom teacher and other school staff; after-school programs; augmentative alternative communication support; and parent training.

POSITION

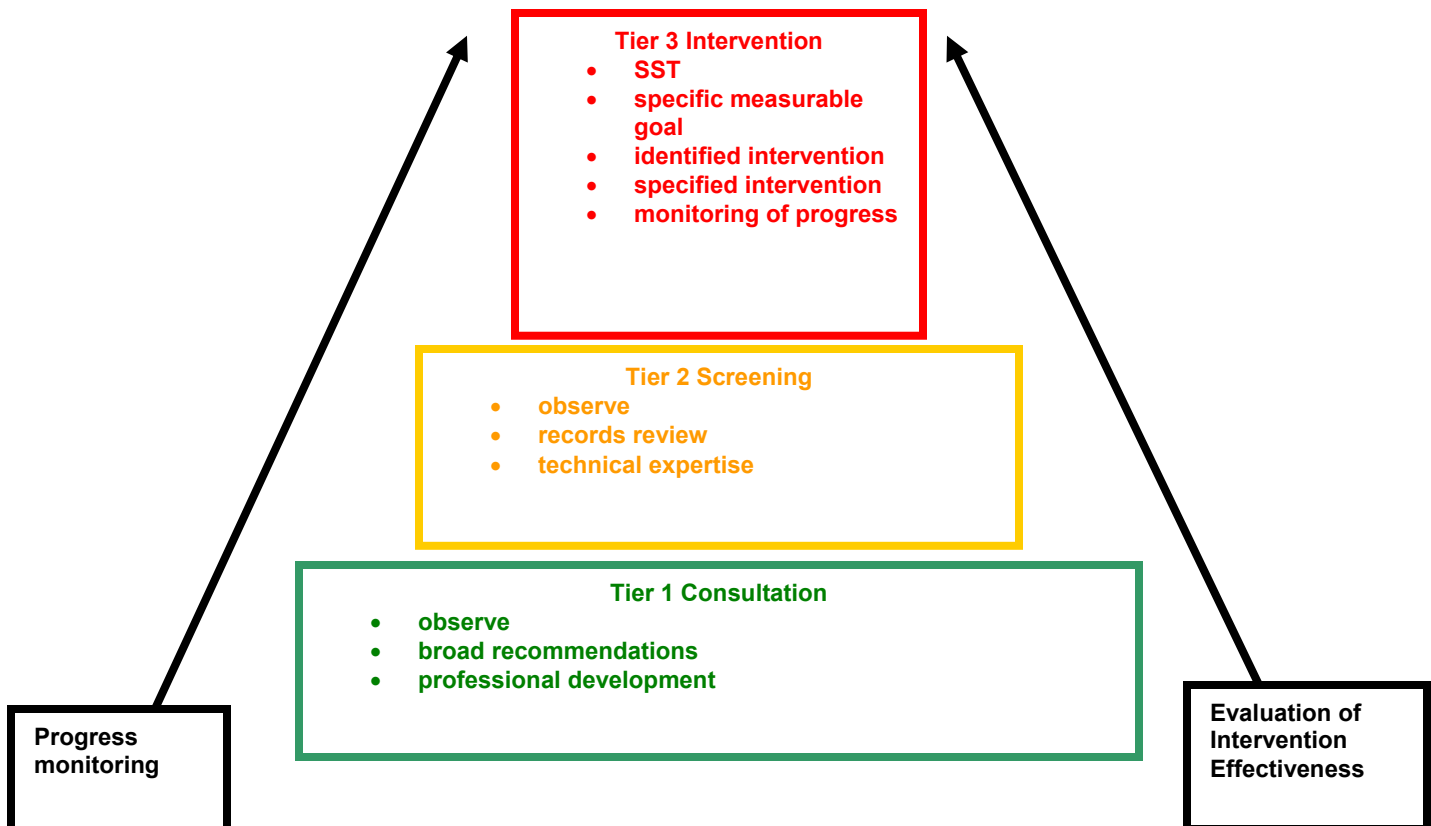
The District advocates:

- a systematic approach to prevention and early intervention for students with suspected speech and language disorders;
- a continuum of intervention options and service delivery models for students with identified speech and language disorders;
- educationally relevant outcomes for speech and language services which contribute to student's academic success.

SECTION I: PREVENTION AND PRE-REFERRAL (EARLY INTERVENING) PRACTICES IN GENERAL EDUCATION

The school-based speech-language therapist has an important role to play on the general education school team in addressing prevention and early intervention when a student appears to be “at risk” for normal speech and language development. Prevention requires increased efforts to avoid, or minimize, the onset or development of communication disorders and their causes (ASHA, 1997). For the school-based provider this may include consultation regarding the normal acquisition of speech and language skills. It also means working with general education school staff to carefully differentiate communication difference from communication disorder for students who have limited English proficiency (Adler, 1991; ASHA, 2000).

A Three-Tiered Model of Prevention and Pre-Referral (Early Intervening) Practices in General Education



Prevention Tier 1: Consultation

During Tier 1, the speech-language therapist serves as a consultant to the teacher, school staff and parent regarding the normal acquisition of speech and language. This consultation may include the distribution of literature on normative development (see *Appendix A*) and/or in-service presentations to school personnel and parent groups. The emphasis at Tier 1 is on classroom accommodations. When successful, it prevents the need for special education intervention.

It is the responsibility of the classroom teacher and school staff to review and incorporate the normative information provided by the speech-language therapist when considerations are made about a student's communicative development. In addition, they should review and utilize to the fullest extent possible the information provided in *Appendix B* related to classroom strategies that will enhance communication for all students.

If it is determined that the student continues to be "at risk" for a speech and language disability following implementation of Tier 1, school site attention should move to Tier 2.

Prevention Tier 2: Screening

During Tier 2, it is the responsibility of the speech-language therapist to screen a student for possible speech and language delays. Screenings are conducted in a natural environment conducive to eliciting a representative sample of the student's speech and language. Screenings must not involve pull-out or any activity which removes the student from his/her regular school activities. Screenings may include observation of a student in a peer group if the observation does not in any way identify or single-out the student as the one who is being observed. Screenings may be accomplished by using published or informal screening measures, non-standardized checklists, questionnaires, interviews, or observations which are interpreted by the speech-language therapist (ASHA 2000).

Typically, the speech-language therapist functions as a school team participant to provide one or more of the following screening activities:

- Observes the student in the classroom and/or other environments
- Consults with parents, teachers, and other school staff regarding their concerns about the student
- Reviews teacher data regarding the outcomes of classroom accommodations from Tier 1
- Provides follow-up screening, as appropriate

Several outcomes may follow the screening. The speech-language therapist may:

- Provide information to the referral source to support the determination that the student's communication skills are within normal limits
- Refer the student to the school Student Study Team (SST)
- Provide recommendations for targeted interventions or accommodations to be implemented and documented by the classroom teacher and/or parents and provide follow-up consultation and monitoring as appropriate
- Recommend a speech and language evaluation

Prevention Tier 3: Classroom Intervention

During Tier 3, the speech-language therapist provides follow-up consultation and monitoring in order to focus on specific abilities required for the development of effective communication skills. Speech and language service moves into a Tier 3 phase if the screening results in the recommendation for targeted intervention and accommodations to be implemented by the classroom teacher and/or parents.

It is the responsibility of the classroom teacher to implement and document progress for the recommended targeted interventions. It is the responsibility of the speech-language therapist to consult with the classroom teacher and/or parent on a regular basis to monitor the recommended supports and accommodations and to adjust those recommendations as needed. Tier 3 continues as long as the student continues to make progress in the development of the targeted skills.

If a student continues to struggle with speech and language skills after targeted interventions and accommodations are in place and documented for a reasonable length of time (as determined by the SST), a referral for a speech and language assessment may be initiated. The assessment will include all progress monitoring data as a basis for establishing the speech and language disability.

Special Considerations

Each school Student Study Team should be aware of the following special factors when referrals for a speech and language assessment are considered:

English Language Learners.

Current Federal and State special education regulations require school districts, as part of the special education determination, to assure that the suspected disability is not due primarily to second language acquisition. Differences in oral language patterns may occur when spoken English is acquired as a second language. These variations in the production of standard American English are not perceived as disorders or deviations in speech. **A student who is acquiring English as a second language would be eligible for speech-language therapy services only if a communication disorder or deviation is found to be present in the student's primary language.**

This has special importance for the appropriate identification of speech and language disorder for second language learners. Prior to referral for speech and language assessment, the school site should ensure that:

- The student's primary language skills have been evaluated;
- The student has received an appropriate instructional placement as an English language learner;
- The school psychologist has ruled out second language learning as a primary contributing factor to poor school performance.

Central Auditory Processing Disorders (CAPD)

Central Auditory Processing Disorders (CAPD) or Auditory Processing Disorders (APD) are terms frequently used interchangeably (Bellis, 2003). These disorders occur when hearing is within normal limits but there is a disruption in the way auditory information is processed. CAPD/APD is not an eligibility as defined by the Individuals with Disabilities Education Act (IDEA); rather it is recognized as a characteristic of some of the eligibilities which are found within IDEA (for example, autism and specific learning disabilities). As such, referrals should not be made to the Speech and Language Program specifically for CAPD/APD. Prior to referral for a suspected CAPD/APD, the school site should refer to the tiered approach to intervention found in *Appendix C: Central Auditory Processing Disorders*.

SECTION II: SPEECH AND LANGUAGE INTERVENTION MODELS WITHIN SPECIAL EDUCATION

Once a student is found eligible for speech and language services based on a complete evaluation by a speech-language therapist, intervention may target the areas of articulation/phonology, language, fluency, and/or voice disorders. It is the position of the District that speech and language intervention is dynamic and should be implemented through an array of service delivery models which change as the needs of the student change. No one service delivery model is necessarily used exclusively during intervention (ASHA 2000). The speech-language therapist uses his/her professional judgment in determining the nature and type of service a student needs at any point in time.

The District supports inclusive practices for the delivery of speech and language services. “It is no longer appropriate for speech-language therapists to provide their services independently. The classroom teacher is the expert on curriculum. The speech-language therapist is the expert on language acquisition. Putting these two together will facilitate the most efficacious treatment for the student.” (Campbell, 1999). Research models that incorporate collaboration were the most effective in teaching curricular vocabulary for students enrolled in speech and language services (Thorenburg, Calvert, Sturm, Paramboulkas, & Paul, 2000). In other research, “collaborative classroom intervention yielded significantly higher gains in children’s articulation goals than did the traditional pull-out model even though the classroom-based approach involved only half as much practice” (Waldowski, 2002). Collaboration between speech-language therapists and classroom teachers has been found to increase the likelihood of student success (Prelock, 1997; Montgomery & Rooney Moreau, 2003).

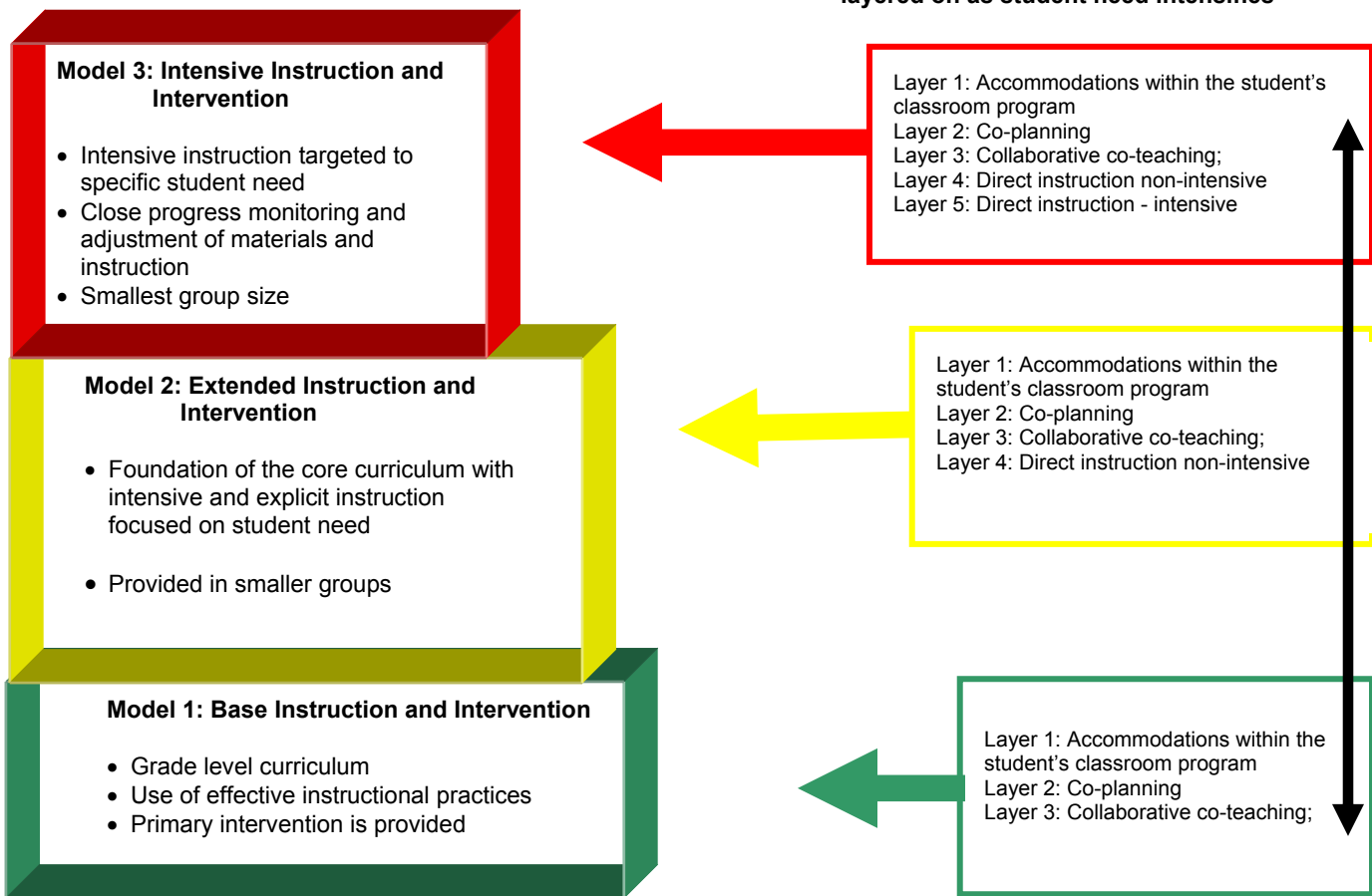
Literacy development is a high priority for instruction in the Los Angeles Unified School District. Research demonstrates that language is continuous across both oral and written modalities (Achilles, Yates, & Freese, 1991; Adams, 1990; Canaday & Krantz, 1996; Horowitz & Samuels, 1987; Olson, Torrance, & Hilyard, 1985). Speech-language therapists play a significant role in the development of literacy (ASHA, 2001; Roth, 2001). Explicit awareness of the speech sound system (phonological awareness) is related to early reading development (Blachman, 1994; Catts, 1993; Swank & Catts, 1994; Torgeson & Wagner, 1994; Wagner & Torgeson, 1987). However, struggling readers rarely have deficits in phonology alone. They often have a significant history of language problems in the areas of vocabulary, grammar, and word finding (ASHA, 2001; Catts, Fey, Zhang & Thomblin, 1999; Lombardino, Ricco, Hynd &

Pinhiero, 1997). Oral language skills establish the bedrock for both reading decoding and comprehension (ASHA, 2001; Catts & Kahmi, 1999; Paul, 2002).

It is recognized that students with speech and oral language disabilities may be at risk for failure with regard to the communication skills required by the language arts curriculum, specifically reading, writing, speaking and listening (Butler, 1996). Goals for speech and language services should be developed in collaboration with the classroom teacher and should be developed to target the communication required for the performance of the same standards targeted by the teacher. Goal responsibilities should also be shared jointly between the classroom teacher and the speech-language therapist, reflecting the three-tiered model of intervention.

A Dynamic Continuum of Instructional Delivery Models For Students with Speech and Language Disabilities

Layered Special Education Services
**Special education services are gradually
layered on as student need intensifies**



Model 1: Base Instruction

In Model 1, the role of the speech-language therapist is to serve primarily as a consultant to the classroom teacher. Service is primarily indirect. Consultation may include the following activities:

- gathering information through observations, a review of records and materials, interviews, and assessments
- evaluation of the type and extent of assistance required by the student
- providing monitoring or follow-up services
- making recommendations to teachers, school staff, or parents for classroom accommodations or modifications
- making recommendations to establish carryover of newly established speech and language skills, including activities which will lead to dismissal from speech and language services at the end of the transition phase

In some cases co-teaching may be appropriate to model intervention and carryover strategies. Co-planning between the therapist and teacher is required to maximize student success in this model.

For students receiving instruction in the alternate curriculum, this model may include a trans-disciplinary related services team approach to classroom-based services that support the functional areas of: communication, self-care/independent living, motor skills/mobility, functional academics, vocational, social/emotional and recreation and leisure. School-wide professional development support inclusive of parents, teachers, para-professionals, and administrators is part of this service delivery model.

Model 2: Extended Instruction

In Model 2, speech and language intervention is typically delivered in a classroom with co-planning and collaborative co-teaching between the classroom teacher and the speech-language therapist. Support for this model is required from school-site personnel, including the building principal, to allow for common planning time. On the secondary level services may be delivered through Integrated Learning Centers or an elective class called *Developing Reading Skills in Content Areas*.

The role of the speech-language therapist is to:

- work with the classroom teacher (and literacy coach) to develop shared goals which link speech and language services to the standards-based curriculum
- use tasks and materials from the classroom to maximize carryover of targeted oral communication skills
- modify the presentation of the materials and/or scaffold a student's responses to assure success during listening and speaking activities
- pre-teach lessons with a focus on the communication needs of specific students in the classroom
- interact with other related services personnel to maximize the student's potential for skill development across all areas of need

As a student gains mastery over the targeted skill and carryover skills have been established, extended instruction should be faded. In some cases services will change to a Model 1 level as the student transitions to dismissal. In other cases, as new speech and language skills are targeted, a return to Model 3 may be appropriate until mastery for that skill begins and the cycle to other service options is repeated.

Model 3: Intensive Intervention (Pull-out)

In Model 3, intensive intervention is a form of service which is typically delivered in a “pull-out” model involving individual or small-group sessions. Pull-out service is the most restrictive form of service delivery because it removes the student from the physical instructional setting and/or from the instructional focus of the classroom teacher.

Intensive intervention (pullout) may be indicated when a student begins intervention directed toward specific speech and language skills. As a student gains mastery over the targeted skill, pullout should be faded and replaced with other service options (Model 1 or Model 2) to maximize skill carryover and integration with the communications skills required in his/her classroom. As new speech and language skills are targeted, a return to a pullout model may be needed until mastery of that skill begins and the cycle to other service options is repeated.

SECTION III: SPEECH AND LANGUAGE SERVICE COMPLETION GUIDELINES

Good practices require that expected outcomes and service completion criteria are discussed with the IEP team upon a student’s enrollment in speech and language services and when any change in service is initiated (ASHA, 2000).

General Considerations

There are several factors the IEP teams should consider when making decisions regarding speech and language service completion:

1. The student’s speech and language disability no longer negatively affects his/her educational performance in the regular education or special education program.
2. The student no longer meets the qualification criteria for a speech and language disorder under which he or she is receiving therapy as a primary special education service OR the student no longer requires therapy as a related/DIS service in order to benefit from his/her special education program.
3. The student consistently demonstrates behaviors that inhibit progress in speech therapy such as a lack of cooperation, motivation, or chronic absenteeism. In these circumstances the IEP Team should consider the initial eligibility decision since these behaviors may reflect social maladjustment, environmental, cultural, or economic factors rather than an actual disability. The IEP team may also explore alternative services or strategies to remedy interfering behaviors or conditions.

4. The student's needs will be better served by an alternative program and/or service, as determined by the IEP team.
5. He/she graduates from high school.
6. He/she reaches the age of 22 years.

Articulation Guidelines

Speech and language services for articulation/phonology disorders are completed when it is determined that any one or more of the following conditions exist:

1. The student has achieved at least 85% accuracy and acceptable use of articulation skill(s) targeted on the IEP as demonstrated in a conversational sample and successful transition from a Model 2 to a Model 1 level of intervention.
2. The student uses compensatory communication skills appropriately, effectively, and independently.
3. Articulation skills are determined to be commensurate with chronological and/or developmental age.
4. Other associated and/or disabling conditions prevent the student from benefiting from further therapy. Examples are dental abnormalities, velopharyngeal insufficiency, or inadequate physiological support for speech.

Fluency Guidelines

Speech and language services for fluency disorders are completed when it is determined that any one or more of the following conditions exist:

1. The student has achieved at least 85% accuracy and acceptable use of fluency skill(s) targeted on the IEP as demonstrated in a conversational sample and successful transition from a Model 2 to a Model 1 level of intervention.
2. The student uses compensatory communication skills appropriately, effectively, and independently.
3. Student perceives him/herself to be a competent communicator.
4. Other associated and/or handicapping conditions, such as neurological impairments, prevent the student from benefiting from further therapy.

Language Guidelines

Speech and language services for language disorders are completed when it is determined that any one or more of the following conditions exist:

1. The student has achieved at least 85% accuracy and acceptable use of language skill(s) targeted on the IEP as demonstrated in a conversational sample and successful transition from a Model 2 to a Model 1 level of intervention.
2. The student demonstrates language skills within the range expected for his/her developmental level.
3. The student uses augmentative communication aids appropriately, effectively, and independently.
4. The student uses compensatory communication skills appropriately, effectively, and independently.
5. The student's communication skills are most effectively reinforced and monitored in a classroom setting.

Voice Guidelines

Speech and language services for voice disorders are completed when it is determined that any one or more of the following conditions exist:

1. The student has achieved at least 85% accuracy and acceptable use of voice skill(s) targeted on the IEP as demonstrated in a conversational sample and successful transition from a Model 2 to a Model 1 level of intervention.
2. The student uses compensatory communication skills appropriately, effectively, and independently.
3. The student's voice is within normal limits as related to age, gender, and culture.
4. Other associated and/or disabling conditions prevent the student from benefiting from further therapy. Examples are dental abnormalities, velopharyngeal insufficiency, or inadequate physiological support for speech.

Appendix A

Developmental Milestones for Speech and Language

Adapted from Guidelines- Roles and Responsibilities of the School-Based Speech-Language Pathologist, American Speech-Language Hearing Association (2000)

Age	Language and Speech Behaviors
1 year	recognizes his or her name understands simple instructions initiates familiar words, gestures, and sounds uses “mama,” “dada,” and other common nouns
1 ½ years	uses 10 to 20 words, including names recognizes pictures of familiar persons and objects combines two words, such as “all gone” uses words to make wants known, such as “more,” “up” points and gestures to call attention to an event and to show wants follows simple commands imitates simple actions hums, may sing simple tunes distinguishes print from nonprint
2 years	understands simple questions and commands Identifies body parts carries on conversation with self and dolls asks “what” and “where” has sentence length of two to three words refers to self by name names pictures uses two-word negative phrases, such as “no want,” forms some plurals by adding “s” has about a 300-word vocabulary asks for food and drink stays with one activity for 6 to 7 minutes knows how to interact with books (right side up, page turning from left to right)
2 ½ years	has about a 450-word vocabulary gives first name uses past tense and plurals; combines some nouns and verbs understands simple time concepts, such as “last night,” “tomorrow” refers to self as “me” rather than name tries to get adult attention with “watch me” likes to hear same story repeated uses “no” or “not” in speech answers “where” questions

	<ul style="list-style-type: none"> uses short sentences, such as “me do it” holds up fingers to tell age talks to other children and adults plays with sounds of language
3 years	<ul style="list-style-type: none"> matches primary colors; names one color knows night and day begins to understand prepositional phrases as “put the block under the chair” practices by talking to self knows last name, sex, street name, and several nursery rhymes tells a story or relays an idea has sentence length of three to four words has vocabulary of nearly 1,000 words consistently uses m, n, ng, p, f, h, and w draws circle and vertical line sings songs stays with one activity for 8 to 9 minutes asks “what” questions
4 years	<ul style="list-style-type: none"> points to red, blue, yellow and green Identifies crosses, triangles, circles, and squares knows “next month,” next year,” and “noon” has sentence length of four to five words asks “who” and “why” begins to use complex sentences correctly uses m, n, ng, p, f, h, w, y, k, b, d, and g stays with activity for 11 to 12 minutes plays with language (e.g., word substitutions)
5 years	<ul style="list-style-type: none"> defines objects by their use and tells what they are made of knows address identifies penny, nickel, and dime has sentence length of five to six words has vocabulary of about 2,000 words uses speech sounds correctly, with the possible exceptions being y, th, j, s/z, zh, and r knows common opposites understands “same” and “different” counts 10 objects uses future, present, and past tenses stays with one activity for 12 to 13 minutes questions for information identifies left and right hand on self uses all types of sentences shows interest and appreciation for print

6-7 years	<ul style="list-style-type: none"> identifies most sounds phonetically forms most sound-letter associations segments sounds into smallest grammatical units begins to use semantic and syntactic cues in writing and reading begins to write simple sentences with vocabulary and spelling appropriate for age; uses these sentences in brief reports and creative short stories understands time and space concepts, such as before/after, second/third comprehends mathematical concepts, such as “few,” many,” “all,” and “except”
8, 9, 10, 11 years	<ul style="list-style-type: none"> by second grade, accurately follows oral directions for action and thereby acquires new knowledge substitutes words in oral reading, sentence recall, and repetition; copying and writing dictation are minimal comprehends reading materials required for various subjects, including story problems and simple sentences by fourth grade, easily classifies words and identifies relationships, such as “cause and effect”; defines words (sentence context); introduces self appropriately; asks for assistance exchanges small talk with friends initiates telephone calls and takes messages gives directions for games; summarizes a television show or conversation begins to write effectively for a variety of purposes understands verbal humor
11, 12, 13, 14 years	<ul style="list-style-type: none"> displays social and interpersonal communication appropriate for age forms appropriate peers relationships begins to define words at an adult level and talks about complex processes from an abstract point of view; uses figurative language; organizes materials demonstrates good study skills follows lectures and outlines content through note taking paraphrases and asks questions appropriate to content
Adolescence and young adult	<ul style="list-style-type: none"> interprets emotions, attitudes, and intentions communicated by others’ facial expressions and body language takes role of other person effectively is aware of social space zones displays appropriate reactions to expressions of love, affection, and approval compares, contrast, interprets, and analyzes new and abstract information communicates effectively and develops competence in oral and written modalities

Source: Ohio Statewide Language Task Force. (1990). Developmental milestones: Language behaviors. In *Ohio Handbook for the Identification, Evaluation and Placement of Children with Language Problems* (1991). Columbus: Ohio Department of Education, Reprinted by permission.

Editor's Note. These milestones are variable due to individual differences and variance in the amount of exposure to oral and written communication.

Appendix B
**Suggestions for Classroom Adaptations to
 Enhance Listening and Speaking Skills**
 Adapted from *Classroom Performance Assessment*, Wiig & Secord (2003).

<i>Listening Comprehension may be improved by...</i>
<input type="checkbox"/> Reducing noise levels in/outside classroom
<input type="checkbox"/> Cues that focus and direct attention to listening
<input type="checkbox"/> Instruction that can be seen from all points in the classroom
<input type="checkbox"/> Preferential seating to improve the student's opportunities for listening, learning, and communicating
<input type="checkbox"/> Reducing the rate of instructional speaking to allow time for student to process auditory information
<input type="checkbox"/> Reducing the complexity of instructional language
<input type="checkbox"/> Increasing the pitch and/or volume in instructional language to emphasize key words or phrases
<input type="checkbox"/> Varying the volume of the instructional voice based on the level of background noise in the classroom
Providing visual supports for auditory activities: <ul style="list-style-type: none"> <input type="checkbox"/> Pictures <input type="checkbox"/> Flow diagrams <input type="checkbox"/> Graphs <input type="checkbox"/> Outlines of lessons or texts <input type="checkbox"/> Word webs, concept or mind maps <input type="checkbox"/> List of procedural steps
<input type="checkbox"/> Pre-teaching the meaning of key-words and concepts before introducing a lesson, topic, or text
Providing cues to: <ul style="list-style-type: none"> <input type="checkbox"/> follow two- or three-step directions accurately <input type="checkbox"/> listen for and remember specific information (names, facts and details) <input type="checkbox"/> listen for and understand main ideas and relationships <input type="checkbox"/> listen for rhythm and rhyme and recognize patterns <input type="checkbox"/> recognize intonation patterns and know the effects on meaning
Guided questioning and scaffolding to: <ul style="list-style-type: none"> <input type="checkbox"/> listen for and evaluate supporting material and conclusions <input type="checkbox"/> summarize main facts accurately <input type="checkbox"/> sequence major events or procedural steps accurately <input type="checkbox"/> detect and understand humor and joking <input type="checkbox"/> recognize and evaluate the purpose of communications

Oral and Written Communication Skills may be improved by...

Spoken Cues:

- Phonetic and phonemic cues to help student retrieve a specific word during speaking or writing
- Letter-sound and alphabet cues to help correct naming or oral reading errors
- Contextual cues to help find a word for answering questions, speaking or writing
- Repetition of student's (incorrect) communication attempt with correct sound or language model
- Expansion of student's correct communication attempt to include a more complex language target

Written models, outlines, and scripts for:

- immediate recall of facts and details
- developing ability to inference
- developing hypotheses
- conveying intent to others for the purpose of social interaction
- conversations and sharing information by telephone or e-mail
- different types of discourse
- classroom conversation and discussion
- negotiating terms for games, play or group projects
- making appointments with others
- dealing with reprimands and punishment

Word webs, concepts and mind maps to:

- relate old and new information for the student
- build schema by capitalizing on the student's past experiences or familiar, popular conceptions
- generate ideas for speaking and writing
- plan and organize elements of story grammar for narrative production
- plan and organize key issues for different discourse types

Classroom routines which:

- are predictable and explicit
- are modeled and demonstrated
- are structured to prepare student for transitions between routines
- encourage students to communicate and interact
- allow for delays in processing and/or oral expression
- allow for augmentative or alternative modes for oral expression

Appendix C

Central Auditory Processing Disorders (CAPD)

This document describes District procedures regarding referrals for Central Auditory Processing Disorders. It provides school staff and IEP teams with the information needed to formulate appropriate recommendations for referrals, assessments and intervention.

When a Central Auditory Processing Disorder is suspected as a possible factor contributing to a student's academic difficulties:

A. School-site staff should understand the following characteristics of CAPD:

1. Central auditory processing (and auditory processing) can be defined as “what we do with what we hear” (Katz, 1992). Central Auditory Processing Disorders (and auditory processing disorders) occur when hearing is within normal limits but there is a disruption in the way auditory information is processed.
2. The terms “auditory processing” and “central auditory processing” are frequently used interchangeably (Bellis, 2003).
3. CAPD is not an eligibility as defined by the Individuals with Disabilities Education Act (IDEA).
4. CAPD is recognized as a characteristic of some of the eligibilities defined by IDEA, for example autism and specific learning disabilities.
5. An in-depth assessment for CAPD requires a multi-disciplinary team approach, including an audiology evaluation (ASHA, 1996).
6. Auditory processing disorders can be differentiated by six CAPD sub-types which have different behavioral and intervention profiles:
 - a. Auditory Decoding
 - b. Integration
 - c. Output Organization
 - d. Prosodic
 - e. Associative Deficit
 - f. Tolerance-Fading Memory

B. Through the use of a Student Study Team (SST), school-site staff should:

1. Evaluate student records to rule out hearing loss as a factor.
2. Evaluate the listening environment in the classroom and make modifications to reduce unnecessary noise sources to improve listening conditions. (see Appendix B for additional suggestions to improve listening skills).
3. Refer to LAUSD Audiology Resource Unit (ARU) for consultative support, if needed.
4. Complete an observational checklist (provided by the ARU) to screen auditory processing characteristics and develop appropriate interventions. Monitor and document performance results.
5. Maintain interventions, if successful.

6. If a general education student does not respond to the interventions and academic progress continues to be impeded, a referral for special education assessment may be needed.

If a special education student does not respond to the interventions and academic progress continues to be impeded, a referral may be needed to focus an assessment specifically on auditory processing characteristics.

- C. If the student (general or special education) does not respond to the interventions and academic progress continues to be impeded, assessment referrals for auditory processing should be made only after the above steps (B 1-4) have been completed. Documentation supporting these efforts is sent with the referral as follows:
 1. General education students are referred to the school psychologist for a special education assessment with a specific emphasis on auditory processing.

When the IEP team meeting is held to review the assessment, if the student is found eligible for special education and auditory processing difficulties are identified, the team should develop interventions using a three-tiered approach to address the auditory processing issues.

2. Special education students who have an auditory processing disorder which has a) been previously identified and documented, and/or b) is part of his/her special education eligibility are referred directly to the ARU only by the school psychologist or by the school speech-language pathologist for an in-depth auditory processing evaluation

- D. The Assessment Plan for an in-depth auditory processing evaluation should be completed as follows:

1. Check Section 1. Health and Development, Including Vision and Hearing.
2. Check Alternative Assessment. Enter “ In-depth Auditory Processing.”
3. Check Audiologist

Note: Statements referring to specific equipment (i.e., FM systems) or methodologies (i.e., Fast ForWord; Lindamood Bell) are not appropriate entries on an assessment plan.

- E. After the in-depth auditory processing evaluation has taken place, an IEP will be convened to discuss assessment results and to determine the appropriate follow-up procedures. Recommendations for interventions will be based on the auditory processing profile identified by the assessment.

RELATED RESOURCES:

American Speech-Language-Hearing Association (1996, July), Central auditory processing: Current status of research and implications for clinical practice. *American Journal of Audiology*, 5,2.

Bellis, T.J. (2003), Assessment and management of central auditory processing disorders in the educational setting, Clifton Park, NY: Delmar Learning.

Ferre, J. M. (1999, December), Children's central auditory processing disorders-Solving the puzzle together. *CSHA Magazine*, pp. 4-12.

Jerger, J. & Musiek, F. (2000), Report of the concensus conference on the diagnosis of auditory processing disorders in school-aged children. *Journal of the American Academy of Audiology*, 11, 467-474.

Masters, M.G., Stecker, N.A., & Katz, J. (1998), Central auditory processing disorders: Mostly management. Needham Heights, MA: Allyn & Bacon.

ASSISTANCE: For assistance or further information please contact the LAUSD Audiology Resource Unit (ARU) at (213) 241-8053.