SSW Reports

REPORTS, REPORTS
APPROPRIATE REFERRAL?
ATTORNEY REQUESTS

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Reports, Reports – why do we write them? How do we write them?

Recently, I received a frantic phone call from a social worker. One of the teachers in her school had her child evaluated for CAP at an excellent hospital in the area. The mother (a teacher) went to the Child Study Team because she couldn't understand the report. The social worker who is familiar with the reports that are produced from our department read it. She had more of a clue as to what the audiologist was saying but didn't 'understand it' well enough to explain things to her colleague. She asked if I would review the report and speak with the mother. Statewide testing was soon approaching and if her child needed any accommodations, she wanted to be sure that a 504 plan was in place. I reviewed the audiologist's report and was pleased to see that the Buffalo Battery was part of the work-up and called her to request the raw data. She administered many tests. I used the Buffalo Battery tests to interpret the findings with caution – explaining that since I had not done the testing, some follow-up of questionable results might be advantageous.

When we write reports what are we trying to accomplish? Are we trying to impress physicians who may get the report? I believe that for the most part, if they read the summary we're fortunate. Are we trying to impress our colleagues with every test we've ever learned and every recommendation that was ever thought of? Are we trying to impress the attorneys? Then we'd better be sure that what we are saying is clear. Or do we truly believe that we are conveying our findings clearly and not laced with professional jargon?

The change in my professional setting, from clinics (hospital and private practice) to a large urban public school district, opened my eyes to what life in the educational world is like. **We are testing children** – it's a child's 'job' to be successful in school. If the children we see were achieving success, we wouldn't be seeing them! Our reports are always read by parents; people from all walks of life; if a teacher had trouble understanding a report, what might a banker do? Parents care about their children and usually want to do things to make it better/easier for them. The parents often share the reports with the school. Who in the school reads them and who understands what we have written well enough to be able to explain our findings? At least in my school system, many of the speech-language specialists (they are not all SLPs) are unable to do this. It's important to remember that all a school system is required to do legally is to provide

a child with is **FAPE,** a free and appropriate public education. Note the word appropriate – NOT optimal. Listing every possible intervention not only doesn't make sense, but if your referral source is a school system they may soon decide they know what your report is going to say and that they don't need to spend money for any future evaluations.

Over the years I've seen many cookie cutter reports – reports that list every test in detail, all possible problems a child might show, and tons of 're-commendations', now often called 'suggestions' that have ever been found to help a child with CAPD. Yes, I use templates, but I use different templates depending upon the child I have tested. I find most of the children I test are DEC and TFM, sometimes with a little ORG thrown in. What a different report that is from the report for a child who falls into one of the INT categories. And then there are children who are 10 and older, an age when because of maturation, the problems that they are experiencing may be greater than the actual numbers indicate – that needs to be explained.

I've had requests for CAP testing on children whose root language is not English and on occasion requests for CAP testing on children with hearing loss. Whether we test these children is something that we can discuss at another time, but we certainly can't use the same report form.

What can we do to help?

It is difficult to write simply but it must be done. For example, let's not define auditory processing with the word 'processing' – I often use Jack's simple definition, "It's what you do with what you hear." Other times I will add, it's how the ear talks to the brain and how the brain understands what is being said. Actually, I don't define auditory processing in my reports; I use the term when I'm explaining procedures to parents during the evaluation. I also use it at Child Study Team meetings, teacher conferences and when necessary at mediations. When I'm testing at school, I often use the Buffalo Battery exclusively. It gives me tons of information in a timely manner. I can counsel parents and explain things to teachers. I explain in my reports how the findings may affect learning, attention and communication. I aim to have my reports describe the child and then make recommendations for remediation.

You say "but I use the SSW+ program to do my reports!" The SSW+ is a fantastic program and if you do not own it I strongly urge you to do so! [SSW+ is now available through Gary Bricault at Upstate Advanced Technologies, 12 Shadow Vale Drive, Penfeld, NY 14526] It scores our testing and explains our findings; it allows us to convey very meaningful information. I often wonder how many INT kids I would miss if it weren't for SSW+. The program enables us to see the relationship between our findings and what the speech-language pathologist may find – it helps us to give SLPs a direction and some useful interventions. That being said, it is important to note that the program is extremely sensitive. If a child shows a category based on one 'soft sign,' do you really want to incorporate that into a report? Are there other soft signs? Remember, you are the professional -- this wonderful scoring program is here to guide us, not to write our reports.

Does anyone other than we ourselves know what a *smush* is? Yes, the child had a *smush* – what does that mean, how might it impact listening and academics? Just because a certain qualifier/pattern is seen in some percentage of children with learning disabilities; it does not mean that a child who has

that qualifier necessarily has a "learning disability". Remember, we don't want other professionals diagnosing APD – we should not diagnose LD or even language problems (unless of course, you are truly dually certified).

Because I am doing my evaluations for a school system, I am conducting an *educational* evaluation – but of course, if I think there are medical concerns I will do some further testing and refer the child to the primary care physician. This is the world of HMO's and most children will need a referral from the primary care physician to see a specialist. Participating at a team meeting allows me to raise concerns that the team can review and decide on follow through.

What about recommendations?

Before I was a mother, I 'knew' that if you fed a baby before s/he went to bed the baby would sleep through the night. Then I became a mother – I don't think my daughters slept through the night until they were teenagers. Okay, that's an exaggeration but, life experience is very different from theory. Working in a clinical situation is very different from working in a school.

Often we see a recommendation for an assistive listening device. Just because a child has a CAP problem does not mean that this is an appropriate recommendation. What are the physical properties of the classroom? What is the teacher's teaching style? Does the child have a personal aid? Is the teacher going to use the system or, as happened in our district, is the teacher going to say "I have to call my Union rep about this!" or "I'm not a special ed teacher."

I almost always recommend a speech-language evaluation and therapy. I realize, however, that this is not the private speech therapy that the children in the suburban practice where I consult would receive, but group therapy, often times in groups of 5. It's really difficult to use the *Phonemic Synthesis* training program in a group. Our school system uses *Earobics* but it certainly, does not yield the same benefit that the *Earobics* training that's done on a daily basis – and if we suggest it for home use, and the family doesn't own a computer, the school is responsible for purchasing a computer! The school-based speech therapy case loads are monumental and the shortage of speech personnel, as we know, is great; that is the reality of speech-language services in our district and perhaps in yours as well.

Recently I sent a district-wide e-mail to the speech-language specialists asking them what they are looking for in a CAP/APD report. Among the replies I received were: "Provide suggestions for ways that the SLS (speech-language specialist) and the teacher can help in the classroom or the therapy room with auditory processing weakness." Out of 57 speech language specialists, only 4 replied.

What else could we suggest that can take place in the classroom? Certainly a reading specialist could work on decoding skills. Will changing a child's seat help him/her to focus better? Is there a child in class who could be a 'note-taker'? Does the child need OT? This is my first thought for a child with INT problems. Does the child need but not wear eyeglasses? What can we do to help a child whose parent doesn't show for an IEP meeting or follow up with medical recommendations?

We tease that our professors live in Ivory Towers and don't understand the 'real world'. What has made Jack such an outstanding teacher is the fact that he remained

in the clinic. As a former clinical audiologist who has joined the ranks of educational audiologists, I urge my clinical colleagues to observe and learn about my 'real world.'

Is This An Appropriate CAP Referral?

I saw this child – did I do enough? What might you do? Last week a new case manager came to me with this CAP referral, as I read the case I told her that the child was not appropriate for a CAP evaluation but that I would certainly test his hearing and then make a judgment regarding further follow-up.

'Matthew' is a 13-year-10-month-old young man with an asymmetric hearing loss – the hearing for his right ear is within normal limits except for a conductive dip at 1000 Hz (to 40dB). His left ear has a large ear tag and a narrow canal and audiometric results show a primarily moderate mixed hearing loss. His word recognition in 2001 was 100% for the right ear and 40 – 96% for the left ear depending upon the presentation level. A hearing aid was recommended but was not obtained. No assistive technology had ever been placed in his classroom.

Most recently, a neuro-otologist unsuccessfully operated on Matthew's middle ear – the type of surgery was not detailed by the mother. The mother reports that after some recovery, the otologist would like him evaluated by a physician in New York *who performs surgery using robots.* I question the benefit that this surgery might do for Matthew since he has spent almost 14 years learning language with asymmetric hearing.

Matthew also has anophthalmia (a congenital absence of the eye) of his right eye and has myopia of the left eye; with glasses his vision corrects to 20/20 in that left eye.

Matthew is currently in the 8th grade; he has been experiencing academic difficulties since the 6th grade. I made an appointment to test his hearing, surely low vision in one eye, no vision in the other eye and poor hearing in the ear opposite the absent eye would give a child 2 (if not 3) good reasons for having academic difficulties!

Test Results!

Although I had originally planned not to do any CAP testing I just couldn't let this child go. After all, the SSW does have norms for people with hearing loss. I wondered if I found anything that suggested a "CAP diagnosis" I could write my disclaimer yet suggest modifications to the classroom and/or to his therapies that might help him. Because of the asymmetric hearing, I scored the SSW using both NOE and traditional analysis to determine if there would be a difference in the findings. It should probably come as no surprise that his test scores showed a Type-A pattern. Again, he has poor hearing on one side and no vision in the contralateral eye – the 'good eye' has low vision.

Matthew's word recognition in quiet was 100% for the right ear 84% (norm 92) for the left ear.

His 8 Cardinal numbers were:

	R-NC	R-C	L-C	L-NC
REF	2	0	4	3
LEF	0	2	9	1
	2	2	13	4

He had 2 delayed responses, significant for a 13-year-old but no other Qualifiers.

Using the NOE method of scoring Matthew's scores show a significant Type-A pattern as well as RNC, LC, LNC conditions and the Total score - the latter was **10 standard deviations below the mean for**

his age. That alone suggests that something in addition to auditory processing is impacting on his academic struggle. Using the Traditional method of scoring the Type-A pattern again emerges with a significant number of errors in the RNC and LC conditions. Based on the results of the SSW, Matthew shows signs of INT and DEC.

I routinely suggest Occupational Therapy evaluations for children who have Integration problems, this was no exception. I'm not sure what an OT can do in this case but I did not want to omit any intervention that might help Matthew. I suggested training to strengthen Matthew's auditory processing skills. Without mentioning specific programs I recommended 1) a program that would improve phonemic understanding, 2) auditory figure ground perception training, 3) auditory attention training, 4) pattern recognition training, 5)inter-hemispheric training and 6) the use of 'stage management' techniques – making sure that he positions himself in situations so that the speaker is facing him, that ambient noise is at a minimum, etc.

Because Matthew will be entering high school in the fall, the use of assistive listening devices will be considered after his placement has been determined.

If any of you have any further suggestions for Matthew's academic success please e-mail me at SMBAuD@msn.com .

The Attorney's Request

Our school system's attorney asked if I received a referral for 'Oliver"; there was a *legal case* that that was being mediated. The attorney for the student's family wanted a CAP evaluation. "Oliver," an 8-year-old boy, has been receiving speech-language therapy twice a week. His most recent speech-language evaluation stated that Oliver presents with delays in processing, organizing, semantics, syntax, word knowledge and word retrieval and articulation skills The attorney felt that Oliver needed speech therapy at least three times a week. He is enrolled in special education, in a class for children with multiple disabilities.

This unfortunate child had been abused by his biological parents; he suffered from convulsions and was comatose after being *pushed down a staircase* at 4 years of age. He was diagnosed with hydrocephalus and had numerous surgeries including the implementation of a shunt. He has a scar from the surgeries and is teased about it. Additionally Oliver was diagnosed with ADHD and hypertension. To further cloud CAP results, Oliver lives in a bilingual home.

I told the attorney that I could write Oliver's report without even testing him and that I did not think this was an appropriate referral. I offered to do a classroom observation to assess the classroom acoustics, Oliver's response in the classroom and then confer with the speech pathologist. The student's attorney mentioned the need for speech therapy three times a week and since the speech-language pathologist had only recommended therapy twice a week she wanted the CAP testing completed. In a situation like this, there is no real choice but to do the evaluation; at least she's not diagnosing auditory processing.

Oliver's word recognition score for his right ear was poor for his age (84%) and normal for the left ear. Both scores plummeted when noise was introduced.

His performance on the SSW was **almost 14 standard deviations below the mean**, in

spite of the fact, that he had a significant break after the first 20 test items. As was noted in Matthew's case above, scores that are this poor suggest that something besides auditory processing alone is responsible for the academic difficulties. In addition to his medical history, the report from the psychologist and the report from the learning consultant supported this.

On the SSW, Oliver's 8 Cardinal numbers were:

	R-NC	RC	LC	L-NC
REF	3	11	16	16
LEF	17	15	12	3
	20	26	28	19

Oliver's results suggest both **Decoding** and **TFM** issues. There was one reversal noted; with such a poor score, it is not possible to see many reversals (commonly noted in children diagnosed with ADHD). On the Phonemic Synthesis test, out of the first 13 items, Oliver was only able to obtain one item correct. I discontinued the testing as soon as I heard Jack say "Now the words will be longer." I could not bear to frustrate this child any longer.

After an urgent call to Kansas and a conference with Jack, I was able to prepare myself for the mediation meeting. Oliver had suffered brain damage and brain damage will show up as a processing problem. Unlike most of the children that I see for CAP testing, Oliver did not have a *demonstrable* neuromaturational lag, but rather an adventitious condition. He had speech therapy for a while but was not showing great progress. I suggested to the attorney that it was not more speech therapy that Oliver needed, but rather a different approach. I told her that it would be beneficial to try intense auditory training. I briefly explained the concept and she was accepting. Upon Jack's recommendations the speech-language pathologist will begin with phonemic decoding training and speech-in-noise desensitization training.

Recently, Oliver was entered into a 'Wilson reading program.' This is a multisensory approach to reading. He receives this training in a group of four, 5 days a week for 3o minutes a session. The reading specialist has noted marked improvement in just 10 sessions. I or my colleague will assess the classroom acoustics and determine if an assistive listening device is appropriate.

The combination of speech-language therapy and Wilson reading program should enable Oliver to make strides in his academic ability. He is in special education; according to New Jersey Law, he needs to be exposed to the entire curriculum (modified) for his grade. Oliver needs to have social interaction with his peers. It is important that he not be pulled from the classroom more than he already is. If the attorney and/or the family think that Oliver needs more intervention it would be wise for it to take place after school. The school is providing a Free and Appropriate Public Education for Oliver. He has been approved for an extended school year so that his services can continue over the summer.

Hopefully the coming school year will be a better one for Oliver.

SSW Workshop in the Fall

The SSW Workshop that was originally scheduled for April 2007 has been rescheduled for September 27, 28 and 29. This workshop will take place in New Jersey at Kean (that is pronounced 'cane') University. Please contact Dr. Alan Gertner at agertner@cougar.kean.edu for further information.