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Clinical Forum

Maintaining a Therapeutic Focus and Sharing Responsibility for Student Success: Keys to In-Classroom Speech-Language Services

Barbara J. Ehren
University of Kansas-Center for Research on Learning, Lawrence

Donna is a speech-language pathologist who serves two elementary schools and a middle school. For the past several years now, she has been attending workshops and reading articles and books that have advocated the inclusive delivery of speech-language services. Although it has been called by many different names, and consists of a variety of specific configurations, Donna has synthesized the call to inclusive delivery into one basic theme: Go into the classroom and collaborate with teachers in the delivery of curriculum-relevant therapy.

Donna is a conscientious professional who wants very much to improve services to the students on her caseload. The rationale for working in a truly collaborative fashion with teachers in the setting where students have to function all day long, every school day, has made sense to her. Although she serves three schools, she decided to try a different approach to pullout at one of her elementary schools. She selected a classroom where several of her students "live" and approached Ms. Sampson, a classroom teacher, with the idea of providing therapy in her classroom. Ms. Sampson likes and respects Donna, and reasons that she can always use another pair of hands in her overcrowded classroom, so she agrees. They eat lunch together in order to have planning time. Their service configuration consists mostly of co-teaching in large groups during social studies instruction. Sometimes, Donna teaches a lesson to the entire class with the teacher assisting, and sometimes it's the reverse. Ms. Sampson enjoys the interaction with Donna and feels that her students are benefiting from having Donna in the classroom.

Ms. Sampson has been touting this model to her best friend, Ms. Barrett, in another grade, who asks Donna to do the same with her. Only in this situation, the teacher is having a difficult time teaching several students, three of whom are on Donna's caseload as students with language disorders. Donna and Ms. Barrett do not have planning time. So when Donna goes into this room, the teacher gives her the work with which the students are having difficulty and asks Donna to help them complete the work. In this room, Donna only works with the students on her caseload. This teacher, too, is thrilled to have help with specific students.

Donna, however, is having second thoughts about this whole arrangement. In Ms. Sampson's class, she feels like a teacher. It's not a bad feeling and, in fact, it's fun. But she wonders if this is why she went to school to study speech-language pathology. "All those hours of learning neuro for this?" she wonders. In Ms. Barrett's class, she feels like an aide. She

ABSTRACT: Although speech-language pathologists in the schools are being encouraged to provide services more inclusively, they often express concern that they are becoming like classroom teachers and are "watering down" the therapy they should be providing to students on their caseloads. This article explores these concerns and offers solutions to the role confusion and dissatisfaction of many speech-language pathologists who provide in-classroom speech-language services. Two key principles are offered to preserve the speech-language pathologist's role identity and the integrity of services provided: maintaining a therapeutic focus and sharing the responsibility for student success.

KEY WORDS: inclusion, service delivery, in-classroom services, speech-language pathology in schools, role of the speech-language pathologist

keeps asking herself, "Is this what I'm supposed to be doing? Am I really providing therapy? Are the students on my caseload getting what they need?"

Donna's situation is not unique. Speech-language pathologists, like other practitioners in the schools, are being exhorted, if not mandated in some places, to provide services more inclusively to students with disabilities (Ellis, Schlandecker, & Regimbal, 1995; Farber & Klein, 1999; National Association of State Boards of Education, 1993; Villa & Thousand, 1995; Villa, Thousand, Nevin, & Malgeri, 1996). Although federal law has always mandated the provision of services in the least restrictive environment (LRE), recent changes in the Individuals with Disabilities Education Act (IDEA) of 1997 have reinforced the notion that the general education classroom is the LRE for most students. For many speech-language pathologists, this has meant providing therapy to students in their classrooms instead of pulling them out to a therapy room (Wilcox, Kouri, & Caswell, 1991). Further, the new law specifically requires that progress within the general curriculum be addressed in the individualized educational program (IEP), regardless of the setting in which services are delivered. Now, even if speech-language pathologists continue to use pullout models, they have a responsibility to relate therapy to progress in the general education curriculum.

A related trend in the field is the orientation toward functional outcomes (Fishbaugh, 1997; Gallagher, Swigert, & Baum, 1998; Idol, Nevin, & Paolucci-Whitcomb, 1994). For school practitioners, this trend translates in part to providing therapy that facilitates school success in terms of academic, social, emotional, and vocational progress. Speech-language pathologists are being urged to provide educationally relevant therapy, which includes therapy that impacts curriculum acquisition (American Speech-Language-Hearing Association [ASHA] Ad Hoc Committee on the Roles and Responsibilities of the School-Based Speech-Language Pathologist, 1999; ASHA Ad Hoc Committee on Reading and Writing, in press).

However, like Donna, many speech-language pathologists are not totally convinced that in-classroom services are the way to go. Although philosophically they may appreciate the push to provide educationally relevant therapy, they have reservations about implementing inclusive models. Even when they overcome some of the other obstacles, two of the biggest concerns seem to be whether they are becoming classroom teachers, or even classroom aides, and whether they are shortchanging students by "watering down" therapy. These concerns appear to be related. If speech-language pathologists perceive that what they are doing is what classroom teachers or aides ordinarily do, then they are probably not meeting the needs of those students on their caseload who require therapy. They are likely to feel that their intervention is neither sufficiently prescriptive nor intensive to qualify as the therapy they were trained to do; hence, the feeling of watering down therapy and shortchanging students.

How can Donna and other speech-language pathologists like her resolve these problems to make appropriate use of inclusive models of service delivery? They can contemplate the nature of speech-language therapy and its relationship to other instructional processes and use this understanding to differentiate roles and provide appropriate services.

THE LANGUAGE TEACHING CONTINUUM

Before considering the nature of speech-language therapy, it is helpful to discuss in a broader sense the teaching of language in the schools. The pervasive and critical role that language plays in school learning compounds the difficulty in differentiating the roles of the professionals who are involved in its acquisition and use. Clearly, when general educators teach subjects called language arts or English, they are in the domain of language. The content and processes of language are the same regardless of who is involved. It does not make sense to parse out pieces of language by role. It would be arbitrary to say that the speech-language pathologist deals with syntax and the teacher does not, or that because teachers teach grammar, the speech-language pathologist need not be concerned with it. Neither is it appropriate, given the current status of our knowledge regarding the relationship between spoken and written language, to say that the domain of the speech-language pathologist is spoken language and the teacher's is written language. What makes more sense is to say that teachers and speech-language pathologists deal with language, albeit in different ways, with different populations. It may be helpful to think of the teaching of language—spoken and written—as a continuum defined on the basis of four parameters: (a) the content/process (what?), (b) the delivery (how?), (c) the provider (by whom?), and (d) the learners (for whom?). The concept of language teaching as a continuum is appropriate because, as teaching moves from instruction to therapy, the teaching time dedicated to a student's individual needs increases.

The Content/Process

The content and processes of *language* remain the same regardless of who might be involved in the teaching or learning. With regard to curriculum, language is both an end and a means to an end (Hynds, 1994). Students must learn to listen, speak, read, and write in order to participate in the typical communication events that are appropriate for their respective age and grade levels. Students also use spoken and written language skills and strategies to learn in other subject areas like math, social studies, and science (Bashir, Conte, & Heerde, 1998).

The Delivery

In the elementary grades, language arts is a major component of the curriculum. Middle and junior high school students take at least one class of language arts, with the possibility in some school districts of an additional reading class. In high school, the standard is usually 4 years of English. The type of teaching that occurs in the normal course of events in a school curriculum is referred to as *instruction.*

When typical instruction is insufficient to produce the kind of mastery in language that is required in the curriculum, schools respond by offering a variety of *intervention* services. These might include special programs like Reading Recovery, in-school and after-school tutoring, English for Speakers of Other Languages (ESOL) classes, remedial classes, special education classes, and speech-language therapy. Along this teaching continuum, *therapy* is a very specific, more intensive type of intervention, requiring focused expertise of the provider in the area of language and language disorders.

The Provider

General education *classroom teachers* are the providers of instruction in language arts and English. Various *special teachers* may be involved in providing intervention to students with different problems, for example, Title I teachers, Reading Recovery teachers, literacy tutors, ESOL teachers, and special education teachers. When the nature and severity of the problems are such that students qualify for speech-language services under language eligibility criteria, then the intervention (or at least one of them) would be therapy provided by *speech-language pathologists*. In inclusive settings, classroom teachers would still be involved in providing instruction, collaboratively with special service providers, including speech-language pathologists.

The Learners

Most *students with typical development* will learn language in the normal course of classroom instruction from teachers with a range of expertise. However, there are some students for whom general classroom instruction in language arts/English will not be enough. A variety of reasons may be involved. These include second language issues, a lack of sufficient spoken and/or written language models in the environment, inappropriate or insufficient teaching in early grades, and specific disabilities. A generic description for this rather heterogeneous group, who for a variety of reasons are not using spoken and/or written language at expected levels, might be *students underachieving in literacy*. These students need additional assistance from a special provider, based on their needs. For some programs, like Reading Recovery, ESOL, or special education, specific eligibility rules will apply.

The last group of students, those with the most severe problems, are *students with language disorders*. For them to be successful in acquiring spoken and/or written language, they will most likely need the services of a speech-language pathologist providing the most intensive type of intervention, called therapy.

THE NATURE OF SPEECH-LANGUAGE THERAPY

In the model just described, language teaching provided by teachers in a developmental progression for all students is called instruction. The language service provided by a speech-language pathologist for students on a caseload because of a language disorder is a kind of intervention, called therapy. In this context, instruction and therapy are alike in some ways and different in several important ways. Table 1 compares and contrasts instruction and therapy on seven elements. These elements include purpose, knowledge base, learner engagement, sequence, individualization, mastery, and interaction.

In general, the therapeutic process can be characterized as more intensive and prescriptive, requiring greater expertise in the nature and development of language and language disorders. The understanding of these differences between instruction and therapy provides a basis for preserving the identity of the speech-language pathologist as a therapy provider. It also addresses the admonitions of speech-language pathologists who fear becoming classroom teachers or are concerned that therapy will be watered down.

It is important to note that the view depicted in Table 1 is based on typical practices in the schools. General education classrooms, using practices to meet the needs of diverse learners may, in fact, more closely resemble the clinical, or therapeutic, mode. However, even in such classrooms, it would be highly unusual for the classroom teacher to have an in-depth level of expertise in language and language disorders to provide the kind of service needed by some students without direction from the speech-language pathologist. When all is said and done, speech-language pathologists clearly have a crucial role to play in the education of students with language disorders (Wallach & Butler, 1994).

ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST

Role Issues

In defining the role of the speech-language pathologist in inclusive services, it is helpful to consider three factors that may contribute to role confusion and dissatisfaction. One important issue to clarify is that the fear of speech-language pathologists of becoming classroom teachers is not likely related to devaluing the role of the classroom teacher. Rather, speech-language pathologists recognize that their expertise is different—complementary to that of teachers, but with a different knowledge and skill base. They chose a particular professional field and wish to use the expertise they have developed. They also want to know that they make a difference in the schools by providing a needed service to students that is not available from other professionals. However, speech-language pathologists also want to fit into the school culture and be a part of the faculty. In their eagerness to be of service as a contributing team member, they may be motivated to perform services that colleagues deem valuable, leading to a role that is defined by default. A role defined by default involves doing what needs to be done, what no one else is willing or able to do.

Table 1. Comparison of instruction and therapy according to purpose, knowledge base, learner engagement, sequence, individualization, mastery, and interaction.

	Instruction	*Therapy*	*Common components*
Purpose	Deals with learning new information and skills in the normal course of development	Deals with remediating or compensating for deficient skills that have not fully developed or that have been lost	Both approaches seek a change in behavior (i.e., learning).
Knowledge base	Requires a basic understanding of language and language processing	Necessitates in-depth knowledge of language, language development, and language disorders	Both approaches require knowledge of language and literacy.
Learner engagement	Has a captive audience with varying degrees of active engagement at various times	Depends on the student's ongoing, active participation in the self-help process	Both approaches involve active engagement in the learning process.
Sequence	Uses a teaching sequence based on external criteria, such as curriculum standards and progression	Requires that the sequence of activities be based on individual needs and individual degree of progress	Both approaches are based on a learning sequence.
Individualization	Oriented toward group goals; does not always address individual needs due to time constraints and number of students; typically uses standard approach (e.g., third-grade content taught in third grade)	Requires selection of individual goals; must address individual needs; requires a diagnostic or prescriptive (or clinical) approach	Both approaches meet the needs of learners.
Mastery	Moves forward even when the student has not achieved mastery and sets the pace based on the average student	Requires mastery of prerequisite skills; cannot progress without mastery of the building blocks	Both approaches have prerequisite content and skills as building blocks.
Interaction	Involves the teaching of a planned lesson; interaction with students varies depending on the lesson format; adjustments are typically made before the next lesson	Necessitates that the clinician's actions be contingent on the actions or reactions of the student (e.g., on-the-spot error analysis determines immediate next steps)	Both approaches involve interaction between the provider and the student.

A second issue is that some speech-language pathologists, like Donna, have found themselves teaching large-group subject-area lessons, tutoring students in academic content, or helping students complete classroom tasks. These practices prompt role definition concerns for a number of reasons. Subject-area teaching, other than in special class programs for students with severe language disorders, is probably not the best use of the speech-language pathologist's expertise. Speech-language pathologists have a different job to do—one related to assisting students to acquire the language underpinnings of the curriculum.

Another issue is that speech-language pathologists are not typically trained in areas like literature, math, social studies, and science to assume responsibility for teaching these subjects. Schools have teachers who are certified in specific areas to provide this instruction. Assuming these tasks may also send a message to teachers that they are not responsible for teaching all of the students in their classroom.

Most importantly, speech-language pathologists who handle a regular caseload and take primary responsibility for instructional tasks that are usually performed by classroom teachers or aides should rightly wonder whether the students on their caseloads are receiving the speech-language therapy they need and that is described on their IEPs.

This is not to say that speech-language pathologists should ignore academic subject areas. On the contrary, they need to be grounded in curriculum content without having to be as expert as teachers. Being familiar with the curriculum is necessary for the analysis of language underpinnings. Identifying the specific language skills and strategies required of students in the general education curriculum is the first step in targeting appropriate goals for curriculum-relevant therapy and assisting classroom teachers in addressing any difficulties students may encounter.

A third, and perhaps the most serious and practical, issue is differentiating the role of the speech-language pathologist for reasons of job security. If what speech-language pathologists do looks just like classroom teaching, and there is no unique service they provide, when schools experience budget cuts, those positions may be in jeopardy.

Role Definition and Differentiation

From a theoretical perspective, it may be acceptable to think globally about the role of speech-language pathologists. There are many useful things speech-language pathologists can do in the classroom, based on their expertise. But for practitioners in the schools, an unlimited realm of possibility provides little guidance concerning

long-range program planning, service delivery, and daily decision making about what to do on Monday morning. Although role implementation will differ across schools, districts, and states, a set of parameters should be used to define a specific role for the speech-language pathologist in inclusive services that is differentiated from the role of others in the schools. Five suggested parameters are:

1. Are you making maximum use of the skills you have as a speech-language pathologist?
2. Does your caseload reflect the students who most need your services, and the students you are required to serve under IDEA?
3. Are the students on your caseload receiving the services they need?
4. Are you promoting school success within the context of providing therapy?
5. Is your role defined on the basis of what you should be doing, rather than on the basis of what others are not willing or able to do?

In summary, the basic principle that guides decision making concerning the speech-language pathologist's role in classroom activities can be stated as follows: In providing in-classroom services, the speech-language pathologist's primary responsibility should consist of providing therapeutic services for students on the caseload who need direct service and assisting classroom teachers to meet the needs of these same students and others on the caseload who need indirect service. Although additional benefits accrue to the teacher and other students in the classroom when services are provided there, those benefits should be a by-product, not a focus. Speech-language pathologists cannot become sidetracked from their central mission of providing services to caseload students or else they will be short-changing them.

However, a critical question still arises: When speech-language pathologists provide in-classroom services, how can they avoid doing what the classroom teacher does and provide the kind of service caseload students need? They can accomplish this mission by incorporating two key principles into their work with students: Maintain a therapeutic focus and share responsibility for student success. These two concepts, taken together, form an approach to inclusive services that addresses the major concerns that speech-language pathologists express.

MAINTAINING A THERAPEUTIC FOCUS

For speech-language pathologists in the schools, maintaining a therapeutic focus means applying clinical procedures in the educational setting, similar to the expectation in any other setting. However, the clinical procedures used with school-age students must be curriculum relevant and be defined in the context of classroom needs (Ehren, 1994; Merritt & Culatta, 1998; Nelson, 1994). If speech-language pathologists in the schools are to maintain their clinical identity, they must use specific practices that are consistent with the definition of therapy as outlined in Table 1. In so doing, they will maintain a therapeutic focus in their work with students. They will also be less likely to stray from their central mission and become like a classroom teacher or an aide. And, they will avoid watering down services. Specific activities to assist in this effort might include the following planning and implementation ideas.

Planning

- Plan in advance for activities in the classroom to meet individual students' language needs instead of going into the classroom and "going with the flow." Lack of planning more likely places the speech-language pathologist in the position of being used as an aide. If targets for work in the classroom are not specified based on students' IEPs, and the relevance of those targets to progress within the general curriculum is not articulated, then the classroom teacher will be tempted to ask the speech-language pathologist to "help out." Had Donna planned in advance for Ms. Barrett's students, she might have avoided this pitfall.
- Plan face-to-face with the teacher as often as possible, but at least once every marking period in order to become acquainted with the sequence of events and basic content. Because planning time is in short supply in schools, use other methods to create the frame of reference necessary to make therapeutic activities relevant to classroom performance. For example, use the time spent in the classroom to observe activities taking place. Take note of what is being taught by looking at bulletin boards and student work, as well as reviewing materials being used. Use written communication like a journal that remains in the classroom. Write important notes back and forth about important upcoming content and events, student achievements, and difficulties. Donna had the opportunity to plan with Ms. Sampson because she had lunch with her. If Donna progressed in her use of in-classroom services and it became her major delivery model, she could not possibly plan face-to-face with each teacher each week. She should work with administrators and teachers to create a structure in which an in-depth planning session for each marking period with each teacher is scheduled.
- Select the time for classroom work as carefully as possible. Negotiate with the teacher how time in the classroom will be spent and what will take place when you are there (Pugach & Johnson, 1995). The objective is to have a structure that is conducive to implementing the speech-language goals of the caseload students. In the real world, this is one of the most difficult challenges. At first, activities may be adjusted to the teacher's agenda, but, hopefully, planning will progress to mutual decision making. When Donna started with both teachers, she went into their classrooms when her schedule permitted, and the teachers did not rethink their existing classroom schedules. As her collaborative working relationship

with teachers grows, Donna would be advised to discuss a mutually beneficial structure for her in-classroom time.

- Spend time analyzing the curriculum at specific grade levels for the linguistic, metalinguistic, and metacognitive components underlying the curriculum standards and objectives that are used at the school. Working with students on the language underpinnings that they lack is a way to relate therapy to the general curriculum. Herein lies the key to differentiating content teaching from using curriculum content, like social studies and science, as contexts for teaching the language skills and strategies to facilitate academic success. In her co-teaching work with Ms. Sampson, Donna should be familiar with the social studies curriculum and its language demands. For example, she should identify the vocabulary that the students would ordinarily understand and with which her students might have difficulty. She would then address this need in her work with her students in the class.
- Work to cluster a reasonable number of students with speech-language impairments at a given grade level in a classroom, when possible, to facilitate the provision of in-classroom services in more classrooms. In order for Donna to use the inclusive model more extensively, she would have to work with administrators and teachers to cluster students. Otherwise, her caseload would be scattered across classrooms, making it impossible for her to schedule sufficient time in each class.

Implementation

- Focus on the problems of caseload students. Do not engage in general speech-language development activities, such as routinely teaching phonemic awareness to entire kindergarten classes. There may be specific caseload students who need more intensive work with phonemic awareness on whom the speech-language pathologist should focus. If other students are involved in activities, that should be an added benefit of in-classroom services, not the primary focus. In other words, work with other students in the class should not overshadow the focus on caseload students. At one of Donna's elementary schools, a kindergarten teacher impressed with her in-classroom work with Ms. Sampson and Ms. Barrett is thinking about asking Donna to come to her classroom to help her teach language because she recognizes the importance of a strong language foundation for literacy development. Donna would need to respond to such an invitation in a manner that encourages the teacher's continued collaboration without compromising Donna's therapeutic focus. Helping the teacher with language development work might take the form of helping her plan effective lessons. Again, if Donna went into that classroom, her work should concentrate primarily on her caseload students and the specific difficulties they are having with language.
- Conduct activities that directly relate to the goals and objectives on students' IEPs, making them relevant to classroom performance. Always ask, "Why am I doing this activity? How is it related to individual student goals?" To illustrate, instead of co-teaching a lesson on Native Americans of the Plains in which Donna is responsible for presenting a segment about the Lakotas, she could engineer that opportunity to be more therapeutically oriented. She could teach her students to use a Venn diagram as a tool for comparing and contrasting information, using characteristics of different Plains Indians as content. If the teacher feels that this would be a good technique to use for the entire class, then Donna might teach it to the larger group, as long as her focus remains on her caseload students. For example, she might enhance the activity by sitting the students with language disorders in close proximity to her so as to provide more attention to them. She could also spend more time with her group after the large-group lesson to focus on the language processing and production requirements with which they are having difficulty, when confronted with a compare and contrast task, such as required by a Venn diagram.
- Identify specific targets for each student during each lesson, as well as the performance criteria for targets. Make sure each student is aware of individual targets in terms of IEP goals and objectives, as well as lesson objectives. In the example above, before the lesson, Donna could hand a 3" x 5" note card to each of her students with individual lesson targets corresponding to IEP objectives.
- Engage other students in the process of assisting with implementation. A golden opportunity exists in the classroom that is not readily available in the pullout model. Peers can serve as models in the classroom for therapy or they can be taught to serve as coaches in assisting students with practice (Ezell, Kohler, Jarzynka, & Strain, 1992; Mathes, Fuchs, Fuchs, Henley, & Sanders, 1994; Scruggs & Osguthorpe, 1986). (For some cautions on peer groupings, see Brinton, Fujiki, Montague, & Hanton, this issue.) This can only be done in classrooms where a culture exists for a healthy community of learners. In such environments, students work cooperatively to achieve their goals. Cooperation, rather than competition, is emphasized, and humane treatment and mutual respect for all members of the classroom community, including the adults, are basic values.
- Vary activities to strike a balance. Do not always conduct lessons with the entire class, even when modeling a particular technique for the teacher, or the diverse needs of the caseload will not be met. Do other activities as well, targeting individual goals and objectives. For Donna, this may mean negotiating the classroom schedule with Ms. Sampson to permit configurations other than whole-class teaching to ensure that the needs of Donna's caseload students are met.

- Provide informative and corrective feedback on an ongoing basis. Tell students what they have done well, what needs improvement, and how precisely to improve their performance. As an example, following her lesson on the Plains Indians, Donna would be certain to give feedback to her students on how well each is doing with using the Venn diagram.
- Make certain that sufficient responses are given by students over time in order to promote mastery and generalization of their language objectives. Engage the teacher in this process, as described in the next section.

SHARING RESPONSIBILITY FOR STUDENT SUCCESS

As important as it is to maintain a therapeutic focus, this practice alone may be insufficient to create successful inclusive models for the delivery of speech-language services. Sharing responsibility for student success is also an indispensable companion principle. A key element in sharing responsibility is engaging teachers in a collaborative process with an understanding of differentiated roles. Without this engagement, many speech-language pathologists providing inclusive services will be in the same position in which they have always found themselves—bemoaning the lack of substantial, generalized gains in language use by their students with language disorders.

Too frequently, student performance is parsed out as the responsibility of the professional who is most identified with the area in question. The area of speech and language is often viewed as the responsibility of the speech-language pathologist, whereas academic performance is usually seen as the responsibility of the classroom teacher. In actuality, speech-language pathologists and classroom teachers need to assume shared responsibility for the functional outcomes related to school success for students with speech and language disorders. This can be done within the definitions of respective roles. In providing in-classroom services, this role definition translates into two major functions for the speech-language pathologist:

1. Assist the classroom teacher to make modifications in curriculum, instruction, and assessment in order to facilitate the success of students on the speech-language caseload.
2. Engage the teacher as a partner in the therapeutic process by enlisting the teacher's help in reinforcing targets, setting new objectives, and assessing progress.

These two functions are important for providing in-classroom services because what happens when speech-language pathologists are not in the classroom is as important as what happens when they are there. There is only so much direct service that can be provided by the speech-language pathologist to students on the caseload. Even with the traditional pullout model, this limitation applies. The real value of in-classroom services is the partnership potential it holds for a truly integrated model of delivery in which the classroom teacher plays a major role in supporting the therapeutic process in a variety of ways. Eight specific suggestions to operationalize the notion of shared responsibility are listed below:

1. Promote the writing of IEP goals and objectives that professionals work collaboratively to achieve, as opposed to goals and objectives that are identified only with the speech-language pathologist. One way to accomplish this aim is to write an academically oriented goal with objectives related to the language underpinnings needed to attain the goal. For example, a student in Ms. Barrett's class has decoding problems related to word retrieval problems. A goal on the student's IEP is "Decode fluently third-grade level materials, as measured by 95% accuracy on a reading running record." Donna might then work on a short-term objective like "Use effective word retrieval strategies in oral production and reading."
2. For the students with language disorders on the caseload, be prepared at IEP meetings to make suggestions for modifications. When Donna is attending IEP meetings about her students, she has to think beyond her work and think also of what the teacher can do to adjust instructional and assessment activities to accommodate a student's language disorder so that the student can benefit from classroom instruction. Realistically, because Donna serves three schools, she might not be able to attend all of the IEP meetings for every one of her students, but she can still provide input into the process prior to the meetings.
3. Make specific suggestions to teachers on how to modify lessons, tests, and assigned work. Consider demonstrating appropriate modifications for the teacher, such as providing an oral assessment procedure for the teacher to use in social studies, or rewording a science test to make it less linguistically complex. The need for these kinds of demonstrations should diminish over time as teachers learn the techniques involved. When Donna started working with Ms. Sampson, she reviewed all of the social studies tests the teacher constructed, making suggestions for revisions in structuring questions. Now Ms. Sampson has learned effective ways to structure questions from Donna's modeling and may only ask a specific question or two with reference to a test.
4. Agree on progress assessment procedures and enlist the student's teacher and peers to assess progress based on specific performance criteria, especially to assess the generalization of skills and strategies to classroom performance when you are not there. Some progress measures may more appropriately be taken in the classroom during activities when the speech-language pathologist is not present. For example, with Donna's student for whom an IEP short-term objective deals with word retrieval, she might ask Ms. Barrett to note his progress in word retrieval during oral reading, using a rubric they co-construct. Such a measure would be a much more functional way to assess real progress.

5. Assist the teacher in planning extension activities for when you are not in the classroom. Give the teacher specific suggestions for ways to practice and apply skills and strategies being taught in therapy. To accomplish this, identify recurring or special events that could be used to target speech and language objectives (e.g., weekly presentations, book reports, the class play.) For example, Ms. Barrett has a puppet theater in her classroom. Students take turns in presenting short plays. This is an excellent opportunity for Donna's students to practice their individual speech-language targets. Donna's in-classroom service to this class may revolve around the preparation or presentation activities for the plays with her students, or this time might be used by Ms. Barrett as an extension opportunity.
6. Make suggestions for a learning center and perhaps assist in preparing materials to be used in it. Donna, for example, might review the classroom schedule with Ms. Sampson and identify times during the week when students who have syntax objectives on their IEPs could work at a communication station to practice constructing complex clauses in spoken and written language. Donna may assume responsibility for developing activities for the center, whereas Ms. Sampson agrees to monitor the students' work while they are working there. Ideally, Donna could also work at times with the students at the center when she is in the classroom.
7. Inform teachers of verbal and nonverbal cues that have been found useful for prompting students to use targeted skills and strategies. Then provide sticky notes for the teacher to attach to lesson plans or materials as reminders to prompt specific responses. For example, Donna might give Ms. Barrett a sticky note that says, "Cue Johnny to use the word retrieval strategies he has learned" to place in her copy of the reading materials he will be reading orally.
8. Broadcast successes to other faculty members and administration. Brag about each other's hard work and mutual accomplishments. Remember that it was Donna's work with Ms. Sampson that prompted Ms. Barrett to request in-classroom services. And recall that a kindergarten teacher is inquiring about this model.

WHAT MAINTAINING A THERAPEUTIC FOCUS AND SHARING RESPONSIBILITY FOR STUDENT SUCCESS LOOKS LIKE

Speech-language pathologists will encounter many situations in which they will wonder whether the activities they think about doing or are called on to do by teachers or administration really exemplify maintaining a therapeutic focus and sharing responsibility for student success. In the daily frenzy of working in schools, it is easy to get caught up in the moment and lose the big picture of how the differentiated role of the speech-language pathologist should be implemented. Table 2 presents some examples of recommended and non-recommended in-classroom activities to maintain a therapeutic focus and share responsibility. Each recommended activity includes a rationale for why it is a good idea, based on the principles discussed in this article. Each non-recommended activity also includes a rationale for why it is not a good idea.

Getting Started

On initial reflection, this call to maintain a therapeutic focus and share the responsibility for student success may appear rather daunting. Remember, however, that the beginning structures used for implementing classroom services may not always be the most desirable delivery structures for the future. Creating the optimum configuration may take some time to build. However, this reality should not prevent speech-language pathologists from taking steps toward implementation.

There are many ways to proceed. To get a foot in the door, one strategy is to select one teacher as Donna did, but be clear on the desired goal. Strive to make continuous progress toward the optimum delivery system desired for implementation. Also, do not settle for practices that are acceptable at initial stages of implementation but that need further development. A description of three different approaches, known as "ease in," "jump start," and "go for it" is provided in the following paragraphs.

Ease in. For those speech-language pathologists who have not tried it and are not comfortable with the idea, identify a willing teacher, perhaps a teacher you know well, who has a few students from the caseload. Ask for space to conduct the regularly scheduled therapy session, for example, in a corner of the room. Say "Hi," "Bye," and "Thanks" to the teacher. Gradually, start making a few comments about the problems or progress of the caseload students in the class. Answer any questions the teacher may have. Then, as a relationship with the teacher is established, suggest more collaborative activities. In a best case scenario, the teacher may actually initiate this effort.

Jump start. For those speech-language pathologists who have dabbled in providing in-classroom services, identify one or two willing teachers. Plan for at least half of the total direct therapy time for a given group of students in a classroom to be implemented in the classroom. Converse with the teacher(s) concerning the typical activities and requirements of the classroom. Identify the golden opportunities in the teacher's schedule to use as a context for therapy. Conduct specific curriculum-relevant therapy activities in the classroom and co-plan extension activities with the teacher for those students.

Go for it. For speech-language pathologists who may have conducted some in-class services successfully, or when services at an inclusive school are being offered, sit down with school administration and faculty and discuss school organization and caseload. For example, possible clustering of students in a class at a grade level can be discussed, being careful not to overload any one class with too many students with learning problems. Reorganize the delivery of services to students, minimizing the use of pullout. Certainly the possibility exists that, for a given

Table 2. Examples of activities that are recommended and not recommended for in-classroom services in order to maintain a therapeutic focus and share responsibility for student success.

Activity recommended	*Activity **not** recommended*
1. Take the math worksheet and use the problems to teach a student on the caseload to interpret language and set up the problems to be solved (i.e., identify important information or decide on an operation).	1. Take the math worksheet and help a student on the caseload complete the problems.
Why it is a good idea: Assuming that the student has difficulty with language comprehension, the difficulty with math problem solving may be related to that problem. Therapy that deals specifically with content to be processed in solving math problems is curriculum-relevant without being redundant and also facilitates academic success.	*Why it is **not** a good idea:* Solving the problem for the student is tutoring that can be done by anyone, including an aide. Completing the worksheet with the student does not address therapy goals specifically.
2. Teach vocabulary relevant to the curriculum to a student on the caseload by focusing on the words, metaphors, and idioms in a science textbook with which students with language disorders can be expected to have difficulty. Encourage the teacher to set up a learning station with a language master and provide language master cards for the students to review at specific times in the classroom.	2. Pre-teach the science vocabulary of the next science lesson to a student on the caseload.
Why it is a good idea: Students will have difficulty with the content of a lesson that the classroom teacher is teaching if they lack the basic vocabulary used in the explanation of content. This kind of vocabulary work is directly related to academic success.	*Why it is **not** a good idea:* This teaching is what the science teacher should be doing. Implementing this step exonerates the teacher from responsibility to ensure that all students understand the vocabulary and concepts of a lesson or unit.
3. Co-present a social studies lesson by guiding the students in the practice of the language strategies they have been learning in therapy. Give students cue cards to tape to their desks or use as bookmarks in their textbooks to remind them to use the strategies.	3. Co-present a social studies lesson by taking turns teaching the lesson to all students without addressing the IEP goals of caseload students.
Why it is a good idea: This type of activity specifically addresses the generalization of strategies to classroom performance.	*Why it is **not** a good idea:* Unless the speech-language pathologist is the primary instructor in a classroom program for students with severe language disorders, it is not the essential responsibility of the speech-language pathologist to teach social studies. Time can be used more effectively working on speech-language goals underlying the social studies curriculum.
4. Go into a classroom while students are working in small groups or independently and gather the students on the caseload for a therapy session. The group may be joined by other students not on the caseload who can benefit from the specific activities of the day. Provide practice assignments to be done in the classroom when you are not there, using peer buddies to assist with feedback.	4. Go into a classroom while students are working in small groups or independently. Circulate primarily to help caseload students do their work.
Why it is a good idea: A therapy session can be conducted for caseload students. A bonus is that other students may benefit.	*Why it is **not** a good idea:* This activity falls into the category of academic tutoring and does not deal directly with therapeutic targets.
5. Go into a kindergarten class and do more intensive work in phonemic awareness with students on the caseload who have phonological disorders. This focus would be an addition to the teacher's emphasis on phonemic awareness.	5. Go into a kindergarten class to teach phonemic awareness to the entire class.
Why it is a good idea: Students with phonological disorders may need more intensive work with phonemic awareness from an expert in phonological disorders.	*Why it is **not** a good idea:* The classroom teacher should be offering phonemic awareness instruction in language arts. Taking responsibility for this aspect of general language development takes time away from the caseload. Instead, consider a few demonstration lessons, or conduct professional development activities with teachers in this area.

student for a specific period of time, pullout may be the delivery of choice. The guarantee that a free appropriate public education as mandated by IDEA is being provided requires decisions to be made on an individual basis. If pullout is deemed the appropriate delivery method to implement the goals and objectives on the IEP, then this mode of service delivery should be provided.

It is important to work with teachers to identify setting demands and golden opportunities in their classrooms if services (or most of them) are to be delivered in classrooms. It is also important to remember that maintaining a therapeutic focus and shared responsibility for student success is equally essential.

Developing a Plan

Change is difficult for most people, and changing systemic practices is indeed a challenge (Coben, Thomas, Sattler, & Morsink, 1997; Fullan, 1993). Even if a school favors inclusive models, basic planning can help to smooth the way. Consider the following five components of a plan:

1. Discuss in-classroom direct services with the principal. Present the rationale and guiding principles of this service delivery approach. Anticipate problems the principal will identify and raise them first; then provide answers.
2. Assess parent interest and support.
3. Assess teacher interest and support.
4. Plant seeds with teachers. Provide articles and materials for them to read. Talk about current trends in a faculty meeting. Meet with grade chairs to discuss possible plans.
5. Write a plan. Be sure to include marketing and parent education components.

SUMMARY

Although there are many advantages to providing inclusive speech-language services in the schools, there are many difficulties as well. Two of the major problems discussed are the blurring of roles between the classroom teacher and the speech-language pathologist and the watering down of therapy. Speech-language pathologists can overcome these problems by defining a role that addresses the provision of therapeutic services in classrooms for students on their caseloads. If speech-language pathologists maintain a therapeutic focus and share the responsibility for student success, they can maintain their identity as clinical service providers while providing curriculum-relevant therapy with functional outcomes. To accomplish these aims, speech-language pathologists should be expert in language and knowledgeable about curriculum content, and teachers should be expert in curriculum content and knowledgeable about language.

Perhaps what remains as the greatest challenge in the field of speech-language pathology is the generation of a robust research base that documents the effectiveness of inclusive models for children with speech and language impairments. To this end, researchers and practitioners need to form partnerships that honor dual expertise to address the questions concerning the delivery of services that are crucial to practitioners.

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Contact author: Barbara J. Ehren, EdD, University of Kansas-Center for Research on Learning, Florida address: 15726 SW 7th Place, Sunrise, FL 33326. Email: Libby23@aol.com