



APPROACHES TO SERVICE DELIVERY FOR THE SCHOOL-BASED SLP



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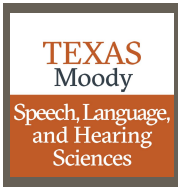

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DISCLOSURES

Financial

No relevant financial relationship exists.

- Ms. Adams is employed by ESC Region 11.
- Mrs. Londenberg is employed by ESC Region 12.
- Dr. Schmitt is employed by University of Texas at Austin.

Nonfinancial

No relevant non-financial relationships exist.

- Ms. Adams is an ASHA member.
- Mrs. Londenberg is an ASHA and a TSHA member.
- Dr. Schmitt is an ASHA member.



PLAN FOR TODAY

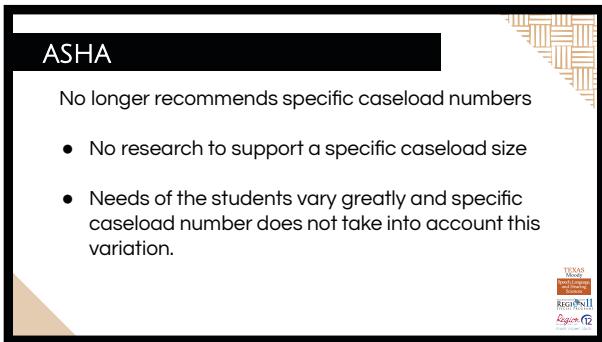
- How did we get here?
- What guides us?
- How might research support our practice?
- Where do we go from here?

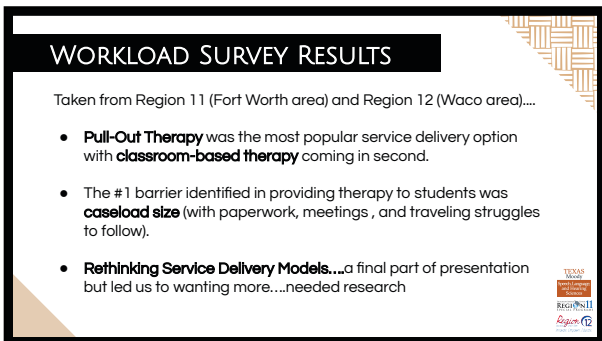
Goal: GROWTH MINDSET

You don't have to change *everything*
to change *something*.

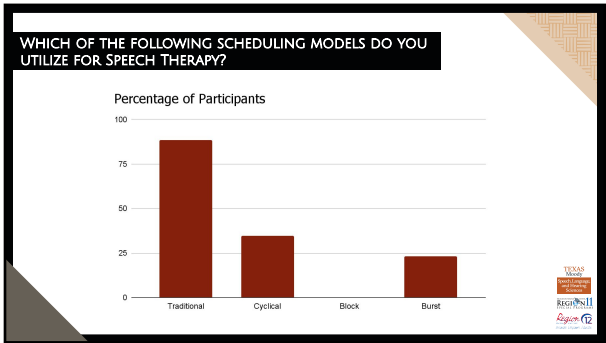


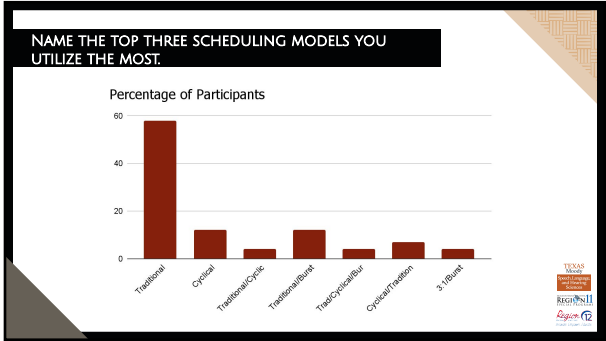












WHAT OTHER CREATIVE MEANS DO YOU USE TO PROVIDE SERVICES TO YOUR SPEECH THERAPY STUDENTS? ARE YOU DOING SOMETHING UNIQUE IN YOUR LEA FOR SERVICE DELIVERY THAT YOU WOULD LIKE TO SHARE?

We are very limited with other options due to the defined times we are given for services. RTI and SPED have the same defined time in the master schedule.

"...push-in for my most-severe students in self-contained classrooms. We have a morning circle time which I believe has been helpful. I have also had some success as another set of hands and they can ask them to 'model'."

...towards, we've started to do 10 minutes, 3 times per week instead of the 30 minutes sessions. This is helping with carry over so far. We've used this for 2nd grade and up and those who are stimuable and moving towards conversation level.

creativity is difficult in a school of 700+ students; speech students are spread across 4 and sometimes 5 classrooms per grade level—with nearly 70 students—push in model is not achievable. Push-in model would require Administration "buy-in"...

we need help with this.

Logos: TEXAS Speech Council, Region 11, Region 12

CONCLUSIONS...

- Every single time it came back to service delivery
- What we were missing = RESEARCH to back it up
- What matters in therapy???
- How do we make school based, student centered decisions that aligns with research?



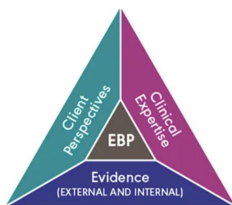
WHAT GUIDES US?



ASHA EBP MODEL



Evidence-based practice (EBP) is the integration of



ASHA
American
Speech-Language-Hearing
Association

When all three components of EBP are considered together, clinicians can make informed, evidence-based decisions and provide high-quality services reflecting the interests, values, needs, and choices of individuals with communication disorders.

(EXTERNAL AND INTERNAL)



```

graph LR
    1[1 Frame Your Clinical Question] --> 2[2 Gather Evidence]
    2 --> 3[3 Assess the Evidence]
    3 --> 4[4 Make Your Clinical Decision]
  
```

1 Frame Your Clinical Question

2 Gather Evidence

3 Assess the Evidence

4 Make Your Clinical Decision



```

graph LR
    1[1. Frame Your Clinical Question] --> 2[2. Gather Evidence]
    2 --> 3[3. Assess the Evidence]
    3 --> 4[4. Make Your Clinical Decision]
  
```

Outcome: What do you want to accomplish, measure, or improve?



ASHA EBP MODEL: STEP 1

1

2

3

4

Formulate Your Clinical Question

Gather Evidence

Assess the Evidence

Make Your Clinical Decision

Population	Intervention	Comparison	Outcome	Question
Children with Severe to Profound Hearing	Cochlear Implants	Hearing Aids	Speech and Language development	For children with severe to profound hearing loss, what is the effect of cochlear implants compared to hearing aids on speech language development?

TEXAS

RECEIVED

REGISTRATION

EXPIRATION

ASHA EBP MODEL: STEP 1

1

2

3

4

Formulate Your Clinical Question

Gather Evidence

Assess the Evidence

Make Your Clinical Decision

Population	Intervention	Comparison	Outcome	Question
School Age Children with Language Disorders	50 reps during and 10 minute sessions	20 reps during a 30 minute session	Speech and Language development	For school aged children with language disorders, what is the effect of 50 reps in a 10 minute session compared to 20 reps in a 30 minute sessions on speech language development?

TEXAS

RECEIVED

REGISTRATION

EXPIRATION

ASHA EBP MODEL: STEP 2

1

2

3

4

Formulate Your Clinical Question

Gather Evidence

Assess the Evidence

Make Your Clinical Decision

Gather the Evidence

Internal evidence

refers to the data that you systematically collect directly from your clients to ensure that they're making progress.

External evidence

refers to evidence from scientific literature—particularly the results, data, statistical analysis, and conclusions of a study.

TEXAS

RECEIVED

REGISTRATION

EXPIRATION

ASHA EBP MODEL: STEP 3



When assessing the internal evidence, you are determining whether an intervention has impacted your client.

- Is your client demonstrating a response to the intervention?
- Is that response significant, especially for the client?
- How much longer should you continue the intervention?
- Is it time to change the therapy target, intervention approach, or service delivery model?



ASHA EBP MODEL: STEP 3



Critically appraising the external evidence can help you determine if the conclusions from one or more studies can help guide your clinical decision. To assess the external evidence, you should:

- determine the relevance to your question,
- appraise the validity and trustworthiness, and
- review the results and conclusions.



ASHA EBP MODEL: STEP 4



Make Your Clinical Decision

The final step of the EBP process requires you to make a clinical decision. To make an evidence-based decision, clinicians must consider evidence (both internal and external), assess the appropriateness of their clinical experience for the situation, and review the individual client's perspectives and priorities—the three components of EBP.





IDEA

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act of 2004 (IDEA) is the federal law that governs the special education process. One of the main purposes of IDEA is to ensure that children with disabilities have available to them a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living.



Identification and Eligibility Overview

Child is identified as possibly needing special education and related services.

ARD committee determines eligibility based on two questions:

1. Does the child have a disability (one or more of 13 eligibility categories)?
2. Does the child need special education and related services?

Step 1

Step 2

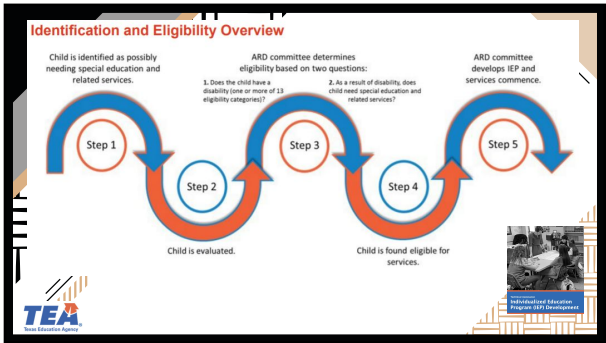
Step 3

Child is evaluated.



Technical Assistance
Individualized Education Program (IEP) Development





LEAST RESTRICTIVE ENVIRONMENT

General education should always be the first consideration.

Individualized Education Program (IEP) Development

TEA Texas Education Agency

Individualized Education Program (IEP) Development

FREQUENCY LOCATION DURATION

- Frequency** — how often the service is to be provided;
- Amount of time** — the minutes per session for the service;
- Beginning/ending date** — the starting and ending dates of the specific service; and
- Location of service** — the setting (e.g., general education or special education) where the service is to be provided.

Frequency	Duration	Location
How often will the service be provided (daily, weekly)?	How long will the services be provided?	Where will the service be provided?
1	2	3
If a service is provided less than daily then the conditions for the provision of the services must be clearly specified within ARD documents using a weekly reference (1 hour a week, 30 minutes every two weeks).	The beginning and ending dates must be specified. How long will each session be (15 minutes, 30 minutes)? If a term (1 class period) is used in the IEP to define duration of service, the term must be defined in the IEP (example: 1 class period = 50 minutes).	

Individualized Education Program (IEP) Development

TEA Texas Education Agency

Individualized Education Program (IEP) Development

HOW MIGHT RESEARCH SUPPORT OUR PRACTICE?



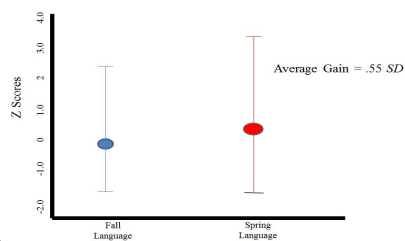
CURRENT STATE OF AFFAIRS

Empirical support that therapy is effective

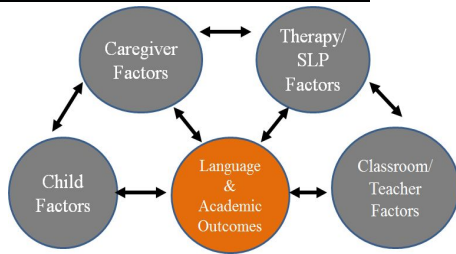
- Children who receive therapy/intervention show more growth in language and literacy skills than those who do not (e.g., Leonard et al., 2006; Tyler et al., 2003; van Kleeck, et al., 1998).
- Many possible “active ingredients” to account for growth... but don’t know exactly what those are.



AVERAGE LANGUAGE GAIN



THEORETICAL MODEL



RATIONALE

If we are to implement best practices for children in speech therapy, we first need to understand the current state of affairs for school-based therapy

- What does school-based language therapy look like (business-as-usual)?
- What aspects of therapy relate to children's language outcomes?

STEPS (SPEECH THERAPY EXPERIENCES IN PUBLIC SCHOOLS)

294 kindergarten, 1st
& 2nd grade students



Receiving language
therapy in schools

75 SLPs in public schools



3-5 students per SLP

WHO DOES THIS INCLUDE?

Focus of the research: Children who qualify with a language impairment as primary diagnosis

May also have:

- Articulation/Phonological Disorders
- Fluency disorders
- ADHD
- high functioning ASD
- Mild cognitive impairment

Who is NOT included?

- Students without language impairment
- Sensory impairments
- OHI that explains the language impairment (e.g., Down syndrome)
- Nonverbal/severe-profound disorders



WHO DOES THIS INCLUDE?

But these data MAY apply to other populations of students

- EBP Triangle
- Your data/experience + client needs + research

Terminology

- DLD (Developmental Language Disorder)
Primary language impairment that is developmental in nature
May or may not include cognitive impairment



GENERAL PROCEDURES



- SLPs recruited and consented
- Children purposefully selected from caseloads (consent, screen, assess)
- SLP questionnaires
- Child direct assessments (fall)
- Therapy videotaping and logs
- Child direct assessments (spring)



STUDY MEASURES

Child Measures	5 subtests of Language Nonverbal IQ 3 measures of literacy
Weekly Therapy Logs	Average of 35 weeks (31 - 40)
Video-Taped Sessions	LIOS
Questionnaires	Family, Classroom Teacher, SLP



WEEKLY THERAPY LOGS

Student's Name: (First & Last)	Day of Week	Start Time	End Time	No Therapy Scheduled	Student Absent	Therapy cancelled	Students	Group composition*		Therapy Location**	Contact with Parent/ Caregiver? ***	Contact with other Teacher? ***						
								Select Grade (SG) or MG & Select EP (EP or EEP)										
Emily	M			☐	☐			SG	MG	IN	HEP	N/A	SR	GEN	SPED	OL		
	Tu	9:30	9:00	☐	☐		3	SG	MG	IN	HEP	N/A	SR	GEN	SPED	OL		
	W			☐	☐			SG	MG	IN	HEP	N/A	SR	GEN	SPED	OL		
	Th	9:30	10:00	☐	☐		1	SG	MG	IN	HEP	N/A	SR	GEN	SPED	OL		
	F			☐	☐			SG	MG	IN	HEP	N/A	SR	GEN	SPED	OL		



LIOS: LANGUAGE INTERVENTION OBSERVATION SCALE

Interactions
7 Behavior Codes

Talk Time
10 Behavior Codes

Materials
20 Behavior Codes

Target
14 Behavior Codes

Techniques
13 Behavior Codes

- 40 hours of training
- 3 reliable videos
- Overall kappa of .80; each behavior of .70
- Inter-rater reliability of .78 kappa



PARTICIPANTS

SLP Demographics (n = 75)

Average Years Experience = 16 (Range 0 to 36 years)

All had state license

93.2 % with CCC

97 % Female

Ethnicity: 90.4% Caucasian; 6.8% African American; 2.8% Hispanic

Child Demographics (n = 294)

65 % Male; 34 % Female

Ethnicity: 55.4% Caucasian; 9.5% African American; 3.7% Hispanic; 5.2% Other; 25.9% Unreported

Fall Language (CELF-4 Core Language; $M = 69.04$; $SD = 17.13$)

Fall Basic Reading Skills (WJ-III Basic Reading Composite; $M = 92.13$; $SD = 15.30$)

Kaufman Brief Intelligence Test – Matrices ($M = 88.28$; $SD = 12.10$)



WHAT MAKES THIS RESEARCH UNIQUE?

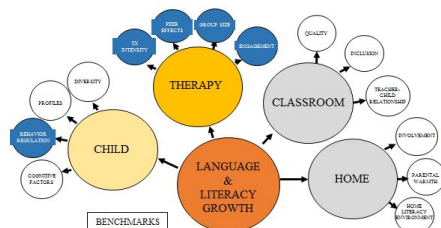
Existing Research	STEPS Study
Children with low language but may not qualify for school-based services	Children diagnosed by SLPs in schools
Rely on surveys and averages	Direct observation/weekly records
Descriptive designs	Rigorous statistical analyses
Conducted by researchers	Conducted by school-based SLPs

Implications: These findings are immediately relevant to other school-based SLPs serving children with DLD.

Not prescriptive: Adds "research" component to EBP Triangle to support your practice

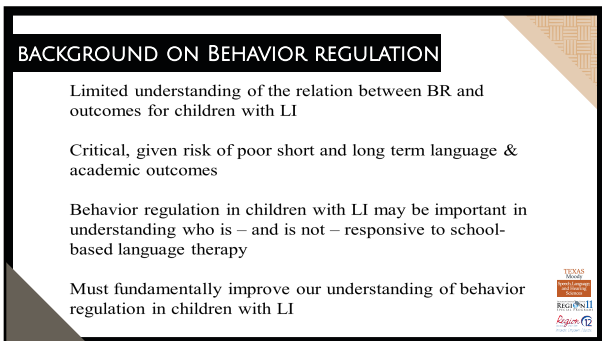


TODAY: 3 ACTIVE INGREDIENTS









ENGAGEMENT

Does behavior regulation, measured as ENGAGEMENT during therapy, relate to language gain?

Schmitt, M. B. (2020). Children's Active Engagement in Public School Language Therapy Relates to Greater Gains. *American Journal of Speech-Language Pathology*, 29(3), 1505-1513.

Funded by: American Speech-Language Hearing Foundation 2012 Student Research Grant in Early Childhood Language Development



ENGAGEMENT

- $N = 137$
- 2 video taped therapy sessions per child (278)
- Coded across 4 levels of engagement in 15 minute intervals:
 - Off Task
 - Passive
 - Intermittent
 - Active
- Analyzed in HLM



LEVELS OF ENGAGEMENT

Engagement	Definition	Examples
Active	Verbally or nonverbally participating in activity; on target; may or may not be accurate	Answers questions Follow directions Volunteers information on topic
Intermittent	Child fluctuates between active and passive engagement	In one interval, child answers a question but otherwise watches and waits
Passive	Focused and attentive, but not speaking or responding	Looking in direction of activity Quietly waiting for turn
Off Task	Uninvolved in directed task	Looking away from task/SLP Refusing to participate Physically disengaged












ENGAGEMENT: IMPLEMENTATION IDEAS

- Share the visual abstract with your colleagues and open discussion
- Identify who on your caseload you want to consider re: active engagement.
 - Who isn't making expected progress?
 - Which groups do you intuitively "know" aren't actively engaged as much as they could be?
 - Special Populations



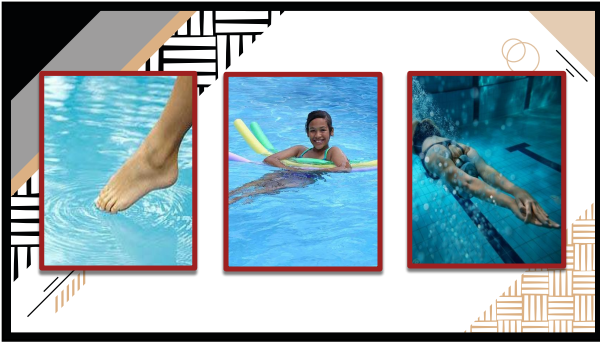

ENGAGEMENT: IMPLEMENTATION IDEAS

- Gather baseline data - judgment free!
 - How many opportunities for active engagement?
 - Identify reasons for lack of active engagement.
- Based on your baseline data, set a goal for increasing active engagement over a 9-week reporting period
- Attempt strategies for increasing active engagement
 - Give children active roles during story readings
 - Reduce time on reward activities

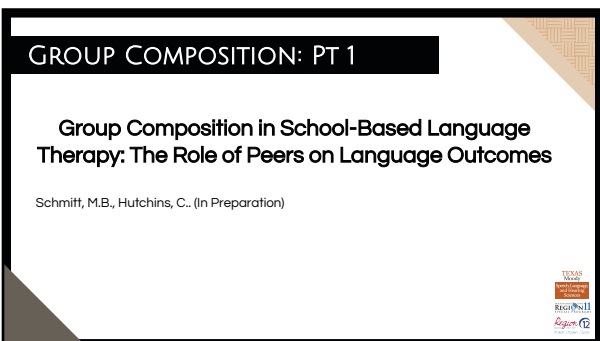



ENGAGEMENT: IMPLEMENTATION IDEAS

- Adapt therapy structure to allow for increased active engagement
 - Peer-to-peer interactions
 - Self-paced participation
 - Let children take data (for themselves or others)
 - Embed physical activity to increase engagement and reduce need for breaks







GROUP COMPOSITION DEFINED

Student's Name: (First & Last)	Day of Week	Start Time	End Time	By Therapy Schedulability	Student Absent	Therapy Location	Other Students	Group composition*	Therapy Location**	Contact with Parent/ Caregiver?	Contact with other Teacher?
	M			☐	☐		☒	SS MG IN EPs N/A SR GEN SPED OL	Class of Therapy	NA	NA
	Tu			☐	☐		☒	SS MG IN EPs N/A SR GEN SPED OL	Class of Therapy	NA	NA
	W			☐	☐		☒	SS MG IN EPs N/A SR GEN SPED OL	Class of Therapy	NA	NA
	Th			☐	☐		☒	SS MG IN EPs N/A SR GEN SPED OL	Class of Therapy	NA	NA
	F			☐	☐		☒	SS MG IN EPs N/A SR GEN SPED OL	Class of Therapy	NA	NA

Group Size

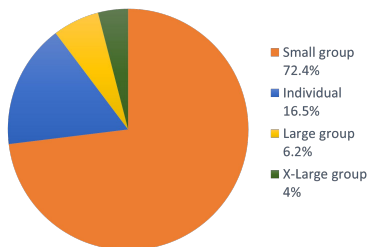
Peers

Setting

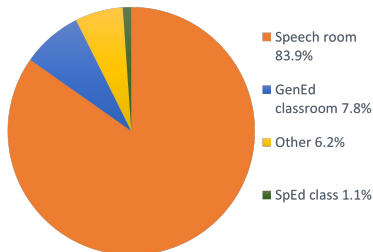
Total # of Therapy Sessions Analyzed: **10,819**

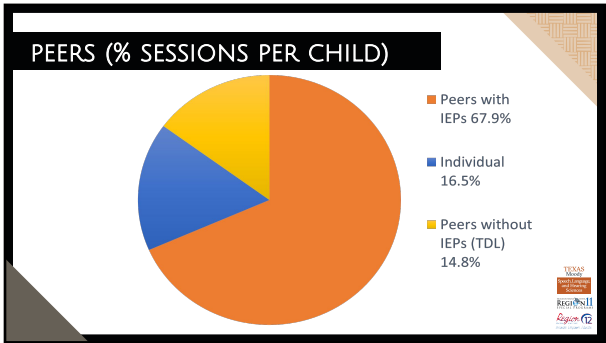


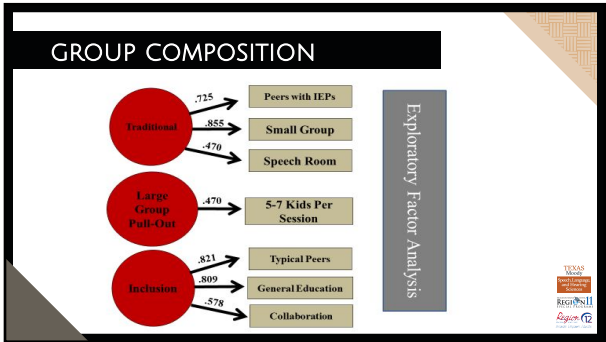
GROUP SIZE (% SESSIONS PER CHILD)



LOCATION (% SESSIONS PER CHILD)







RELATION TO SPRING LANGUAGE

	Coefficient	Robust SE	t	df	p-value
Intercept	70.55	1.36	51.90	72	<.001
Traditional	1.33	0.99	1.34	158	0.182
Intercept	70.55	1.36	51.98	72	<.001
Large Group	-1.81	0.65	-2.76	158	0.007
Intercept	70.54	1.34	52.56	72	<.001
Inclusion	2.14	0.98	2.18	158	0.031

TEXAS
 A&M
 REGIONS
 REGION II
 REGION III

GROUP COMPOSITION: PT 2

Peer Effects in Language Therapy for Preschoolers with Developmental Language Disorder: A Pilot Study

Funded by Texas Speech-Language-Hearing Foundation

Schmitt, M.B., Tambyraja, S., Siddiqui, S. (In Revision). Peer Effects in Language Therapy for Preschoolers with DLD: A Pilot Study.



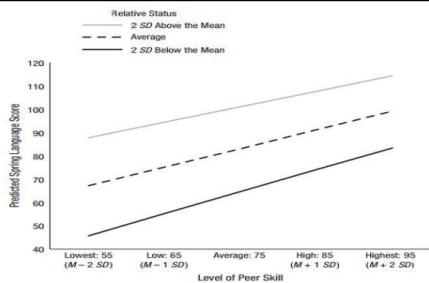
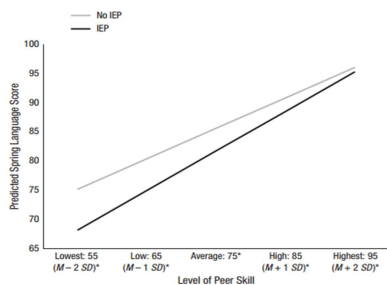


Fig. 1. Predicted spring language score as a function of the average level of language skill exhibited by children within each classroom in the fall (i.e., the peer effect) at these levels of relative skill status.



Justice, Logan, Lin, & Kaderavek, 2014

PILOT STUDY: PEER EFFECTS

30 Preschoolers from a Head Start Preschool

- 20 preschoolers with DLD
- 10 preschoolers with Typically-Developing Language (DLD)

Randomly assigned to intervention (TX with TDL) or control (TX with another child with DLD)

8-week intervention; pre/post test

Thematic units; Soft scripted across all areas of language



EFFECT SIZE ESTIMATES

Language Domain	Experimental	Control DLD	Experimental vs Control DLD
Narrative	0.87	0.18	0.33
Syntax	0.36	0.10	0.24
Morphology	0.46	0.08	0.68
Vocabulary	0.16	0.37	0.06



MAJOR FINDINGS

1. ALL children in study showed growth in language over 8 week period
2. Children with DLD benefitted MORE when received therapy with a child with TDL than another peer with DLD.
3. Children with TDL made gains in their language, too (NO HARM!)
4. Important proof of concept work; aligns with peer effects in educational research.






GROUP COMPOSITION: IMPLEMENTATION IDEAS

- Share these data with your colleagues and open discussion
- Identify who on your caseload you want to consider re: peer effects
 - Who isn't making expected progress?
 - Special Populations
 - Which groups fall in the "large group" category?




GROUP COMPOSITION: IMPLEMENTATION IDEAS

Who on your caseload could be a model for someone else? Consider re-arranging 1 or 2 of your groups. Rather than grouping by similarities, group by a balance of strengths and weaknesses.

- Articulation/typical language + language/typical articulation
- Strengths in pragmatics + weak pragmatics
- Mild impairment + more severe impairment
- Cross age groups



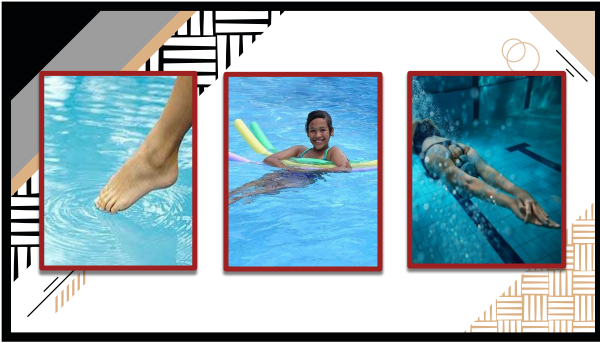

GROUP COMPOSITION: IMPLEMENTATION IDEAS

Considerations for including children without IEPs into therapy:

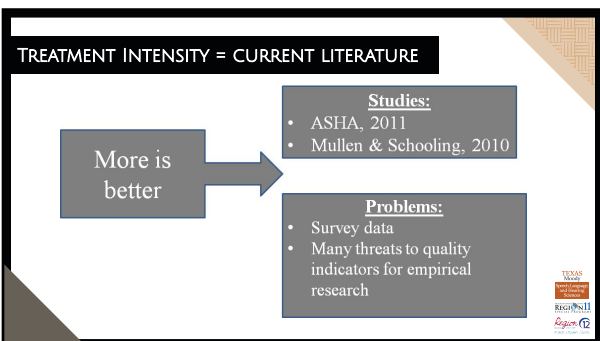
- SLP at centers in the general education classroom
- Therapy during lunch or specials
- Inclusive/push-in treatment sessions

What if you have no choice on large group sessions?

- Self-paced participation instead of round robin
- Peer-to-peer interactions with SLP as coach
- Assign roles during story reading (listen for Vocab targets, past tense markers, feeling words)
- Split the time to allow for smaller groups







TREATMENT INTENSITY = CURRENT LITERATURE

Intensity Matters

Studies:

- Law, Garrett, Nye, 2004
- Nye, Foster, Seaman, 1987

Problems:

- Limited studies included in review (i.e., 4)
- CI for effect sizes included zero.

TREATMENT INTENSITY = CURRENT LITERATURE

No differential effect

Studies:

- Bellon-Harn, 2012
- Proctor-Williams & Fey, 2007
- Ukrainetz, 2009

Problems:

- Only considered one aspect of intensity
- Involve homogeneous samples

DEFINITIONS

Intensity Parameters

Dose:
 "Active ingredients" delivered in a session

Frequency:
 Number of sessions delivered per day and per week

Duration:
 Overall length of treatment

Warren, Fey, & Yoder 2007

TREATMENT INTENSITY

International Journal of
Language &
Communication
Disorders

INT J LANG COMMUN DISORD, MARCH-APRIL 2017,
VOL. 52, NO. 2, 155-167

Research Report

Intensity of language treatment: contribution to children's language outcomes

Schmitt, M. B., Justice, L. M., & Logan, J. A. (2017). Intensity of language treatment: Contribution to children's language outcomes. *International Journal of Language & Communication Disorders*, 52(2), 155-167.



RESEARCH QUESTIONS

1. Do we see differences in treatment intensity across individual children?
2. To what extent does cumulative intervention intensity predict children's language gain?



CALCULATING FREQUENCY & DOSE

Student's Name: (First & Last)	Session	Target	Observed	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity
Emily	1	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	2	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	3	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	4	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	5	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

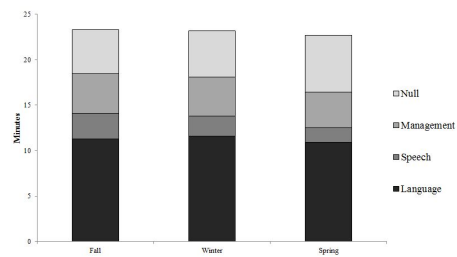
Therapy Session	Target	Observed	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity	Frequency	Intensity	Duration	Intensity
1	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
2	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
3	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
4	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
5	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



TREATMENT FREQUENCY

SLP Logs	N	Mean	SD	Range
Frequency (from logs)				
Time/Week (min)	233	36	12.2	14.1 - 82.7
Time/Year (hrs)	233	17	7.1	2.5 - 46.8
Sessions/Week	233	1.3	.47	.5 - 4.1
Sessions/Year	233	46.4	16.6	16 - 15
Cancellations/Year	233	10.2	6.9	0 - 46
Absences/Year	233	2.2	3.5	0 - 42

TREATMENT DOSE



VARIABILITY IN CUMULATIVE INTERVENTION INTENSITY

	<i>n</i>	<i>M</i>	<i>SD</i>	Range
Dose (minutes)	233	11.8	4.7	0.9-23
Frequency (sessions)	233	46.4	16.6	16-154
Cumulative Intensity (minutes)	233	535.9	275.4	28 - 1645

TREATMENT SCHEDULES

	TX 1	TX 2	TX 3	TX 4
Dose	4 Exposures	4 Exposures	20 Exposures	20 Exposures
Frequency	1/week	5/week	1/week	5/week
Duration	10 weeks	10 weeks	10 weeks	10 weeks
Cumulative Intensity	40 Exposures	200 exposures	200 exposures	1000 exposures
Description	Low Dose Low Frequency	Low Dose High Frequency	High Dose Low Frequency	High Dose High Frequency

TREATMENT INTENSITY & GAIN

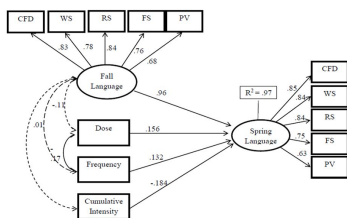
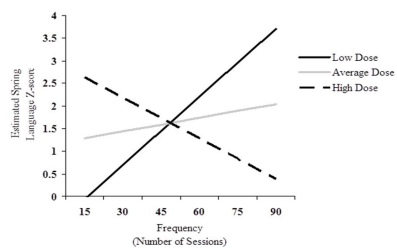


Figure 1. SEM Model exploring the predictive relation of Dose, Frequency, and Cumulative Intensity on Spring Language, controlling for Fall Language.

INTERACTION OF DOSE & FREQUENCY



RESULTS

	TX 1	TX 2	TX 3	TX 4
Dose	4 Exposures	4 Exposures	20 Exposures	20 Exposures
Frequency	1/week	5/week	1/week	5/week
Duration	10 weeks	10 weeks	10 weeks	10 weeks
Cumulative Intensity	40 Exposures	200 exposures	200 exposures	1000 exposures
Description	Low Dose Low Frequency	Low Dose High Frequency	High Dose Low Frequency	High Dose High Frequency



CONCLUSIONS

Do differences in intensity matter?

Yes – individual differences among children in treatment intensity relate to their language gains over time

AND

More $\neq$ Better



TREATMENT INTENSITY: IMPLEMENTATION IDEAS

- Share the visual abstract and/or the article with your colleagues and open discussion
- Identify who on your caseload you want to consider alternative intensity scheduling
 - Who isn't making expected progress?
 - Who has many goals that you struggle to adequately address?
 - Articulation plus language goals



TREATMENT INTENSITY: IMPLEMENTATION IDEAS

WITHIN YOUR CURRENT SCHEDULE (e.g., 30 min 2x/week)

High Dose/Low Frequency

- Address just 1 language goal per session (20 min) then spend 5 min on drills. Choose a different language target each session
- Choose language goals that are harder to drill for the 20 min (e.g., narratives - only address these once every other week) and then drill on articulation, grammar, wh questions, etc.

Low Dose/High Frequency

- Every language goal is addressed every session for 2-5 min each.

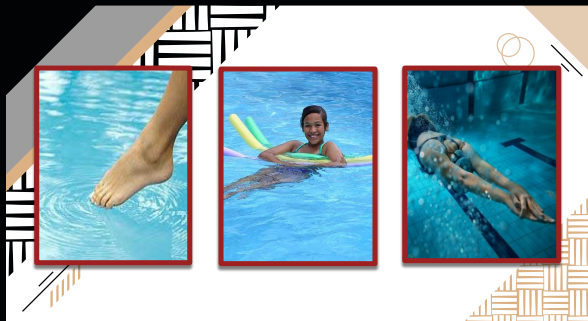


TREATMENT INTENSITY: IMPLEMENTATION IDEAS

Gather data within current scheduling constraints
Present data plus visual abstract to ARD committee
Advocate for alternative schedule of services based on this research AND your data.

- Low Dose/High Frequency (5 min sessions 4x/week)
- High Dose/Low Frequency (30 min sessions every other week)

"IMPORTANT: In our research, the length of session was irrelevant. Dose = time on language! So if you modify the schedule of services, this time needs to be dedicated to goals (not breaks, filler activities, listening to stories being read)"



TREATMENT INTENSITY: CURRENT STUDY

Testing the Causal Relation Between Treatment Intensity and Children's Language Gains

- NIH-Funded
- Providing Tier-2 Vocabulary intervention to ALL children randomly assigned to frequencies and dose
- Children ages 5:0 - 6:11 with LI in schools
- Virtual; Technology Provided

Help us by distributing flyer to children/families who may be interested.

CONTINUING THE CONVERSATION

<https://slhs.utexas.edu/research/cl3/home>

Connect with Us on Facebook & Instagram @utcl3lab

2021

Feasibility of Assessing Expressive and Receptive Vocabulary in Children with Language Impairment. *Journal of Language Disorders*, 2021.

[PDF](#)

2020

Children's Active Engagement in Public School Language Therapy Relates to Greater Gains. *American Journal of Speech-Language Pathology*, 2020, 130(5), 1050-1053.

[PDF](#) [Visual Abstract](#)

Intensity of Language Treatment: Contribution to Children's Language Outcomes

MARY BETH SCHMITT, LAURA M. JUSTICE AND JESSICA A. R. LOGAN

This study included 232 children with DLD in grades K-2. 19 school SLPs provided business-as-usual therapy for one school year. Researchers used video, thermal log and direct assessment to determine which scheduling components (i.e., dose, frequency and duration) led to greater language gains.

Baseline time spent on language goals:
Frequency: number of therapy sessions
Duration: one academic year

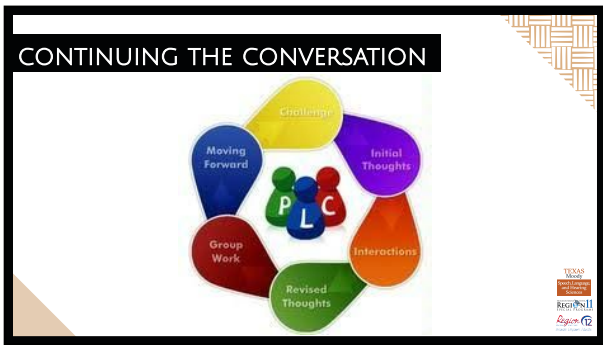
For this study:

- Low dose= 2 minutes
- High dose= 20 minutes
- Low frequency= 1 session every other week
- High frequency= 3-4 sessions per week

Major Findings: More therapy was NOT related to greater gains.

Results of this study suggest that therapy provided via low frequency and high dose or high frequency and low dose was related to the greatest gains. These results are relevant for SLPs when recommending service schedules for children with DLD.

Smith, M. B., Logan, J. R., & Justice, L. A. (2020). Children's Active Engagement in Public School Language Therapy Relates to Greater Gains. *American Journal of Speech-Language Pathology*, 130(5), 1050-1053.



THANK YOU!!!

ASHA
American Speech-Language-Hearing Association

CHILD FIND
EVALUATION • ARD SUPPORTS

THE LEGAL FRAMEWORK

TDLR
TEXAS DEPARTMENT OF LICENSING & REGULATION

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