Readers are now faced with some decision making concerning the types and contexts of service delivery available to support the needs of students with language learning impairment (LLI) in school-based settings. Six perspectives were offered as frameworks for developing the role of a speech-language pathologist in an inclusion classroom and determining the level of shared responsibility with other educational staff for planning, instruction, and evaluation. However, in adopting any combination of the six perspectives, the speech-language pathologist still must be responsible for (a) designing classroom activities that reflect the student’s individualized educational program (IEP) goals and objectives, (b) identifying specific oral language or literacy targets in classroom instruction, (c) developing performance criteria, (d) providing constructive feedback, and (e) ensuring sufficient opportunities for students to respond. Reexamination is now warranted of certain questions posed throughout the articles in this clinical forum.

WHAT ROLES MIGHT SPEECH-LANGUAGE PATHOLOGISTS ASSUME IN INCLUSION CLASSROOMS?

Giangreco defined the broadest role for speech-language pathologists working with students with disabilities in school settings. The scope of this role could extend from supporting prevention to providing “only as much as necessary.” In this flexible framework, related services providers might redefine their therapeutic role in order to meet the instructional and therapeutic needs of students in inclusionary settings. The child- and family-centered perspective that Giangreco presents requires mutual trust and positive regard among all members of the collaborative team, including families, so that roles and responsibilities can be released across disciplines (Linder, 1993; McGonigel, Woodruff, & Roszmann-Millican, 1994).

Whereas Giangreco suggested the broadest role, Ehren urged a narrower role for speech-language pathologists in classroom services, where the focus of attention remains the student with LLI, not the entire class. The therapeutic perspective assumes that students with LLI can have their individual language needs met best by the speech-language pathologist who has the most expertise with language development and language impairment.

Although Ehren recognizes the need to incorporate learning opportunities into relevant curriculum contexts, a more controversial recommendation is that speech-language pathologists cluster students with LLI in specific classrooms so that a therapeutic focus can be maintained more efficiently. The premise is that the speech-language pathologist can be involved in a single classroom, implementing the IEP goals of students through embedding them in the curriculum. An advantage of clustering is that it may meet the scheduling needs of speech-language pathologists, but, at the same time, clustering may impact teachers and the quality of language input because a significant number of students with specific language needs are assigned to a single classroom. Innovative classroom planning might consider, instead, a “pull-in model” where identified students from other classrooms in the same grade are invited to join a classroom at the time the speech-language pathologist is providing services. A pull-in model allows
students with LLI to participate in a general education classroom while receiving speech-language services. This model, however, requires ongoing collaboration among grade-level teachers and the speech-language pathologist.

Palincsar et al. proposed that speech-language pathologists have an important role beyond an individual student’s IEP to make classroom learning activities more accessible through applying the guided inquiry framework. Specifically, Palincsar and her colleagues acknowledge the need for speech-language pathologists to support students’ conceptual understanding and to determine the individual ways in which these students might successfully connect with the curriculum. Further, as these authors indicate, to advance the learning of students with identified needs, all service providers must work together to acquire a deeper knowledge of the subject matter being taught in combination with the kind of critical thinking that the subject area requires. Providers must also more actively engage the student in the instructional context—an engagement that also includes finding effective strategies for assisting the student in gaining access to small-group interaction.

Consistent with the recognition of Palincsar and her colleagues about the power of group work in facilitating student learning, Brinton et al. see a collaborative role for speech-language pathologists in defining the composition of cooperative groups with classroom teachers. Cooperative teaching approaches to small-group work place students with varying ability levels together to accomplish a specific goal and present a unique advantage for students with LLI to learn in the inclusion classroom. However, mere placement in a particular group does not ensure successful interaction, or that the desired learning goals will be accomplished (Nelson, 1998). Brinton and her colleagues remind collaborators to consider individual differences in students’ social and language functions when planning group instructional experiences in the classroom. The implication is that speech-language pathologists have an ongoing role in assessment to identify the social profiles and language skills that are prerequisite for students to work well together.

Silliman et al. also agree that speech-language pathologists play a critical role in assisting students to be responsive to and responsible for their own learning. They suggest that inclusion may work best if teachers and speech-language pathologists integrate their direct instruction with strategy instruction in systematic ways. To achieve success in learning to read for students with LLI, they propose that multilevel, differentiated instruction is necessary in inclusive classrooms. This is an approach that varies the amount of curriculum adaptation based on individual student needs (e.g., see Salisbury et al., 1994).

Hadley et al. carved the most expansive role for speech-language pathologists with their focus on enhancing the language abilities of children who are at risk for academic failure. They proposed that Title 1 funds could be used to develop a role for language enhancement in inner-city school settings. The school district provided support for this role because of the collaborative success teachers and speech-language pathologists had experienced in improving both the vocabulary knowledge and the phonological awareness skills of kindergarten and first-grade students.

Whatever role speech-language pathologists define for themselves in inclusion classrooms, several points must be considered.

• It is important to remember that teachers also have an implementation focus, one that requires all students to meet certain curricular expectations or standards of performance.

• A single-discipline perspective is not sufficient to meet the complex needs of students with disabilities; thus, collaboration among providers is essential.

• A therapeutic perspective may delineate a clearer role for the school-based speech-language pathologist. However, the outcome could be the potential loss of meaningful collaborative partnerships that also lead to valued learning outcomes.

WHAT ARE SOME VALUED OUTCOMES FOR INCLUSIONARY PRACTICE MODELS?

An important factor that speech-language pathologists must consider in their delivery of inclusionary practice is the achievement of prioritized goals, or valued outcomes, as defined by students with LLI and their families. Contributors to this clinical forum offered a set of overlapping outcomes. For example, Silliman et al. identified three key outcomes for successful inclusionary practices. These included (a) evaluation of teaching strategies, which considers the students’ perspective on those methods most likely to ensure their academic success; (b) integration of problem solving with skill-based instruction, which is also responsive to individual differences; and (c) assessment and maintenance of supportive scaffolding to meet instructional goals.

Hadley and her colleagues also acknowledged two important, and related, outcomes that emerged from the classroom-based collaboration between general education teachers and a speech-language pathologist. First, intervention programs need to stress connections between oral language knowledge and literacy outcomes. In their study, inner-city students with a variety of language backgrounds enhanced their language abilities, both in terms of vocabulary building and early reading skills. Second, instructional planning must be premised on collaborative partnerships (Christensen & Luckett, 1990; Ellis, Schlaudecker, & Regimbal, 1995; Farber & Klein, 1999; Prelock, Miller, & Reed, 1995; Throneburg, Calvert, Sturm, Parmboukas & Paul, 2000). These partnerships then led to the successful implementation of a collaborative, classroom-based model of service delivery.

Finally, in assessing the success of educational and related services for students with disabilities, outcomes external to the classroom must also be considered. In this regard, Giangreco proposed that a single question should be addressed: Did the collaborators’ efforts contribute to a better quality of life for children with special needs and their families?
WHAT ARE THE NEXT RESEARCH-TO- PRACTICE STEPS?

Practice-based research should continue to define intervention targets that are most likely to benefit from a collaborative approach to service delivery. A critical area for research is further investigation of the effectiveness of collaborative strategy instruction to support the linguistic and discourse needs of students with LLI across subject areas. Another area for study concerns when, how, and how often inclusionary classroom intervention should be initiated for individual students. Also, a pressing issue to resolve is the building of collaborative, inclusion-based classrooms in the presence of large caseloads with their resulting time constraints. All three of these clinical practice needs provide speech-language pathologists with a unique opportunity for collaboration with university-based researchers/clinicians.

Regardless of how research-to-practice needs are defined, speech-language pathologists must consider multiple perspectives in their collaborative efforts. These perspectives should guide practitioners in determining their role in inclusionary practice, sharing their responsibility for student performance, and designing practice-based research to investigate the effectiveness of intervention plans, procedures, and outcomes. Most importantly, speech-language pathologists must never lose sight of the fact that their primary responsibility is to support the individual needs of students with LLI in mastering relevant, classroom-based curricula.

REFERENCES


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