

TECHNICAL MANUAL

A GUIDE FOR THE
APPROPRIATE ASSESSMENT
OF CULTURALLY &
LINGUISTICALLY DIVERSE
AND INTERNATIONALLY-
ADOPTED INDIVIDUALS



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FOREWORD

The authors have successfully compiled key facts and information from research, state and federal laws, and ASHA policies to create a practical guide for SLPs who work with English Language Learners. The authors provide a cogent, data-based argument for stopping the use of inappropriate, biased, standardized tests with ELLs. The authors provide specific and practical suggestions about acceptable assessment alternatives with ELL and internationally-adopted populations. Kudos to the authors for undertaking such complex and far-reaching topics! It is a pleasure to recommend this manual.

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PURPOSE

Qualification for services and disability determinations are complex processes with several facets. Some populations are overqualified for services, while others are underqualified. Culturally and linguistically diverse (CLD) and bilingual children are often disproportionately identified as having disabilities when, in reality, their seemingly poor performance during evaluations are the result of other factors, such as socioeconomic status (SES), prior experience, dialectal differences, and second language acquisition. In contrast to CLD and bilingual individuals, internationally-adopted (IA) children are often underqualified for services. IA children are often evaluated as if they are bilingual or limited English proficient (LEP) students who will catch up in their ability to communicate when given an adequate level of exposure to English. The reality is, however, that IA students are significantly different than bilingual or LEP students and lack adequate foundational language skills in order to adequately perform in an academic setting.

The purpose of this technical manual is to provide information to protect the legal rights of CLD and IA individuals in the state of New Jersey to ensure that these individuals receive disability evaluations consistent with the standard set forth by the Individuals with Disabilities Education Act 2004 (IDEA 2004). As such, they are entitled to disability evaluations that are free of cultural, linguistic, and racial biases, are valid and reliable, and distinguish a disability from a lack of instruction in reading or math and from limited English proficiency. Such appropriate disability evaluations increase the accuracy of disability determinations ensuring that the appropriate children and adolescents are identified as having speech, language, and/or learning difficulties. This manual also aims to assist evaluators and clinicians in learning about appropriate assessment materials and strategies for CLD and IA individuals.

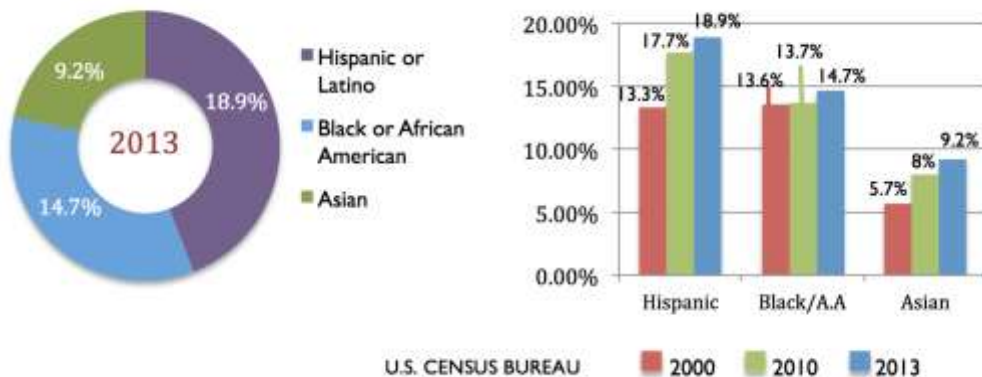
HOW TO USE THIS GUIDE

Some of the information provided in this manual specifically addresses the preschool and school-age disability evaluation process. However, it is important to note that the information and recommendations provided in this manual can be applied to all evaluations, such as those conducted at hospitals or private practices. We hope that this manual will be of service to you and that together we can implement appropriate assessment procedures for CLD and IA individuals in the state of New Jersey. If you have questions about this manual or CLD or IA issues in general, please contact the NJSHA Multicultural Issues Committee at mic.njsa@gmail.com.

ASSESSMENT GUIDELINES FOR CLD INDIVIDUALS

New Jersey's Cultural and Linguistic Diversity

One only needs to take a look around to see that the U.S. and specifically New Jersey is increasingly diversifying. This diversification is the result of a growing intersection of cultures and languages taking place today. According to the 2013 census, 29.6% of New Jersey residents, ages 5 and older, speak a language other than English at home and 20.8% were born in a foreign country ([U.S. Census Bureau, 2014](#)). Furthermore, 18.9% of residents are Black/African American, 14.7% are Hispanic/Latino, and 9.2% are Asian ([U.S. Census Bureau, 2014](#)). The data also show that there has been a steady increase in the percentage of minority populations residing in New Jersey. With these current demographic trends in the state, it is clear that populations that were once considered “minority” are rapidly becoming the “majority.”



Despite the growing diversification of the general population, only 3.5% of New Jersey ASHA certified speech-language pathologists are Hispanic/Latino, 2.5% are Black/African American, 2.4% are Asian ([ASHA, 2013](#)), and only 5.3% indicated that they meet the ASHA [definition](#) of bilingual service provider ([ASHA, n.d., a](#)). As a result, speech-language pathologists will inevitably encounter individuals from cultural and linguistic backgrounds different from their own, making it crucial that they learn appropriate assessment methods for CLD children.

Who is CLD?

A **CLD** child is one “...who has had experiences that are different from those of middle-class, mainstream, Standard American English speaking children that often make up the majority of children used in normative samples in norm-referenced tests” ([Crowley, n.d.](#)). Bilingual children also fall under the umbrella term of CLD. **Bilingual** refers to an individual’s use of two (or more) languages. Bilingual individuals may learn more than one language at the same time or from a very young age (**simultaneous bilingual**), or may learn them at different points in their lives (**sequential bilingual**).

Difference vs. Disorder

Cultural and linguistic diversity, including second language acquisition and bilingual language development, creates some challenges in speech and language assessment. Clinicians must be careful to distinguish whether the individual has a difference or disorder. A **speech/language difference** refers to the differences in a person's speech and language skills as the result of speaking or being exposed to languages and dialects other than or in addition to Standard American English (SAE), whereas a **speech/language disorder** refers to a significant discrepancy in speech and language skills compared to other individuals of the same age and from the same cultural and linguistic background and speech community.

Unfortunately, it is often difficult for speech-language pathologists to make the distinction between a difference and a disorder due to a lack of training on this topic. In a 2001 study, Roseberry-McKibbin, Brice, and O'Hanlon (2005) found that approximately 40% of respondents had not taken any coursework related to working with bilingual students. It was also discovered that more respondents from Mid-Atlantic states hadn't taken coursework in this area compared to those that had. Yet, speech-language pathologists who have taken bilingual coursework have better knowledge of differences and disorders compared to those who haven't (Levey & Sola, 2013). Without this type of coursework or training, speech-language pathologists experience difficulties in providing appropriate services to CLD children.

Overrepresentation of CLD Children in Special Services

The lack of training on appropriate assessment of CLD students, as well as the mismatch of cultural and linguistic backgrounds among teachers, children, and clinicians, contribute to an overrepresentation of CLD individuals being classified for special services and receiving speech therapy. According to the U.S. Congress, "more minority children continue to be served in special education than would be expected from the percentage of minority students in the general population" [20 U.S.C. § 1400(c)(12)(B)]. Of the 220,532 students (ages 3-21) in New Jersey who were classified with a disability as of October 15, 2013, approximately 2% were LEP, 4% were Asian, 19% were Black, and 23% were Hispanic (A. Samson, personal communication, March 23, 2014). Based on the New Jersey Department of Education (n.d.) enrollment data for the [2012-2013](#) and [2013-2014](#) school years, there are larger percentages of Black and LEP students classified with a disability than there are in the general population. To ensure that CLD individuals do not continue to be misdiagnosed and incorrectly classified with a speech, language, or learning disability, speech-language pathologists need to increase their awareness and knowledge of appropriate assessment methods.

For over a century, educational placements and entitlements for individuals have been determined by standardized testing and continue to be a significant part of placement decisions for CLD individuals. However, no test can distinguish a disability from LEP or

outside influences, such as lack of prior experience. Moreover, standardized tests are not developed to identify a disorder relative to a particular student’s speech community. Traditional assessment materials in the form of norm-referenced tests, assume similar prior experiences and common use of the SAE dialect. This dissonance between the diversity of experiences and linguistic exposure and the assumed shared prior experiences and dialect has allowed for cultural and linguistic biases to develop. The use of standardized tests and traditional assessment materials may, therefore, inadequately measure a CLD child’s cognitive and communication abilities and, as such, should not be the sole or primary factor in determining a need for services.

The New Jersey Administrative Code

The [New Jersey Administrative Code \(N.J.A.C.\)](#) states that evaluations should consist of standardized tests *when it is appropriate* or required to use them [N.J.A.C. 6A:14-3.4(f)(3)], but there is no specification as to when a standardized test should be “required,” and, in the case of CLD individuals, standardized tests are not appropriate. Yet, speech-language pathologists across the state are repeatedly demanded standard scores to identify disability. Many school districts require standardized testing without realizing why such testing is not appropriate for CLD individuals and that by administering such tests, speech-language pathologists are going against their ethical and legal obligations.

Within the N.J.A.C., there are different guidelines that protect the rights of New Jersey’s children, depending upon their chronological age. Children from birth to the age of three are protected under Chapter 8, Title 17 of the N.J.A.C. (Early Intervention System), whereas children over the age of three are protected under Chapter 6A, Title 14 of the N.J.A.C. (Special Education). Although these chapters of the N.J.A.C. present different eligibility criteria, one constant among the criteria is that tests should be used *when appropriate*. The eligibility and classification criteria, as described in the N.J.A.C., will be detailed below.

“**Developmental Delay**” is the classification criteria used to describe children in New Jersey who are receiving Early Intervention services. Developmental delay refers to a minimum of a 33 percent delay in one developmental area or a minimum of a 25 percent delay in two or more developmental areas, “or, if *appropriate* [emphasis added] standardized instruments are individually administered..., a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas” [N.J.A.C. 8:17-1.3]. Title 8 of N.J.A.C. further dictates that evaluations “should be based on informed clinical opinion” [N.J.A.C. 8:17-6:1(a)] and that assessment practices should not be racially or culturally discriminatory or rely on a single procedure as the sole criterion for eligibility [N.J.A.C. 8:17-6:4(a)]

“**Preschool child with a disability**” is another classification criteria described in the New Jersey Special Education Code. This criterion specifically relates to children ages three through five, who present with developmental delays. The code states that the development delay should be “measured by *appropriate* [emphasis added] diagnostic

instruments and procedures” [N.J.A.C. 6A:14-3.5(c)10] and, as previously stated, standardized tests are not considered appropriate when working with CLD populations.

The New Jersey state classification criteria “**Communication Impaired**” (CI) requires that the speech-language specialist play a key role in making eligibility decisions for a suspected communication impaired student. CI, as defined in the N.J.A.C., specifies that an individual’s performance must be “below 1.5 standard deviations, or the 10th percentile on a least two standardized language tests, *where such tests are appropriate* [emphasis added]” and the communication disorder must adversely affect the student’s educational performance [N.J.A.C. 6A:14-3.5(c)4]. The CI criteria also entails the use of functional assessment in a setting other than a testing situation to assist with demonstrating a student’s functional and academic language and learning skills and if there is an existing problem affecting their educational performance.

In addition to the aforementioned guidelines, the N.J.A.C. also dictates that all assessments or measures selected be valid and reliable [N.J.A.C. 6A:14-3.4(f)(3)(ii)] and “normed on a representative population,” or in layman’s terms, accurately represent and reflect the population to which the child belongs [N.J.A.C. 6A:14-3.4(f)(3)(iii)], which is consistent with the standard set forth by the federal government.

Federal Standard for Disability Evaluations

IDEA 2004, which guarantees the right to a free, appropriate public education to children with disabilities, does not require nor mention the use of standardized tests when making disability determinations. IDEA 2004 does require each school district to select and administer appropriate assessments and evaluation materials (e.g. observations, questionnaires, functional assessments) that are free of racial or cultural biases in order to prevent discrimination [20 U.S.C. § 1414(b)(3)(A)]. IDEA 2004 also dictates that professionals comprehensively assess an individual by using a “variety of assessment tools and strategies to gather relevant functional, developmental, and academic information, including information provided by the parent” [20 U.S.C. § 1414(b)(2)(A)] and should “not use any single measure or assessment as the *sole criterion* [emphasis added]” in diagnosing and determining the eligibility of an individual [20 U.S.C. § 1414(b)(2)(B)]. IDEA 2004 further mandates that all assessments or measures selected should be valid and reliable [20 U.S.C. § 1414(b)(3)(A)]. Assessments must also be able to distinguish disability from limited English proficiency and/or lack of instruction in reading and/or math [20 U.S.C. § 1414(b)(5)].

Current Assessment Practices

Although the requirements for appropriate disability evaluations are clearly stated in state and federal law (as detailed above), our current assessment practices are flawed and undermine our duties to the children we serve.

Examples of Inherent Problems with Current Assessment Practices:

- ❖ Many standardized tests focus on labeling. However, many cultures do not place a heavy importance on naming skills (Peña & Quinn, 1997).
- ❖ Standardized tests often test vocabulary knowledge (Crowley, 2012). Yet, this knowledge is linked heavily with one's experiences (e.g. consider the relevance of the word "skyscraper" in the Midwest vs. in NYC) and exposure to language, which is influenced by SES (Hart & Risley, 1995 and 2003), as well as cultural and ethnic backgrounds (Stockman, 2000). English vocabulary knowledge, listening comprehension, syntactic skills, and metalinguistic language skills are also affected by oral proficiency in English, which means that English language learners may lag behind their peers in these areas (August & Shanahan, 2006). Vocabulary tests are, therefore, typically biased against CLD populations.
- ❖ Speech and language assessments employ known-answer question formats, meaning that the clinician already knows the answers to the questions being asked. Some cultures do not use these types of questions, which may make it difficult for a CLD individual to answer them to their fullest potential, as they may not realize what type of response is being expected of them (Heath, 1982).
- ❖ Standardized tests can have poor discriminant accuracy, meaning that the tests do not correctly separate children with language disorders from those that are typically-developing.
- ❖ Translated tests normally do not consider the fact that speech and language milestones vary across languages. Languages have different morphological, syntactical, semantic, and phonological features and rules (e.g., Chinese languages lack morphemes, whereas SAE has 7 inflectional morphemes). Translations simply cannot reflect all of these differences.
- ❖ Standardized tests assume that students are comfortable with 1) interacting with an unfamiliar adult, and 2) verbally displaying their knowledge to that adult. In many cultures, children are to remain respectful and silent around adults. Verbally displaying knowledge may be considered a challenge to the adults' authority.
- ❖ Standardized tests often lack **validity** (degree of accuracy in which an assessment measures what it is intended to measure) and **reliability** (degree of consistency of the assessment, across economic, cultural, racial, gender differences, etc.) when used to assess the abilities of CLD individuals (Caesar & Kohler, 2007).
- ❖ Traditional assessment materials are not adapted to the needs of CLD individuals in order to appropriately assess their abilities (McLean, 1995).

Using standardized test scores to determine the eligibility of CLD individuals for services can have serious ramifications and may lead to gross misdiagnoses and overrepresentation of minority children receiving special services. These traditional eligibility practices that heavily rely on standardized tests ultimately yield unsound results in determining the eligibility of CLD individuals for services. Such assessments produce results that often do not fully reflect the abilities and skills of a CLD individual and should, thus, not be relied upon when determining if an individual has a speech or language disorder.

Adopting Appropriate and Authentic Assessment Methods for CLD Individuals

“ Presumably, the reason why speech-language pathologists are best equipped to assess the communication skills of language-impaired children is that we have also been trained in matters involving children’s development and use of behaviors important to communication. It is this training that is called on in the adoption of non-standardized measures, and it is this training that we need to apply if we are to serve language-impaired children adequately, and demonstrate that we have an important service to offer in the area of language assessment. ”

Leonard, Prutting, Perozzi, & Berkley (1978, pp. 375-376)

“ As professionals, we must be prepared to provide services that are responsive to...diversity to ensure our effectiveness. Every clinician has a culture, just as every client/patient has a culture...Only by providing culturally and linguistically appropriate services can we provide the quality of services our clients/patients deserve. Regardless of our personal culture, practice setting, or caseload demographics, we must strive for culturally and linguistically appropriate service delivery. ”

[ASHA \(2004, p.1\)](#)

As Leonard et al. (1978) argue, clinicians are most equipped to appropriately assess such ‘language-impaired’ individuals because they are, unlike standardized tests, capable of distinguishing the subtleties between speech-language differences and speech-language disorders—a process that is both qualitative and multi-dimensional in nature. Bearing federal and state laws in mind, it is most important that evaluators carry the knowledge and skills necessary to evaluate CLD individuals to ensure an accurate diagnosis. It is an evaluator’s job to entail an abundance of investigative work to fairly and appropriately evaluate and treat CLD populations. Although this can take time, it can avoid many “false positive” diagnoses of language impairment, and in the end, many hours of paperwork and meetings are saved. It is, thus, critical for clinicians to always be mindful of this in order to provide CLD clients/patients with an unbiased and fair assessment of their skills and abilities.

There are alternative assessment procedures that are more appropriate and useful in accurately identifying language disorders in CLD individuals (ASHA, 2004; Caesar & Kohler, 2007; Kayser, 1995; Patterson & Pearson, 2012; Roseberry-McKibbin, 2014). According to [ASHA \(2004\)](#), the following are alternative assessment procedures that should be used with CLD individuals: “dynamic assessment, portfolio assessment, structured observation, narrative assessment, academic and social language sampling, interview assessment tools, and curriculum-based procedures” (p. 4). ASHA’s 2004 Policy document, [Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services](#), expresses that appropriate assessment of CLD populations includes the “application of appropriate criteria so that assessment materials/tests/tools that fail to meet standards be used as informal probes, with no accompanying scores.” It is further stated that speech-language pathologists and audiologists should understand the

problems associated with the use of translated tests and use these tests “only as informal probes, with no accompanying scores” (ASHA, 2004).

Appropriate & Authentic Assessment Methods for CLD Individuals

The Referral Process

The pre-referral process is a crucial one in ensuring that CLD children are not misidentified or over-identified as needing services. The pre-referral is “a screening and intervention process that involves identifying the (1) child’s problems, (2) source of the problems, and (3) steps to resolve the difficulties within the classroom setting” (Olson, 1991, as cited in Kayser, 1995). The speech-language pathologist plays a key role in the pre-referral process by helping the child study team to determine the child’s level of bilingualism, as well as his/her language environment and use (Kayser, 1995).

In order to conduct a complete and thorough pre-referral, vital information should be obtained from the family. By obtaining this information, clinicians can reduce the number of individuals that are unnecessarily referred for speech-language evaluations and speech-language services. If this information is not obtained during a pre-referral process, it is imperative that the clinician obtain the below information while conducting an evaluation of the CLD individual.

Components of the Parent/Family interview

- Obtain socio-cultural information: family’s socioeconomic status, cultural background (e.g., dialects, customs, traditions, ethnicity), family composition, level of connection with family outside of the United States
- Obtain a thorough birth, developmental, and medical history
- With the support of a social worker, collect information pertaining to prenatal risk factors, such as:
 - ❖ History of neglect and abuse in the family
 - Type (i.e., physical, sexual, emotional)
 - ❖ Family history of mental illness
 - ❖ Family history of substance abuse
 - ❖ Mother’s use of drugs and/or alcohol during pregnancy
 - Determine how many months along the mother was when she found out she was pregnant
- Obtain a thorough educational history
- **For families that speak languages other than English, professionals should determine the following information:**
 - ❖ What language(s) the individual speaks
 - ❖ Age when the child began learning each language

- If sequential bilingual, was the development of LI typical?
- ❖ Which language the individual speaks more fluently
- ❖ With whom the child speaks each language
- ❖ How long the child has been exposed to both languages
- ❖ Where the individual is exposed to both languages
- ❖ When the child is exposed to each language
- ❖ Who speaks to the child in each language
- ❖ What language(s) the individual hears others speak in the home
- ❖ Where the individual was born
 - If born outside of the U.S., when s/he moved to the U.S.
- ❖ What his/her speech/language skills were like prior to the move to the U.S.
- ❖ If the child has received speech/language therapy
 - If so, in what language(s)/country the therapy
- ❖ Where the parents were born
 - If the parents were born in another country, when they moved to the U.S.
- ❖ The family's concerns
 - If the concerns are the same for both languages

The Evaluation

Speech-language pathologists need to be well-trained and intuitive to appropriately evaluate CLD individuals. Ensuring that children are neither over- nor under-identified as needing services is a significant part of the job. Although evaluations of CLD individuals may be more complex and time-consuming than simply administering a few standardized tests, a child's cultural and linguistic diversity is not reason enough to delay or decline to perform a speech and language evaluation. Therefore, each child's skills and difficulties must be considered individually. Speech-language pathologists need to know and understand when reported weaknesses are more than speech or language differences; evaluations should be conducted as soon as true speech and language deficits are suspected.

Gathering Information

- Obtain information from classroom teachers and others who are in contact with the student on a daily basis
- Ask the "Critical Questions" (see p. 10)
- Determine the extent in which the bilingual child has had the opportunity to use each language
- Interview parent, student, teacher and other professionals or collateral resources
- Collect information concerning student's overall development, pertinent medical and educational information, and hearing history

Crowley (2012) has identified the “Critical Questions” needed to distinguish a linguistic and cultural difference from a true disability:

- Exposure, over time, to languages and/or dialects?
- Highest educational level of the mother or primary caregiver?
- Any significant changes in the family structure (death, divorce, serious sickness, insecure home, e.g., shelters, moving often)?
- Family history of speech, language and/or learning problems (Restrepo, 1998, as cited in Crowley, 2012)?
- How the child’s speech and language development and skills compare to his/her siblings at the same age or to peers in the same speech community (Restrepo, 1998, as cited in Crowley, 2012)?
- Does the child’s performance during the evaluation represent how he typically communicates and behaves?
- What does your child do to make you know that s/he is smart?
- Progress/regression in the past six months?
- Ten examples of the student’s best communications and where it breaks down

Components of the Teacher Interview

Crowley, Friedman, and Tancredi (2006) recommend conducting a teacher interview to perform a thorough and accurate assessment of the child’s skills. They encourage evaluators to review the student’s portfolio, or class notebook, with the teacher to determine performance over time. They also suggest that the following information be obtained during the teacher interview:

- The individual's grade-level performance in reading and math
- The support the individual may need
- The individual’s strengths and weaknesses
- If the individual’s English language skills are typical for a child with the same amount of exposure to English
- How well the student learns new materials
- If the SLP’s impressions of his communication skills are consistent with his usual performance in class and at school

Articulation/Phonology Assessment

- Obtain speech samples in L1 and L2, when possible
 - ❖ Single word
 - ❖ Continuous speech
- Perform independent analysis
 - ❖ Used with individuals with reduced phonological inventories (Bankson & Bernthal, 2004)
 - ❖ Describing the child’s speech sound system independent of the adult standard (Bankson & Bernthal, 2004)
- Describe phonetic inventories
 - ❖ Place, manner, voicing
- Perform relational analysis

- ❖ Describing the child’s speech sound system relative to the adult standard (Bankson & Bernthal, 2004)
- Examine consonant and vowel accuracy
- Examine accuracy of shared and unshared sounds between L1 and L2
- Perform substitution error analysis
 - ❖ Which sounds is the child not producing?
 - ❖ Are there crosslinguistic, dialectal effects?
 - Crosslinguistic, dialectal effects are not considered errors (Goldstein & Fabiano, 2007)
- Compare the child’s speech to the speech of others in the same linguistic community

NOTE: It is important not to overgeneralize the crosslinguistic or dialectal effects of one speech community to all speech communities. For example, one African American may speak African American English (AAE) and produce dialectal differences associated with AAE (e.g. “baf” for *bath*), whereas another African American may not (Goldstein & Iglesias, 2004). Professionals should not assume that all individuals from a specific geographical region or of a certain ethnicity or race speak the same dialect.

Fluency Assessment

- Obtain a detailed case history
 - ❖ Age of stuttering onset
 - ❖ Effect on client
 - ❖ Past therapies
 - ❖ Degree of stuttering in each language spoken
- Language samples – collect samples in L1 and L2
 - ❖ Conversations
 - ❖ Narratives
 - ❖ Reading
- Establish frequency, duration, severity, types, secondary characteristics
- Comprehensive language testing
 - ❖ Are the child’s speech-language abilities above, below or WNL?
- Are there concomitant speech-language deficits?

Van Borsel, Maes, and Foulon (2001) found that severity and distribution of dysfluencies differ from one language to another. Lim et al (2008) found that language dominance influences the severity but not the types of stuttering behaviors; bilingual speakers tend to show stuttering in both languages but exhibit different stuttering patterns. Stuttering occurs more often on content words in L1 and more often on function words in L2.

Watson and Kayser (1994) found that stuttering will be present in both languages, is usually accompanied by self-awareness, and will be accompanied by secondary behaviors. To calculate stuttering frequency in bilingual speakers, word-based measures may be more relevant than syllable measures. Speech-language pathologists need to account for linguistic variability, take into account cultural speaking norms as well as consider impact of cultural factors/beliefs on stuttering.

Language Assessment

- Observe the student in different settings, if possible
- Implement non-standardized assessment measures, including checklists, scales, trial teaching, self reports
- Use dynamic assessment to determine the student’s learning potential
 - ❖ Interactive process
 - ❖ Provides embedded instruction
 - ❖ Minimizes effects of previous experience
 - ❖ Refer to [ASHA](#) for information on how to conduct dynamic assessment
- Determine the impact of student’s communication proficiency on interactions with family, friends, and community members
- Assess the benefit the child receives from instruction
- Determine the impact of pre-referral interventions and or/any other interventions conducted to remediate the language problem
- Compare the student’s language skills with peers in his/her speech community
- Complete a BICS/CALP analysis for multilingual individuals
 - ❖ **BICS** stands for Basic Interpersonal Communication Skills and **CALP** represents Cognitive Academic Language Proficiency (Cummins, 2000).
 - ❖ Bilingual children take approximately 2 years to demonstrate BICS and approximately 5-7 years to develop CALP (Cummins, 2000; Collier, 1995), though Roseberry-McKibbin (2014) cautions that these timelines may be more variable than originally thought and may be greatly affected by socioeconomic status.
 - ❖ Many English proficiency tests administered in school systems focus on BICS, so bilingual children may be deemed to be proficient in English, even though they have yet to develop or master CALP. This will lead them to have difficulties in the classroom and may cause them to be wrongly referred for a speech and language evaluation ([Roseberry-McKibbin & Brice, n.d.](#)).
- Assess information processing skills (e.g. nonword repetition)
 - ❖ Culturally non-biased assessment measure (Haynes & Pindzola, 2012, as cited in Roseberry-McKibbin, 2014)
 - ❖ A child’s performance on information processing measures “can be compared to that of siblings and peers from similar cultural, linguistic, and socioeconomic backgrounds” (Roseberry-McKibbin, 2014, pp. 289).
 - ❖ Nonword repetition tasks are useful in the assessment of ELLs and have clinical significance in other languages (Gutiérrez-Clellen & Simon-Cerejido, 2010)
 - ❖ The following subtests of the CTOPP-2 may also be used CLD children: Memory for Digits, Nonword Repetition, Rapid Digit Naming, Rapid Letter Naming, Rapid Color Naming, Rapid Object Naming (Roseberry-McKibbin, 2014).
 - When using the CTOPP-2, like any other standardized test, it’s important to be mindful of the normative sample to ensure that the child being assessed is being compared to others from a similar cultural and linguistic background.
- Obtain narrative samples

- ❖ Children with language impairment produce linguistically and structurally poorer narratives (Boudreau, 2008).
- ❖ Children with language impairment display less of the following: conventional introductions/conclusions, total words, different words, cohesive ties, story grammar elements, complete episodes, communication repairs, and attempts, plans, and internal responses (Crais & Lorch, 1994).
- ❖ Narrative cohesion is not negatively impacted by dialect (Burns, de Villiers, Pearson, & Champion, 2012).

According to Roseberry-Mckibbin (2014), indicators of language impairment in bilingual children typically include, but are not limited to, the following:

- Slow language and academic gains even with assistance (resource room, ESL, etc)
- Immature/deficient vocabulary
- Decreased utterance length
- Communication difficulties in a variety of settings (e.g. school, home, community) and with a variety of individuals (e.g. peers, teachers, parents)
- Memory and attention deficits in L1 and L2
- Lack of narrative coherence and cohesiveness
- Family history of language/learning issues
- Poorer language and cognitive skills as compared to peers
- Deficits in the comprehension and use of social language

Working with Interpreters

Language differences between CLD individuals and clinicians have serious implications for effective communication. It is crucial that clinicians seek to bridge any language gaps so that the client receives a fair assessment of their skills and abilities. IDEA 2004 requires that assessments be unbiased and be conducted in child's primary language [20 U.S.C. § 1414(b)(3)(A)]. It is, therefore, imperative for clinicians to work with an interpreter when evaluating a CLD individual to determine whether they have a disorder or not.

Selecting an interpreter

As [ASHA](#) (n.d.) states, the background and training of interpreters can vary a great deal. Even if an interpreter shares the same native language as the client, s/he may speak different dialects, which may lead to communication discrepancies. So, it is vital that clinicians carefully consider an appropriate interpreter for their CLD clients. [ASHA](#) (2004), thus, requests that clinicians ensure that interpreters:

- Have native proficiency in the individual's language(s) and dialect(s)
- Are capable of accurately interpreting and translating information
- Are familiar with and have respect for the client's culture and speech community
- Are knowledgeable in interviewing techniques, such as ethnographic interviewing
- Demonstrate professional ethics
- Maintain confidentiality
- Have knowledge of professional terminology
- Know and understand basic assessment principles

The Interpreter's Role and Responsibilities

An interpreter's role is to facilitate communication between the clinician and the client and their family; they are the bridge between two different languages. Thus, one of the most crucial keys to being an excellent interpreter is accuracy in translation. An interpreter must accurately interpret the ideas and concepts that the clinician is trying to convey to the CLD client and their family in order for the assessment and evaluation to be effective. As a result, [Langdon \(2002, April 02\)](#) suggests that interpreters should:

- Have professional oral and written proficiency in both languages: the CLD individual's primary language and the primary language of the interpreter (the mainstream language).
- Display in depth knowledge of both cultures, as well as well as both languages. A good interpreter is someone who is keenly adept at understanding both cultures well and who can convey such cultural information to both the clinician and the family for effective communication and mutual understanding.
- Maintain neutrality, confidentiality, and honesty.
- Understand the procedures and assessments being used.
- Demonstrate familiarity with relevant vocabulary.

The Clinician's Role and Responsibilities

Clinicians should ensure that they clearly convey their expectations to the interpreters to prevent any miscommunication. As a result, clinicians should distinctly instruct interpreters to only interpret exactly what they say and ensure that interpreters do not send any verbal or non-verbal cues. Clinicians should discuss this with their interpreters so that they may understand and ensure the validity of the assessment. Clinicians should also:

- Prepare and review materials, procedures, assessments, and evaluation plans ahead of time with interpreters to get them familiarized with the process and technical terms ([ASHA, n.d.](#)). Because interpreters are not professional clinicians, it is important to go over any questions they may have and to explain and clarify any information beforehand so that everyone is on the "same page" and the process runs smoothly.
- Be mindful that interpreters usually lag a few seconds behind when interpreting information from clinicians. Clinicians should consider the pace and length of what they say so that interpreters can appropriately interpret in the other language ([Langdon, 2002, April 02](#)).
- Eliminate technical jargon ([ASHA, n.d.](#)).
- Avoid translating and solely relying on standardized assessments and scores. Words, references, and phrases in standardized tests may have cultural/linguistic/dialectal biases that may not translate accurately into another language. Clinicians should adopt alternative qualitative assessments that appropriately assess a CLD individual's skills and abilities ([Langdon, 2002, April 02](#)).
- Be mindful of their body language to ensure that they do not offend the client or family ([ASHA, n.d.](#)).
- Be aware that it is possible that interpreters may give the client cues (physical and/or verbal) during the evaluation. Make sure the interpreter is aware that cues should not be provided ([ASHA, n.d.](#)).

Following the BID Process: Briefing, Interaction, and Debriefing

Familiarizing an interpreter with the evaluation process and procedures is crucial. Preparing interpreters beforehand will allow them understand the expectations being set when interaction with the client/patient and their family takes place. This will not only help the interpreter, but will as well help the clinician. Langdon and Cheng (2002) recommend that clinicians utilize the BID (Briefing Interaction, Debriefing) process with the interpreters to ensure a successful outcome.

Briefing

The Briefing step of the BID process is meant to fully prepare and brief the interpreter on expectations and procedures beforehand so as to prevent any kind of miscommunication or confusion when evaluating or assessing the client/patient. Thus, clinicians should ensure that they:

- Review the client's background and cultural information and family history with interpreter.
- Review materials and procedures with interpreter.
- Provide overview of the purpose of the evaluation and/or assessment and any strategies that will be used throughout the process with the client/patient.
- Elaborate on and clarify any professional terms and vocabulary the interpreter may not understand. Clinicians should allow interpreters time to translate these items ahead of time and agree on proper phrasing or wording to avoid confusion or misunderstanding later in the process.
- Discuss confidentiality and neutrality with interpreter.
- Discuss precise interpretation and limiting of verbal and non-verbal cues.
- Establish seating arrangements ahead of time. The interpreter should be seated in a manner that facilitates communication between the clinician, the client/patient, and the family.

Interaction

The Interaction step of the BID process refers to actual evaluation session in which the clinician and interpreter interact with the client/patient and their family. Thus, it is utterly crucial that the clinician and interpreter establish rapport with one another and work together seamlessly as a team to ensure successful outcomes.

- Clinicians and interpreters should both introduce themselves to the client/patient and their family and explain both their roles and expectations in the native language.
- Clinicians should avoid directly addressing their questions to the interpreter, i.e. "Ask her to point to the circle." Instead, all members of the team should directly address the client/patient and their family directly with direct eye contact.
- Use short, concise sentences and pause frequently to allow the interpreter time to process the information accurately.

- Both the clinician and interpreter should be taking notes. The clinician should not only take notes on the client/patient's behavior, but also on the interpreter's behavior and how they can improve for the next session. The interpreter should similarly take notes of the client/patient's responses and their impressions of the client's abilities and skills with regard to their linguistic and cultural background.

Debriefing

The Debriefing step of the BID process is the last step and is meant for the clinician and interpreter to review together and reflect back on the evaluation of the client/patient after the evaluation session is over.

- Both the clinician and interpreter should review the process and evaluation session, including the client/patient's behavior and responses.
- The interpreter may share their impressions and observations of the client/patient's skills and abilities and elaborate on any notes they took during the session.
- The clinician and interpreter may discuss the cultural appropriateness of assessments, wording, or strategies utilized in the session and whether they may need to improve.
- Clinicians should take this time to provide the interpreter with feedback about their performance and address any difficulties in the assessment or interpretation process and any behaviors/habits, strategies that may need to change for the next session in order to produce successful outcomes.

The Report

Because standardized tests do not appropriately assess a CLD individual's skills and abilities, it is important, when writing a report of a CLD client/patient, that clinicians be comprehensive and qualitative in their analysis of the client/patient's performance and not rely solely on results produced by such tests. The report should provide a clear visual picture of the individual's strengths and weaknesses. Clinicians should ensure that they:

- State the findings of the evaluation as related to the suspected disabling condition.
- Identify the reason for referral and by whom.
- Describe the student's weaknesses in the general education grade level curriculum and the general program.
- Describe the student's strengths in the general grade level curriculum and general program.
- Provide recommendations to increase participation in the general education curriculum and general program.
- Add a cautionary statement if standardized tests were administered.
 - ❖ **Example:** Testing materials are not available in standardized form for the student's unique (bilingual/bicultural, etc.) background. In accordance with IDEA 2004 [20 U.S.C. §1414(3)], official use of standard scores for this child would be inaccurate and misleading, so the raw scores (# of answered questions) are presented in descriptive form for comparison with future performance only.

ASSESSMENT GUIDELINES FOR IA CHILDREN

Between 1999 and 2012 more than 240,000 children were adopted from countries around the world and brought to United States. Almost 8,500 of these children were adopted by parents who live in the state of New Jersey ([Intercountry Adoption](#), n.d.). Age of adoption is often critical when it comes to new language acquisition. Children adopted at younger ages (under 2) typically have more time to develop adequate language proficiency (even despite birth language delays) prior to beginning school (Glennen, 2007). Older children (3+) often lack this opportunity. Several studies have found that age of adoption was strongly correlated with language outcomes (Glennen & Masters, 2002; Krakow & Roberts, 2003). In other words, older internationally-adopted (IA) children are potentially at greater risk of having poorer language outcomes than children adopted at younger ages.

Subsequent to the school-aged child's arrival to the receiving country, one of the major concerns that arise is the issue of appropriate school placement (Gindis, 2005) and whether speech language services should be provided to the child in question. Unfortunately, due to their unique linguistic status (rapid birth language attrition long before the acquisition of second language is complete), many speech language pathologists continue to have difficulties with determining the best service options for these children (Scott & Roberts, 2011).

Internationally-Adopted vs. Bilingual Children

It is important to understand that internationally adopted post-institutionalized children are not bilingual children since they are adopted by parents who do not speak the child's birth language. No matter at what age IA children are adopted they rapidly lose their birth language. Gindis (2005) has found that children adopted between 4-7 years of age lose expressive birth language abilities within 2-3 months and receptive abilities within 3-6 months post-adoption. Birth language attrition is more rapid in younger children (3.6-4 years of age) whose expressive language is just emerging or is delayed/impaired at the time of adoption (Gindis, 2008). IA children will acquire the new language via the subtractive model of language acquisition in which the birth language will be replaced and eliminated by the new language (Gindis, 2005). Numerous IA children adopted at younger ages (under 3) often present with limited language abilities and significant delays in their birth language as a result of which they tend to undergo "second first language acquisition" (Roberts, et al, 2005). First language attrition at the time when the second language has not been firmly established has a negative impact on the development of the new language (Lambert, 1975; Roberts, et al, 2005)

New Language Acquisition

The "initial" stage of new language (L2) acquisition is very rapid during the first year (Geren, Snedeker & Ax, 2005; Gindis, 2005; Pollock, 2005) with IA children displaying impressive language gains (Glennen, 2009). Data from parental surveys, research studies as well as published clinical experience show that "fully functional communicative fluency is usually achieved by international adoptees of school age within the first 6 to 12 months of

their life in their new country” (Gindis, 2005, p. 301). This is known as the “Communicative Language Fluency” (CLF) or the ability to express basic wants and needs as well as interact with others socially on a daily basis in familiar contexts (Gindis, 2005). This ability differs from “cognitive language mastery” (CLM) or what Silliman & Scott term: the mastery of “academic language register,” which refers to the child’s ability to meet the rigorous academic demands of the classroom in order to successfully keep up with the curriculum (Gindis, 2005; Silliman & Scott, 2009; Scott & Roberts, 2011).

CLF and CLM should not be confused with Cummins’ (1984) Basic Interpersonal Communication Skills (BICS) / Cognitive Academic Language Proficiency (CALP) Model, developed for bilingual language learners, since there are marked differences. For instance, according to Cummins (1984), when it comes to BICS, it takes bilingual school-age children approximately 2 years to reach native language proficiency. In contrast it takes IA school-aged children only a fraction of that time to develop the same abilities. Similarly, research cites a period of approximately 5-7 years for bilingual children to develop CALP (Cummins, 1984; Collier, 1995) however, presently researchers are uncertain how many years it takes for IA older school-aged children to display similar mastery as no such reliable data is currently in existence (Scott & Roberts, 2011).

Many older IA children struggle to meet academic language requirements and display poorer language outcomes as compared to peers adopted at younger ages or non-adopted peers (Desmarais, et al 2012; Hough & Kaczmarek, 2011; Scott, Roberts, & Glennen, 2011; Beverly, McGuinness, & Blanton, 2008). This is due to inconsistent/impaired pre-adoption foundational language abilities and early literacy skills; lack of consistent care-giving and prolonged time spent in institutionalization has been found to correlate with greater language delay/deficits as well as poorer long-term outcomes across cognitive, socio-emotional and physical domains (e.g. Tarullo & Gunnar, 2005; Judge, 2003). Thus when performing assessments on IA children it is important to explain to parents, teachers, as well as other educational professionals the difference between the child’s surface language abilities and true comprehension of academic subject matter.

Appropriate & Authentic Assessment Methods for IA Individuals

Post-Adoption Assessment Recommendations

After a preschool or school-aged child arrives in the United States, a comprehensive speech and language assessment is recommended, if a speech-language pathologist can be found speaking the child’s birth language. Due to rapid birth language attrition, an evaluation in the birth language will not be valid after +/- 4 months in the receiving country (Glennen, 2007) for a child without documented birth language delay. However if a child has a documented history of delayed and disordered speech-language abilities (Gindis, 2008) then a window of opportunity to assess the child in the birth language narrows to weeks vs. months (Elleseff, 2011). After that time period a child should be evaluated in English in order to determine how rapidly s/he is acquiring it (Glennen, 2007).

To optimize assessment, careful consideration of risk factors are needed (Hough & Kaczmarek, 2011; Glennen, 2007; Jenista, 2000).

Pre-assessment Procedures (all IA Children)

- ❖ Review pre-adoption records containing relevant diagnoses (medical, speech language delay, etc) in order to determine if there are any diagnoses impacting speech, language and cognition (Miller, 2005; Gindis, 2004)
 - Attempt to obtain as complete of a history regarding pre- and post-natal development as possible
- ❖ Alcohol related deficits are significant concern for any children adopted from Eastern European countries
 - Any anecdotal information the adoptive parents may have gained regarding maternal alcohol use during pregnancy **will be very important.**
- ❖ Asking adoptive parents the right questions regarding FASD-related risk factors (if known)

Questions Regarding Prenatal History

- ❖ What was the age of the biological mother when she gave birth to the child in question?
- ❖ How many other pregnancies occurred prior to/post that one?
- ❖ How many children did the mother have in total?
- ❖ What was maternal socioeconomic status?
- ❖ Was there a family history of mental illness?
- ❖ Was there a history of maternal neglect and abuse in the family?
 - Physical, sexual, emotional?
- ❖ Was the father known? If yes was he involved in the family?
- ❖ Why were maternal rights terminated?
- ❖ Was maternal geographic region known for history/tolerance of heavy drinking?
- ❖ Was there a maternal history of substance abuse?
- ❖ If known, was the mother taking any substances prior to finding out she was pregnant? Alcohol? Drugs?
 - If yes, how frequently **per day**?
 - What amount and type?

Questions Regarding Developmental Milestones (if known/available)

- ❖ Did the child have history of:
 - Significant medical issues?
 - If so what type and how were they treated?
 - Failure to thrive?
 - Swallowing deficits and/or feeding deficits?
 - What is known about delayed speech/language milestones?
 - At what age did the child start using first words?
 - At what age did the child start using word combinations?

- Did the child ever have inconsistent language gains (e.g., had the skill then lost it)?
 - Gross/Fine Motor Milestones?
 - Self help skills?
- ❖ Did/does the child have self-regulation difficulties?
 - Was s/he excessively irritable and difficult to soothe?
 - Does the child have severe temper tantrums and behavioral outbursts?
 - ❖ Is the child socially inappropriate with peers/adults?
 - If yes explain and provide details.
 - Is the child inattentive and hyperactive?
 - Does the child have poor impulse control?
 - Does the child have poor decision-making skills?
 - Is the child anxious?
 - Easily over stimulated?
 - Oppositional?
 - Ignores what s/he is told?
 - ❖ Does the child have challenges with transitions/changes?

Questions Relevant specifically to School-Aged Children

- ❖ Has a child been diagnosed with a psychiatric disorder?
 - Concomitance of psychiatric impairments with FASD is very high
- ❖ Does the child have learning disabilities?
 - Reading and writing deficits?
 - Listening comprehension deficits?
 - Information processing deficits?
 - Social pragmatic language deficits?
- ❖ Are the child's language abilities significantly poorer than those of his/her peers?
 - Does s/he speak in shorter less complex sentences?
 - Have immature vocabulary?
 - Have impaired story-telling skills?

A Note on Records Review: If the child's records contain a mention regarding birth language delay then it should be considered seriously (Gindis, 1999) and speech-language services should be provided. Language delays in birth language transfer and affect the new language (McLaughlin, Gesi, & Osani, 1995). Delays will continue to persist unless relevant speech-language interventions are provided. "Any child with a known history of speech and language delays in the sending country should be considered to have true delays or disorders and should receive speech and language services after adoption" (Glennen, 2009, p. 52).

Assessment Recommendations: Newly Adopted Children

IA children's language abilities should be retested and monitored at regular intervals during the first several years post arrival. Glennen (2007) recommends 3 evaluations during the first year post arrival, with annual reevaluations thereafter. Hough & Kaczmarek (2011) recommend a reevaluation schedule of 3-4 times a year for a period of

two years, post arrival. Researchers have found that some IA children continue to present with language-based deficits many years (5+) post-adoption (Desmarais, et al 2012; Eigsti et al, 2011; Hough & Kaczmarek, 2011; Beverly, McGuinness, & Blanton, 2008). Consequently, an individualized approach is needed to decide on frequency and type of reassessments since deficits can manifest during any given period post-arrival.

If a speech-language pathologist speaking the child's first language is not available consider assessing the child in English between 3-6 months post-arrival depending on the child and the situational constraints.

Assessment Areas

- ❖ Comprehension of basic directions with and without gestures/visuals
- ❖ Basic vocabulary of nouns, verbs, and adjectives
- ❖ Speech intelligibility
- ❖ Any atypical socialization patterns

Red Flags

- ❖ Limited ability to comprehend basic one-step directions without embedded concepts
- ❖ Very limited vocabulary (slow, halting, inconsistent gains)
- ❖ Poor speech intelligibility
- ❖ Odd behaviors/poor socialization with others
- ❖ Aggressive/oppositional behaviors

Newly adopted older children should be demonstrating rapid language gains in the areas of receptive language, vocabulary, and articulation (Glennen 2007, 2009). It is important to note that standardized scores cannot be reported during the first several assessments. Scores cannot be reported because there are no published standardized tests created for IA children. Additionally, similar to our discussion about CLD populations, existing standardized tests are not valid or reliable when used with IA children. Therefore, speech-language pathologists should use clinical judgment to determine if gains are adequate. For preschool children adopted between 3-4 years of age, standardized tests can be used to validly assess the above areas, but not expressive language after one year home (Glennen, 2009). Assessing **expressive language** one year post-arrival speech-language pathologists need to use “peer-based local norms” [to] “provide insights into who is doing well and who has a true language-learning disorder” (Glennen, 2009, p. 60). Speech-language pathologists need to use language samples and dynamic assessment measures to provide a more accurate picture of the child's abilities (Hough & Kaczmarek, 2011; Gindis, 2005). Please note that there may frequently exist a gap between receptive and expressive language abilities of IA children for many years post adoption, with receptive understanding being superior to language expression.

Assessing Older Children Several Years Post-Adoption

- ❖ What are the parental concerns?
- ❖ What are the teacher's concerns?
- ❖ What is hoped to be gained by this assessment?

- Accommodations/Modifications?
- Related Services?
- Type and frequency of appropriate interventions?
- ❖ Are concerns related to the child’s basic language abilities?
 - Still not as developed as hoped
- ❖ Are concerns related to the child’s academic language functioning?
 - Still struggling and falling farther and farther behind?
- ❖ Are concerns related to the child’s processing of language?
- ❖ Are concerns related to the child’s social pragmatic language abilities?

Pre-Assessment

- ❖ Complete caregiver intakes
- ❖ Prioritize assessment based on present needs
- ❖ Determine greatest impairment areas
 - Not all IA children display similar severity of deficits
- ❖ Create a referral form for teachers and caregivers to ensure consistency of deficit recognition across all reporters
- ❖ Select instruments based on findings
- ❖ Use less cognitively demanding tests for children with severe language deficits
 - Examples of less cognitively demanding tests:
 - Elementary Language Processing Test-3 (LPT-3)
 - The Expressive Language Test -2 (ELT-2)
 - Receptive One-Word Picture Vocabulary Test-4 (ROWPVT)
 - Expressive One-Word Picture Vocabulary Test-4 (EOWPVT)
 - Test of Auditory Processing Skills-3 (TAPS-3)
 - Word Test-2 Elementary
- ❖ Target ‘deficit specific tests’ in higher functioning children
 - Examples of deficit specific tests:
 - Tests of Problem Solving-3 Elementary (TOPS-3)
 - Tests of Problem Solving-2 Adolescent (TOPS-2)
 - Test of Pragmatic Language-2 (TOPL-2)
 - Social Emotional Evaluation (SEE)
 - Social Language Development Test-Elementary (SLDT-E)
 - Social Language Development Test-Adolescent (SLDT-A)
 - Executive Functions Test-Elementary (EFT-E)
 - Clinical Assessment of Language Fundamentals-5 Metalinguistics (CELF-5M)

Determining Severity of Impairment

If the child’s language “appears” intact determine “hidden deficits” such as problem solving abilities and social language skills. If the deficits are very severe administer general language testing of reduced complexity in order to get a starting point for prioritizing intervention

Monitoring of Possible Problem Areas

As the children's communicative language fluency improves make sure gains are still made in all other areas of language, which contribute to academic success.

- ❖ Specific areas of weakness of IA children identified by studies (Desmarais, et al 2012; Hough & Kaczmarek, 2011; Loman et al 2009; Beverly, McGuinness, & Blanton, 2008; Croft et al. 2007; Dalen, 2001; Dalen, 1995; Gindis, 2005; Glennen & Bright, 2005; Tarullo, Bruce & Gunnar, 2007; Jacobs, Miller, & Tirella, 2010; Welsh & Viana 2012) include:
 - Impaired verbal memory and sentence comprehension
 - Reduced sentence length and complexity
 - Reduced discourse and narrative abilities
 - Impaired reading and writing abilities
 - Impaired problem solving and verbal reasoning
 - Impaired social pragmatic skills
 - Impaired executive function skills

CONCLUSION

Assessment of CLD and IA individuals is a dynamic process. These children are vastly different than the mainstream, U.S.-born, SAE speakers for which many standardized tests were designed. Therefore, clinicians need to employ a variety of assessment procedures when working with these populations to ensure fair, unbiased, and accurate results. It's important that professionals don't further contribute to the overrepresentation of CLD and bilingual children in special education, and equally important that speech-language pathologists don't let individuals with real speech, language, or learning difficulties fall through the cracks. By utilizing research-based assessment practices and abiding by federal law and ASHA guidelines, clinicians can correctly identify children in need of services.

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