THE PROMISES AND REALITIES OF EVIDENCE-BASED PRACTICES: PERCEPTIONS FROM ASSESSMENT PERSONNEL

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Assessment personnel are those individuals who work in the capacity of evaluation of students with disabilities, including, but not limited to, educational diagnosticians, educational examiners, psychometrists, and instructional specialists. These professionals are responsible for identifying strengths and weaknesses and for providing teachers with evidence-based recommendations that can be implemented in the classroom to improve performance of students with learning deficits. This qualitative study examines 19 educational diagnosticians' perceptions related to the barriers and supports that impacted their ability to provide evidence-based recommendations for students who are learning disabled. Three categories of barriers to issuing successful evidence-based recommendations emerged as a result of the study: Knowledge of Evidence-Based Interventions, Time to Complete Assessments, *and* Support from Administrators and Teachers.

Keywords: assessment personnel, educational diagnosticians, assessment, learning disabilities, evidence-based recommendations

Providing early intervention is an essential principle in response to intervention (RTI) models (Shinn, 2007). Numerous studies indicate that the use of RTI models are more prevalently implemented in school districts as a means, within the general education curriculum, to prevent referrals for special education services (Cummings, Atkins, Allison, & Cole, 2008; Fuchs, Fuchs, & Stecker, 2010; Overton, 2009).

> The transition toward a Response to Intervention (RTI) approach has created new professional dialogues and discussions regarding the best conceptions and practices to follow. The new approaches to assessments and tiered interventions have defined new roles and systemic changes in how students experiencing academic and literacy difficulties are viewed and served. Questions are under scrutiny related to identifying promising principles, instructional approaches, professional preparation, and progress monitoring systems. (Simpson, Lynch, & Swicegood, 2011)

Although the literature is replete with evidence-based intervention practices for schools, little is known about the knowledge and recommendations of evidence-based interventions made by assessment personnel in full individual evaluations (FIE). Specifically, a lack of information exists regarding the ability of assessment personnel to link evaluation findings to evidence-based intervention practices that are communicated to special and general education teachers serving students identified with learning disabilities.

Individuals who work in the capacity of assessment personnel may have the job titles of educational diagnosticians, educational examiners, psychometrists, or instructional specialists. Regardless of titles, employment, and certification practices by states, educational diagnosticians share an ability to diagnose the learning problems of students (Council for Exceptional Children [CEC], 2000).

In searching databases such as EBSCO, only two articles were found that address RTI among assessment personnel, specifically educational diagnosticians. Key-terms such as diagnostician, educational diagnostician, educational examiners, psychometrist, psychometrician, and instructional specialists were used in the search. The lack of findings may be linked to the fact that the role of educational diagnosticians varies from state to state, and the titles by which they are known are not consistent. Moreover, there is a lack of information available about the degree to which edu-

cational diagnosticians recommend evidence-based practices in relation to the level of knowledge that educational diagnosticians have regarding such practices themselves.

Despite limited findings of research directly related to recommendations of evidence-based practices in relation to the knowledge level of educational diagnosticians, research on educational diagnosticians practicing in a large southern state indicates that educators are becoming more comfortable with the RTI process, possibly as it "relates to having the flexibility to build assessment and intervention schemes that are familiar and logically implemented" (Simpson, Lynch, & Swicegood, 2011, p. 3). The Simpson et al. study revealed that "virtually all respondents indicated that a Teacher Assistance Team (TAT) shared roles and responsibilities in the process. Other specifics in the process include universal screening, increased collaboration, and the provision of evidence-based interventions" (2011, p. 12). Moreover, the educational diagnosticians that participated in the study indicated that they have a greater comfort with the RTI process in comparison to data elicited from a similar study conducted three years prior. However, concerns outside the realm of collaboration, specifically making evidence-based recommendations and the RTI process, still exist.

In one of the few studies published regarding educational diagnosticians and intervention practices, Chappell, Stephens, Kinnison, and Pettigrew (2009), reported that nearly half of the educational diagnosticians (N=22) that participated in a survey regarding their understanding of reading were unable to correctly identify the definition of phonological awareness. In contrast, nearly 80% identified phonological awareness as a predictor to read. In a second study, in which 110 educational diagnosticians completed a 34-question survey on the knowledge and recommendations of Strategic Instruction Model (SIM) strategies in FIE, participants reported that they possessed limited knowledge of SIM strategies related to reading, storing and remembering information. (Rueter & Kinnison 2009).

The results of these studies are not surprising, as the focus within FIE has been on student eligibility for special education services (Mather & Wendling, 2005) rather than on recommendations of evidence-based interventions. General roles and responsibilities involve educational diagnosticians scheduling and holding individualized education program (IEP) meetings with teachers and parents to review assessment results and student progress, and determining eligibility for special education services. Because the emphasis in most states has been on referral to placement for special education, limited time has been devoted to consultative and direct services related to intervention practices for students who are at-risk for academic and behavioral disorders (Rueter & Trice, 2011).

In many cases, educational diagnosticians spend the majority of their time assessing students and writing reports, completing paperwork, and conducting IEP meetings. These activities have resulted in less time to focus on educational strategies or interventions (Stephens, Kinnison, Naquin, & Rueter, 2007). The results of a study about the role of the education diagnostician indicated that the profile of an educational diagnostician encompasses their spending approximately 10 to 20 hours per week in testing, interpretation of testing, and report writing (Cook, 1997). Findings also revealed that the two most important duties of the educational diagnostician were testing and coordinating, and conducting IEP team meetings. However, there were disagreements as to which duty was identified as the most important. For instance, half of the educational diagnosticians rated their primary role or first duty as testing, while the other half rated coordinating and conducting IEP meetings as the number one priority (Cook, 1997). Because the focus of full individual evaluations is on eligibility (Mather & Wendling, 2005; Meyer, 2000), little importance has been placed on obtaining knowledge of evidence-based interventions.

In addition to the aforementioned reasons for an absence of specific evidence-based strategy knowledge, assessment training programs and state procedural practices that emphasize eligibility criteria (Rueter & Kinnison, 2009) may factor in. Cavin (2007) conducted a study of 432 educational diagnosticians in a larger southern state regarding the state competencies for certification. Participants reported that they received little to no training in understanding appropriate curricula and instructional strategies for students with disabilities. Such findings are important because educational diagnosticians are responsible for identifying strengths and weaknesses and for providing teachers with evidence-based recommendations that can be implemented in the classroom to improve students' deficits. Without instruction in this area, educational diagnosticians' skills may lack proficiency.

Although the literature is limited regarding educational diagnosticians and intervention practices, comparisons to school psychology provide valuable insight into general evaluation practices and early intervention activities. Within

school psychology literature, there is a movement to shift from traditional evaluation practices toward early intervening and consultation (Stoiber & Vanderwood, 2008). This trend reflects the emphasis on response to intervention and preventive measures. In 2002, the President's Commission on Excellence in Special Education suggested the following:

> Eliminating IQ tests from the identification process would help shift the emphasis in special education away from the current focus, which is on determining whether students are eligible for services, towards providing students the interventions they need to successfully learn. There is little justification for the ubiquitous use of IQ tests for children with high-incidence disabilities, except when mild mental retardation is a consideration, especially given their cost and the lack of evidence indicating that IQ test results are related meaningfully to intervention outcomes. (p. 25)

A study that examined the use, importance, and level of competence of traditional assessment, consultation, and intervention practices of 86 school psychologists in an urban district reported that their greatest level of proficiency was in traditional assessment rather than in consultation and intervention processes. The same participants reported that consultation and intervention activities were more important and thus more valued as compared to traditional assessment practices (Stoiber & Vanderwood, 2008). The authors stated that "a practice gap was noted in our school psychologists with regard to *what they value* (rate as most important) and *what they do and do well* (as indicated by their use and competence ratings)" (p. 282). Moreover, Shernoff, Kratochwill, and Stoiber (2003) conducted a study of school psychology programs that provided training in evidence-based interventions. The results of the study indicated that the lack of time was rated as the most serious challenge to evidence-based intervention training. However the same study results indicated that evidence-based interventions were either *somewhat important* or *important*.

PURPOSE OF THE STUDY

The purpose of the study was to obtain information regarding educational diagnosticians' perceptions of the barriers and supports that impact their ability in recommending evidence-based interventions for students who are learning disabled. The following research questions guided the study:

- What are the barriers that educational diagnosticians experience when writing evidence-based recommendations?

- What supports do educational diagnosticians require in order to overcome barriers when writing evidence-based recommendations?

METHOD

Participants

Participants voluntarily selected the focus group session as conference attendees at the Texas Educational Diagnostician Conference (TEDA) held in Arlington, Texas, in April 2009. Informed written consent was obtained prior to participation. Participants were able to opt out of the focus group session and attend another session if they did not want to participate in the study. The time length of the focus group session was approximately 60 minutes.

Nineteen individuals participated in the focus group session. All participants were Caucasian. Eighteen of the participants were female and one was male. The age of participants ranged from one in the 25-30 age group to seven in the 50-plus age group. The experience level of participants also varied. Twelve of the participants had less than five years of experience as educational diagnosticians; two individuals had 11-plus years of experience. The majority of the participants reported having 12 hours of assessment credit hours. Two individuals reported having 18 credit hours, and two individuals reported having 18-plus credit hours (See Table 1).

Data Collection

Two types of measurement systems were used to measure participants' responses. The first measure was the written responses of participants gathered during the focus group meeting and categories of responses generated by participants, moderator, and assistant moderator. Second, individual participant rating and voting sheets were utilized

to verify the importance of each category generated by the group.

Written Focus Group Measures

Focus group participants recorded their individual responses on 3x5-inch color-coded sticky notecards using statements of seven words or less if possible. The statements were responses to the

Table 1
Demographic Data for Focus Group (N-19)

Categories	Number
Age in Years	
25-30	1
31-35	3
36-40	2
41-45	1
46-50	5
50+	7
Gender	
Female	18
Male	1
Ethnicity	
Caucasian	19
Degree	
Master's	5
Master's degree plus	14
Years of experience as educational diagnostician	
Less than 5 years	12
6-10 years	5
11 plus years	2
Course credits completed in assessment	
12-15 hours	15
18 hours	2
18 plus hours	2

research questions asked by the moderator. After focus group members recorded responses onto the notecards, the notecards were clustered into sets by the participants, moderator, and assistant moderator. Each set of notecards was then given a categorical label.

Participants' Voting and Rating Sheets

Two rating and voting sheets were developed which corresponded with the two questions discussed during the focus group meeting. Each rating and voting sheet had a two-part design. The purpose of the first part of each measurement sheet was to validate individual participant's perception of the importance of each category that had been generated by the group. A line was provided for participants to record the name of each established category. A 7-point Likert scale with number values ranging from 1 as "Very Unimportant" to 7 as "Very Important" was located to the right of each line on which the category was recorded. Participants circled a number according to how they rated the category when considering importance of the category.

The purpose of the second part of each measurement sheet was for the moderator to determine the most important categories for each question according to participants' votes. Blank lines were provided for participants to list their top choices from among the total set of categories. Participants were requested to vote for one-half of the categories (e.g., if the group had identified six categories, they were asked to vote for the three categories they valued most).

Before the questioning session began, each participant received an individual file folder with the following items

inside the folder: Focus Group Discussion Protocol and two color-coded rating and voting sheets. Two sets of color-coded sticky notecards were also distributed. The sticky notecards corresponded with the two color-coded rating and voting sheets.

Second, the moderator, assistant moderator, and participants read and discussed the Focus Group Discussion Protocol with the moderator being the group leader. During this time, concepts related to the importance of evidence-based recommendations in FIE were highlighted. The ground rules for discussion were based on the Metaplan procedure. This technique is a tool for creating more effective and efficient focus group discussions (Metaplan, n.d.; Schnelle & Stoltz, 1987; Vance, 1995). The Metaplan Steps are presented below:

- Step 1: A question is stated.

- Step 2: Participants write thoughts and feelings on notecards.

- Step 3: Participants write clearly and neatly.

- Step 4: Write on one idea per card.

- Step 5: Use seven words or less if possible.

- Step 6: The moderator collects and reads note-cards aloud and displays them on the wall.

- Step 7: The moderator, with participants' assistance, organizes the notecards into clusters or categories of thoughts, feelings, and opinions.

- Step 8: Participants may continue writing their thoughts during the clustering process.

- Step 9: The moderator and participants discuss their thoughts, feelings, and ideas through the clustering process.

- Step 10: The participants conclude the process by rating the categories according to how important they perceive them to be. They also rank their top categories according to perceived importance.

After the steps were presented, the moderator and assistant moderator modeled how participants were to record their answers. During the modeling, the moderator asked the assistant moderator to write down as many characteristics as she could think of that described her favorite teacher. The assistant moderator wrote her responses on sticky notecards with no individual response totaling more than seven words. During the modeling, the assistant moderator thought out loud as she wrote the responses onto the sticky notecards. When finished, the moderator read each of the assistant moderator's responses. With participants and assistant moderator's help, the moderator and assistant moderator began clustering responses into definable groups on the white board in front of the room.

Once the modeling concluded, the focus group questions were posed, with time allowed after each question for the participants to record responses and to complete the Focus Group Member Rating and Voting process. Following is the sequence of events that occurred for each question posed during the meeting.

Recording, Voting, and Rating of Participants' Responses

Participants recorded their written responses to each of the focus group questions on 3x5-inch color-coded sticky notecards using statements of one to seven words if possible. As the participants recorded their responses, the moderator and assistant moderator collected the responses and posted them on the white board. The notecards were read individually by the moderator or the assistant moderator, and were clustered into groups by participants, moderator, and assistant moderator. During the process of clustering, focus group members, moderator, and assistant moderator discussed the individual responses, moving responses as needed into other categories. This process allowed for member-checking of the data. Next, each clustering of note-cards was given a categorical label. The categorical labels were also written on the white board above each clustering of notecards.

Following the clustering of the notecards, participants were directed to complete the Focus Group Member Rating and Voting sheet. First, participants wrote each category onto their rating and voting sheets, and then the participants rated each category individually on a Likert scale of 1 to 7 as to the importance of the category. Second, participants were instructed to vote for one-half of the categories that they felt were most important.

Data Analysis

From the rating sheets, a mean rating was calculated for each category by tallying the number values the participants circled for a particular category and dividing the total number by the number of persons who had responded. Next, standard deviations were calculated for each of the individual categories.

Following the focus group meeting, the moderator analyzed the rating and voting sheets. A tally mark systemization process was utilized to determine how the person ranked their choice of top categories determined by the group. Each time a category appeared on a participant's voting sheet, a tally mark was noted for that category. The category with the most tally marks received the group rank of 1, the next category with the highest number received a 2, and so forth. Once the categories were ranked by importance, the researchers engaged in peer examination, in which a colleague outside of the field of special education sifted through the data and commented on the findings as they emerged (Merriam, 1998).

FINDINGS

Three categories received a group ranking of 1 were verified during the peer examination process and were validated by descriptive statistics: *Knowledge of Evidence-Based Interventions, Time to Complete Assessments*, and *Support from Administrators and Teachers*. The following is a discussion of the categories. See Table 2 for descriptive statistics of the research study and Table 3 for summary of the research findings.

Knowledge of Evidence-Based Interventions

Knowledge of evidence-based interventions materialized as a barrier that prevents educational diagnosticians from writing recommendations that are evidence-based. This category received 13 individual tally marks and a shared group rank of 1, a mean rating of 6.21, and a standard deviation of 1.22.

Two subthemes were noted within the category of Knowledge. The first subtheme was the lack of understanding of evidence-based interventions and thus what to recommend in full individual evaluations. Participants responded that they lack knowledge of what constitutes evidence-based interventions for the children they are testing. This finding is consistent with Mather and Wendling (2005) and Meyer's (2000) premise that assessment personnel (e.g. educational diagnosticians) have focused on eligibility rather than on providing evidence-based recommendations that can be translated to measurable goals and objectives. This is an important point with respect to what is valued in the FIE process. If the emphasis is on establishing or maintaining eligibility, there is little value placed on providing evidence-based recommendations.

The second subtheme related to Knowledge was directly related to the theme of Time; not as the lack of time to complete tasks, but the time it takes to research recommendations due to the lack of understanding regarding evidence-based interventions. This concept is noted in the following comment in which a participant identified/reported a need for "Time to write and research appropriate recommendations." Another participant summed it up this way: "Sufficient time to research appropriate strategies and write effective recommendations." In other words, participants lack knowledge of what constitutes evidence-based practices, and therefore they need to spend time researching strategies in order to write recommendations that are evidence-based. This is not surprising given that one of Cavin's (2007) study conclusions indicated that educational diagnosticians received little to no training in understanding instructional strategies for students with disabilities.

Time to Complete Assessments

Time to complete assessments emerged as both a barrier and a support that educational diagnosticians face. With regards to barriers that educational diagnosticians face, Time obtained a shared group raking of 1, with 13 individual tally marks, a mean rating of 6.15, and a standard deviation of 1.21. With regard to supports that educational diagnosticians require, Time obtained a group ranking of 2 with 13 individual tally marks and a mean rating of 6.52 with a standard deviation of 1.02.

Table 2

Mean Ratings and Group Ranks on Categories of Barriers and Supports Related to Knowledge and Recommendations of Evidence-Based Strategies

Categories	MR	SD	GV	GR
Barriers				
Knowledge of evidence-based interventions	6.21	1.22	13.0	1.00
Time to complete assessments	6.15	1.21	13.0	1.00
Supports				
Support from administrator and teachers	6.47	0.96	14.0	1.00
Time to complete assessments	6.52	1.02	13.0	2.00

Note: MR = Mean rating based on individual ratings; SD = Standard deviation; GV = Group votes based on raw votes of the group; GR = Group rank based on member votes.

Table 3

Summary of Findings

Categories	Subtheme
Barriers	
Knowledge of evidence-based interventions	Lack of understanding of evidence-based interventions
	Time it takes to research evidence-based interventions due to the lack of understanding regarding evidence-based interventions
Time to complete assessments	Large caseloads
Supports	
Support from administrator and teachers	Administrators must ensure that recommendations are being implemented by classroom teachers
	Teachers must be willing to implement recommendations in their classrooms
Time to talk to and discuss with classroom teachers	Smaller caseloads
	Collaborative time to talk to and discuss with classroom teachers about the instructional practices that are being implemented in their classroom

Within the category of Time, two subthemes were noted. The first subtheme relates to caseload size. Responses from participants for barriers concentrated on the following point: "Caseload too large so not enough time." With respect for supports that are needed, the following response, "Smaller caseloads to spend more time on report writing," emerged as the key point. One of the goals of RTI is to provide interventions for students who are at-risk for special education, thereby reducing the numbers of students who are referred (Fuchs & Fuchs, 2007). Obviously, for these participants, little has changed with regard to the size of caseloads and the numbers of students who are being referred to special education. Educational diagnosticians are still experiencing caseloads that are too large, with the implication being that the focus of FIE is still on establishing or maintaining eligibility status. The results are also consistent with Rueters' (2008) findings, where knowledge of recommendations and time to complete assessments emerged as the two most important categories with respect to barriers that educational diagnosticians face.

Time to work with classroom teachers also emerged as a support and as the second subtheme within the category of Time. Overall, participants reported that they needed more collaborative time to talk to and discuss the instructional practices being implemented in teachers' classrooms. They also noted that without this collaborative time, it is difficult to know what to recommend. This point is illustrated by the following participant comment, which identified a

desire/need for "more time to discuss issues." "More time to discuss issues that teachers are willing to try." This implies that there is a need for open lines of communication between the teacher and the educational diagnostician.

Support from Administrators and Teachers

The category of Support from administrator and teachers was in response to the second research question that asked, "What supports do educational diagnosticians require in order to overcome barriers when writing evidence-based recommendations?" This category received 14 individual tally marks, a group rank of 1, a mean rating of 6.47, and the lowest standard deviation of 0.96 of all of the primary categories that were generated by the focus group.

Two subthemes emerged. The first subtheme centered on administrators' support in implementing the recommendations that are written in FIE. Also related to this subtheme is the idea that administrators must ensure that recommendations are being implemented and followed by classroom teachers. The following comment illustrates this point: "Support of administration so that recommendations are used." It is reasonable to expect that if educational diagnosticians take the time to write evidence-based recommendations, support must be provided in seeing that the recommendations are being implemented. If there is no administrator support, little will change in the day-to-day instructional practice.

Teacher-follow-through and willingness to implement evidence-based recommendations is the second subtheme that emerged in this category. Participants reported that when they write evidence-based recommendations teachers must be willing to implement the recommendations in their classrooms. They also expressed feelings of disillusionment with respect to special education teachers using the results of the FIE in their everyday instructional practices. One of the participants summed it up this way: "Feelings that no one reads them."

However, the news is not all negative. Burns and Ysseldyke (2009) conducted a study concerning the frequency with which evidence-based practices are engaged in the education of students with disabilities. One hundred and seventy four special education teachers and 333 school psychologists completed a 12-item survey in which they rated the frequency of various practices used in special education. The results of this study indicate that 60% of the special education teachers reported using mnemonic strategies at least once per week. With a mean effect size strategy of 1.62, mnemonic strategy instruction is an effective instructional practice (Kavale, 2007). The results of the study indicate that special education teachers report that they engage in practices that are grounded in research, "but there is definite room for improvement" (Burns and Ysseldyke, p. 9).

Limitations

While a pattern has emerged regarding the barriers and supports that impact educational diagnosticians' ability to make evidence-based recommendations for inclusion in FIE, the research presented should be interpreted with caution for the specific reasons identified:

1. The evidence presented above represents a single focus group session consisting of 19 participants which makes its scope somewhat limited.

2. The demographics of participants are limited to those educational diagnosticians who volunteered to be a part of the study at a state assessment conference.

3. The demographics of the participants are primarily those who perform the duties of the educational diagnostician under the certification title of "educational diagnostician." Other certification or titles given to personnel who serve in the same capacity as the educational diagnostician were not represented in the study.

However, given that the emphasis of full individual evaluations is on eligibility, rather than on provision of evidence-based recommendations (Mather & Wendling, 2005; Meyer, 2000), and that there is a greater level of proficiency on traditional assessment rather than in consultation and intervention processes (Stoiber & Vanderwood, 2008), the findings suggest that the results of this study are not unique to the individuals who participated in the session.

Implications

Even with the limitations of research described above and the issues identified, there are several implications that

were derived from the study. Each implication is identified by the corresponding category and/or subcategory described within the methods section of this paper and each is based on the original purpose of the study: to obtain information about educational diagnosticians' perceptions of the barriers and supports that impact their ability in writing evidence-based interventions.

Knowledge of Evidence-based Interventions

It is clear that the participants in this study indicated a lack of knowledge of evidence-based interventions. In order for an educational diagnostician to make valid and reliable recommendations, an understanding of such practices is necessary. To improve the outcomes of successful intervention strategies assessment personnel should be provided with:

- training/workshops with a focus on what constitutes an evidence–based practice;

- educational preparation programs that include components of evidence-based interventions/strategy training; and

- assessment personnel preparation programs should place a greater emphasis on linking to classroom practices and less on eligibility when training pre-service professionals on report writing.

Time to Complete Assessments

The feedback obtained from the study indicated that caseloads are often too large, which impacts the amount of time spent on report writing. Larger caseloads limit the time that assessment personnel can dedicate in providing evidence-based recommendations for interventions for students. Larger caseloads may also impact the time available for these professionals to receive specific training on making evidence-based interventions. In an effort to overcome time challenges, the following recommendations can be made:

- Placing less emphasis on eligibility and strengthening the district RTI models will permit more time to develop strong, evidence-based practices.

- By communicating to response to intervention teams a strong value on interventions and prioritizing eligibility less, administrators can facilitate a culture of prevention rather than reactive measures such as identification and placement in special education.

Time to Collaborate with Teachers

Collaboration between assessment personnel and teachers in determining evidence-based practices for children with learning disabilities will enable assessment personnel to obtain information from general and special education teachers to be included into students' FIE. This can be obtained by building collaborative planning time into standard assessment practices. School administrators should also encourage and value increasing communication between special education and general education teachers.

Support from Administrator and Teachers

Administrators, teachers, and assessment personnel must work collaboratively to ensure that evidence-based practices are implemented in the classroom. However, given that recommendations are not often shared or read, as indicated by one of the participant's statements "Feelings that no one reads them," the following suggestions apply:

- Once evidence-based recommendations are written into the FIE, they should be shared with the IEP team.

- A standard process or procedure should be developed to assure such practice occurs.

- Once recommendations are discussed at the IEP meeting, measurable goals and objectives should be developed.

- Once recommended and implemented in the classroom setting, evidence-based practices/strategies should be monitored on a continual basis.

CONCLUSION

There are few who would argue that teachers, administrators, and parents expect assessment personnel to produce recommendations for instructional interventions based on assessment findings. However, some controversy exists as to whether or not assessment personnel are adequately prepared to make evidence-based recommendations. The current research further examined this issue and identified three main categories (*Knowledge of Evidence-Based Interventions, Time to Complete Assessments,* and *Support from Administrator and Teachers)* that had a direct impact on the educational diagnosticians' perception of their ability to make evidence-based recommendations based on assessment results and to relay such findings within the assessment report. Data collected suggests that a need to strengthen this component of linking assessment to instruction is critical.

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