BIRTH TO THREE, SPECIAL EDUCATION PROGRAMS

IOWA, 1984

State of Iowa
DEPARTMENT OF PUBLIC INSTRUCTION
Special Education Division
Grimes State Office Building
Des Moines, Iowa 50319

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BIRTH TO THREE, SPECIAL EDUCATION PROGRAMS

IOWA, 1984

This document provides an overview of aspects of the education programs for children from birth to three years who have handicapping conditions. Compliance or regulatory issues are not dealt with in this publication.

The information provided here is based upon the responses submitted to the Department of Public Instruction from Area Education Agencies and the Des Moines Independent Community Schools. Fourteen of the 15 AEAs responded to the questionnaire; therefore, this document provides an excellent summary of infant and toddler special education and related services throughout Iowa. No attempt was made to ascertain how these services interface with the many services also provided by other agencies. The format used is basically the question from the survey letter followed by AEA response. In some instances, the responses were very similar and are summarized. Responses are always identified by AEA number or DM for Des Moines Schools. To the extent possible, referenced documents, guidelines, etc., have been included in the Appendices. Please contact the agency using those guidelines, etc., not included to obtain a copy.

This document is meant to be used as a reference of current procedures and practices. The primary intent of the gathering of this information was for exchange among AEAs within Iowa. Due to the time and effort a number of persons put into this task, it is felt this publication will also be extremely helpful to other states who are providing birth to three services for the handicapped. Please feel free to duplicate any portion of this material that would be of assistance.

Since each response is referenced, you are encouraged to write or call the contact person listed by AEA for further information (Appendix A). An AEA map is also included for the convenience of those who are unfamiliar with the geographic divisions of the Iowa Area Education Agencies (Appendix B).

The letter-type survey requesting the information contained in this document was for purposes of obtaining general information on three separate topics: Services for handicapped, birth to three; current status of childfind activities for young children with disabilities; and level of service interaction between AEAs and Head Start. The responses to the "Birth to Three" service section were particularly worthwhile and are included here in detail by AEA with an Appendix.

The request submitted to each Area Education Agency and the Des Moines Preschool Unit in May, 1984, is as follows:

1. Please outline the general services provided to the handicapped population from birth to three.
   a. What criteria is being used to determine who receives services?
   b. What medical or health information is required prior to providing service?
   c. Do you have certain staff members who provide service to this population? (Give general overview of who is responsible for this group.)
   d. Are services more directed toward the parents or the children at this age?
   e. List three evaluation or screening instruments which would be frequently used with this population.

f. List curriculum guides or resource materials which are being used by staff to assist with programming for handicapped infants and toddlers.

g. Briefly describe the service options available for birth to three-year-olds who are handicapped.

h. What activities or services are provided by your agency for parents of handicapped children from birth to three years old?

i. List any unique problems you feel this age group (0-3) poses for your agency.

j. List ideas, problems, or inservice needs you would like to see dealt with from the state level.

RESPONSES BY AEA

"BIRTH TO THREE YEARS"

WHAT CRITERIA IS BEING USED TO DETERMINE WHO RECEIVES SERVICES?

Responses by AEA:

#1 - Any child who has significant problems in one or more of the following areas:
- speech & language
- motor control
- learning abilities
- social development
- behavior skills
- vision
- hearing

#2 - Each discipline deals with its departments set criteria.
- Severity rating scale in use by speech and occupational therapy.

#3 - Same criteria which is used for other preschool aged students (See Appendix C and Rules of Special Education 12.3(281). (Appendix D)

#4 - Criteria used for children one year of age and above are the same as for school-aged children. Criteria for children under one year of age: scores below one standard deviation below the mean on the Marshalltown Profile cognitive scale (Appendix E).

#5 - Marshalltown Profile (Appendix E) or medical diagnosis.

#6 - Criteria is based upon a child's medical and physical history (i.e., presence of a syndrome, high risk infant, premature, transfer to another hospital, oxygen deprivation, etc.) or the results of a developmental assessment which indicates significant lags in development (Appendix E).

#9 - CM-utilize Severity Rating Scale (Appendix F)
- MD-utilize state criteria (Appendix G)
- BD-Preschool Agency Criteria (Appendix H)
- PD-Agency criteria (Appendix I)
- VI-State criteria (Appendix J)
- LD-None for preschool - do not identify at Preschool level
- HI-State criteria (Appendix K)

#10 - All children referred for service are evaluated by 1 or more staff members, depending upon needs. Occupational therapists, Physical therapsits, psychologists, social workers, speech clinicians, and hearing clinician, are available and typically conduct evaluations. <u>All</u> staff are trained in and focus on the 0 to 5 population. They have special skills not found, or needed, in the K-12 area.
- After evlauation, staffings are held during which decisions are made concerning eligibility and placement. Decisions are guided by two principals:
  - State guidelines currently do not fully address the 0-3 area. However, every effort is made to extend downward the intent contained within current state guidelines for th K-12 area to direct decisions in the birth to three range.

- Grant Wood early childhood staff have also prepared guidelines which extend downward the anchor points established by the state Speech and Language Severity Rating Scale and which also refer to other disability areas. Comparisons and priorities can thus be established for children whose problems cross categories, i.e. speech, retardation, learning disability, physical disability.

#11 - Team recommendation drawing upon Staffing Decision Guide (contact AEA #11 to obtain a copy) and professional judgement).

DM - State guidelines

#12 - AEA #12 critiera. (Appendix L)

#13 - Each child referred to the agency receives a developmental screening, usually done in the home environment. If the child fails the screening, the multidisciplinary team evaluates as appropriate. After all evaluations are complete a staffing is scheduled. At this time all of the professionals who have tested the child, the local building principal and the parents meet and review the testing results. At this point a decision is made as to eligiblity for services.

#14) - State definitions of handicapping conditions are used whenever possible. Deferred diagnosis (Appendix M) is used for some children under three as long as a developmental delay is documented. Medical concerns which may influence development are also taken into consideration and services may be provided on the basis of medical conditions until which time other qualifying conditions must be met.

#15 - Children placed in these programs must have a comprehensive evaluation and meet the guidelines found in AEA 15 Preschool Criteria (Appendix N).

#16 - Criteria developed by AEA #12 (Appendix L).

WHAT MEDICAL OR HEALTH INFORMATION IS REQUIRED PRIOR TO PROVIDING SERVICE?

Responses by AEA:

#1 - A complete health history is compiled by the special education nurse.
- A release of confidential information is obtained from the parent if child has already been seen in one of the medical facilities.
- If child is in need of occupational/physical therapy services, a prescription is given or received from the physician).

#2 - A developmental/health history questionnaire is completed in all referrals.

#3 - A health case history and immunization form are completed. Vision is screened by local optomologist/opthamologist or preschool handicapped teacher.

#4 - Medical information would include hearing acuity testing, vision acuity testing, immunization record and complete health history.

#5 - A health history and medical information from outside sources are obtained before staffing.

#6 - A medical and health history is collected on each child and a release of information is obtained in order to secure information from other agencies and centers who serve the child.

#9 - Complete health/family history questionnaire is fulled out by parent.
- Information is secured from the physician.
* - If the child is medically fragile, the physician approval to serve is required.
- Immunization information.

#10 - All relevant information is requested from all medical agencies providing service to the child. Typically, these requests are honored.

Until July 1, 1984, all P.T. services were at the direction of a physician. This will change during the coming year. Still, every effort will be made to obtain full medical information.

A current concern is that some of the information is time consuming for the physician to develop then proves irrelevant, i.e. xerox reports of 8 pages of visits for ear infections and colds. (Someone could have said the child had 14 ear infections in an 18-month period, and saved lots of paper.) We currently are considering developing a report form for the physician to complete that will be quick, simple and reveal medical information relevant to educational needs. Also, we need to develop an internal policy which establishes a procedure whereby irrelevant data may be summarized and the original destroyed.

#10 We need to be able to store 20 medical pages of information in 1 paragraph when that is sufficient.

#11 Health history is completed and medical records, as needed, are requested as part of the staffing information.

#12 - Health history

#15 - Parent completes an intake form as part of the evaluation.
- If pertinent, medical information is obtained from the medical community.

#16 - Health history is completed by social worker and parent.

Summary

Medical information required for the birth to three population falls into the following categories:

1. Health and developmental history is obtained through interviews with the parents by a nurse, social worker or teacher who may be acting as a case manager for the child.

2. A release of confidential information is obtained from the parent if a child has already been through a diagnostic evaluation.

3. Immunization records are obtained.

4. Vision and hearing screenings are obtained at the earliest appropriate time.

5. Some agencies require approval from a physician prior to serving the child who is medically fragile.

DO YOU HAVE CERTAIN STAFF MEMBERS WHO PROVIDE SERVICE TO THIS POPULATION? (Give general overview of who is responsible for this group.)

Responses have been summarized:

In the mid '70s, Iowa had preschool interdisciplinary teams whose specific assignments were to provide instructional and support services to handicapped children who were below mandatory school age. These teams basically functioned with this model between 1975 and 1980. In about 1979-80, agencies began to look more at cost effectiveness and many area education agencies began providing services more on a geographic basis as opposed to an age level. This transition required additional inservice opportunities for support staff who had perhaps not worked with very young children prior to this time.

The composition of the teams providing services to young handicapped children and their families are typically: certified special education preschool teachers, speech clinicians, occupational/physical therapists, special education nurses, school psychologists, social workers and itinerant teachers of hearing or visually impaired. A few AEAs still retain support staff whose primary function is to serve preschool handicapped, but the rural areas have moved almost entirely to geographic assignments.

The preschool home instruction teachers and preschool consultants are still assigned to case loads of children below six years of age. These professionals serve on a multidisability basis which requires them to have a broad background of knowledge specific to young disabled children and their families. Since early childhood special education is still a relatively new area for many communities to deal with, it is especially critical to maintain staff with strong backgrounds in early childhood to continue to assist with quality programming and development for this age group. There should always be a strong interaction with the discipline specific staff by the early childhood staff in order to maximize the use of resources available.

ARE SERVICES MORE DIRECTED TOWARD THE PARENTS OR THE CHILDREN AT THIS AGE?

Responses by AEA:

#1 - Approximately 60% of the focus on parents with 40% spent with the child. Consider parent carry-over a crucial part of the program.

#2 - Services are generally directed toward the parents. Children who are severely handicapped may enter a center-based program at age 18 months where the primary focus is more on the child.

#3 - Services are generally directed toward parents. In limited instances, children age 2 1/2 years may enter a center-based program. In these instances, home visits are scheduled once every two weeks. - In order to better facilitate home-school communication, early dismissal (2:00 p.m.) has been implemented in some schools on a pilot basis.

#4 - Parents are the focus except in cases of children staffed into class placements.

#5 - It depends on the case. Parent needs are certainly kept in mind.

#6 - Depends upon needs of both children and family. The infant project is based primarily on services to families and the emphasis is placed on the functioning of the family unit.

#9 - Children are primary program target. Parents are an integral part due to nature of home instruction.

#10 - The child is always the target; but efforts focus on serving the child through the parent. Early childhood intervention staff are not itinerant teachers, but Parent/Child Educators.

#11 - Both instructional and support services are directed toward parent with the appropriate person modeling the special education services.

DM - Both

#13 - On the average 60% of time is spent working directly with the child and 40% is spent helping the parent understand and work with their child on a consistent basis.

#14 - There is probably a slightly heavier emphasis on services directed to parents than services directed to children. A home visit by an itinerant preschool teacher involves more time training the parent than in providing direct teaching to the child. However, support services such as physical and speech therapy and audiology are directed more to the child.

#16 - Services are directed towards children and teaching parents to work with their children.

LIST THREE EVALUATION OR SCREENING INSTRUMENTS WHICH WOULD BE FREQUENTLY USED WITH THIS POPULATION?

Responses by AEA:

AEA 9 Preschool Vision Screening Instrument (#9)
Alpern-Boll (#16)
Bayley Scales of Infant Development (#1, 2, 4, 5, 6, 9, 16)
Brazelton Neonatal Behavioral Assessment Scale (#5)
Brigance Inventory of Early Development (#3)
CIP (#9)
Cattell Infant Intelligence Scale (#1)
Callier-Azusa (#11)
Continuum of Assessment Programming, Evaluation & Resources (CAPER) (#3, 10, DM,12, 15)
Developmental Profile II (#13)
Denver Developmental Screening Test (#2, 3, 5, 9, DM, 13, 14)
Developmental Screening Inventory (Armatruda) (#3, 6)
Developmental Test of Visual Motor Integration (Beery & Vuktenica) (#3)
Education for Multihandicapped Infants (#6)
Education for Multihandicapped Infant (EMI) (#9, 15)
Hawaii Early Learning Profile (HELP) (#3, 10)
Home Observation for Measurement of the Environment (HOME) Birth to Three (Caldwell) (#3)
Kaufmann ABE (#6)
Koontz Child Development Program (#11, 15)
Marshalltown Behavioral Developmental Profile (#3, 4, 5, 6, 14)
Marshalltown Developmental Screening Inventory (#6)
McCarthy (#1, 6)
McComb (#DM)
Merrill-Palmer (#10)
Michigan Developmental Program for Infants and Young Children (#11)
Minnesota Child Development Inventory (Treton & Thwig) (#3, 6, 5)
Minnesota Infant Development Inventory (#1, 5, 13)
Peabody Motor Scales (Folio & Dubose) (#3)
Preschool Language Scale (#16)
Referral Form Check List (Rutland Center) (#3)
Rockford Infant Developmental Evaluation Scales (RIDES) (#1, 3, DM)
Sensorimotor Cognitive Assessment (Uzgiris-Hunt) adapted by M.C.R.I. (#14)
SICD (#10)
Stanford-Binet (#1, 4, 9, 10)
University of Michigan's Developmental Profile (#1)
Vineland Social Maturity Scale (Doll) (#3)
Wisconsin Behavior Rating Scale (#10)

NOTE: Designation was not given as to whether the stated instruments were used for screening or for assessment.

LIST CURRICULUM GUIDES OR RESOURCE MATERIALS WHICH ARE BEING USED BY STAFF TO ASSIST WITH PROGRAMMING FOR HANDICAPPED INFANTS AND TODDLERS.

Responses by AEA:

Boehm Resource Guide for Basic Concept Teaching (#6)
Brigance Diagnostic Inventory of Early Development (#6, 14)
CAPER (#1 ,2 ,4, DM, 12, 13, 15, 16)
Carolina Curriculum Sequences (#5)
Carolina Curriculum for Handicapped Infants (#13, 15)
Chapel Hill Preschool Curriculum and Resource Guide (#4)
DLM Training for Daily Living (#6)
Developmental Programming for Infants and Young Children (#5, 10)
E-LAP (Early Learning Accomplishment Profile) (#2, 4, 6, 10)
ELI - Environmental Language Intervention Program (#15)
EMI Learning Packet (#5, 9, 14, 15)
Ferguson-Florissant School District Parent-Child Early Education Materials (HCEEP) (#14)
HELP (Hawaii Early Learning Profile) (#1, 2, 4, 5, 9, 10, 14, 15, 16)
Heartland Data Bank (similar to CAPER) (#11)
Helping Your Exceptional Baby Checklist (Cunningham and Sloper) (#14)
In and Out Sound Activities for Spatial Relations (#10)
Infant Learning (Carl Dunst), Learning Resources (#14)
Karnes Early Language Activities (#10)
Keystone Unit Based Activity Manual (#1)
Learning Language at Home (#10)
Live Oak
Marshalltown Behavioral Developmental Profile Curriculum Guides (#4, 6, 10)
Nisonger Infant Program (#2)
Oregon (#1)
PREP (Parent Readiness Education Project) (#10)
Parent-Infant Communication (#4)
Peabody Motor Scales (#14)
Portage (#1, 6, 9, 10, 13, 14)
Preschool Curriculum for Exceptional Children (#6)
RIDES (DM)
SKI-HI for Hearing Impaired (#16)
The Small Wonder, Sets 1 and 2, (# 10, 13, 14, 15)
South Dakota (#13)
Teaching Your Down's Syndrome Infant by Marci Hanson (#4, 14)
University of Michigan Early Development (#1)
Uzgiris-Hunt (#11)
Ypsilanti, Michigan Preschool Materials (#14)

The following resource list was submitted by Melissa Drago, AEA #3 and is being submitted in its entirety. Due to the time and effort which she put forth, this section will be extremely helpful to those needing to locate some of the most timely resources pertinent to birth to three programming.

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BRIEFLY DESCRIBE THE SERVICE OPTIONS AVAILABLE FOR BIRTH TO THREE-YEAR-OLDS WHO ARE HANDICAPPED.

Responses have been summarized:

1. Home Intervention or Instruction

   a. Provided throughout the state by all AEAs.

   b. The typical model is a once per week visit by a certified preschool teacher of preschool handicapped for approximately one hour per visit.

   c. The frequency of visits may vary dependent on the needs of the child.

   d. Some children may be placed on a monitor basis and perhaps followed on a monthly or semi-annual basis. A regular follow-up schedule should be established for children being followed on a medical high-risk registry.

2. Support services only or in conjunction with an ongoing home instruction person.

   a. The staffing team may determine that a child will receive support services in the home or in a central location which is established by the agency.

   b. Some children could require therapy only and not have other deficits which would require instructional type services.

   c. Parental counseling may be one of the support services provided.

3. Center-based play groups conducted by Parent/Infant Education Team.

   a. Approximately one-half of the AEAs (plus Des Moines) now have infant/toddler groups.

   b. The approach is always multi-disciplinary.

   c. The parents or care givers always accompany the children.

   d. Care givers are together for a portion of the time and with the children for the remainder of the time at the center.

   e. Some of these groups are held in the evening to facilitate working parents being able to attend (staff is provided compensatory time for participation in these sessions).

4. Center Based, regular attendance

   a. If it is appropriate, some students may be entered in centers at a point from 18 months of ages to three years of age.

b. Some students of very young age only attend class for a portion of time that other students are there. Many severely handicapped may be too fragile to be transported to a center on a regular basis. A consideration must be made on each individual case as to the child's ability to make gains from attending a center on a regular basis or the circumstances that indicate attendance would be valuable.

c. Representative ages indicated for entrance in centers are 18 months, AEA 2; 2 years, AEA 16, 2 1/2 years, AEA 13, SPH and Hearing Impaired can be admitted to centers prior to age 3. (Although not indicted in writing, this appears to be true for some other AEAs also.)

5. Miscellaneous Services

a. Toy lending libraries are available in a number of the AEAs which provide a toy resource for both preschool handicapped teachers and parents of young handicapped children.

b. Consultation to programs and families.

WHAT ACTIVITIES OR SERVICES ARE PROVIDED BY YOUR AGENCY FOR PARENTS OF HANDICAPPED CHILDREN FROM BIRTH TO THREE YEARS OLD?

Responses by AEA:

The responses on this item were very diverse and yielded a more general type of information. It is hoped that readers might be able to obtain a general overview from this information as some of the Area Education Agencies have worked hard to provide specialized programs and services designed to meet the needs of parents.

This activity offers great challenges as to how to involve parents in experiences which will prove valuable to them and to their handicapped child.

#1 - Parent organizations
- Parent workshops
- Manual entitled Beginnings (contains facts to help parents better understand their handicapped child).
- Occasional meetings with parents.

#2 - Counseling services through social work and speech departments.
- Infrequent parent groups

#3 - Reference books
- Respite Care resources available
- Behavioral concerns addressed with prents

#4 - Parent classes
- Counseling by social workers, special education nurse or psychologist
- Summer program guides (teacher-written)
- Assistance in locating services from other agencies

#5 - Parent/Infant Education Team
- Parent education modules done in the home.

#6 - Parent classes 0-6
- Infant program classes that focus on children below 2 1/2 years (available in limited geogrpahic area)

#9 - Parent participation in the infant or toddler groups.
- Evening parent education series offered in selected geographic areas.
- Social worker available for short term counseling.

#10 - Parent/Child groups (6-18 months and 18-38 months). Each session provides parents opportunity to learn how to teach new skills and to discuss concerns, feelings, plans. Meetings held every two weeks. Home visits made alternate weeks.
- Efforts are made to involve fathers as well as mothers/babysitters in the above activities, with growing success.

Item 1h - 0-3 Years
Parent Activities

#11 - Parent meetings as part of LEA parent meetings
- Parent workshops
- Linkage to parent groups as Pilot Parents, ARC, etc.

DM - Parent groups
- Educational meetings
- Individual intervention
- Social activities
-.Participation in all activities with their child

#12 - Parent/Infant program

#13 - Toddler group parent activities
- Instructional direction provided by the home instruction teachers
- Assist parents to develop support groups

#14 - Instructional direction provided by the home instruction teachers.
- Support staff provides input to parents during therapy sessions.
- Support for Pilot Parents, etc.

#15 - Infant stimulation programs.
- Parent/Child swimming.
- Parent groups.

#16 - No parent-only services.

LIST ANY UNIQUE PROBLEMS YOU FEEL THIS AGE GROUP (0-3) POSES FOR YOUR AGENCY.

Responses by AEA:

#1 - This age group posses more health problems which need to be sorted out.
- Parents are going through the grieving process.
- The reliability of testing is questionable.
- Some parents are apathetic.
- The limitation of contact time needed to serve the child.
- Children living in remote rural areas are difficult to locate, identify, and serve.

#2 - If parents work, it is often difficult to meet with them on a regular basis.
- Development of the child proceeds rapidly at this age making it difficult to get valid test results.

#3 - The importance of medical input in interdisciplinary programming.

#4 - None

#5 - Not always equipped to deal with the problems of a very handicapped infant.

#6 - Local school administrators have expressed concern and resistance to transporting children this young to a center via school bus.
- Many support staff from various disciplines who admittedly are not comfortable with their skill ability in providing service to this population.
- Our preschool teachers have less competence (and confidence) in dealing with this particular population.

#9 - Children are usually medically involved.
- Families are often unpredictable and may encounter varied emotional states.
- Working parents.

#10 - There is a continuing need to communicate information about how to refer children, benefits of the program, and special needs of this population. Communication must be maintained both within the agency and with the community. Publicity of the program cannot be on a one-time basis because staff change both in this and other agencies and new children with special needs are born each day. The problem is compounded because news agencies only want information about the new, not the ongoing.
- The need to understand that this program is not babysitting or medical, but educational in mission. Also, that prevention is paramount. If a child can be prevented from developing the bad habits that make him/her dependent/passive/understimulated, then maybe the child will be less, or even not, handicapped as an adult.

#11 - Assisting parents to work through the acceptance of a handicapped child.
- Rescheduling of appointments when parents need to cancel.

DM - Working parents
- Acceptance of the handicapping condition.
- Transportation

#13 - None

#14 - Due to ruralness, the distance between students is a problem for the teachers.
- Travel to centers for parents is often a problem due to bad weather or unreliable transportation.

#15 - Communication with working parents.
- Working with children at a sitter's home.
- Getting parents involved.
- Shortage of physical therapists.

#16 - Parental isolation
- Grief and acceptance of handicap.
- Frequent reluctance of physicians to respond to parents' initial concern about child.
- Lack of awareness of programs available by physicians, parents, and social service agencies.

The responses by the agencies to this question are excellent and represent a myriad of problems or concerns in serving the very young child. These responses would be helpful to educational type service agencies as they begin to develop programs. Some of the listed problems are unsolvable except with time, while others may be somewhat diminished through education and problem solving.

LIST IDEAS, PROBLEMS, OR INSERVICE NEEDS YOU WOULD LIKE TO SEE DEALT WITH FROM THE STATE LEVEL.

Responses by AEA:

#1 - We need a network of information regarding preschool services, trends, research, etc. on a national and state level as well as more teleconferences, resource guides, bibliographies on parent/infant ideas, or training packages such as the one used in training aides in the classroom. A mandatory registration of all one-year-olds would be helpful. For inservice ideas, we suggest Ken Moses on the grieving process. Another inservice idea would be to have the authors of the University of Michigan Preschool Curriculum at a workshop. We would also like to see the continued development of the State Conference on Special Education.

#2 - The presentation of curricula and parenting activities.

#3 - Coordination of services for motor concerns with instructional staff, occupational and physical therapists and their aides. Implementing motor objectives throughout the day.
- Severe/Profound techniques (The low incidence of children make this an inservicing topic many will not select for traveling. Can these techniques be shared at the AEA level?)
- Annual new materials fair.
- Exploring alternative modes of communication (Bliss Symbols, various picture symbols for communication and boards, head sticks, electronic boards, etc.).
- An introduction to microswitches.
- SIDS (Sudden Infant Death) handbook (utilizing the monitor, implications for parents, resources, etc.).
- Behaviorally written objectives by support staff.

#4 - Assessment of infants--what to look at.
- Educational treatment of neuromuscularly damaged children.

#5 - Assessment of infants.
- Parent-infant interaction.

#6 - Any ideas, inservices, workshops dealing with physical therapy/ occupational therapy skills for staff will be appreciated.

#9 - Changing family styles.
- SAPH for 0-3 -- practical programming information and hands-on ideas.
- Use of microswitches with infants and SAPH.

#10 - No suggestions submitted.

#11 - Developing techniques/strategies to bridge from family dependency to interdependency with staff and LEAs.

DM - Parent education.
- Working with low-functioning parents.

#12 - No suggestions submitted.

#13 - How other AEAs in the state are providing group instruction for handicapped toddlers.
- Practical instructional techniques as well as appropriate curriculums used in educating the severely handicapped infants.
- Providing itinerant instruction to the child with a gastrostomy tube or tracheotomy.
- Types of seizures, control, and side effects with educational significance.

#14 - Telenets on medical topics.

#15 - N.D.T.
- Working with parents.
- Pre-feeding and Pre-speech.

#16 - More inservicing for new teachers on how to respond to parents' intense needs in a home program.
- More training for teachers on NDT techniques.
- Working with multi-impaired physically handicapped children.
- Feeding and pre-speech activities and their correlation.
- Positioning to facilitate learning.

APPENDICES

Iowa

Birth to Three

5100-E69038-8/84

APPENDIX A

State of Iowa
DEPARTMENT OF PUBLIC INSTRUCTION
Special Education Division
Grimes State Office Building
Des Moines, Iowa 50319

IOWA
CONTACT PERSONS FOR PRESCHOOL HANDICAPPED
1984-1985

Joan Turner Clary, State Consultant
Preschool Handicapped
515/281-3176

AREA EDUCATION AGENCY 1

RAY DENEVE, Contact Person
Preschool Handicapped
Keystone AEA 1
Route 2, Box 19
Elkader, Iowa 52043
319/245-1480
1-800/632-5918

PAUL LENGER, Consultant
Preschool Handicapped
Keystone AEA 1
1473 Central Avenue
Dubuque, Iowa 52001
319/588-0538

AREA EDUCATION AGENCY 2

MARY HARRIS-SCHERTZ
Preschool Handicapped
Northern Trails AEA 2
P.O. Box M
Clear Lake, Iowa 50428
515/357-6125
1-800/392-6640

AREA EDUCATION AGENCY 3

MELISSA DRAGO, Consultant
Preschool Handicapped
Lakeland AEA 3
Cylinder, Iowa 50528
712/424-3720
1-800/242-5100

AREA EDUCATION AGENCY 4

JOYCE RUNYON, Contact Person
Preschool Handicapped
Area Education Agency 4
102 South Main Avenue
Sioux Center, Iowa 51250
712/722-4374
1-800/572-5073

AREA EDUCATION AGENCY 5

JEANYCE HUME, Supervisor
GARY PETERSON, Consultant
Preschool Handicapped
Arrowhead AEA 5
1235 5th Avenue South
P.O. Box 1399
Fort Dodge, Iowa 50501
515/576-7434
712/732-2257 (Gary Peterson)
1-800/362-2183 (Central Office)

SUE RIEDER, Consultant
Arrowhead AEA 5
218 North Wilson
Jefferson, Iowa 50129
515/386-8188

AREA EDUCATION AGENCY 6

ARLENE KEISER, Supervisor
Preschool Handicapped
Area Education Agency 6
210 South 12th Avenue
Marshalltown, Iowa 50158
515/752-1578

AREA EDUCATION AGENCY 7

RICH REBOUCHE, Principal
Preschool Handicapped
1925 Newell
Waterloo, Iowa 50707
319/232-4529

AREA EDUCATION AGENCY 9

JOYCE SHAUL LEAVELL, Supervisor
BARBARA BANERDT, Consultant
GAYLE POWELL, Consultant
BETH RANDLEMAN, Consultant
DIANNE SCHUERCH, Consultant
Preschool Handicapped
Mississippi Bend AEA 9
800 23rd Street
Bettendorf, Iowa 52722
319/359-1371, ext. 265

AREA EDUCATION AGENCY 10

DR. REID ZEHRBACH, Supervisor
STEPHANIE FRANTZ, Consultant
BILL LANDERS, Consultant
Preschool Handicapped
Grant Wood AEA 10
4401 6th Street, SW
Cedar Rapids, Iowa 52404
319/399-6700
1-800/332-8488

AREA EDUCATION AGENCY 11

MS. J. R. PHILLIPS, Supervisor
CHARLOTTE BUTTIN, Consultant
JOHN DRINNIN, Consultant
Preschool Handicapped
Heartland AEA 11
1932 S.W. Third
Ankeny, Iowa 50021
515/964-2550
1-800/362-2720

DR. LARRY SARGENT, Principal
KAREN SZNAJDER, Consultant
Preschool Handicapped
Smouse Opportunity Center
2820 Center Street
Des Moines, Iowa 50312
515/277-6238

AREA EDUCATION AGENCY 12

DEBRA RICE, Supervisor
Preschool Handicapped
Western Hills AEA 12
1520 Morningside Avenue
Sioux City, Iowa 51106
712/274-6010
1/800/352-9040

AREA EDUCATION AGENCY 13

GLENN GROVE, Contact Person
PATRICIA BAHL, Consultant
Preschool Handicapped
Loess Hills AEA 13
Halverson Center for Education
P.O. Box 1109
Council Bluffs, Iowa 51502
712/366-0503
1-800/432-5805 or 5804

AREA EDUCATION AGENCY 14

STACY SWANSON, Head Teacher
HAROLD CONNOLLY, Director
Special Education
Green Valley AEA 14
Green Valley Road
Creston, Iowa 50801
515/782-8443, ext. 55
1-800/362-1864

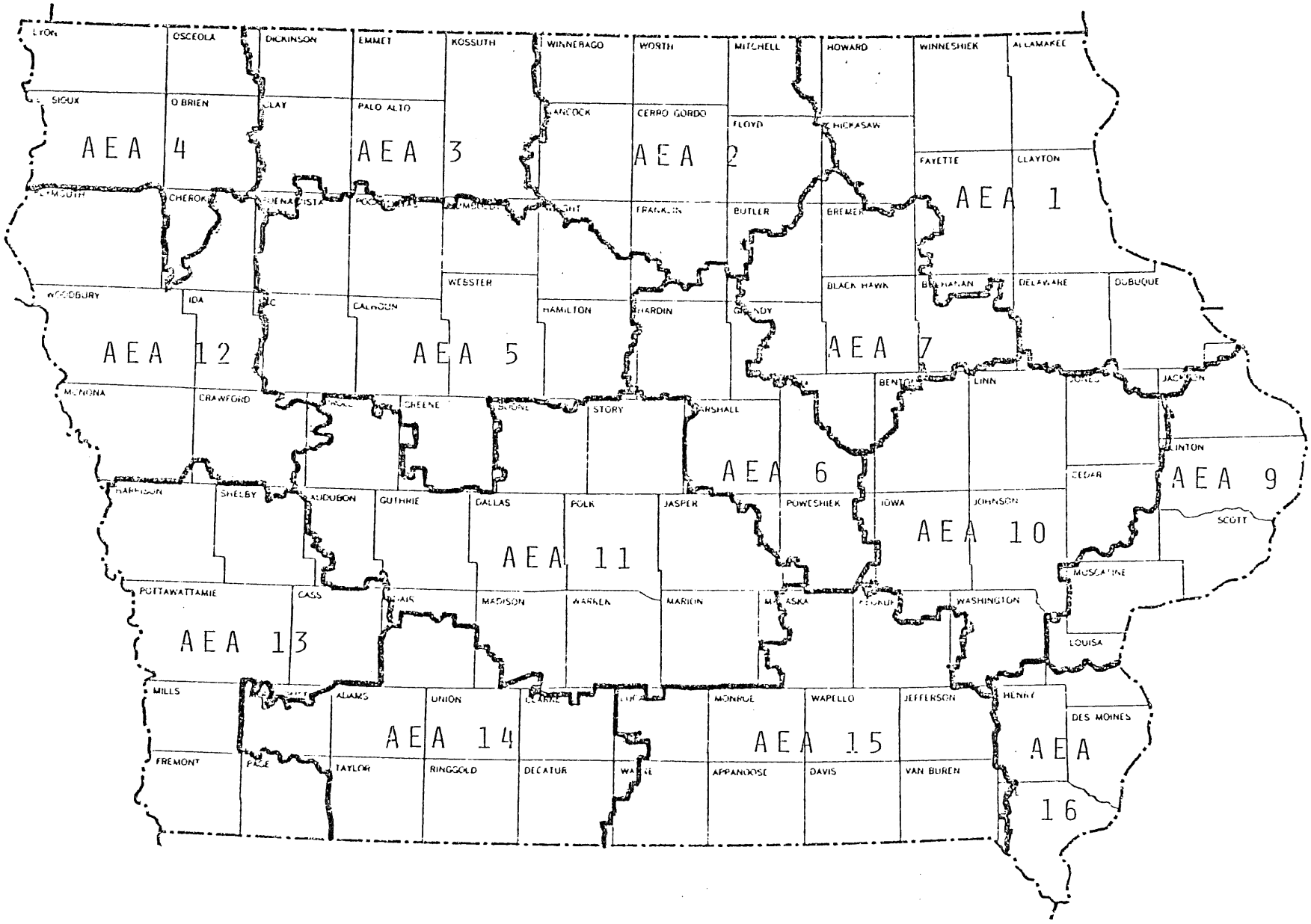
AREA EDUCATION AGENCY 15

LINDA HOLLOWAY, Supervisor
Preschool Handicapped
Southern Prairie AEA 15
Route 5, Box 55
Ottumwa, Iowa 52501
515/682-8591

AREA EDUCATION AGENCY 16

VACANT, Supervisor
Preschool Handicapped
Great River AEA 16
1200 University
Burlington, Iowa 52601
319/753-6561
1-800/582-2381

Iowa AREA Education Agencies



AEA #3

CLARIFICATION OF PRESCHOOL CRITERIA

No criteria has been established at this time which would differentiate birth to 3 from older students. Diagnosis of disability and service model recommendation is the responsibility of the staffing team.

VI - Based upon identified visual deficit by a medical or omthalmological team. (See Appendix J)

HI - (Hearing Impaired) Determined as needed by staffing team. Severity rating scale is to be devised at state level. (See Appendix K)

MD - Refer to Mental Disabilities Handbook (See Appendix G), and Iowa Rules of Special Education (Appendix D).

BD - Waiting for guidelines in fall, 1984.

DD - Refer to deferred diagnosis (Appendix M).

CM - Clinicians utilize the State Severity Rating Scale. Children receiving a 3 or 4 rating on this scale generally receive services.

SL - Refer to communication disability.

LD - Currently not identified in 0-3 population.

PD - AEA and State are developing criteria for Occupational Therapy Services. Refer to definition as defined by the State.

12.3 (281) Definitions. As used in these rules:

12.3 (1) "Department" means the state department of public instruction.

12.3 (2) "Parent" means a natural parent or any other person who has personal guardianship rights and responsibilities for a pupil.

12.3 (3) "Pupil" means a person over seven and under sixteen years of age who pursuant to the statutes of this state is entitled or required to receive a public education; a person under seven or over sixteen years of age who pursuant to the statutes of this state is entitled to receive a public education; and, a person under twenty-one years of age who pursuant to the statutes of this state is entitled or required to receive special education programs and services.

12.3 (4) "Children requiring special education" are those pupils handicapped in obtaining an education as specified in Chapter 281 of the Code, and as defined in these rules.

a. "Physical disability" is the inclusive term used in denoting physical or visual impairments of pupils requiring special education programs and services.

(1) Pupils with physical impairments manifest an aberration of an essential body structure, system or function. Included may be disabilities resulting from cardiac, congenital or orthopedic anomalies and conditions, or conditions of unknown or miscellaneous causes.

(2) Pupils with visual impairments are those whose vision deviates from the normal to such an extent that they, in the combined opinion of an educator qualified in the education of the visually impaired and an eye specialist, require special education programs, facilities or services. Visual acuity and educational functioning are used in determining needs of partially sighted and blind pupils.

b. "Mental disability" is the inclusive term denoting significant deficits in adaptive behavior and subaverage general intellectual functioning. For educational purposes, adaptive behavior refers to the individual's effectiveness in meeting the demands of one's environment and subaverage general intellectual functioning as evidenced by performance greater than one standard deviation below the mean on a reliable individual test of general intelligence valid for the individual pupil.

c. "Emotional disability", which is manifested as a behavior disorder, is a pattern of situationally inappropriate behavior, observed in the school setting, which deviates substantially from behavior appropriate to one's age and significantly interferes with the learning process, interpersonal relationships, or personal adjustment of the pupil. The determination of this handicap is largely based on the consistency, intensity, and duration of the behavior of concern.

d. "Communication disability" is the inclusive term denoting deficits in language, voice, fluency, articulation and hearing.

(1) Impairment in language is a disability in verbal language resulting in a markedly impaired ability to acquire, use or comprehend spoken, read or written language due to difficulties in acquisition and usage of

syntax, morphology, phonology and semantics.

(2) Impairment in voice is an abnormality in pitch, loudness or quality resulting from pathological conditions, psychogenic factors or inappropriate use of the vocal mechanism which interferes with communication or results in maladjustment.

(3) Impairment in fluency is a disruption in the normal flow of verbal expression which occurs frequently, or is markedly noticeable and not readily controllable by the pupil. These disruptions occur to the degree that the pupil or the pupil's listeners evidence reactions to the manner of one's communication and one's disruptions so that communication is impeded.

(4) Impairment in articulation is defective production of phonemes which interferes with ready intelligibility of speech.

(5) Impairment in hearing is a loss of auditory sensitivity ranging from mild to profound which may affect one's ability to communicate with others.

"Deaf" pupils include those individuals whose hearing impairment is so severe that they do not learn primarily by the auditory channel even with a hearing aid, and who need extensive specialized instruction in order to develop language, communicative and learning skills.

"Hard of hearing" pupils include those individuals whose level of communicative ability is adequate to allow them to acquire speech, language and to learn by auditory means although they may experience difficulty, under certain circumstances, in oral communication, language and learning skills with or without amplification and who may need various classroom and instructional modifications in order to make full use of school experiences.

e. "Learning disability" is the inclusive term denoting the inability to learn efficiently in keeping with one's potential when presented with the instructional approaches of the regular curriculum. The inability to learn efficiently is manifested as a disorder in an individual's ability to receive, organize, or express information relevant to school functioning and is demonstrated as a severe discrepancy between an individual's general intellectual functioning and achievement in one or more of the following areas: School readiness skills, basic reading skills, reading comprehension, mathematical calculation, mathematical reasoning, written expression and listening comprehension. A learning disability is not primarily the result of sensory or physical impairments, mental disabilities, emotional disabilities, cultural difference, environmental disadvantage, or a history of an inconsistent educational program. The following criteria shall be applied in identifying a pupil as learning disabled and in need of special education.

(1) Hearing sensitivity must be within normal limits unless the hearing loss is temporary or not educationally relevant, such as a high frequency loss above the speech range.

(2) Vision must be within normal limits after correction unless the impairment is temporary or not educationally relevant.

(3) Intellectual functioning must be at or above one standard deviation below the mean as measured by an instrument recognized as a valid

measure of intellectual functioning. A total or full-scale score shall be used in applying the intellectual criterion. In cases where measured intellectual functioning does not meet this criterion, but the results are suspect and the pupil's level of intellectual functioning is believed to be within the stated criterion, the individual responsible for assessing intellectual functioning shall state in writing the specific data which supports that conclusion.

(4) A severe discrepancy between current achievement and intellectual functioning exists when a pupil has been provided with learning experiences that are appropriate for the pupil's age and ability levels, and obtained scores in the achievement area(s) of concern are below the pupil's present grade placement and are greater than one standard deviation below the mean on the distribution of achievement scores predicted from obtained intellectual functioning scores. In establishing the difference of one standard deviation, the effects of regression toward the mean and errors of measurement must be applied. If the technical data necessary to account for the effects of regression are not available, the discrepancy between the obtained achievement and intellectual functioning standard scores must be at least two standard errors of measurement for the difference. If norm-referenced tests are not available in a particular achievement area, the diagnostic-educational team shall state in writing the assessment procedures used, the assessment results, the criteria applied to judge the importance of any difference between expected and current achievement, and whether a severe discrepancy is present that is not correctable without the provision of special education.

(5) A member of the diagnostic-educational team must observe the pupil's performance in the regular classroom setting. The primary purposes of the classroom observation are to seek evidence for the existence of a learning disability, and to determine the degree to which the learning disability, if any, affects classroom performance. The individual responsible for the observation must be someone other than the pupil's classroom teacher who is trained to use observation as a diagnostic procedure.

(6) The severe discrepancy between achievement and intellectual functioning must not be primarily attributable to emotional disabilities, chronic health problems, physical impairments, environmental disadvantage, cultural difference, or a history of an inconsistent educational program.

(7) The degree of the achievement-intellectual functioning discrepancy may decrease as a pupil receives special education, progresses academically, and maintains that progress. Consideration of these factors will be used to determine a pupil's movement along the continuum of special and regular education options, and in targeting appropriate transfer from a special education instructional program. A pupil who attains an achievement level commensurate with expected performance, given current grade level placement and intellectual functioning, and is able to maintain satisfactory educational performance in the regular classroom program shall be transferred from the special education instructional program. A trial placement in the regular classroom program of not more than forty-five school days without the provision of direct instruction from the special education teacher may be provided a pupil prior to transfer from the special education instructional program.

This definition of Behavioral Disorders replaces the definitions for "Emotional disability" (in Section 12.3(4)c., page 2) and "Chronically disruptive" (in Section 12.3(4)f. on page 4) in the Rules of Special Education, 1982.

c. "Behaviorally disordered" is the inclusive term for patterns of situationally inappropriate behavior which deviate substantially from behavior appropriate to one's age and significantly interfere with the learning process, interpersonal relationships, or personal adjustment of the pupil to such an extent as to constitute a behavioral disorder.

(1) Clusters of behavior characteristic of pupils who are behaviorally disordered include: Cluster I - Significantly deviant disruptive, aggressive or impulsive behaviors; Cluster II - Significantly deviant withdrawn or anxious behaviors; Cluster III - Significantly deviant thought processes manifested with unusual communication or behavioral patterns or both; and Cluster IV - Significantly deviant behavior patterns characterized by deficits in cognition, communication, sensory processing or social participation or a combination thereof that may be referred to as autistic behavior. A pupil's behavior pattern may fall into more than one of the above clusters.

(2) The determination of significantly deviant behavior is the conclusion that the pupil's characteristic behavior is sufficiently distinct from his or her peer group to qualify the pupil as requiring special education programs or services on the basis of a behavioral disorder. The behavior of concern shall be observed in the school setting for school-aged pupils and in the home or center-based setting for preschool-aged pupils. It must be determined that the behavioral disorder is not maintained by primary intellectual, sensory, cultural or health factors.

(3) In addition to those data required within the comprehensive educational evaluation for each pupil requiring special education, the following areas of data collection shall be gathered when identifying a pupil as behaviorally disordered which describe the qualitative nature, frequency, intensity, and duration of the behavior of concern. If it is determined that any of the areas of data collection are not relevant in assessing the behaviors of concern, documentation must be provided explaining the rationale for such a decision.

"Setting Analysis" data includes: information gathered through informal observation, anecdotal record review and interviews describing the setting from which a pupil was referred; documented prior attempts to modify the pupil's educational program so as to make behavioral and academic achievement possible in the current placement; and social functioning data that includes information, gathered from sources such as teacher interviews and sociometric measures, regarding the referred pupil's interaction with his or her peers.

"Pupil Behavioral Data" includes: measures of actual behavior that include the specific recording, through systematic formal observations, of a pupil's behavior including the frequency of behaviors of concern; and measures of reported behavior that includes information gathered through checklists or rating scales and interviews that document the perceptions of school personnel regarding the behavioral pattern of the referred pupil and information regarding the perception of the pupil's home and school behavior obtained from the parent or surrogate parent.

"Individual Trait Data" includes information about the unique personal attributes of the pupil. This information, gathered through pupil and teacher interviews and relevant personality assessments, describes any distinctive patterns of behavior which characterize the pupil's personal feelings, attitudes, moods, perceptions, thought processes, and significant personality traits.

(8) In accord with Section 281.3(5), the Code, the director of each area education agency shall submit to the department on forms provided by it data necessary for the department to monitor the implementation of this rule.

f. "Chronically disruptive" is the inclusive term describing those pupils who repeatedly exhibit markedly unacceptable behavior preventing a satisfactory adjustment to the regular school program and significantly interfering with the pupil's learning process and interpersonal relationships. This behavior occurs to such a degree that the administration or local school district board has excluded the pupil from the regular instructional program. The school shall document prior attempts to modify the regular educational program in such a way as to meet the educational needs of the pupil. The director of special education shall consult with representatives of appropriate juvenile agencies as a part of the diagnostic-educational staffing process.

12.3 (5) "Children who are handicapped in obtaining an education" are those pupils whose educational potential cannot be adequately realized in the regular school experience without the provision of special education programs or services.

12.3 (6) "Special education programs and services" are all special education activities provided for children requiring special education by the department, area education agency or school district. Special education provides a continuum of program and service options in order to provide the intervention which is required to meet the educational needs of each pupil regardless of the disability.

12.3 (7) "Special education instructional programs" are those regular or special education classroom and instructionally related activities for children requiring special education ordinarily provided by the school district but which in some instances, subject to the approval of the department, may be contracted from the area education agency or another public or private agency.

12.3 (8) "Special education support programs and services" are those special education activities including interdistrict transportation and other unique service needs as approved by the department which augment, supplement or support regular or special education programs and services for children requiring special education and which are ordinarily provided by the area education agency but may be provided by contractual arrangement, subject to the approval of the department, by the school district or another qualified public or private agency.

12.3 (9) "Director of special education" means the director of special education of the area education agency.

12.3 (10) "Severely handicapped" are those pupils referred to as 'severely and profoundly handicapped' who are defined operationally in terms of infantile or primitive behavioral and developmental characteristics, and who need intensive special education programs and services. These pupils manifest developmental and adaptive behavior deficits affecting a combination of the following areas: Sensory awareness, sensory-motor skill development, communication skills, self-help skills, and social skills. For educational purposes, the intensity of the handicapping condition is of primary importance in the identification of these pupils.

12.3 (11) "Agency" is a public or nonpublic organization which offers special education programs and services in one or more disability areas.

12.3 (12) "Multidisability" refers to a special education program or service in which the pupils receiving the particular program or service may have different disabilities. The term 'multicategorical' may be used interchangeably.

12.3 (13) "Preschool handicapped" are those pupils below compulsory school age who require special education instruction or services which are not appropriately provided within the scope of general education or other special education instructional programs and when such instruction or service will reasonably permit the child to enter the educational process or school environment when the child attains school age.

IDENTIFICATION CRITERIA

AEA #6

PRESCHOOL IDENTIFICATION CRITERIA

2.2 Goal: To identify all children between the ages of 0-6 years who may experience developmental delays in language, cognitive, social, emotional, self-help and gross/fine motor skills.

2.2.1 Preschool Identification

2.2.1.1 Preschool Identification Criteria

Objective: Identification shall be based on the degree to which the child's rate of demonstrated development deviates from the normal developmental progression.

Activity:

a. Early signs of difficulty shall be identified through observations by:
   1. Trained observers
   2. Concerned public
   3. Parents
   4. Others

b. Identification of the at risk population shall be made on the basis of the following criteria. Criteria refers to testing using Marshalltown Behavioral Developmental Profile.

Age Range	Developmental Lag
0 - 6 months	1 month
6 - 12 months	2 months
12 - 24 months	4 months
24 - 36 months	6 months
36 - 48 months	6 months
48 - 60 months	6 months
60 - 72 months	6 months

c. Criteria for identification shall be disseminated through:
   1. Direct contact with referral sources
   2. Inservice with referral sources
   3. Parenting classes
   4. Training programs
   5. Public service announcements
   6. Brochures

d. The Supervisor of the Preschool Division, in conjunction with a Transdisciplinary Team, shall review the effectiveness of this process and modify when appropriate.

Responsible:

Direct - Preschool Teacher
Child Find Coordinator

Indirect - Preschool Supervisor
Preschool Staff
LEA Administrator

SECTION V

IOWA'S
SEVERITY RATING SCALES
FOR COMMUNICATION DISABILITIES
2½ to 3 YEAR OLD CHILD

Comment

Only one parameter area was defined when assessing 2½ to 3 year old children. Their future success as communicators seemed best reflected in their expressive language skills.

Copies available from: Iowa Department of Public Instruction
Special Education Division
Grimes State Office Building
Des Moines, Iowa 50319-0146

EXPRESSIVE LANGUAGE SEVERITY RATING SCALE
2½ to 3 YEAR OLD

RATING	CHARACTERISTICS
0	Normal
1	a. Speech and language clinician observes or parent reports child consistently uses a variety of intelligible 2 and 3 word utterances. Use of earlier developing linguistic structures are emerging. b. Verbal imitations are minimal. Spontaneous speech predominates. c. Portions of spontaneous conversation may be unintelligible. However, the listener knows the topic of conversation.
2 - 3	A child must exhibit a preponderance of these factors: a. Speech and language clinician observes or parent reports child consistently uses a variety of intelligible one-word utterances. However, use of longer utterances is emerging. b. Alternative communication systems may be used (gesturing, pointing) but usually in conjunction with verbalization or vocalization. c. Speech and language clinician observes or parent reports that the child produces unintelligible utterances which contain normal inflectional patterns. d. Child is spontaneously imitating at the verbal level. e. Speech and language clinician or parent reports that the child uses communication for appropriate social interaction.

RATING	CHARACTERISTICS
2 - 3	f. At least a 20% deficit when language age is compared with an estimated nonverbal developmental age.
4	A child must exhibit a preponderance of these factors:
	a. Child exhibits limited verbal expression within the home.
	b. Child relies on alternative communication system (gestures, points, grunts, other family members talk for child).
	c. Child primarily uses jargon.
	d. Child does not spontaneously imitate at the vocal or verbal level, according to parent report.
	e. Limited social interaction with family members.
	f. At least a 30% deficit when language age is compared with an estimated nonverbal developmental age.

NONVERBAL DEVELOPMENTAL AGE GUIDELINES

EXAMPLE

Chronological Age	20% Deficit	30% Deficit	40% Deficit
5 years	4 years	3 years, 6 months	3 years
4 years	3 years, 2 months	2 years, 10 months	2 years, 5 months
3 years	2 years, 5 months	2 years, 1 month	1 year, 10 months
2 years	1 year, 7 months	1 year, 5 months	1 year, 2 months
1 year	10 months	8 months	7 months

(A 20% deficit is approximately one standard deviation.)

SECTION VI

IOWA'S
SEVERITY RATING SCALES
FOR COMMUNICATION DISABILITIES
2 to 2½ YEAR OLD CHILD

Comment

Only one parameter area was defined when assessing 2 to 2½ year old children. Their future success as communicators seemed best reflected in their expressive language skills.

NOTE: Revisions to the Severity Rating Scale are currently in pilot phase in the Grant Wood AEA #10 Early Childhood Special Education Division.

EXRESSIVE LANGUAGE SEVERITY RATING SCALE
2 to 2½ YEAR OLD

RATING	CHARACTERISTICS
0	Normal
1	a. Child communicates predominately through one-word utterances although a few two and three-word utterances are present. b. There may be a history of significant health factors which delayed general development.
2 - 3	A child must exhibit a preponderance of these factors: a. Child evidences development of the proper sequence of prerequisite communication skills but at a slower rate: 1. child expresses a few meaningful one-word utterances. 2. child demonstrates appropriate affect, gestures and other nonverbal communication skills. 3. speech and language clinician observes or parent reports child is spontaneously imitating at the motor and vocal levels. b. Parent reports child demonstrated significant spurts of growth in the motor area which appear to take precedence over language development. c. No immediate family history of late onset of talking. d. No serious medical complications during birth and early infancy. e. At least a 20% deficit when language age is compared with an estimated nonverbal developmental age.

RATING	CHARACTERISTICS
4	A child must exhibit a preponderance of these factors: a. Child is nonverbal within the home. b. General lack of effort to communicate (verbal, vocal, nonverbal or any combination). c. Child is not spontaneously imitating at the motor, vocal or verbal level according to parent report. d. No immediate family history of late onset of talking. e. No serious medical complications during birth and early infancy. f. At least a 30% deficit when language age is compared with an estimated nonverbal developmental age.

NONVERBAL DEVELOPMENTAL AGE GUIDELINES

EXAMPLE

Chronological Age	20% Deficit	30% Deficit	40% Deficit
5 years	4 years	3 years, 6 months	3 years
4 years	3 years, 2 months	2 years, 10 months	2 years, 5 months
3 years	2 years, 5 months	2 years, 1 month	1 year, 10 months
2 years	1 year, 7 months	1 year, 5 months	1 year, 2 months
1 year	10 months	8 months	7 months

(A 20% deficit is approximately one standard deviation.)

IOWA
MENTAL DISABILITIES CRITERIA
(Minimal to Severe/Profound)

Educational Classification There can be a discrepancy of 10-12 points in the range shown.	Birth to 6 Years MATURATION AND DEVELOPMENT	Ages 6 - 21 Years TRAINING AND EDUCATION	Ages 21 and Over SOCIAL AND VOCATIONAL ADEQUACY	Possible Class Placements - (Determined by the diagnostic educational staffing team)
MINIMALLY DISABLED IQ Range 85-70	Behavioral growth appears in a normal and predictable fashion and the child learns to walk, eat, talk, toilet train, develop physiological stability, forms simple concepts of social and physical reality, learns to relate emotionally to parents, siblings and other people, and is able to distinguish right and wrong. There will be a slight lag in acquiring these skills but may be so slight that it initiates little or no concern.	Profits from regular education programming but may or may not (depending on a number of criteria) be able to meet the demands of programming in regular education without the assistance of a resource teacher. In some instances, because of the pupil's academic and adaptive behavior needs, a more structured learning environment is required. If this cannot be facilitated utilizing the intervention and support of the resource teacher, the staffing team will need to consider the utilization of other classroom options.	Generally will become self-supporting and a competent community citizen. May need guidance and assistance, as does any citizen, when there is extended periods of unusual social, emotional and economic stress.	Regular Education Resource Teacher Support or Special Class with Integration
MILDLY DISABLED IQ Range 70-55	Behavioral growth appears in a normal and predictable fashion and the child learns to walk, eat, talk, toilet train, develop physiological stability, forms simple concepts of social and physical reality, learns to relate emotionally to parents, siblings and other people, and is able to distinguish right and wrong. The lag in learning these early skills will be noticeable at the lower ranges of functioning but may be shrugged off as slowness, immaturity which will be caught up someday.	Profits from concrete learning situations and generally can acquire skills that will allow the individual to live very well in a community with the lessening of academic constraints. Needs a career education oriented program to assure training in vocational skills with competence to attain economic efficiency, worthy home membership, citizenship, and self realization.	Generally will become self-supporting and live in a familiar community well. May function independently for the majority of the time but may need some assistance when major new situations confront them. Can benefit from the availability of community support.	Special Class with Integration or Self-Contained with little integration or Self-Contained Class Can profit from integration and socialization in regular education.
MODERATELY DISABLED IQ Range 55-40	There will be a noticeable lag in developmental growth. The child only communicates well enough to have their needs met. They are generally very sociable but lack ability to comprehend social behavior without supportive instruction and maintenance. Profits from training in self-help skills, communication skills, socialization activities, physical development, and concrete, hands-on learning activities.	Profits from training in social, academic and vocational skills; academic progress seldom progresses beyond what is expected of children in 2nd grade. They do learn to communicate successfully in familiar surroundings and will need continued support systems (post-secondary) in the community to assure their semi-independence in daily living skills, personal-social skills and occupational guidance and preparation.	May achieve self-maintenance in unskilled or semi-skilled work under semi-sheltered or sheltered conditions. They will need supervision and guidance when under mild social, emotional or economic stress.	Self-Contained Special Class with little integration. Needs more structured learning experiences on an individual basis as well as in group activities. Profits from social interaction with regular education pupils.
SEVERELY DISABLED IQ Range 40-25	Will evidence poor sensori-motor development; language is minimal; can profit from programs that are able to stimulate awareness and pre-readiness for academics that are very functional in nature such as self-help skills; communication skills; physical strength development, and safety training.	May learn receptive and expressive language or an adequate substitution. Profits from training in independent functions, physical development, language development, economic activity, domestic, social and vocational skills.	Will need supervision in daily life. May be able to attend to individual needs but needs a supportive and structured living environment. Can be productive in some vocational activities when there is direct guidance and supervision.	Self-Contained Special Class for severely handicapped. One-to-one instruction within the special class. Profits from social interaction with regular education pupils.
SEVERELY/PROFOUNDLY HANDICAPPED IQ Range 25-0	Grossly handicapped with minimal capacity for awareness and responsiveness to the surroundings and to other individuals. Needs constant care and supervision. Communication will be primitive or non-existent. Needs constant care and supervision.	Some motor and expressed language may be developed; needs continuous supervision and maintenance care.	May have developed some receptive and expressive language (oral, manual, pictorial). Needs constant supervision, care, and maintenance.	Self-Contained Special Class for the Severely/Profoundly Handicapped (one-to-one instruction). May profit from socialization and association with others.

AEA #9

EMOTIONAL DISABILITIES

GUIDELINES FOR ASSESSMENT AND PROGRAMMING

FOR THE PRESCHOOL CHILD

Victoria Nimmo
Karen Bruce
Dianne Schuerch
Pat Deere

Preface

In 1980, a multidisciplinary AEA 9 task force developed guidelines and procedures for assessment and programming for emotional disabilities students. However, the issues related to preschool aged children were not addressed. Therefore, a preschool task force was established to address identification and programming for children with emotional disabilities. The basic philosophy of this document is consistent with the previous guideline, but it has been adapted for the preschool population.

This is not meant to be a final document on the topic of emotional disabilities in preschool children, but to be a framework for examining the many issues in this area and to provide a common orientation. This outline does not provide a cookbook approach but rather incorporates appropriate standards and practice within a philosophical orientation.

NOTE: This document is scheduled for revision during the 1984-85 school year to reflect the rule changes specific to behavior disorders.

INTRODUCTION

The term emotional disability is very difficult to define because it cannot be seen or measured directly. Therefore, many differing definitions and views result. Emotional disabilities may be the most complex disability to operationalize within special education for the school aged population. Currently in the state of Iowa a 2 percent incidence rate is expected with school age children. At the preschool level only a.5 percent incidence rate is projected by DPI. As a result, children identified as ED and in need of service at the preschool level would be those children evidencing the more severe problems.

One of the key issues is defining the point at which problematic behaviors become educationally significant and thus handicapping. At the preschool level, these problems are further magnified by the many inherent problems in diagnosis of young children.

Thus the "state of the art" in both preschool diagnosis and programming compounds the difficulties and issues with emotional disabilities. The problems specific to preschool children include the following:

1. Children at this age are in a period of rapid development in all areas and therefore subject to frequent change.

2. Patterns of behavior are not necessarily clearly established.

3. Behavior problems are frequent at this age, and are the norm during certain developmental periods.

4. Some preschool children have minimal, consistent experiences outside of the home. This makes it difficult to obtain cross-situational data regarding behavior.

5. The parent, or primary caretaker, is the main provider of information concerning the child's behavior. This can, at times, minimize the range and objectivity of data available.

6. Information, standardized assessment instruments, research, and data are limited for this population, because of the recency of this area for educational intervention. This further compounds data gathering and programming recommendations.

7. Behavior is intimately related with cognitive skills, language, and experience and as a result, many of these children present multiple problems.

All of these factors, inherent in both the child and the assessment, further complicate the issues and necessitate close monitoring of children with this suspected disability. Furthermore, at this age level, this diagnosis may be subject to change and of a more temporary nature than evidenced within the school age population.

DEFINITION

According to the Iowa Department of Public Instruction's Rules and Regulations and "emotional disability is manifested as a behavior disorder...". Especially at the preschool level, the focus needs to be on observable behavior; therefore, our operational definition will reflect the behavior disorder frame of reference.

> At the preschool level an emotional disability which is manifested as a behavior disorder is a pattern of situationally inappropriate behavior, which deviates substantially from behavior appropriate to one's functional age and significantly interferes with the learning process, inter-personal relationships, or personal adjustment of the child. These behaviors are ones which are observable in an educational setting and/or are ones which may adversely affect the child's future educational programming. The determination of this handicap is largely based on the consistency, intensity and duration of the behavior of concern.

Autism is defined in the Iowa Department of Public Instruction's Rules and Regulations as being within the area of emotional disabilities. Please see the appendix for a discussion of the issues related to autism.

OPERATIONALIZED DEFINITION:

EMOTIONAL DISABILITY:

1. <u>is a pattern of situationally inappropriate behavior, which deviates substantially from behavior appropriate to one's functional age</u>.

   This means that the observed behaviors have been consistently inappropriate given the child's experiences, developmental level of functioning (mental age), and social-cultural background.

2. <u>and significantly interferes with the learning process, inter-personal relationships, or personal adjustment of the child</u>.

   The behaviors of concern interfere with (1) the rate of acquiring developmentally appropriate skills, (2) the actual learning performance, or (3) the learning of other children. This learning deficit cannot be primarily attributable to any other handicapping condition, e.g., mental disability,

communication disability, physical disability. This also may imply that the child is experiencing a serious deficit in relating satisfactorily with significant individuals in the immediate environment and s/he may be evidencing serious deficits with daily living activities, e.g., excessive fears, somatic complaints, anxiety.

3. These behaviors are ones which are observable in the child's educational setting and/or are ones which may adversely affect the child's future educational programming.

This means that the behaviors are not simply reflecting a management problem within the home that could be potentially corrected if appropriate management techniques were implemented.

4. The determination of this handicap is largely based on the consistency, intensity and duration of the behavior of concern.

A. Consistency:

Consistency implies that an observed behavior is not an occasional reaction to a given situation; rather, it occurs frequently enough that it becomes a predictable pattern. Since many preschool children are not in school settings, the behavior needs to be such that it interferes with the acquisition of age appropriate skills.

B. Intensity:

Intensity refers to the degree of impact of the interfering behaviors on the environment and on the acquisition of age appropriate skills.

C. Duration:

Duration refers to a pattern of behavior occurring over an extended period of time and/or the length of time of a significant behavioral episode.

ASSESSMENT

INTRODUCTION

The classification of emotional disabilities as a handicapping condition for any child is determined through a comprehensive evaluation by a multidisciplinary team.

Examination in each of the following areas is required for the determination of emotional disabilities. Relevant information from each major category must be documented and describe the manner in which it relates to the child's difficulties.

HISTORY

1. Family and Social:

   A. Description of the family unit (size, composition, relationships, and dynamics of interaction).

   B. Traumatic or disruptive events which have been experienced by the family and/or the child.

   C. Parental perceptions of the child's problems and attempts by the family to deal with them. Include the utilization of any resources or settings outside the home.

   D. Parents' style and effectiveness of child management.

   E. Strengths within the family to assist the child with his/her problems.

   F. Any other relevant information, hereditary traits, community involvement, environmental factors, that may provide insight into the child's difficulties.

2. Involvement Outside the Home:

   A. Preschools, daycare, Sunday School, babysitters, significant others.

   B. Include information on the number and types of settings, description of the individual settings such as age groupings and number of children.

C. Describe the frequency and duration of involvement as well as performance and adjustment.

D. Include patterns and/or changes in performance, behavior, and attendance.

E. Describe adaptive behavior and social emotional adjustment.

3. Medical:

A. Birth history.

B. Developmental milestones.

C. Illnesses and injuries

D. Medications.

E. Vision and hearing.

F. Other.

BEHAVIOR

Accurate and current information about the child's behavior is essential. Particular attention must be given to the intensity, duration and consistency of the behavior. Consideration should be given to the behavior relative to the child's functioning level, environmental and social experiences, and the degree to which this behavior deviates from the norm. This behavior needs to be assessed from the perspective of its interference with the learning process and/or interpersonal relationships.

1. Observation:

A. Essential. Observations in the following settings are essential. Best practice would indicate both formal/systematic and informal/descriptive observation should be conducted.

a. Direct observation during evaluative sessions

b. Observation during free play or in unstructured situations

B. Optional

a. Gather observational data from a group setting to clarify the degree of behavioral difficulty. This data may be gathered by someone other than a diagnostic team member, e.g., parents, preschool teachers.

b. With the consensus of the evaluation team and administrative approval, a 3 to 10 day diagnostic

evaluation may also be utilized for assessment purposes.

2. Behavioral Checklists:

   A. Parents.

      a. For children over 3 a checklist should always be attempted.

      b. For children under the age of 3 a checklist may be inappropriate.

      c. At the preschool level the parent, or the primary caretaker, has the greatest opportunity for ongoing contact with the child. Therefore, they are primary sources of information about the child's behavioral functioning in all cases.

   B. Teacher and/or other significant adults

      a. For children enrolled (may be a diagnostic evaluation) in a private preschool or educational program or ongoing group, a teacher checklist should be utilized.

      b. If a behavior checklist is completed at the initial developmental screening, this and other observations and checklists should be utilized.

      c. Other individuals with regular contact with the child may be requested to complete checklists.

   C. Behavior rating scales which might be used:

      a. Burks' Preschool and Kindergarten Behavior Rating Scale.

      b. Conner's Parent or Teacher Symptom Questionnaire.

      c. Individually constructed questionnaire.

      d. Louisville Behavior Problem Checklist

      e. Personality Inventory for Children.

      f. Specialized behavior checklist:

         1. Autism Rating Scale.

         2. Rimland's Behavior Checklist

PERSONALITY

Personality assessment at the preschool level is exceedingly difficult due to the age of the population and the lack of standarized instruments and procedures. Inferences regarding development in this area must be based primarily on observable behaviors.

INTELLIGENCE

1. Current (within a calendar year) and age appropriate intellectual assessment is necessary. Assessments are difficult with preschool children, especially those with behavioral difficulties, and the results may not reflect a child's true potential. Clinical judgment combined with a knowledge of the child's level of adaptive behavior may be necessary.

2. Intelligence is not the primary determinant of this handicap. It is recognized that multiple handicapping conditions can exist. In determining that emotional disabilities is the primary handicapping condition the behavior must deviate significantly from the child's functioning level or mental age. It is possible that a child may be primarily mentally disabled (in terms of long term disability), but may be in need of behavioral programming as the behavior is the most presenting and interfering problem at a given point in time.

3. Recommended intellectual assessment instruments:

    a. Bayley Scales of Infant Development, Mental and/or Motor Scales.

    b. French Pictorial Test of Intelligence.

    c. Hiskey-Nebraska Test of Learning Aptitude.

    d. Leiter International Performance Scale.

    e. McCarthy Scales of Children's Abilities.

    f. Stanford-Binet Intelligence Scale.

    g. Wechsler Preschool and Primary Scale of Intelligence.

ADAPTIVE BEHAVIOR

1. Developmental Milestones.

2. Self-help Skills.

   A. Describe the child's self-help skills in areas such as toileting, grooming, dressing, eating, and daily responsibilities.

   B. Note any significant patterns or changes in these areas.

3. Social Skills.

   A. Include information about the child's exposure to peer groups, and note the frequency and type of involvement. Describe such things as degree of interaction, degree of cooperation, frustration tolerance, and the ability to share and to take turns, in comparison to the peer group norms.

   B. Include information about the child's relationships with siblings, caretakers, and significant others, noting any patterns or changes.

4. Formalized Measures.

   A. Minnesota Infant Development Inventory.

   B. Preschool Attainment Record.

   C. Vineland Social Maturity Scale.

SPEECH AND LANGUAGE

A speech and language assessment is typically conducted as part of the multidisciplinary evaluation. Such testing is essential since there may at times be a relationship between severe communication disorders and emotional/behavioral disorders. A child who does not have an adequate communication system may evidence many behavioral problems.

The child with emotional or behavioral problems will at times evidence deviant and/or delayed language development patterns.

The following areas are typically evaluated:

1. Expressive Language:

   A. Communicative behaviors, e.g., communicative intent, appropriateness of language, selective use of language.

2. Receptive Language:

   A. Vocabulary.

   B. Question Comprehension.

   C. Concepts.

   D. Following Directions.

3. Articulation:

   A. Specific sound errors.

   B. Overall intelligibility.

4. Fluency and/or Voice:

   (When warranted)

PROGRAMMING

The following continuum for service options includes those which begin with identification and no special assistance (least restrictive) and end with placement in a residential facility (most restrictive). The staffing team is charged with the responsibility of evaluating the child's needs and the resources that are available within the educational setting and the community before recommending a service option. Consideration may be given to a combination of the options or to other non-educational programs or service alternatives not listed.

SERVICE OPTIONS

Option #1 - Identified - No Special Education Assistance:

The child remains in the home setting, private preschool, daycare, babysitter, etc., and needs are met by caretakers, private preschool teachers and appropriate community resources without special assistance from special educational support personnel. The caretakers, teachers, etc., modify the child's environment. Monitoring may be provided.

Option #2 - Identified - With Special Education Support Personnel Services:

The child remains in the home setting, private preschool, daycare, babysitter, etc., and needs are met by caretakers, private preschool teachers, etc., with ongoing special assistance or consultation from special education support personnel. The caretakers receive consultation in understanding the child's situation and are provided with information about community resources, and ideas and activities for the child. Behavior management counseling may also be provided, when appropriate.

Option #3 - Special Education Services in a Home Intervention Instructional Program:

The child receives individual instructional programming at home in parent instructed program. The preschool handicapped teacher provides educational activities and other child related services through the parent. Counseling will be provided to the parent by special education support personnel, when appropriate. Consultation services will be available to the teacher from the special education support staff.

Option #4 - Special Class with Integration Placement:

A. A classroom where the child receives special educational services in a regular preschool or general educational setting with both special education teachers, and regular education teachers. Support services will be provided as needed.

B. This option would consist of the majority of the child's educational experiences within the special education class with some integration into regular education settings. Support services will be provided as needed.

Option #5 - Self-Contained Special Education Placement in Addition to the Regular Educational Program:

The child is in a self-contained special education program but is integrated with other students in regular education programs whenever this is appropriate. Support personnel will provide services as needed. This may reflect a partial day self-contained placement with attendance for the remainder of the day in a private preschool or kindergarten.

Option #6 - Self-Contained Multi-Categorical Preschool Handicapped Program:

The child receives basic educational instruction in a preschool handicapped classroom. This may be supplemented by inclusion in a part of the general school program, if available. Support services will be provided as needed.

Option #7 - Self-Contained Emotional Disability Preschool Handicapped Program in a Special Setting:

A child whose behavior characteristics are so significant that his/her needs cannot be met in a multi-categorical preschool handicapped program may be placed in a self-contained emotional disability preschool handicapped program. Support services will be provided as needed.

Residential Placement:

A child whose handicapping characteristics are so profound or complex that no special education service offered in the community can adequately or appropriately meet his/her needs may be referred for consideration for placement in a private or publicly operated residential facility. This more restrictive environment typically consists of a 24 hour a day treatment program.

Appendix

Autistic or Autistic-Like

> Autistic children are defined in Chapter 444,12 of the Iowa Code as:
>
> . . . persons, regardless of age, with severe communication and behavior disorders that become manifest during the early stages of childhood development and that are characterized by a severely disabling inability to understand, communicate, learn and participate in social relationships. "Autistic children" includes but is not limited to those persons afflicted by infantile autism, profound aphasia and childhood psychosis.

A combination of some or all of the following behaviors characterize children who are referred to as "autistic." These behaviors vary from child to child and time to time in severity and manner. Many preschool children may occasionally exhibit one of these characteristics or several of these characteristics; however, children identified as autistic or autistic-like will exhibit a pattern of these behaviors occurring on a frequent and consistent basis.

1. Impaired or complete lack of relatedness and social inaccessability to children, parents and adults; apparent lack of desire for affection; aloneness; withdrawal.

2. Severely impaired speech or complete lack of speech.

3. Extreme distress for no readily discernible reason.

4. Lack of intellectual development or retardation in certain areas, sometimes accompanied by normal or superior abilities in other areas.

5. Repetitive and peculiar use of toys and objects in an inappropriate manner and/or similar repetitive and peculiar body motions, such as incessant rocking, ritualism.

6. Unusual reaction to perceptual stimuli, such as seeming not to hear certain sounds and overreacting to others (e.g., holding hands over ears) or "looking-through" objects, poor eye contact, or inability to appropriately perform certain gross and/or fine motor activities (walking with peculiar gait, limpness in fingers, inability to hold a pencil appropriately).

7. Onset of disorder at birth or apparent normal early development followed by deterioration in functioning or decreased developmental rate within approximately the first three years of life.

8. Hyperactivity or passivity.

9. Apparent insensitivity to pain.

As part of the assessment process for a child who may be autistic, the Autism Rating Scale or Rimland's Behavior Checklist should be used in addition to the other required assessments. Also, when a child is actually identified as autistic it is recommended that this be verified by a clinical/medical facility. This "second opinion" is not mandatory but it is a best practices standard.

AEA #9 CRITERIA
OCCUPATIONAL THERAPY/PHYSICAL THERAPY

IDENTIFICATION/SCREENING PROCEDURES

The identification of a student who may have an educationally significant physical impairment or motor lag should be determined by the building referral review team or a D & E team following these recommended guidelines. The child should meet one or more of these criteria.

A. Review of medical data indicate that the child has a diagnosis of:

1. Cerebral Palsy
2. Cerebellar Ataxia
3. Muscular Dystrophy
4. Spina Bifida
5. Down's Syndrome under three years of age
6. Cystic Fibrosis or other respiratory disease
7. Hydrocephalus
8. Amputee
9. Brain damage or Brain tumor
10. Burn
11. Neurofibromatosis
12. Myotonic dystrophy
13. Arthrogryposis

B. Any child with a diagnosis that causes physical impairment such as arthritis, leukemia, or other forms of cancer.

C. Any child under three with a fine or gross motor lag of six months or more. This should be determined by a general developmental screening such as the C.I.P., Denver, Bayley, or Gesell.

D. Any child age three years to eight years with a fine or gross motor lag of two or more years as determined by a general developmental screening such as the Gesell, Berry VMI, Frostig, or Stanford.

E. Any child with medically documented abnormal muscle tone.

F. Any child with orthopedic or postural deformities interfering with school.

G. Any child identified as severely or profoundly handicapped with motor involvement.

H. Any child in a wheelchair or walking with adaptive equipment.

I. Any child with oral-motor problems, such as feeding problems, drooling, etc...

INFORMATION FROM IOWA VISUALLY HANDICAPPED PROGRAM STANDARDS

A. Definition

"Visually handicapped" means a visual impairment which, even with best correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.

1. "Legal blindness" means a central visual acuity of 20/200 or less in the better eye with correcting lenses, or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than twenty (20) degrees.

2. "Partially seeing" - Those less handicapped in vision but whose educational programs need to be modified because of visual loss. Visual acuity is greater than 20/200 but not greater than 20/70 in the better eye after correction.

The term as used in these standards does not refer to a disability confined to one eye only or disorders of visual processing such as reversals or poor visual memory.

The extent of visual impairments as measured by the eye specialist, should be classified according to the legal definitions of blindness and partial vision. These classifications are essential in establishing eligibility to receive certain specific services and/or materials. Examples would be: educational placement and program service, rehabilitation services, Library of Congress services, and American Printing House for the Blind federal quota materials.

IOWA

APPENDIX K

CLASSIFICATION OF HEARING LOSSES FOR STUDENTS WITH A LOSS IN BOTH EARS

Amount of hearing Loss - Better ear	Effect of Hearing Loss	Educational Needs
MILD LOSS	*May have difficulty hearing faint or distant speech.*	Preferential seating in the regular classroom. May need attention to vocabulary development. May need clinical speech services. May profit from hearing aid.
MODERATE LOSS	*Usually understands conversational speech at 3 to 5 feet. May miss as much as 50% of class discussion if voices are faint or faces not visible. May be defects in articulation. Limited vocabulary.*	Needs educational follow-up. May profit from a hearing aid and training in its use. May benefit from speech reading, auditory training, speech correction, language, conservation of speech, and preferential seating. Special assistance in curriculum subjects may be necessary.
MODERATE TO SEVERE LOSS	*Conversation must be loud to be understood. Will have considerable difficulty in classroom group discussions. Is likely to be deficient in language usage and comprehension. Abnormalities of articulation and voice production are usually obvious.*	Needs educational follow-up. Hearing aids, auditory training, speech reading, speech and language work, and preferential seating. May be a candidate for placement in a resource room. Special help in language skills vocabulary development and usag reading, writing, grammar, etc.
SEVERE LOSS	*May hear sound of loud voice about 1 foot away. May identify environmental noises. May be able to distinguish vowels but not all consonants. Quality of voice usually not normal. Speech and language defective.*	Needs educational follow-up. Hearing aid. Needs speech reading auditory training, comprehensive language developmental program, and speech development. Consideration of oral and/or total communication skills. Program needs specialized and comprehensive supporting services. Resource room, full time special program for deaf and vocational guidance should be considered.
PROFOUND LOSS	*May hear some very loud sounds, but never can rely on the auditory channel as primary avenue of communication. Speech and language will not develop normally without a comprehensive program for the hearing impaired.*	Needs educational follow-up. Hearing aid. Program emphasis on speech reading, auditory training, speech and language skills. Continuous appraisal of needs in regard to oral and total communication skills. Needs specialized supervision and comprehensive supporting services. Resource room, fulltime special program for deaf, and vocational guidance should be considered.

The problems associated with a hearing loss are dependent upon not only the severity of the loss, but on a number of variables including: time of onset, type of loss, intelligence, quickness of perception, amount of training and age begun, motivation, and auditory and language environment. In specifying the above categories, it is imperative to remember that there are many factors which will affect the hearing impaired child's performance. Performance between two children whose audiograms are identical may be vastly different. Audiogram figures may be helpful, but

CATEGORY: PRESCHOOL LEARNING DISABILITIES

A. Western Hills Education Agency Definition (September, 1978):

"Learning disability" is the inclusive term denoting deficiencies which inhibit a pupils ability to efficiently learn in keeping with one's potential by the instructional approaches presented in the usual manner and require special education programs and services for education progress. These deficiencies occur in the acquisition of learning skills and processes or language skills and processes manifested by intrapersonal differences. These deficiencies may also be manifested in an inability to receive, organize, or express information relevant to functioning. The deficiencies displayed by pupils with learning disabilties are not primarily due to sensory deprivation, mental disabilities, severe emotional disabilities, or a different language spoken in the home." The following criteria are those that need to be considered in the identification process:

B. Criteria

1. Sensory Criteria

   a. Hearing sensitivity not the primary handicap.

      Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance. If no record is available, each preschooler referred must be tested for hearing.

   b. Visual acuity - not the primary handicap.

      Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

2. Intellectual Criteria

   a. Performance at or above the minus one standard deviation point on a major instrument of general intellectual functioning.

b. Must use an individual or series of individual intelligence tests that are both language and non-language based.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

1) Stanford-Binet
2) WPPSI
3) Pictoral Test of Intelligence
4) Hiskey-Nebraska Test of Learning Aptitude
5) Leiter International Performance Scale
6) Infant Intelligence Scale (Cattell)
7) Bayley Scale of Infant Development
8) Merrill-Palmer
9) Minnesota Preschool Scale
10) Other Standardized Tests approved by the Division

c. In those cases where there is reason to suspect that the test results are not true indices of a particular student's ability (after considering the SEM), then other data supporting the professional judgement that intellectual potential is at or below minus one standard deviation must be submitted in written form to the Supervisor of Psychologists. The Supervisor must verify acceptance or rejection.

3. Emotional-Status

a. Students with learning problems primarily due to emotional disabilities are not labeled Learning Disabilities.

b. Must use observation to determine if there are emotional problems severe enough to interfere with the learnint process. Some areas to consider are:

1) Social relationships such as peer relationships, inter-family and intra-family relationships, etc.

2) Behavior problems in various settings such as classroom, playground, home, neighborhood, as well as other unstructured time.

Process: Observation should not only be done by the primary evaluator, but will also include the following:

1) At least one team member other than the child's developmental/behavioral performance in the home and/or classroom setting.

2) In the case of a child of less than school age, a team member shall observe the child in an environment appropriate for a child of that age.

3) Other assessment measures if deemed necessary by the professional examiner using at least one of the measures listed in the Category: Emotional Disabilities. Should the examiner have enough data to determine that the learning difficulty

is not due primarily to emotional disabilities, evaluation should continue to Developmental Discrepancy. If the emotional factors cannot be ruled out, continue evaluation using appropriate instruments (see E.D. category) to either substantiate or reject that the learning problem is due to emotional difficulties.

4. Developmental Discrepancy Criteria

   a. Determine student's developmental deficiency by his performance on an individual standardized test(s).

      Process: The examiner shall select from the list of standardized instruments a measurement which is most appropriate to the student being evaluated. Standardized Developmental Tests:

      1) Minnesota Child Development Inventory (MCDI)
      2) Alpern-Boll Developmental Profile
      3) Preschool Attainment Record
      4) Vineland
      5) Other Standardized Tests approved by the Division

   b. The child must be significantly underachieving in one or more of the following basic developmental areas: fine motor, gross motor, language, cognitive. The child's developmental scores may not be viewed apart from his estimated intellectual ability.

c. The amount of developmental discrepancy may be less as students participate in a preschool handicapped program, begin to make developmental growth, and eventually reach a stage of maintenance. Consideration of this will help to determine movement along the continuum of service options and assist in targeting appropriate dismissals from preschool handicapped programs.

5. Developmental History

a. A pupil may not be identified as having a learning disability if the developmental discrepancies between ability and achievement is primarily the result of environmental, cultural, or economic disadvantage.

1) Inappropriate parenting

2) Non-English speaking home

3) Cultural or economic and environmental factors

Process:

1) Review all existing records

2) Parent interviews

6. Health History

Prior to placement in a special education program, a health history for the student will be compiled by the preschool social worker. Should the health history indicate the need for further collection of medical data, the appropriate sources should be contacted. In such a case as this, it would seem appropriate to have someone knowledgeable about

the health implications as it relates to the child's special education instruction program be present at the placement staffing.

7. Learning Skills and Processes or Language Skills and Processes Criteria

   a. When learning processes or language skills are suspected to be deficient, use appropriate instruments to measure:

      1) Perceptual skills
      2) Learning modalities
      3) Memory functions
      4) Levels of meaningfulness
      5) Language development
      6) Sensory integrative functions

      Process:

      1) Selection of the appropriate instrument(s) to determine strengths and weaknesses in the above areas should be determined by the appropriate professional. Professional judgements shall be the outgrowth of direct observation as well as traits noted by others who have worked with the student. Suggestions for appropriate instruments are:

         a) Illinois Test of Psycholinguistic Abilities (ITPA)
         b) Detroit Test of Learning Aptitude
         c) Ayres Sensory Motor Integration Test
         d) Boehm Test of Basic Concepts

e) Beery-Buktenica Visual-Motor Integration Test (VMI)

f) McCarthy Scale of Children's Abilities

g) Frostig

h) Other Standardized Tests approved by the Division

2) When used in determining eligibility, the relationship of findings in these areas to the student's developmental performance should be clearly established. Data in these areas, whether based on observation in the classroom, home, standardized instruments, surveys, or clinical judgements extrapolated from instruments primarily designed to assess other variables, should be documented in written form.

3) Findings should also be correlated with the estimated intellectual ability.

CATEGORY: PRESCHOOL EMOTIONAL DISABILITY

A. Western Hills Area Education Agency Definition (September, 1978):

"Emotional disability" which is manifested as a behavior disorder, is a pattern of situationally inappropriate behavior, is any social situation with possible exclusion of home, which deviates substantially from behavior appropriate to one's age and significantly interferes with the child's growth and development and/or lives of others. The determination of this handicap is largley based on the consistency, intensity, and duration of the behavior of concern.

B. Criteria

1. Sensory Criteria

a. Hearing sensitivity - not the primary handicap.

Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance. If no record is available, each preschooler referred must be tested for hearing.

b. Visual acuity - not the primary handicap.

Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

2. Intellectual Criteria

a. Performance at or above the minus one standard deviation point on a major instrument of general intellectual functioning.

b. Must use an individual or series of individual intelligence that are both language and non-language based.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

e) SOMPA (ABIC)

f) Piers-Harris Self-Concept Scales

g) Devereux (Elementary, Child Behavior, Adolescent)

h) AAMD Public School Version

i) Vineland Social Maturity Scale

j) Pupil Rating Scale - Myklebust

k) Jesness Inventory

l) Mooney Problem Checklist

m) Burkes Behavior Rating Scale

3. Anecdotal Records

a) School Record Review

b) Other Agency Record Review

C. Program Options

Itinerant Teacher	Resource Teaching Program	Special Class with Integration		Self-Contained Special Class			Severely Handicapped
		Elem.	Sec.	Pre	Elem.	Sec.	
Departmental Approval	18	12	15	8	8	10*	5

*Self-contained special classes at the secondary level may be operated with an enrollment limit of 15 students if a work experience instructor supervises on-the-job work experience and provides related instruction.

CATEGORY: COMMUNICATION DISABILITIES

A. Department of Public Instruction Definition:

"Communication disability" is the inclusive term denoting deficits in language, voice, fluency, articulation and hearing.*

1. Impairment in language is a disability in verbal language resulting in a markedly impaired ability to acquire, use or comprehend spoken, read or written language due to difficulties in acquisition and usage of syntax, morphology, phonology and semantics.

2. Impairment in voice is an abnormality in pitch, loudness, or quality resulting from pathological conditions, psychogenic factors or inappropriate use of the vocal mechanism which interferes with communication or results in maladjustment.

3. Impairment in fluency is a disruption in the normal flow of verbal expression which occurs frequently, or is markedly noticeable and not readily controllable by the pupil. These disruptions occur to the degree that the pupil or the pupil's listeners evidence reactions to the manner of one's communication and one's disruptions so that communication is impeded.

4. Impairment in articulation is defective production of phonemes which interferes with ready intelligibility of speech.

5. Impairment of hearing is a loss of auditory sensitivity ranging from mild to profound which may affect one's ability to communicate with others. (Refer to the section on hearing impaired for definitions).

B. Criteria

1. Sensory Criteria

a. Hearing sensitivity - not the primary handicap

Process: review file to determine if uncorrected hearing problem might exist that has educational significance.

*Rules of Special Education, 1974, Amended July 20, 1977

1) Stanford-Binet

2) WPPSI

3) Pictoral Test of Intelligence

4) Hiskey-Nebraska Test of Learning Aptitude

5) Leiter International Performance Scale

6) Infant Intelligence Scale (Cattell)

7) Bayley Scale of Infant Development

8) Merrill-Palmer

9) Minnesota Preschool Scale

10) Other Standardized Tests approved by the division

c. In those cases where there is reason to suspect that the test results are not true indices of a particular student's ability (after considering the SEM), then other data supporting the professional judgement that intellectual potential is at or above minus one standard deviation must be submitted in written form to the Supervisor of Psychologists. The Supervisor must verify acceptance or rejection.

3. Developmental Criteria:

Significantly inappropriate development which cannot be definitively explained by intellectual, sensory, language processing skills, neurophysiological or general health factors.

Process: Selection of one or more of the developmental inventory instruments listed below:

a. Minnesota Child Development Inventory (MCDI)

b. Alpern-Boll Developmental Profile

c. McCarthy Scale of Children's Abilities

d. Meeting Street School Screening Test

e. Vineland

f. Preschool Attainment Record

g. Other Standardized Tests approved by the Division

4. Emotional and Behavioral Criteria

A disability to build or maintain satisfactory intra- and inter-personal relationships with peers, family, and others.

Process: Selection of both subjective checklist data from below:

a. Burke's Behavior Rating Scale

b. UPAS Specific Inappropriate Behavior Checklist

c. Cassell

d. Devereux Child Behavior Rating Scale

e. Other Standardized Tests approved by the Division and observational data that contains recorded information obtained by direct observations by an objective observer, other than the child's parent, of the child's behavioral characteristics:

a. Consistency of characteristics

b. Intensity of characteristics

c. Duration of characteristics

d. Age appropriateness of characteristics

e. Environmental factors which may contribute to a child's adjustment.

5. Affective Assessment

It may be possible to provide additional information through the use of written and projective evaluations of the student's personality and social functioning by qualified evaluator(s).

Process:

a. California Apperception Test

b. Draw-A-Person

c. House-Tree-Person

d. Bender-Gestalt

e. Guess-Why-Game

6. Health History

Prior to placement in a special education program, a health history for the student will be compiled by the preschool social worker. Should the health history indicate the need for further collection of medical data, the appropriate sources should be contacted. In such a case as this, it would seem appropriate to have someone knowledgeable about the health implications as it relates to the child's special education instruction program be present at the placement staffing.

7. Consultation

Consultation with a licensed Western Hills Area Education Agency psychologist or psychiatrist for the purpose of reviewing the potential effects of the proposed program on the student. This consultation may also include additional recommendations related to most appropriately meeting the

pupil's needs. A record of completion of a consultation prior to the pupil's placement in the proposed program shall be documented.

CATEGORY: PRESCHOOL MENTAL DISABILITIES

A. Western Hills Area Education Agency Definition (September, 1978):

"Mental disability" is the inclusive term denoting significant deficits in adaptive behavior and sub-average general intellectual functioning. For educational purposes, adaptive behavior refers to the individual's effectiveness in meeting the demands of one's environment and sub-average general intellectual functioning as evidenced by performance greater than one standard deviation below the mean on a reliable individual test of general intelligence valide for the individual pupil. In the case of pre-school children, there must be (at least attempted) a collaborative measure of intellectual functioning (ie; one language based, one non-language based) and a measure of developmental and/or adaptive behavior.

B. Criteria

1. Sensory Criteria

   a. Hearing sensitivity - not the primary handicap.

      Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance. If no record is available, each preschooler referred must be tested for hearing.

   b. Visual acuity - not the primary handicap.

      Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

2. Intellectual Criteria

   a. Performance greater than minus one standard deviation point on a major instrument of general intellectual fuctioning.

   b. Must use an individual or series of individual intelligence that are both language and non-language based.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

1) Stanford-Binet
2) WPPSI
3) Pictoral Test of Intelligence
4) Hiskey-Nebraska Test of Learning Aptitude
5) Leiter International Performance Scale
6) Infant Intelligence Scale (Cattell)
7) Bayley Scale of Infant Development
8) Merrill-Palmer
9) Minnesota Preschool Scale
10) Other Standardized Tests approved by the Division

c. In those cases where there is reason to suspect that the test results are not true indices of a particular student's ability (after considering the SEM), then other data supporting the professional judgement that intellectual potential is greater than minus one standard deviation must be submitted in written form to the Supervisor of Psychologists. The Supervisor must verify acceptance or rejection.

3. Adaptive Behavior Criteria

During infancy and early childhood, deficits in adaptive behavior will be reflected in the following area of development according to age and cultural group:

a. Motor

b. Cognitive

c. Communication

d. Self-Help

e. Social

A significant delay in acquisition of the majority of these early developmental skills is of prime importance as a criterion of mental disabilities during the preschool year.

Process: Major Developmental Instruments:

a. Family History

b. Minnesota Child Developmental Inventory (MCDI)

c. Alpern-Boll Developmental Profile

d. Preschool Attainment Record

e. Vineland

f. Portage (Oregon Version for Blind)

g. VMI

h. Other Division approved checklists.

4. Health History

Prior to placement in a special education program a health history for the student will be compiled by the preschool social worker. Should the health history indicate the need for further collection of medical data, the appropriate sources should be contacted. In such a case as this, it would seem appropriate to have someone knowledgeable about the health implications as it relates to the child's special education instruction program be present at the placement staffing.

CATEGORY: PRESCHOOL COMMUNICATION DISABILITIES

A. Western Hills Area Education Agency Definition (September, 1978):

"Communication disability" is the inclusive term denoting deficits in language, voice, fluency, articulation, and hearing. The following definitions refer to preschool age children:

1. Impairment in language is a disability in verbal language resulting in a markedly impaired ability to acquire, use, or comprehend spoken language due to difficulties in acquisition and usage of syntax, morphology, phonology, and semantics.

2. Impairment in voice is an abnormality in pitch, loudness, or quality resulting from pathological conditions, psychogenic factors, or inappropriate use of the vocal mechanism which interferes with communication or results in maladjustment.

3. Impairment in fluency is a disruption in the flow of verbal expression which occurs frequently, or is markedly noticeable and not readily controllable by the child. These disruptions occur to the degree that the child or the child's listeners evidence reactions to the manner of one's communication and one's disruptions so that communication is impeded. Preschool children may exhibit periods of normal dysfluency during their acquisition of language.

4. Impairment in articulation is defective production of phonemes which a child should be using correctly for his age level.

5. Impairment in hearing is a loss of auditory sensitivity ranging from mild to profound which may effect one's ability to communicate with others.

6. In determining communication disability, some evidence must be available to indicate average or above intellectual potential.

B. Criteria

1. Sensory Criteria

a. Hearing sensitivity - not the primary handicap.

Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance. If no record is available, each preschooler referred must be tested for hearing.

b. Visual acuity - not the primary handicap.

Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

2. Intellectual Criteria

a. Performance at or above the minus one standard deviation point on a major instrument of general intellectual functioning.

b. Must use an individual or series of individual intelligence that are both language and non-language based.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

1) Stanford-Binet
2) WPPSI
3) Pictoral Test of Intelligence
4) Hiskey-Nebraska Test of Learning Aptitude
5) Leiter International Performance Scale
6) Infant Intelligence Scale (Cattell)
7) Bayley Scale of Infant Development
8) Merrill-Palmer

9) Minnesota Preschool Scale

10) Other Standardized Tests approved by the Division

3. Speech/Language Criteria

Significant delays (not age appropriate) in one or more areas of language, voice, fluency, articulation, or hearing.

Process: The speech and language clincian will administer a battery selected from the following instruments in order to yield a combined language age, a receptive language score, an expressive language score, and an articulation measure:

a. Preschool Language Scale (Zimmerman)

b. Carrow Elicited Language Inventory

c. Arizona Articulation Proficiency Scale

d. Goldman-Fristoe Test of Articulation

e. REEL

f. Full Range Action Agency (Gesell)

g. Utah Test of Language Development

h. Carrow Test for Auditory Comprehension of Language

4. Health History

Prior to placement in a special education program , a health history for the student will be compiled by the preschool social worker. Should the health history indicate the need for further collection of medical data, the appropriate sources should be contacted. In such a

case as this, it would seem appropriate to have someone knowledgeable about the health implications as it relates to the child's special education instruction program be present at the placement staffing.

CATEGORY: PRESCHOOL PHYSICAL DISABILITY

A. Department of Public Instruction Definition:

"One who manifests an abberation of an essential body structure, system, or function - included may be disabilities resulting from cardiac, congenital, or orthopedic anomalies and conditions, or conditions of unknown or miscellaneous causes."*

B. Criteria

1. Medical Criteria

   a. Health history comprehensive

   b. A medical diagnosis

   c. Occupational therapy and/or physical evaluation

      Process:

      1) Obtain comprehensive health history

      2) Obtain medical evaluation and diagnosis or information

      3) Obtain occupational and physical therapy evaluations when applicable.

   The staffing team including a member of the medical profession must determine if the physical disability has implications that relate to the educational, instructional program. If so, this student may indeed be placed in a Physical Disability class program intervention model.

2. Sensory Criteria

   a. Hearing sensitivity - not the primary handicap.

*Rules of Special Education, 1974, Amended July 20, 1977

Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance. If no record is available each preschooler referred must be tested for hearing.

b. Visual acuity - not the primary handicap.

Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

3. Intellectual Criteria

a. Performance at or above the minus one standard deviation point on a major instrument, unless the staffing team determines that physical disability is the cause of the academic or intellectual deficiency.

b. Must use an individual or series of individual intelligence tests that are both language and non-language based.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

1) Stanford-Binet
2) WPPSI
3) Pictoral Test of Intelligence
4) Hiskey-Nebraska Test of Learning Aptitude
5) Leiter International Performance Scale

6) Infant Intelligence Scale (Cattell)

7) Bayley Scale of Infant Development

8) Merrill-Palmer

9) Minnesota Preschool Scale

10) Other Standardized Tests approved by the Division

c. In those cases where there is reason to suspect that the test results are not true indices of a particular student's ability (after considering the SEM), then other data supporting the professional judgement that intellectual potential is greater than minus one standard deviation must be submitted in written form to the Supervisor of Psychologists. The Supervisor must verify acceptance or rejection.

4. Developmental Criteria

Determine child's developmental age by performance on an individual standardized test.

Process: Assessment instruments in Western Hills Area Education Agency have been defined to be:

a. Family History

b. Minnesota Child Developmental Inventory (MCDI)

c. Alpern-Boll Developmental Profile

d. Preschool Attainment Record

e. Portage (Oregon Version for Blind)

f. Vineland

g. Other Division approved checklists

5. Emotional Status

Students with learning problems primarily due to emotional disabilities are not to be labeled Physical Disabilities. If there is cause to suspect emotional problems:

Process: Observation should not only be done by the teacher, but will also include the following:

a. At least one team member other than the child's regular teacher shall observe the child's academic/behavioral performance in the regular setting.

b. In the case of a child of less than school age, a team member shall observe the child in an environment appropriate for a child that age.

c. Other assessment measures by the professional examiner using at least one of the measures listed in the Category: Emotional Disabilities. Should the examiner have enough data to determine that the learning difficulty is not due primarily to emotional disabilities, evaluation should continue to Academic Discrepancy. If the emotional factors cannot be ruled out, continue evaluation using appropriate instruments (see E.D. category) to either substantiate or reject that the learning problem is due to emotional difficulties.

6. Developmental History

Assessment of the following:

a. Student's physical functioning at home and community.

b. Student's physical condition in participation with age mates.

c. Student's movement (reasonable speed, safety, and independence).

Process:

a. Review available files and other relevant records.

b. Conduct parent interviews.

CATEGORY: PRESCHOOL HEARING IMPAIRED

A. Department of Public Instruction Definition:

"Impairment in hearing is a loss of auditory sensitivity ranging from mild to profound which may effect one's ability to communicate with others."*

Deaf pupils include those individuals whose hearing impairment is so severe that they do not learn primarily by the auditory channel even with a hearing aid, and who need extensive specialized instruction in order to develop language, communicative, and learning skills.

Hard of Hearing pupils include those individuals whose leve of communicative ability is adequate to allow them to acquire speech, language, and to learn by auditory means although they may experience difficulty, under certain circumstances, in oral communicative language and learning skills with or without amplification and who may need various classroom and instructional modifications in order to make full use of school experience.

B. Criteria

1. Sensory Criteria

a. Hearing evaluation - a battery of diagnostic evaluations shall be administered for all hearing impaired pupils by a certified or state approved audiologist. The evaluations should include pure tone air and bone conduction thresholds, speech reception and speech discrimination testing, and/or other tests deemed appropriate by the audiologist. In cases where the pupil is wearing a personal hearing aid or where amplification may be indicated, the initial evaluation should include a hearing aid evaluation. Auditory perceptual testing should not be considered an assessment tool prior to placement, but used as supporting

*Rules of Special Education, State of Iowa, Department of Public Instruction, 1977, Division I, pp2, 3. 12.3 (282)d.

information in the educational planning. A child must have a loss of auditory sensitivity ranging from mild to profound which effects a child's learning and/or communicative abilities to be considered hearing impaired.

Process: Audiological Evaluations:

1) Pure tone air conduction thresholds
2) Pure tone bone conduction thresholds
3) Speech reception thresholds via headsets in quiet and with competing messages (aided scores when appropriate)
4) Speech Discrimination Percentage via headsets (aided scores when appropriate)
5) Sound field SRT and SDP in quiet and with competing messages (aided when necessary)
6) Impedance measurement
7) Hearing aid test box analysis

Supplemental tests may include:

1) Comfortable Loudness Level and Tolerance Level
2) Lindamood Audition Conceptualization
3) G-F-W Test of Auditory Discrimination
4) Differential diagnostic tests
5) Willeford Tapes
6) Others approved by the Division

b. Visual acuity - not the primary handicap.

Process: Review all existing records to determine if uncorrected vision problem exists that has educational significance.

2. Educational Criteria

Comprehensive educational evaluations shall be as stated in DPI Rules of Special Education 12.19 (281). This will include intellectual, emotional, and achievement testing.

Process:

a. Intellectual Evaluation for hearing impaired pupils shall be administered individually and shall be selected from the following (but not limited to) standardized tests for hearing impaired individuals:

1) Hiskey-Nebraska Tests of Learning Aptitudes
2) Leiter Performance Scale
3) Grace Arthur Point Scale Performance Test
4) Bayley Scales
5) Cattell Infant Intelligence Scale

Supporting information may be obtained from portions of the following tests:

1) Stanford-Binet
2) WPPSI
3) Pictoral Test of Intelligence
4) Columbia Mental Maturity Scale
5) Minnesota Preschool Scale

6) Illinois Test of Psycho-linguistic Abilities

7) Visual-Motor Skills Test (from Stanford-Binet)

8) Goodenough Draw-A-Man Test

9) California Test of Mental Maturity

10) Raven's Progressive Matrices

11) Milani-Comparetti

12) Other Tests approved by the Division

b. Social Evaluation tests shall be given by qualified personnel and may be selected from the following, but not limited to:

1) Vineland Social Maturity Scale

2) Caine-Levine Social Competency Scale

3) Preschool Attainment Record

4) Gessell Developmental Record

3. Developmental Discrepancy Criteria

a. Determine student's developmental deficiency by his performance on an individual standardized test(s).

Process: The examiner shall select from the list of standardized instruments a measurement which is most appropriate to the student being evaluated. Standardized Tests:

1) Minnesota Child Developmental Inventory (MCDI)

2) Alpern-Boll Developmental Profile

3) Beery-Buktenica Visual-Motor Integration Test (VMI)

4) McCarthy Scale of Children's Abilities

5) Meeting Street School Screening Test

6) Other Standardized Tests approved by Division

4. Communication Skills

A speech and language evaluation is needed to determine the nature and extent of the hearing impaired child's communicative skills.

Process: Speech/Language assessment may be selected from:

a. Carrow Elicited Language Inventory

b. Peabody Picture Vocabulary Test

c. Arizona Articulation and Proficiency Scales

d. Goldman-Fristoe Test of Articulation

e. Boehm Test of Basic Concepts

f. Preschool Language Scales

g. Other instruments approved by the Division

5. Medical History

Medical history of hearing impaired pupils shall be obtained by the school nurse or audiologist. Referral to an otolaryngologist or family physician shall be made by the audiologist when deemed appropriate.

Process:

a. Review of health records

b. Parent conference

CATEGORY: PRESCHOOL VISUALLY IMPAIRED

A. Department of Public Instruction Definition:

"Pupils with visual impairments are those whose vision deviates from the normal to such an extent that they, in the combined opinion of an educator qualified in the education of the visually impaired and an eye specialist, require special education programs, facilities, or services. Visual acuity and educational functioning are used in determining needs of partially sighted and blind pupils."*

B. Criteria

1. Sensory Criteria

a. Visual criteria - The primary criterion for determining if an individual is visually impaired is an abnormality of the eyes, the optic nerves, or the visual center of the brain resulting in decreased visual acuity.

1) Distance Acuity - The generally accepted upper limit of visual impairment is 20/70 or less in the better eye with ordinary corrective lenses. A distance acuity of 20/200 in the better eye after correction is considered legal blindness.

2) Near Acuity - This refers to the size print the individual can read at 14 inches or less as noted.

3) Visual Field - This is the degree to which an individual can see up, down, left, or right

*Rules of Special Education, 1974, Amended July 20, 1977.

while looking straight ahead. It is measured for each eye. A visual field of 20 degrees or less is considered legal blindness.

Process: The cause of a prognosis of the visual impairment must be determined by written report.

1) Opthalmologist

2) Optometrist

b. Hearing sensitivity - not the primary handicap.

Process: Review all existing records to determine if uncorrected hearing problem might exist that has educational significance.

2. Intellectual Criteria

a. Must obtain an intellectual assessment.

b. Must use an individual or series of individual intelligence tests.

Process: Major instruments have been identified in Western Hills Area Education Agency to be:

a. Stanford-Binet

b. WPPSI (verbal)

c. Leiter International Performance Scale

d. Infant Intelligence Scale (Cattell)

e. Bayley Scale of Infant Development

f. Merrill-Palmer

g. Minnesota Preschool Scale

h. Other instruments approved by the Division

3. Developmental Discrepancy Criteria

a. Determine student's developmental deficiency by his performance on an individual standardized test(s). Process: The examiner shall select from the list of standardized instruments a measurement which is most appropriate to the student being evaluated. Standardized Tests:

1) Minnesota Child Development Inventory (MCDI)
2) Alpern-Boll Developmental Profile
3) Berry-Buktenica Visual-Motor Integration Test (VMI)
4) McCarthy Scale of Children's Abilities
5) Meeting Street School Screening Test
6) Other Standardized Tests approved by Division

b. The child must be significantly underachieving in one or more of the following basic developmental areas: fine motor, gross motor, language, cognitive. The child's developmental scores may not be viewed apart from his estimated intellectual ability.

c. The amount of developmental discrepancy may be less as students participate in a preschool handicapped program, begin to make developmental growth and eventually reach a stage of maintenance. Consideration of this will help to determine movement along the continuum of service options and assist in targeting appropriate dismissals from preschool handicapped.

4. Health History

Prior to placement in a special education program, a health history for the student will be compiled by the preschool social worker. Should the health history indicate the need for further collection of medical data, the appropriate sources should be contacted. In such a case as this, it would seem appropriate to have someone knowledgeable about the implications as it relates to the child's special education instruction program be present at the placement staffing.

CATEGORY: PRESCHOOL SEVERELY AND PROFOUNDLY HANDICAPPED

A. Department of Public Instruction Definition:

"Severely and profoundly handicapped are defined operationally in terms of infantile or primitive behavioral and developmental characteristics, and who need intensive special education programs and services. These pupils manifest developmental and adaptive behavior deficits affecting a combination of the following areas: sensory awareness, sensory-motor skill development, communication skills, self-help skills, and social skills. For educational purposes, the intensity of the handicapping condition is of primary importance in the identification of these pupils."*

B. Criteria for Identification

1. Infantile adaptive behavior: Observable behaviors that are commonly found in a child that results in the child's total dependence on others.

   Primitive behavior: Behavior retained far beyond the age at which it is appropriate (Ex. asymmetrical tonic neck reflex (ATNR), suckling pattern for feeding, etc.). Basically observed in neuro-motor development.

2. Developmental characteristics: Adaptive behavior that is no more than ½ of the child's chronological age. The adaptive behavior is determined by a composite of measures that include the degree of self-sufficiency, sensory-motor development, language development, and socialization.

3. Intellectual functioning: Measures of IQ will designate this population at 25 or below.

*Rules of Special Education 1974, Amended July 20, 1977.

4. Exhibiting behaviors: Two or more of the following behaviors will be present with a degree of regularity:

   a) Self-mutilation behaviors such as head banging, body scratching, hair pulling, etc., which may result in danger to oneself.

   b) Ritualistic behaviors such as rocking, pacing, autistic-like behavior, etc., which do not involve danger to oneself.

   c) Self-stimulation behaviors such as masturbation, stroking, patting, etc., for a total of more than one hour of a waking day.

   d) Failure to attend to even the most pronounced social stimuli, including failure to respond to invitations from peers or adults, or loss of contact with reality.

   e) Lack of self-care skills such as toilet training, self-feeding, self-dressing, and grooming, etc.

   f) Lack of verbal communication skills.

   g) Lack of physical mobility including confinement to bed, inability to fine one's way around the institution or facility, etc.

To be considered as severely and profoundly handicapped the individual must meet all three criteria, and two or more exhibiting behaviors will be observed with a degree of regularity.

Process:

a. Formal assessment shall be chosen from two or more of the following scales (in total, in part, or in combination):

1) Allied Agencies Functional Scales
2) A Manual for the Assessment of a Deaf-Blind, Multi-handicapped Child
3) APT. A Training Program for Citizens with Severely or Profoundly Retarded Behavior
4) Basic Skills Screening Test
5) Bayley Scales of Infant Development
6) BCP: Behavioral Characteristics Progression
7) Callier-Azusa Scale
8) CADRE
9) Denver Developmental Screening Test
10) Developmental Record
11) Developmental Scales: To be used in assessing the development of deaf-blind children
12) Education for Multi-handicapped Infants
13) Fairview Behavior Evaluation Battery
14) KOONTZ Child Developmental Program
15) LAP: Learning Accomplishment Profile
16) LAP-I: Learning Accomplishment Profile for Infants
17) Maxfield-Buonholz Scale of Social Maturity
18) Memphis Instruments
19) Pennsylvania Training Model

20) Portage Project

21) PPAC: Primary Progress Assessment Chart of Social Development

22) RADEA Materials

23) TARC Inventory

24) Vineland Social Maturity Scale

b. Written observation summary used in conjunction with formal assessment. The attached matrix will identify those areas covered by the scales for reference in determining criteria.

Interpretations

A child should be assigned to a program for the severely/profoundly handicapped according to whether the primary educational service needs of the child are basic or academic, distinction to be discussed. If the diagnosis and assessment process determines that a child with multiple handicaps needs academic instruction, that child should not be referred to the severely/profoundly handicapped program. If the child's service needs basic skill development, the referral to the severely/profoundly handicapped program is appropriate. Basic skill development consists of:

1) Self-help skills

2) Fine and gross motor skills

3) Beginning communication development

4) Beginning social skill development

5) Beginning cognitive or preacademic skills.

Obviously, this solution to the problems of program referral and placement is not perfect. Some children may be found who require both basic skill training and academic instruction. Perhaps these children should divide their school time between two separate programs.

In general, the lower incidence population of children who are most severely impaired are the children for whom this program designation pertains. Retardation is the underlying factor - not mental retardation as a primary diagnostic consideration, but functional retardation resulting from severity of handicap. Most severely/profoundly handicapped children are functionally severely retarded (and, hence, untestable by standardized measures of intelligence). Regardless of handicapping conditions, the factor determining a child's placement in a class for severely/profoundly handicapped children is basic skill development needs.

c. Program Options

The staff-pupil ratio for severely and profoundly handicapped pupils shall be one teacher and one aide

for each five pupils. When pupils numbering six through nine are added, an additional teacher or aide must be added. When the tenth pupil is added another teacher must be employed.

DEFERRED DIAGNOSIS AND EXTENDED EVALUATION

Categories for Handicapped from Birth to Three Years

Due to difficulty of correctly pinpointing the disability for some handicapped children below the age of three years, it will be possible as of July 1, 1979, to place such children in a "deferred diagnosis" status for a maximum time period of one year or until such time as an accurate educational diagnosis can be obtained. "Deferred diagnosis" status must be changed to a specific disability category when the child reaches his/her third birthday prior to September 15 of that year.

Deferred diagnosis status should be utilized only when determination of a specific disability area cannot be made. For example, if a child is known to have Down's Syndrome, be visually or hearing impaired, or severely/profoundly handicapped, the appropriate category is to be selected and coded when data is collected in September and January of each year. Conditions which can be determined from existing medical and/or educational diagnosis should be coded by disability on the child's records and use of the "deferred diagnosis" status should not be considered. Only a small percentage of the handicapped between the ages of birth and age three should require the utilization of the "deferred diagnosis" category as most children requiring special education programs and services at this age usually fall within the moderate to severe range of handicapping conditions. Within these ranges, the determination of disability can usually be made with greater precision.

All children receiving service while placed in the "deferred diagnosis" category must have on file an interdisciplinary staffing report which contains the observational, medical, and educational assessment information obtained prior to placing the child in the diagnostic category (Rules of Special Education, 12.19). Detailed health histories shall be obtained on all children prior to beginning special education programs or services. Such histories are to be obtained by a nurse whenever possible. All children receiving special education programs or services who are placed in the deferred diagnosis category must have had a hearing assessment prior to placement. If valid hearing assessment results are not attainable due to the inability to condition the child or for other reasons, continued attempts should be made until valid results are obtained.

An annual review is to be held on these children to determine: (a) if additional data obtained permits a current, accurate diagnosis to be established; (b) whether the child is to continue receiving programs and (c) the child is no longer in need of programs and/or services.

It remains the responsibility of the professionals providing the special education programs and services to keep parents informed of the developmental status of the child as perceived by the staff, i.e. amount of developmental lag exhibited by the child in areas of motor, cognition,

and language. Information regarding adaptive behavior may also be interpreted to parents. As soon as the disability area can be determined, this information is to be shared with parents and support provided to assist parents in understanding the special needs of their child.

As with any young child in need of special education programs or services, the parents are a critical member of the service team. The educational and diagnostic personnel should make every effort to explain the child's needs and stress the importance of early intervention for the child.

Categories which are options for children below age three are listed in Chapter 281, Code of Iowa.

Whether an Area Education Agency chooses to use the "deferred diagnosis" category is optional. All children who are weighted in order to generate state and local funding must be placed in one of the appropriate categories based on their primary disability. The "deferred diagnosis" category is only available for 0-3 children who are served with federal funds.

Program options available to the handicapped child below age three are home instruction, center based classes, and support services such as physical or occupational therapy, audiology, speech therapy, social work, and psychological services.

Details regarding the coding for use on the "handicapped pupil survey" will be forwarded to you as soon as possible. It was not possible to make computer changes prior to the September, 1979 count as was anticipated.

Extended Evaluation

The proposed changes in the Rules of Special Education would project the "extended evaluation" as a replacement for the "deferred diagnosis" category. If adopted, the new rule for "extended evaluation" would read as follows:

12.3(13) "Extended evaluation" is a status which may be utilized for pupils below age three who are in need of special education but for whom the diagnostic-educational team cannot determine the primary educational disability. A pupil may receive special education for a maximum of one year within this status to provide an opportunity to gather additional data for determination of a primary disability. A pupil whose disability can be determined shall be so diagnosed in order to assist parents and agencies in planning for the pupil's needs. An extended evaluation is to be used only in unique situations when need for special education is imperative and time would assist with providing a definite educational diagnosis. A pupil receiving special education while placed in extended evaluation status must have on file an interdisciplinary staffing report which defines the educational, observational and medical information obtained prior to provision of special education.

SOUTHERN PRAIRIE AEA #15

PRESCHOOL

CRITERIA FOR PLACEMENT

Developed - November, 1980

Revised - April, 1984

TASK FORCE:

Ken McLeland, Audiologist
Mary Whitting, Teacher of the Hearing Impaired
Steve Halverson, Social Worker
Harry Wright, Physical Therapist
Sharon Moritz, Preschool Instructor
John Lindstrom, Psychologist
Anne Silvey, Speech Clinician
Tom Mosbach, Consultant
Mary Schertz, Preschool Supervisor

12.3(13) "Preschool handicapped" are those pupils below compulsory school age who require special education instruction or services which are not appropriately provided within the scope of general education or other special education instructional programs and when such instruction or service will reasonably permit the child to enter the educational process or school environment when the child attains school age.

I. PLACEMENT

A. Before any child is placed in the preschool program, a comprehensive evaluation must be completed by the diagnostic educational team.

B. Those children under two years of age must have evaluations addressing the following:
   1. vision
   2. hearing
   3. intellect
   4. motor functioning
   5. adaptive behavior
   6. social functioning
   7. developmental
   8. health history

C. Those children two years of age and older must have evaluations addressing the following:
   1. vision
   2. hearing
   3. intellect
   4. motor functioning
   5. adaptive behavior
   6. social functioning
   7. academic
   8. health history
   9. speech/language

D. Other evaluations may be requested as deemed necessary.

E. All children in the preschool program will have a comprehensive annual evaluation addressing the following:
   1. vision
   2. hearing
   3. intellect
   4. motor functioning
   5. adaptive behavior
   6. social functioning
   7. academic
   8. health history
   9. speech/language (children two years of age and older)

II. AUTISM

A. Definition: The National Society for Autistic Children defines autism as a brain disorder that severely impairs the way sensory input is assimilated, causing problems in communication, social behavior, and irregularity in learning.

B. Criteria
1. The absence of normal social and emotional responsiveness to other children or to adults.
2. A development disorder of language manifested by both:
   a. failure to develop use of speech at the usual age, or odd use of speech and language;
   b. inadequate understanding of spoken language. An operational criterion of (1) is failure to develop phrase speech by age four.
3. Either (1) resistance to change in routine or surroundings, or (2) compulsive repetition of odd behaviors.
4. Onset of such behavior before age 3.
5. Chronic duration.

III. BEHAVIOR DISORDERS

A. "Behavior disorder" is an inclusive term for patterns of situationally inappropriate behavior which deviates substantially from expectations appropriate to ones age and overall developmental status. Such inappropriate behavior must significantly interfere with learning, interpersonal relationships, or personal adjustment.

B. "Behavior disorder" shall not be considered when the behavior in question is primarily the result of intellectual, sensory, cultural, or health factors which have not received appropriate attention.

C. Placement in a preschool handicap center shall be made only when the consistency, intensity, and duration of the behavior limits the possibility for effective intervention through less restrictive service models (i.e., behavioral consultation, parent training, etc.).

D. As delineated by the present state definition, characteristics of behavior disordered children include:
1. Significantly deviant disruptive, aggressive or impulsive behaviors.
2. Significantly deviant withdrawn or anxious behaviors.
3. Significantly deviant thought processes manifested by unusual communication, behavior patterns or both.
4. Significantly deviant behavior patterns characterized by deficits in cognition, communication, sensory processing, social participation or a combination thereof.
5. A combination of the above.

E. The behavior of concern shall be directly observed in the home of children below center age. Otherwise, the referred child's behavior should be observed in multiple settings including the home and a preschool environment. A diagnostic teaching placement in a preschool handicapped center should be obtained in cases where the referred child is not already attending a preschool setting and/or the child's behavior is such that a placement would enhance the evaluation process.

F. Besides those areas required for a comprehensive special education evaluation, the assessment shall includes strategies which allow for description of the qualitative nature, frequency, intensity, and duration of the behavioral concern. The assessment should include a setting analysis, behavioral data (direct and indirect), and individual trait data.

G. The individualized educational plan for children placed on the basis of a behavior disorder must include a home component.

IV. COMMUNICATION DISABILITY

A. "Communication disability" is the inclusive term denoting deficits in language, voice, fluency, articulation and hearing.
   1. Impairment in language is a disability in verbal language resulting in a markedly impaired ability to acquire, use or comprehend spoken, read or written language due to difficulties in acquisition and usage of syntax, morphology, phonology and semantics.
   2. Impairment in voice is an abnormality in pitch, loudness or quality resulting from pathological conditions, psychogenic factors or in appropriate use of the vocal mechanism which interferes with communication or results in maladjustment.
   3. Impairment in fluency is a disruption in the normal flow of verbal expression which occurs frequently, or is markedly noticeable and not readily controllable by the pupil. These disruptions occur to the degree that the pupil or the pupil's listeners evidence reactions to the manner of one's communication and one's disruptions so that communication is impeded.
   4. Impairment in articulation is defective production of phonemes which interferes with ready intelligibility of speech.
   5. Impairment in hearing is a loss of auditory sensitivity ranging from mild to profound which may effect one's ability to communicate with others.

B. Appropriate diagnostics should assist in determining if communication skills are appropriate to the child's chronological age.

C. Only when communication is the primary disability may the child be determined to be communicatively handicapped.
   1. A child who is communicatively handicapped and also

demonstrates secondary inappropriate cognitive and/or social behaviors may be considered for placement in the preschool handicapped program.

2. Children who are functionally non-verbal may be considered for placement in the preschool handicapped program.

D. If articulation is the only problem area, placement in the preschool handicapped program is not appropriate.

E. Language skills as measured by a diagnostic instrument testing several tasks will be considered delayed at an SRS of 4 if scores fall below this level of delay:

AGE LEVEL	EXTENT OF DELAY
Up to age 3	10 months or more
Age 3-0 to 3-11	12 months or more
Age 4-0 to 4-11	12 to 15 months
Age 5-0 to 5-11	More than 15 months

F. Clinical judgment will continue to play an important part in overall case selection. Factors to consider are:
1. Where child actually scores on the SRS.
2. Chronological age of the child.
3. Response to stimulation of effected speech/language structure.
4. Consistency of speech/language errors.
5. Effect of communication problem upon child's ability to relate to others.
6. Effect of communication problem upon school performance.
7. Effect of communication problem upon the listener (to what extent).
8. Ability of child to communicate to satisfy his needs.
9. Status of language stimulation in the home.
10. Consideration of other symptoms or behaviors.

G. Suggested Assessments:
1. Arizona Articulation Proficiency Scales
2. PPVT (Peabody Picture Vocabulary Test)
3. Expressive One-Word Vocabulary Test
4. Test for Auditory Comprehension of Language
5. Sequenced Inventory of Communication Development
6. Boehm Test of Basic Concepts
7. Vocabulary Comprehension Scale
8. OLSIST (Oral Language Sentence Imitation Screening Test), Stage III

V. DEFERRED DIAGNOSIS

A. Only those children under three years of age may be placed under this category.

B. This category may be used only in the following situations:
1. The child shows a significant delay in two or more areas and the primary handicap cannot be determined at this time.

2. The child has been identified as being at high risk by a professional of the medical community. Final determination for placement will be made by diagnostic-educational team.

VI. HEARING IMPAIRED

A. "Deaf" pupils include those individuals whose hearing impairment is so severe that they do not learn primarily by the auditory channel even with a hearing aid, and who need extensive specialized instruction in order to develop language, communicative and learning skills.

B. "Hard of hearing" pupils include those individuals whose level of communicative ability is adequate to allow them to acquire speech, language and to learn by auditory means although they may experience difficulty, under certain circumstances, in oral communication, language and learning skills with or without amplification and who may need various classroom and instructional modifications in order to make full use of school experiences.

C. Under the conditions that a preschool for hearing impaired cannot be produced, a child with a sensorineural hearing loss of 40 dB or greater may be placed in a preschool for the handicapped with direct educational services by a teacher of the hearing impaired.

D. Those children with a chronic conductive or sensorineural hearing loss ranging from 25 to 40 dB may be placed in the center for a period of 4 to 6 weeks for diagnostic teaching to assess apparent difficulties.

VII. LEARNING DISABLED

A. "Learning disabled" is the inclusive term denoting deficiencies which inhibit a pupil's ability to efficiently learn in keeping with one's potential by the instructional approaches presented in the usual curriculum and require special education programs and services for educational progress.

B. These deficiencies occur in the acquisition of learning skills and processes or language skills and processes, including, but not limited to the ability to read, write, spell or arithmetically reason and calculate. These deficiencies may also be manifested in an inability to receive, organize, or express information relevant to school functioning.

C. The deficiencies displayed by pupils with learning disabilities are not primarily due to sensory deprivation, mental disabilities, severe emotional disabilities, or a different language spoken in the home.

D. It is the philosophy of the Southern Prairie AEA that a child under five years of age would seldom be diagnosed as being learning disabled due to the academic nature of the definition.

VIII. MENTAL DISABILITY

A. "Mental disability" is the inclusive term denoting significant deficits in adaptive behavior and sub-average general intellectual functioning. For educational purposes, adaptive behavior refers to the individual's effectiveness in meeting the demands of one's environment and sub-average general intellectual functioning as evidenced by performance greater than one standard deviation below the mean on a reliable individual test of general intelligence valid for the individual pupil.

B. To be considered for placement in a preschool program on the basis of a mental disability, a child must exhibit a relatively stable set of behaviors and developmental patterns which fall significantly below average. Children who score more than one standard deviation below the mean on an individual intelligence test appropriate to their age shall be considered as meeting the intellectual criterion for the mental disabilities classification. Other factors which would affect the validity and reliability of the obtained scores must also be considered when interpreting evaluation findings. Instrument selection should also be based on known or suspected characteristics of the child such as sensory impairment, delayed expressive language skills, motor difficulties, and degree of delay. Additional interpretation should be given to intelligence test results in reference to corroborative and/or contradictory developmental findings. Because of the risks in predicting long term intellectual ability of young children, impressions of the child's intellectual skills must always be viewed as reflecting present status. This necessitates frequent evaluations of the child's abilities occurring on at least an annual basis.

C. It is recognized that formal psychometric techniques may not yield useful results with some children with suspected low incidence handicapping conditions. For these children, the diagnostician should utilize alternative assessment techniques which provide relevant information in describing their functioning level.

D. The child must be displaying significant deficits in adaptive behavior as well as significantly subaverage general intellectual functioning to be considered for placement on the basis of a mental disability. For educational purposes, adaptive behavior refers to an individual's effectiveness in meeting the demands of one's environment. The child's communication, sensory-motor, self-help, and social skills should be compared with developmental checklists of expected behaviors if a formal adaptive behavior inventory is not administered.

IX. PHYSICAL DISABILITY

A. Pupils with physical impairments manifest an abberation of an essential body structure, system or function. Included may be disabilities resulting from cardiac, congenital or orthopedic anomalies and conditions, or conditions of unknown or miscellaneous causes.

B. Criteria for Placement
1. Child has a documented orthopedic handicapping condition.
2. Child has fine motor problems significantly interfering with schoolwork.
3. Child has a documented abnormal muscle tone.
4. Child under three with a motor lay of 3 to 6 months or greater.
5. Child over three with a motor lay of 1 year or greater.
6. Child has a chronic health problem - such as asthma, cardiac condition - which interferes with schoolwork.

C. Assessment may include but is not limited to:
1. The evaluation of gross motor development
2. The evaluation of fine motor development
3. The evaluation of neuromuscular development
4. The evaluation of sensory integration
5. The evaluation of perceptual-motor development
6. The evaluation of self-care activities
7. The evaluation of the need for adaptive equipment
8. The evaluation of prevocational skills

D. Screening tools
A preschool child can be screened without a physician's referral. This is only to determine if the child does require a physical/occupational evaluation to observe and compare the child's performance on the standardized scale.

The following screening tools may be used:
1. Denver Developmental Screening Test
2. Program Development for Infants and Young Children
3. Sensory Motor Integration in Preschool Children
4. Brigance Early Inventory
5. Peabody Motor Scales
6. Portage Guide Checklist
7. Gesell Motor Assessment
8. University of Iowa Upper Extremity Development Assessment Scale

E. Prioritizing preschool children of occupational and physical therapy services.
1. Extent of Motor Disability: First priority will be given to orthopedically impaired or multihandicapped children. Second priority consideration to other children classified as having handicaps qualifying them for other services through the AEA.
2. Age of Child: The younger child will be given a high priority. Many disabling conditions resulting from birth, illness, or

injury can be prevented or minimized through effective early intervention of therapeutic treatment.

3. Therapist's Clinical Judgment: The therapist will use clinical judgment and may rate the child by the use of The Rating Guidelines for Occupational/Physical Therapy Screening Assessment Tool. Heavy emphasis will be placed on the expected response to treatment, the possibility of needs being met by other personnel, immediacy of need, and the child's behavior. He will be placed in a level of service according to the severity of disability and need.

X. SEVERE AND PROFOUND

A. "Severely handicapped" are those pupils referred to as "severely and profoundly handicapped" who are defined operationally in terms of infantile or primative behavioral and developmental characteristics, and who need intensive special education programs and services. These pupils manifest developmental and adaptive behavior deficits affecting a combination of the following areas: Sensory awareness, sensory-motor skill development, communication skills, self-help skills, and social skills. For educational purposes, the intensity of the handicapping condition is of primary importance in the identification of these pupils.

B. Criteria for Placement:
   1. Child functions at least 50% below age level in two or more areas of development.
   2. Child needs two or more of the following support services:
      a. Speech/language clinician
      b. Teacher of the hearing impaired
      c. Physical therapist
      d. Occupational therapist

XI. VISUALLY IMPAIRED

A. Pupils with visual impairments are those whose vision deviates from the normal to such an extent that they, in the combined opinion of an educator qualified in the education of the visually impaired and an eye specialist, require special education programs, facilities, or services. Visual acuity and educational functioning are used in determining needs of partially sighted and blind pupils.

B. The child must have central vision acuity of 20/70 or less in the better eye after correction (they can see at 20 feet what the average person can see at seventy feet).

C. Need statement from physician and/or opthamalogist.