

**Preferred Practice Patterns for Speech-Language Pathologists
In
Service Delivery to Infants and Toddlers and Their Families
Guidelines for Intervention Planning and Delivery**

California Speech-Language-Hearing Association
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Ad Hoc Committee on Early Intervention
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Successful interventions for communication delays with very young (0-3) children result in children who have enhanced comprehension of their immediate environment and the ability to interact with and/or modify their environment through meaningful, interpersonal communicative behaviors.

Early intervention for communication delays is defined as intervention in the form of assessment and/or treatment provided to families and their children below the age of three years, who demonstrate, or are at-risk for demonstrating, either a disability or delay involving communication, language, speech, or oral-motor behavior. (ASHA, 1989)

The foundation for meaningful assessments and successful interventions with very young children lie in the establishment of a respectful, family-professional relationship that results in positive, family-centered practices. Relationship-based, family-centered practices include the mutual processes of communication, collaboration and negotiation which, when practiced positively and consistently, strengthen family-professional partnerships.

The development of communication skills in young children is intricately associated with the acquisition of other developmental skills including cognition, motor, psychosocial and self-help skills and may involve sensory, medical, mental health and/or environmental and other issues. Appropriate service delivery to the child and family necessitates a collaborative, cooperative multi-, inter-, and/or trans-disciplinary team effort resulting in a broad range of expertise and service delivery options.

Functions of the Speech-Language Pathologist in Assessment With Young Children

Communication disorders in young children include disorders of speech (i.e., articulation, fluency, resonance and voice), language (i.e., preverbal communication and phonology, morphology, syntax, semantics, and pragmatic/social aspects of verbal communication), and swallowing or other upper aerodigestive functions. and may include cognitive, motor and/or sensory components which are related to communication or swallowing functions.

The speech-language pathologist (SLP), in collaboration with the child's family or primary caregivers and other members of the child's multi-disciplinary team, develops a communication intervention plan for a very young child on the basis of an appropriate developmental assessment, preferably in the family's primary or home language. (ASHA, 1997 a,) The assessment should consist of: 1) determination of the parent/caregiver's concerns and priorities, 2) identification of the child's existing prelinguistic communicative signals, language precursors, comprehension and use of language and speech, 3) determination of the effectiveness of the child's existing semantic, syntactic, phonological, and pragmatic communication schemes and/or oral motor skills including feeding and swallowing, and 4) an evaluation of the appropriateness and effectiveness of the care giving environment to interpret and act upon the child's communicative attempts.(ASHA, 1990,)

The SLP conducts a developmental assessment by using a combination of indirect and direct assessment methods which may include the use of developmental assessment instruments, parent/caregiver interviews, direct observation(s) of the child and caregiver(s) in natural play or care giving environments and appropriate standardized assessment instruments.

Functions of the Speech-Language Pathologist in Interventions with Young Children

According to a report prepared by the American Speech Language Pathology Subcommittee on Speech-Language Pathology Service Delivery with Infants and Toddlers (ASHA, 1990), the SLP functions as a direct provider of services to families with young children with communication, language, speech and/or oral motor difficulties. In addition, as a member of a collaborative team involved with a child and family, the speech language pathologist also serves as a consultant to other professionals, agencies and individuals concerning assessment and strategies for communication enhancement and the prevention and remediation of communication disorders with young children. Additionally, the SLP may consult for the purposes of enhancing public awareness regarding speech, language, socio-communicative and oral-motor problems.

In serving these functions the speech language pathologist:

1. *Determines, in consultation with the child's primary caregivers, developmentally and culturally appropriate communication intervention objectives and methods based on family goals and priorities, communication*

needs within the child's environment and the child's potential for functional improvement in a reasonable and generally predictable period of time.

2. *Implements individual and group interventions* specifically designed for the family and the infant/toddler who is delayed, disabled, or at-risk. This may include assistance provided to parents and other family members or interventionists, as well as direct intervention with the child.
3. *Evaluates intervention results and progress towards goals* on an ongoing basis, revising goals or establishing new goals as appropriate.
4. *Provides instruction, strategies or sets communication goals for implementation by other individuals* who work or care for the child.
5. *Evaluates the effect of intervention efforts* on a child's communication development.
6. *Collaborates, consults and/or participates as a member of multidisciplinary teams with families, other professionals and/or interventionists* concerning assessment, intervention and case management issues as they pertain to communication delays and disorders in young children.
7. *Provides information, input or otherwise contributes to enhanced public awareness concerning communication disorders* (ASHA, 1989).

Professional Personnel Standards

The speech-language pathologist (SLP) has the expertise and is the primary professional concerned with identifying, assessing, evaluating, and treating childhood disorders involving communication delays and disabilities and oral-motor disabilities. (ASHA, 1989).

A speech-language pathologist should hold the appropriate state license and/or any additional qualifications as may apply. The California Business and Professions Code 2530 and the Department of Consumer Affairs Speech-Language Pathology and Audiology Board regulations (Title 16) define, limit and oversee the practice of speech-language pathology and audiology, including the licensing of SLPs. Licensing exemptions are generally limited to public school employed speech-language specialists certified by the California Commission on Teacher Credentialing. National organizations such as the American Speech-Language-Hearing Association (ASHA) have established, accepted certification standards (i.e., the Certificate of Clinical Competence – CCC).

All professional activity must abide by and be consistent with the ASHA Code of Ethics. The Code of Ethics require that speech-language pathologists engaging in early

intervention services should provide clinical services for which they are competent, by education, training and/or experience. (ASHA, 1997b, ASHA, 2001a).

Support Personnel

The use of well-trained paraprofessionals or support personnel is one way to increase the frequency and intensity of services for populations of children that are increasingly more diverse and complex. Paraprofessionals are often drawn from the surrounding community and may provide a link to families who are culturally and linguistically diverse. Use of these individuals also provides a way to better allocate limited resources and deliver services cost effectively.

While there is a growing awareness of the potential of paraprofessionals, there is equal concern for ensuring that these individuals are appropriately integrated and have appropriate responsibilities. They need to receive adequate training and supervision for the roles and responsibilities they will assume.

The California Speech-Language-Pathology and Audiology Licensure Board has designated two categories of support personnel: “Assistant” (SLPA) and “Aide”. As stated in the Guidelines for the Training, Credentialing, Use and Supervision of Speech-Language Pathology Assistants (ASHA, 1996), SLPAs are support personnel who, following academic and/or on the job training, perform tasks as prescribed, directed, and supervised by certified and/or licensed speech-language pathologists. The California Speech-Language Pathology and Audiology Licensing Act (Business and Professions Code 2530) has established provisions for the education of SLPAs (i.e. an Associate Degree as an SLPA), along with other training, duties, and supervision requirements.

The act also authorizes speech aides whose duties are more limited than SLPA duties. Aides receive limited training on specific tasks and must have 100% direct supervision by an SLP. These two categories of support personnel are defined in California law (Business and Professions Code Section 2530-2530.6) as follows:

“Speech-language pathology assistant” (SLPA) means a person who meets the academic and supervised training requirements set forth by the board and who is approved by the board to assist in the provision of speech-language pathology under the direction and supervision of a speech-language pathologist who shall be responsible for the extent, kind, and quality of the services provided by the SLPA.

“Speech-language pathology aide” (Aide) means any person meeting the minimum requirements established by the board, who works directly under the supervision of a speech-language pathologist.

Successfully incorporating support personnel in the service delivery process involves:

- Administrative understanding that will support the use of paraprofessionals in speech-language pathology.
- Administrative understanding of the benefits and restrictions of using paraprofessionals in speech-language pathology.
- Appropriate target population for service by paraprofessionals
- Sufficient awareness training so other professionals (e.g. teachers, OTs, PTs, etc) are aware of the role of paraprofessionals in the delivery of speech-language pathology services.
- Provision of sufficient time and resources for speech-language pathologists to adequately train and supervise paraprofessionals
- Adequate preparation in the area of supervision so SLPs clearly understand how to use these individuals effectively.

Purposes of Intervention

Decisions to intervene with young children are based on the identification of, or potential for, atypical, delayed development of communication skills. Generally speaking, there are five reasons for implementing interventions with the communicatively impaired. They include:

1. Prevention of a disorder.

Prevention implies that there is a means for delaying or avoiding the onset of a disorder. The Individuals with Disabilities Education Act (IDEA) encourages prevention by stressing the early identification and treatment of communication disorders.

2. Elimination of a disorder

Elimination implies that the child will become a normal speech or language user, an outcome which is difficult to predict for most very young and young children for whom an etiology and course of development is either unknown, uncertain and/or not always modifiable.

3. Modification or remediation of a disorder.

The most common reason for intervention with young children with communication delays, this rationale attempts to improve the functioning of identified delayed or disordered areas. Specific targets are identified which enhance the child's communication attempts, enabling the child to

advance developmentally by becoming a more effective communicator within the parameters of his or her disability. This approach often can prevent other, secondary problems (such as behavior problems) from occurring.

4. Teaching of compensatory strategies.

Generally used with older children with more cognitive maturity, intervention focuses on providing the child with alternative strategies to achieve communication goals when the disorder is judged to be ongoing and/or unalterable. It may include the use of strategies to aid recall or the selection and training in the use of an augmentative communication device. When appropriate for the young child (0-3), intervention in this area may target introductory signaling and other activities associated with operative, cause and effect actions, preparatory to the selection and/or use of an augmentative communication system.

5. Modification of the environment.

This option is often combined with one of the other four to maximize the child's communication development. With this option, the child is not the focus of the intervention effort. Rather, elements in the child's environment are targeted which will promote or facilitate communication opportunities or exchanges. Additionally, the child's primary caregiver(s) are instructed in methods and strategies effective in promoting and facilitating specific communication goals.

By selecting which option(s) to pursue in intervention, the SLP is able to: Individualize developmentally appropriate long and short term goals for intervention; specify intervention environments; work with care giving individuals to facilitate communication goals; and, devise reasonable prognostic expectations for the procedures to be undertaken.

Approaches to Intervention With the Very Young Child

There exists a large body of evidence indicating that early intervention for language and speech disorders with young children is effective. In McClain and Cripe's (1997) review of 56 different studies published between 1986 and 1995, two basic fundamentals were clear:

1. Early intervention for all types of communication disorders can be effective and more efficient than intervention provided at later ages.
2. The interventionist must rely on informed clinical judgment to determine the treatment objectives, settings and procedures most appropriate for any one child's individual needs.

However, reviewers (Farran, 2000; McLean & Cripe, 1997) acknowledge that most research studies to date are so disparate that it is difficult to draw specific conclusions concerning the efficacy of any one particular approach over another. The variables confounding cross comparisons are extensive. They include the wide range of therapy interventions available, the experiential and stylistic differences of interventionists employed, the frequency and duration of intervention efforts, the types of settings and locations where therapy can be performed, the diversity and variable severity of childhood communication disorders and the potential that each child may have based upon his or her innate abilities. Additionally, the unique nature of each care giving environment, the degree to which the child participates in the environment and with whom, further contributes to outcome differences.

Although there are many promising studies and reports, no one approach to therapy delivery has clearly emerged as the methodology of choice when working with very young children. Indeed, there are instances where intervention by an SLP may not be warranted and the child's needs may be adequately met by an informed parent or caregiver, a guided and /or supervised preschool teacher or some other early interventionist. In these instances, a qualified speech language pathologist should provide periodic monitoring of communication development and additional guidance, as necessary, concerning appropriate objectives for communication experiences.

Interventions for Communication Disorders

Generally speaking, there are three basic styles of therapeutic interventions commonly used to facilitate communication, language and speech development. When working with the young child, it would be expected that an SLP working with this age group would be competent in selecting and implementing appropriate methodologies and techniques from any of the three types of intervention delivery systems based upon the needs of the child, his/her immediate caregivers and the goals in question.

Briefly, the three therapeutic styles include:

1. Clinician Directed Approaches

- a. Includes traditional drill, drill-play and clinician modeling formats.
- b. May involve a formal or semi-formal behavioral (stimulus-response-reward) approach.
- c. Stylistically is considered to be "trainer-oriented" and direct in intent.
- d. Provides a high level of structure with clear targets and reinforcement schedules.
- e. Has demonstrated effectiveness in eliciting new language forms, particularly with older children with established language patterns.
- f. Drawbacks center around the occurrence of spontaneous carry-over outside the structured situation and the effectiveness of exclusive use of the approach with pre-linguistic and early language users.

2. Indirect Language Stimulation (Facilitative Play)

- a. Represents a group of procedures collectively called “naturalistic” in approach and often referred to as “child-centered” interventions.
- b. The clinician follows the child’s focus of attention and reinforces language targets that occur as a direct result of the child’s interests and actions in the play environment.
- c. Most closely follows the way typically developing children learn to use language.
- d. Includes many techniques that facilitate play activities such as mirroring, self-talk, parallel-talk, imitation, expansions, extensions, etc.
- e. Advantages include the promotion of spontaneous communication use and the development of functional communication skills.
- f. Requires knowledge of the child’s communicative abilities and developmental goals to be maximally effective.
- g. Naturalistic, child-centered facilitative techniques may be employed, with appropriate professional guidance and monitoring, by any responsive caregiver in any setting where the child may be, such as the home, a preschool, playground or clinical setting.
- h. Particularly appropriate for use with the very young, non-verbal or emerging language user as well as children who do not respond to directive techniques.

3. *Combinations of Clinician Directed and Child Centered Methodologies*

- a. Intervention techniques in this category involve some combination of direct and indirect methodologies adapted to a particular environment, child and/or behavioral goal.
- b. Following the child’s lead continues to be a core component.
- c. The child’s natural environment is structured to facilitate the learning of a particular language or other communication objective through the use of objects or activities of high interest to, or motivation for, the child.
- d. Most commonly used techniques include “milieu”, or environmentally based therapies including incidental teaching and mand/model strategies, as well as other forms of modified indirect interventions such as focused stimulation or vertical structuring.
- e. Effective with young, emerging language learners and where language expansion is desired.

All three styles of therapeutic intervention are effective in advancing communication goals and can be effective in positively influencing meaningful adult /child interactions. Although, with some childhood communication disorders, specifically, autism, there are genuine philosophical differences surrounding the virtues of a remediation versus a developmental approach to intervention (clinician-directed versus child-centered), in reality, judicious applications of any of the three styles are effective and appropriate for most young children with communication delays. The defining factors in the selection of a method to be used at any particular time depend on the child’s age, capabilities, behavior, interests, environment and the particular objective to be achieved.

Services should be provided in an agreed upon setting that is in keeping with the child's individual needs and family priorities. Developmentally and communicatively appropriate interventions can be provided in a variety of settings including the child's home, daycare or children's center, or other locations such as schools, hospitals, community or university clinics and/or private practice.

Preferred Practices for Special Populations

Culturally and Linguistically Diverse Populations

Culturally sensitive and appropriate assessment and intervention with young (0-3) children from non-English speaking families may require additional background and skills on the part of the SLP. Many states, local agencies, and school districts have laws or regulations regarding specific competencies that may be needed by individuals providing services to culturally or linguistically diverse populations, including competency in the primary language and/or evidence of cultural sensitivity. Depending on a child's use and/or exposure to language, recommendations for the competencies of professionals may vary depending on the young child's age, developmental level and whether he/she is preverbal, an emerging language learner, limited in English and the minority language, limited English proficient or bilingual English proficient (ASHA, 1985). Applicable local and state regulations and guidelines should be identified before services are undertaken.

Every effort should be made to assess the child in his/her primary language or mode of communication (including sign language). If a qualified professional cannot be located, the team should collaborate with an appropriately trained interpreter. Specific procedures on best strategies in collaborating with an oral language interpreter can be found in Langdon and Cheng (2000). As with any young child with delays in acquiring communication skills, the SLP should determine family concerns and priorities for communication and language development.

The SLP should identify the strategies to be used to promote and provide functional, communicatively relevant behaviors, including speech and language, which are developmentally appropriate, consistent with the family's cultural values and beliefs and capable of being utilized within the context of the family and community. It is recognized that families may have specific preferences concerning the language that the child learns. Whenever possible, services should be provided in a mutually agreed upon language. This may necessitate the additional involvement of a trained interpreter or translator.

Infants and Toddlers Who Are Deaf or Hard of Hearing

Young children with hearing loss or deafness include a broad range of functional communication styles and abilities, and may involve a range of services and involved professionals. The family's choice of communication system(s) for their child and the child's ability to develop language may vary and be variable over time.

The role of the SLP with the young child with hearing loss or deafness includes the promotion of early detection and intervention for hearing loss. Collaboration with other professionals, including an audiologist, a teacher of the deaf and/or, utilization of an appropriately trained, qualified interpreter is advisable for assessment and/or intervention services. (ASHA, 2000)

The SLP's role in assessment is to determine the impact of the child's hearing loss on family dynamics and the child's emerging receptive and expressive communication skills. A comprehensive assessment includes the evaluation of the child's awareness and emerging communication signals and may involve the determination of comprehension and production of language in oral, signed or other communication modes; speech and voice production; listening skills; speech reading and operative communication strategies, as appropriate (ASHA, 2000).

As performed by the SLP, aural (re)habilitation of the young child with hearing loss includes soliciting family concerns and priorities and promoting family involvement. Additionally, the SLP, in consultation with the family, selects and implements appropriate intervention strategies that promote comprehension and appropriate communication signaling. Objectives may include "the production of language in oral or signed modalities; speech and voice production; auditory training; speech reading; multimodal (e.g. visual, auditory-visual, and tactile) training; communication strategies; and education and counseling" of family members. (ASHA, 1997c, ASHA, 2000)

Interventions may be performed in a variety of settings including, but not limited to, center-based, clinical and/or natural environments as determined by the nature of the child's hearing loss and what best facilitates the child's communication development. Culturally sensitive family counseling and family involvement is an integral part of the intervention process.

Swallowing and Other Oral-Motor Interventions

Pediatric swallowing and feeding disorders are among the most rapidly evolving treatment areas for the medically based SLP (ASHA, 2001b) and for some infant-toddler program, preschool and school-based SLPs when children transition to educational settings. There is a need for additional evidence based data and research to support work with this age group (ASHA 2001, b). The SLP who evaluates and treats young children with feeding and swallowing problems needs specialized knowledge, skills and clinical experience related to this population (ASHA, 2001d). The SLP is a primary professional involved with the assessment and management of young children with swallowing and feeding disorders.

Feeding and swallowing interventions must be individualized to the specific needs of the child and promote a child's neurodevelopmental potential by supporting adequate hydration and nutrition and minimizing the risk of pulmonary complications and oral defensiveness. Interventions facilitated by an SLP should strive to promote the development of coordinated movements of the mouth, respiratory, and phonatory systems for communication as well as for oral feeding (ASHA, 2001b). They are typically

environmentally based, involve primary caregivers and utilize a variety of instrumental, compensatory and habilitative/rehabilitative techniques. These include procedures that address oral, pharyngeal and laryngeal neuromotor function and control, positioning, seating, muscle tone and hyper/hypo sensory issues (ASHA, 2001b, ASHA, 2001 c). Infants and young children with swallowing disorders typically need child-centered intervention techniques to address functional feeding or swallowing objectives that do not require the children to follow commands.

Additional Factors Contributing to the Advancement of Communication Skills

Additional strategies found in the literature (Dawson & Osterling, 1997; Farran, 2000) for promoting positive communicative gains and, thereby, useful to consider as guidelines for best practices for developing meaningful communication skills in young children include:

1. *Active involvement of a parent or other primary caregiver.*
 - a. The literature suggests that parents can be effective mediators of their child's communication development at the pre language and the emerging language levels (Farran, 2000).
 - b. However, best results are seen when a parent or other primary caregiver receives appropriate professional instruction, guidance and/or support in implementing interaction strategies that promote the child's communication development.

2. *Identification of developmentally based communication goals supported by functional communication objectives in predictable daily routines.*
 - a. Systematic attention to emerging prelinguistic and linguistic markers facilitates realistic setting of communication objectives in the natural environmental setting.
 - b. Expectations for successful functional communication behaviors evolve from collaboration with caregivers, observation of the child's existing communication attempts, appropriate developmental targeting and the child's unique interests, needs or wants.
 - c. An SLP should collaborate with the primary caregivers to identify appropriate functional communication behaviors in the context of existing daily activities and either evoke or instruct others in how to encourage the child to use them.

3. *Individualized goal setting.*
 - a. The SLP should determine communication targets based upon the caregiver's stated priorities and the child's environmental needs, communication strengths and factors relating to his particular form of developmental delay.
 - b. If someone other than an SLP implements targeted objectives, periodic monitoring is needed by an SLP to assure ongoing progress toward identified targets and long range communication objectives.

4. *Frequent updating of the child's communication objectives.*
 - a. At a minimum, an SLP should routinely be involved in six-month updates and annual reviews for any child with a communication delay, particularly if not actively providing the child's intervention.
 - b. Routine updating of communication objectives assures that appropriate developmental advances in communication skills are taking place, not just the acquisition of limited functional repertoires specific to a particular activity or location.

Anticipated Outcomes of Intervention Efforts

According to the Preferred Practice Patterns of the Profession of Speech-Language Pathology (ASHA, 1997d), the expected outcomes for treatment/instruction/early intervention include:

1. Improved, altered, augmented or compensated speech, language (or pre-speech and pre-language), and cognitive-communication behaviors and/or processes for listening, speaking,....., and cognitive communication.
2. Treatment/instruction/early intervention conducted in the individual's first or second (or other) language depending on which is deemed most functional after assessment.
3. Recommendations for additional assessment, follow-up or referral for other evaluations or services.

In addition, the primary outcomes expected for children with feeding and swallowing difficulties include (ASHA, 1997e, ASHA, 2001b):

1. Improved nutrition and hydration.
2. Prevention or reduction of oral defensiveness.
3. Improved, functional, safe eating practices.
4. Enhanced coordination of the oral mechanism and respiratory and phonatory systems for communication.
5. Reduction of the risks of pulmonary complications.
6. Improved quality of life.
7. Enhanced neurodevelopmental potential.

Documentation

The speech-language pathologist must submit timely, appropriate and required documentation concerning interventions that are recommended or delivered. These written materials include:

As appropriate, pertinent background information, hearing status, treatment/instruction/early intervention goals, results, prognosis and specific recommendations (ASHA, 1997f).

Recommendations may include the need for further treatment, follow-up or referral. When further treatment is recommended, information is provided concerning the frequency, estimated duration, and type of service (e.g., individual, group, home program) required (ASHA, 1997f).

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