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ABSTRACT

The report of a 1974 cooperative study focuses on current educational service delivery for 708 visually impaired (VI) Kansans (up to 21 years old). Provided is a summary of data from unified school districts (USDs), state services for the blind (SFB), and institutions on such topics as age, sex, geographic distribution, handicapping conditions, behavioral characteristics, academic achievement, self-care skills, and educational programs. Described are relevant legal provisions; the current extent of residential and home care, the rationale for residential care; and the roles of the USDs, the SFB, and three of the residential care institutions in providing service to VI individuals with 12 selected characteristics (such as handicapping condition and degree of dependence). Educational and training programs offered to VI home based and residential populations are also analyzed. Among the conclusions cited are that 37 percent of the preschool Ss have no program, that 19 percent have home programs, and that 18 percent have readiness programs. Attention is given to general recommendations in such areas as needs analysis and program development and to additional recommendations by a Vision Task Force Committee in such areas as individualized programs structured within a cascade system. Also included are a sample questionnaire, a brief discussion of the normalization principle and the cascade system, and detailed examples of cross tabulation data analyses. (LH)

A Study of the Visually Impaired Young People of Kansas and a Review of Educational Services

July 1974

Special Committee for Study
of the
Visually Impaired Young People
of Kansas

FOREWORD

The findings and recommendations in this study came from many hours of professional input from the Kansas State Department of Education, the Kansas State School for the Visually Handicapped, Kansas Neurological Institute, State Department of Social and Rehabilitation Services, the Kansas Association for the Blind, and the Budget Division of the State Department of Administration.

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We are also indebted to Mr. Verlyn Leiker, Budget Division, State Department of Administration, who provided the excellent guidance and structure for the study.

We are grateful to Mr. Warren Bell, Assistant Commissioner, Division of Instruction, Kansas State Department of Education, who coordinated the personnel involved in producing the research concerned with the visually handicapped children in Kansas. Dr. Lawrence Casto, Assistant Commissioner, Division of Development, and Dr. Ann Harrison, Specialist, Planning, Research, and Evaluation Section, are to be commended for their assistance in the computer programming and data analysis associated with the research.

The study was made possible by both state and federal funds.

*Vision Task Force Committee Members

CONTENTS

THE STUDY

The present study of the visually impaired young people of Kansas is the result of a larger effort initiated by the Kansas State Board of Education and the Department of Social and Rehabilitation Services (formerly the Department of Social Welfare).

The larger effort is aimed at gaining more information about, and a better understanding of, the present status of the educational programs for all handicapped young Kansans. This study focuses only on the visually impaired or visually handicapped.

The study comes at time when a particular approach to delivering educational services to the handicapped is becoming recognized. This particular approach is based on the concept of "normalization." The normalization concept stresses that a handicapped child should be well anchored and well integrated into his own home, community, and neighborhood school and to the maximum degree possible. This concept of normalization, in turn, implies a "cascade system" which has a goal of providing services (educational) that are the least "special" as possible for the adequate education of the child. A more detailed handling of normalization and the cascade system can be found in the attachment section of this report.

An additional consideration that emerged after the study was initiated . . . but a consideration that needs to be inserted here . . . was the passage of a new piece of legislation that will affect planning and the delivery of educational services not only for the visually impaired, but as well, for all other school age children who require special education efforts and programs. The recommendation of the present study should conform in spirit and substance with this new law.

THE NEW LAW

The 1974 legislative session produced a significant piece of legislation that will affect the school aged visually impaired and should be considered here (at least briefly). The bill, H.B. 1672 (as amended by S.B. 1024), amends and repeals the laws relating to special education in article 9 of Chapter 72 of the Kansas Statutes Annotated. The bill provides a comprehensive revision and recodification of the special education law. The principle changes are listed below:

1. A mandate as of July 1, 1979, that all boards of education provide approvable special education services for all exceptional children in the school district. (The present July 1, 1974, mandate for programs for the developmentally disabled is not changed.);

2. a requirement that the State Board of Education prepare, adopt, and administer a comprehensive state plan, including standards and criteria, for special education services;

3. the inclusion within the purview of the state plan, the special education programs of the state institutions under the jurisdiction of the Department of Social and Rehabilitation Services and the Kansas State School for the Deaf and Kansas State School for the Visually Handicapped. (These two institutions are under the jurisdiction of the State Board of Education.);

4. a provision for a due process hearing at the school district level concerning any assignment, reassignment, or exclusion of a child with regard to special education services;

5. a requirement that all new rules and regulations adopted by the State Board pertaining to special education be submitted to the legislature during each regular session, to be modified, approved, or disapproved;

6. the combination of the three existing state categorical aid programs for special education into a single program, and revision of the method of distributing categorical funds;

7. the creation of a nine-member state advisory council for special education to be appointed by the State Board of Education for terms of three years;

8. the substitution of the comprehensive term "exceptional children" for the several different terms presently in law that define specific categories of exceptionality. Such children would be school age, as determined in accordance with rules and regulations adopted by the State Board;

9. the recognition in the categorical state aid distribution plan of paraprofessionals who, in accord with State Board standards, assist certificated teachers in the instruction of exceptional children; and

10. a provision that special education cooperative agreements be for a term of not less than three years and not more than five years. (Under prior law, there were no time limitations with respect to these agreements.)

Sections of the new law that are particularly relevant to the present study are seen in points (1), (2), (3), (4), and (8). The law indicates that all USD's must provide approvable services for all exceptional children (including the visually impaired), that the Kansas State Department of Education (KSDE) must develop and administer a plan (including standards for service), that all the appropriate institutions must be included in the plan, that there are provisions for a hearing whenever a USD attempts to assign or exclude a child from special education services, and that the law refers to only school age children (ages to be determined by rules and regulations of the State Board of Education and reviewed by the legislature). And, of course, the provision for additional monies in the later bill and the recognition of the use of paraprofessionals assisting special education teachers is bound to have impact.

The new law is basically consistent with the normalization concept and will no doubt put both additional pressure on the 309 unified school districts of Kansas to educate their own whenever possible.

THE *VISUALLY IMPAIRED YOUNG PEOPLE OF KANSAS

The present study is concerned not only with the visually impaired young people of Kansas but as well with the present educational efforts and programs associated with these visually impaired young people in Kansas. And although the study does provide a better picture of what is going on in Kansas in this area, it does have a number of limitation that came about as a result of certain shortcomings in research techniques (see page 27).

In order to better understand both what is now going on and what is needed, data was collected in 1973 on a total of 708 individuals with visual impairments. The data was collected using mailed out questionnaires (see attachments). Completed questionnaires were received from all 309 Unified School Districts (USD's) of Kansas, the Services for the Blind and Visually Handicapped (SFB), the Kansas State School for the Visually Handicapped (KSSVH), the Kansas Neurological Institute (KNI), Parsons State Hospital and Training School (Parsons), Winfield State Hospital (Winfield), and the Institute of Logopedics (IL) at Wichita. No accurate estimate of the number of young people with visual impairments who were not included in the study is possible from the results of this study. There is a good probability, however, that most of the young people (generally 21 and under) in Kansas who do have visual impairments touch on at least one of these agencies. Consequently, it is felt that most of the group under study are included in the study, and as a result much can be learned from the data collected and analyzed here.

*For the purpose of this report, the terms "visually handicapped" or "visually impaired" refers to children who have no vision or whose visual impairments after correction result in educational handicaps requiring special provisions for maximal educational achievement. Such children's eye conditions generally fall within one of the following categories:

1. Visual acuity of 20/70 or poorer in the better eye after correction.
2. Constricted visual field or impaired field of vision.
3. An eye condition or disorder diagnosed by an eye specialist as requiring special provisions either on a temporary or long-term basis.
4. Multiple-handicapping conditions including a visual problem.

THE EXTENT OF RESIDENTIAL CARE AND HOME CARE AT PRESENT

The majority of the visually impaired young people of Kansas are presently living at home (61%) and most of these living at home (41%) are serviced either by the regular school system (USD's—special education) or by the Services for the Blind and Visually Handicapped (20%) or both. The data received from the State Hospital at Parsons and the Institute of Logopedics at Wichita indicates that these two institutions house and service very few (slightly over 1%) of the visually impaired school age children of Kansas. KSSVH provides a home and services to 13% of the population under study while KNI and the State Hospital at Winfield house and service 18% and 7% of the population. Below is a table indicating the location of and servicing agency of the 708 identified visually impaired Kansas young people. Also, please see the map on page 4 for home counties of the visually impaired.

Table No. 1

Location of Kansas Visually Impaired Young People						
*USD's	*SFB	KNI	KSSVH	Winfield	Parsons	I.L.
41%(home) N=289	20%(home) N=143	18% N=127	13% N=94	7% N=48	1% N=4	1% N=3

* For purposes of obtaining an unduplicated count of visually impaired youngsters, school aged children were reported on by USD personnel and not by the SFB agency.

Conclusions:

1. Based on the figures presented in Table No. 1, it is apparent that the majority (61%) of the population under study lives at home and is serviced by either the public school system or the Services for the Blind and Visually Handicapped or both.

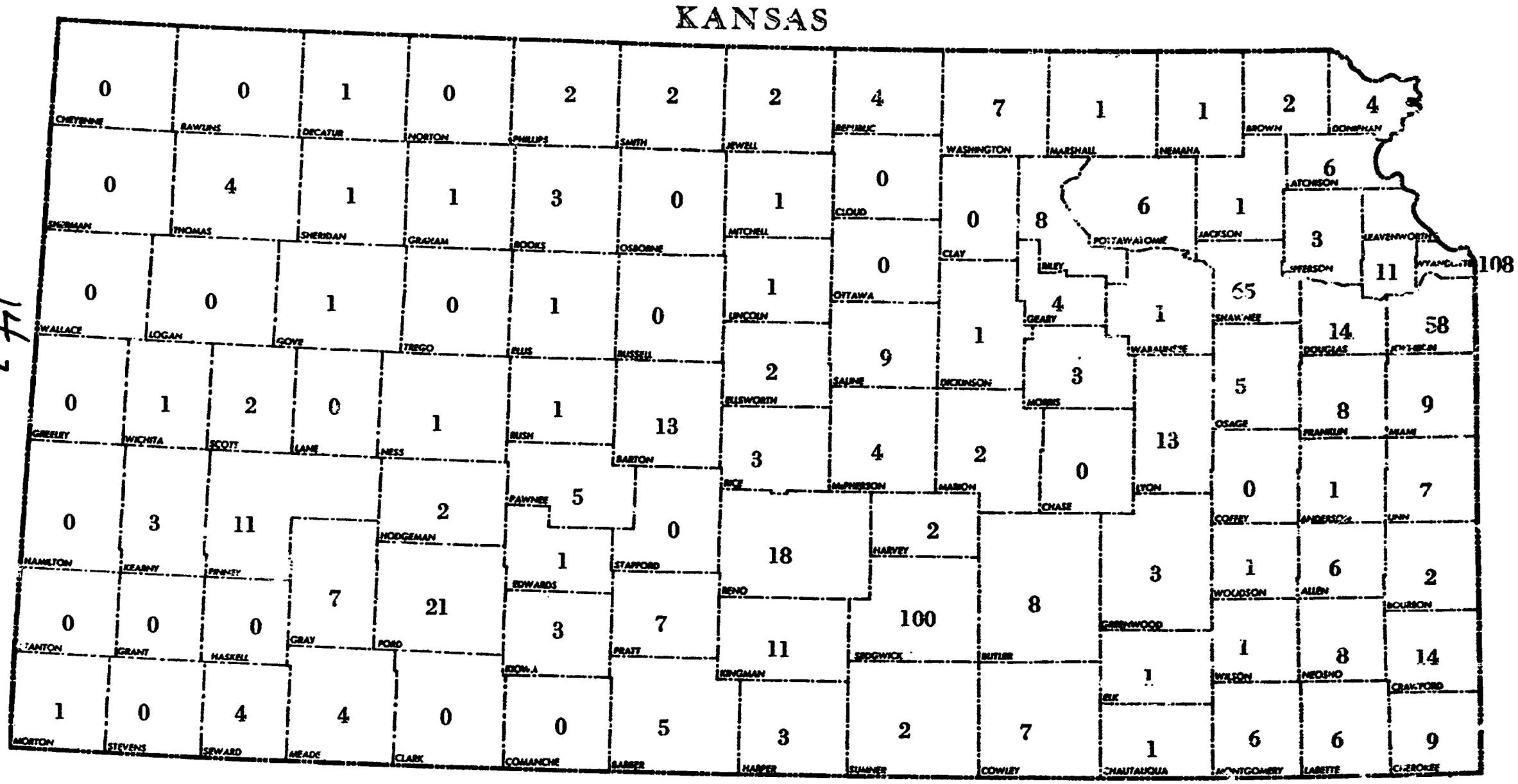
   The nature of this majority, the nature and extent of the services they receive, and the nature of the roles that these two separate providers of services play . . . will be examined later. Also we should point out that it is likely that the children overlooked in this study, if any, probably fall into the home based group.

2. Based on the figures in Table No. 1 it appears that, of the 5 residential settings studied, two (Parsons State Hospital and Training Center and the Institute of Logopedics) provide services to a very small number (7) and proportion (1%) of this population. Consequently, they will not be considered a significant part of the overall delivery system and will be dropped from further analyses.

   Both the unique and common aspects of the individuals served by these remaining 3 residential settings as well as the uniqueness of the services provided by these three will be examined later in this report.

3. Based on the results of plotting the home counties of the identified visually impaired (see page 4), it can be concluded that although the density of the distribution of the visually handicapped generally follows the overall population density distribution of the state, it is obvious that the visually impaired come from all parts of the state.

DISTRIBUTION OF HOME COUNTIES OF VISUALLY IMPAIRED YOUNG PEOPLE



THE REASONS AND JUSTIFICATION FOR RESIDENTIAL CARE

In order to begin to better understand the need or justification for residential care of a visually impaired young person, a number of possible psychological, medical and maintenance characteristics were extracted from the questionnaire data and used as a criterion for possible residential placement. These variables have to do with psychological characteristics (e.g., aggressiveness, disturbed), mental ability (very low intellectual level of functioning), medical problems (e.g., frequent seizures), personal maintenance problems (totally dependent on others for eating, dressing, or toilet) and rejection in the home or community. *A complete list is footnoted below. We should point out however, that the decision to place an individual in a residential setting is sometimes based on other types of considerations, such as other management problems, discipline, lack of interest, and lack of available health or special education resources in the local area. This criterion for possible placement in a residential setting is based strictly on a need for very close care and not just an absence of local special education services.

* Listed as having one or more of the following characteristics: Uncontrolled Grand Mal (2%), Rarely or Never Normal (11%), Usually Disturbed (12%), Frequently Physically Aggressive to Self (3%), Frequently Physically Aggressive to Others (3%), Frequently Physically Aggressive to Objects (2%), Frequently Verbally Aggressive (5%), Frequently Hyperactive (4%), Frequently Passive (13%), Frequently Withdrawn (10%), Profound (24%) or Severe (7%) Mental Retardation, Totally Dependent—Dressing (20%), Totally Dependent—Eating (17%), Totally Dependent—Toilet (18%), or Overt Rejection at Home (3%).

Conclusions:

4. A ready conclusion that derives from the percentages listed above is that compared to the normal population, the visually impaired young people (including the multi-handicapped visually impaired) of Kansas display a higher probability of being passive or withdrawn, and a very large proportion of those on which data was available are labelled as intellectually borderline or retarded to some degree (60%). They do differ from the normal population and the normal school population and probably do need special consideration and/or care for characteristics beyond their visual impairments.

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Following the above criterion, the total population was analyzed and it was found that a full 51% of the total population under study came under this criterion by virtue of displaying (or being victim to) one or more of the characteristics. You will recall, however, that only 39% of the population was presently in residential care settings. Also we should add that when the question of proper placement was asked of the home based young people 9 were indicated as being better placed in a residential setting (1 as better placed in a residential setting for the mentally retarded and 8 as better placed in a residential setting for the visually impaired) while only 2 individuals in residential settings were identified by agency personnel as being better placed at home.

However, when one examines the characteristics of the young people in the residential settings and the characteristics of the home based young people, the results raise some questions about placement decisions based on these care needs. The following table should be of interest.

Table No. 2

Percent of Total in Each Location that Meets One or More of the Possible Criteria for Residential Care				
USD's(home)	SFB(home)	KSSVH	KNI	Winfield
42%(120)	19%(26)	39%(37)	95%(121)	100%(48)

Again, keep in mind that the criterion for placing an individual in a residential care setting (one or more of the selected psychological, mental, medical, maintenance, or rejection characteristics) was an extremely liberal one and that obviously any of these conditions that could be treated, handled or cared for at home or in the local community would (in those cases) most likely eliminate the need for residential care.

But quite apart from what might serve as justification for residential care is the question of what is actually being done. In the table above it is apparent that the bulk of the population at KNI (95%) and at Winfield (100%) obviously meet the very liberal criterion in one way or another. Further examination of the specific characteristics of the individuals in these institutions will be undertaken later but the general point here is that the decision to place in a residential care setting could be justified in almost all cases. Note, however, that on the surface and according to this very

general criterion; roughly the same proportions can be observed in the population serviced by the USD's and the KSSVH. A somewhat smaller proportion is observed in the SFB population (to jump ahead however we should point out that 25% of the studied SFB population is made up of pre-school aged children who are generally dependent* and protected and 67% are 15 or older and looking for employment). Of course, this needs to be examined more closely but it should indicate that some of the problems that might be cited by some as justification for placement in a residential care setting are in some cases (USD's) being taken care of in the community or at home.

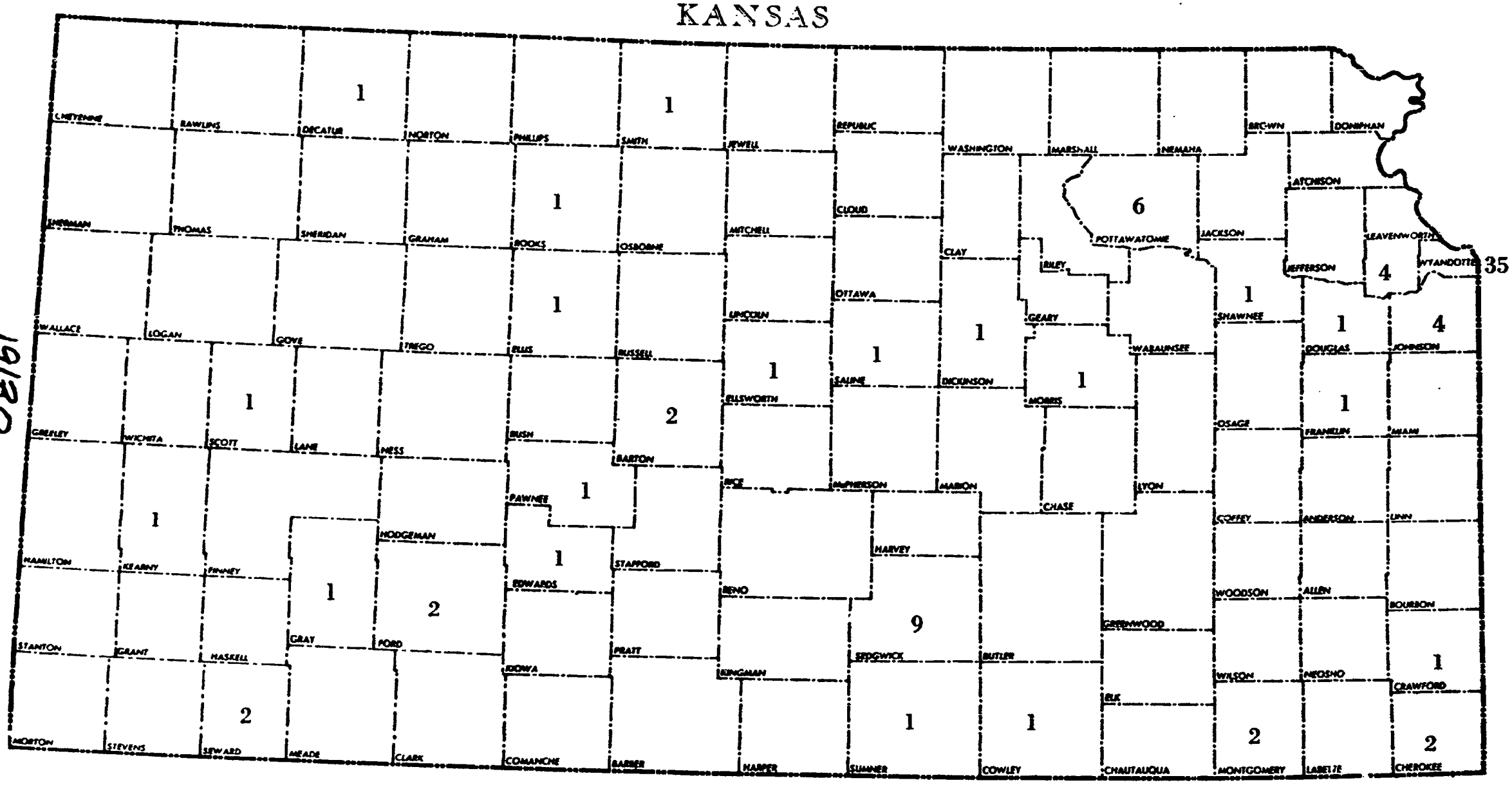
The extent of the practice of placing a young person in a residential setting because of lack of appropriate special education services in their home area can only be approximated by the present study but it needs to be examined in as much as possible and particularly for KSSVH.

When one examines the home counties of those placed at KSSVH (located in Wyandotte County) it becomes apparent that at least 36% of the young people are themselves from Wyandotte County and are well within driving distance from the Shawnee Mission USD and the Kansas City USD, both of which have special education programs for the visually handicapped (see maps on page 8 and 9). Another approximate 15% came from counties such as Sedgwick, Ford and Shawnee where again there are already special education programs for the visually impaired in progress in the USD's or within close proximity. In summary, about 50% of the population of KSSVH comes from a county where there is a USD with a special education program for the visually handicapped already in progress. If district boundries were not a problem, or a problem that could be easily resolved, then some resources at least are close to home for some of those at KSSVH.

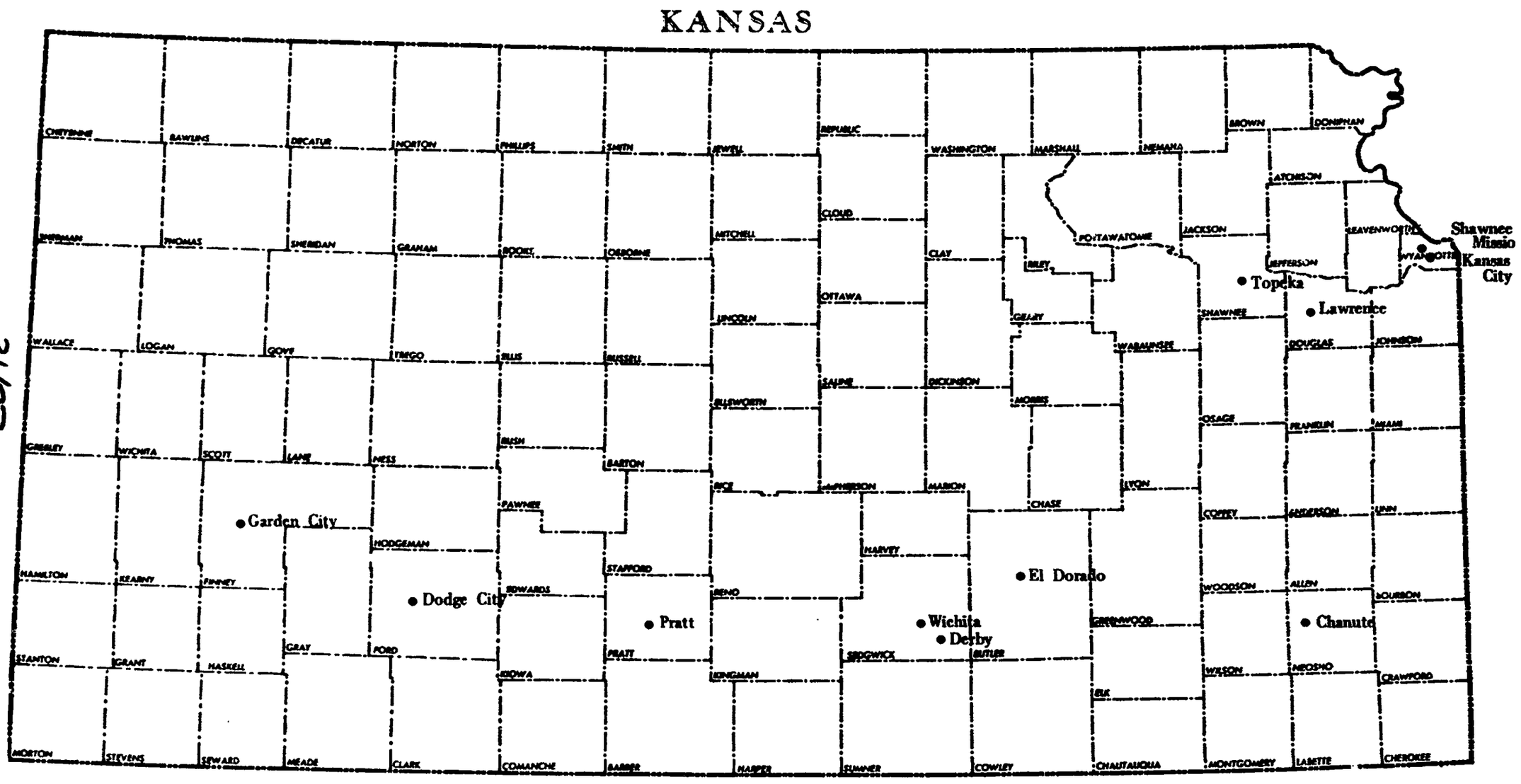
One can also observe that future increases in the availability of special education resources within the local USD's will quite likely reduce the practice of placing young people in residential settings (if the motive for the decision had to do with the need for appropriate special education resources).

* 2 years old and younger were removed from "dependency" part of criterion for placement in residential care settings.

HOME COUNTIES FOR YOUNG PEOPLE AT KANSAS STATE SCHOOL FOR THE VISUALLY HANDICAPPED



11 U.S.D.'S WITH SPECIAL ED PROGRAMS FOR VISUALLY HANDICAPPED



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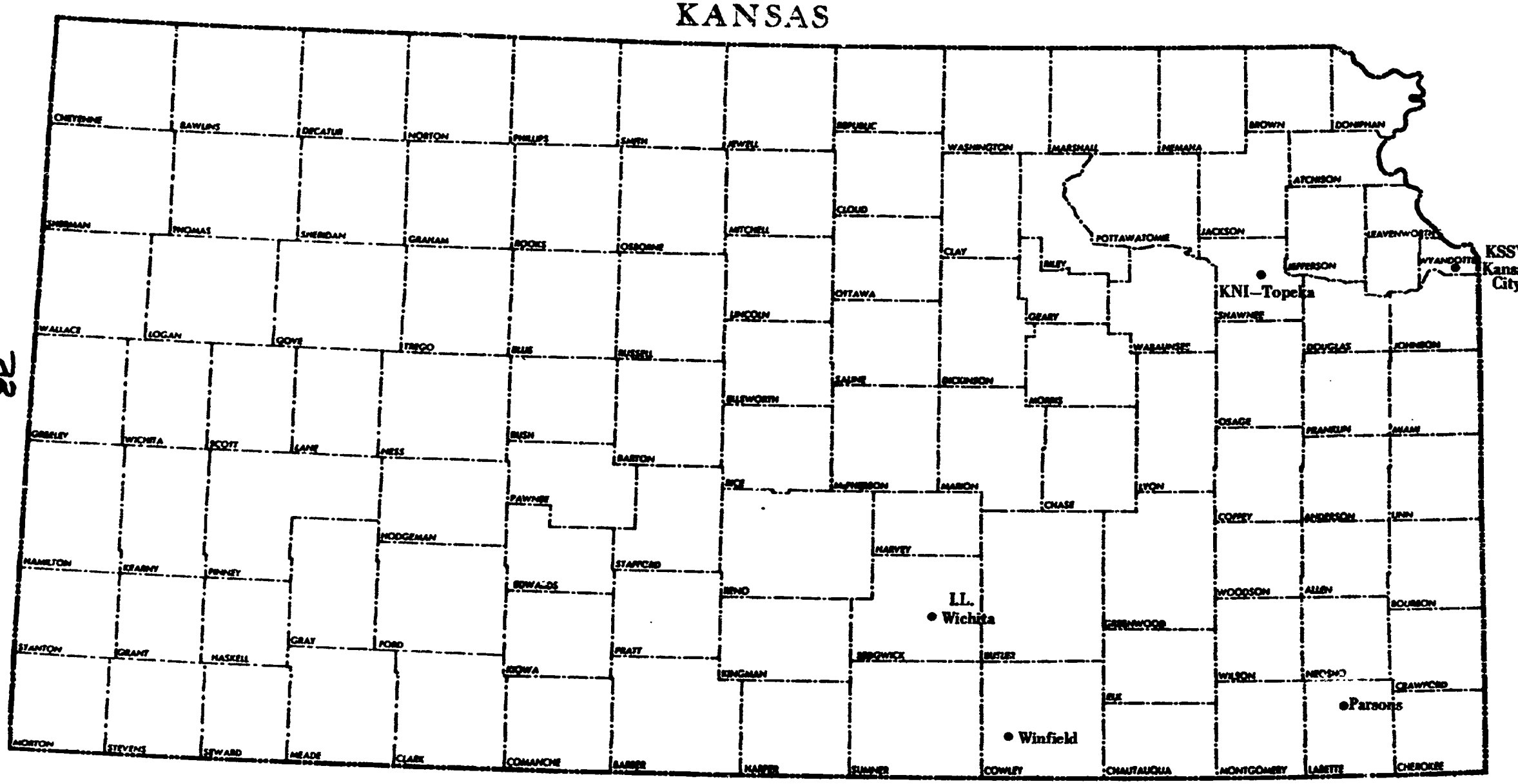
THE INSTITUTIONS THAT SERVE THE VISUALLY IMPAIRED



Conclusions:

5. Clearly the number of placements in residential care settings we have in Kansas could be justified in many cases (because of medical, psychological, and social variables) and most easily for KNI and Winfield State Hospital. Also, a surface examination of the children in the USD's and KSSVH incidates a much lower but a similar proportion of children qualifying under a liberal criterion for residential care for both the USD's and KSSVH.

6. Conditions that might justify residential care placement for some are in a home in almost half (42%) of the instances where the USD's are servicing the visually impaired child (see Table No. 2 page 9).

7. KSSVH may be unnecessarily duplicating (or vice versa) the programs in its own county, neighboring counties, and counties with existing programs for the visually impaired. However, the quality of the programs cannot be compared without further study. Their service load is definitely skewed to their own geographic area (however, some families may have moved to that area to be close to KSSVH).

8. Based on an inspection of the map on which the 11 Special Education programs (USD's) are plotted, there are clearly no special education programs for the visually impaired in the north central and northwestern areas of Kansas.

9. Based on an inspection of the map on which the residential settings are plotted, it can be concluded that there are no residential settings that could serve the visually impaired in north, west, and central Kansas.

THE ROLES OF THE VARIOUS AGENCIES AND RESIDENTIAL CARE SETTINGS
– AN ANALYSIS OF THEIR CLIENTS –

An examination of certain aspects of the data from the survey needs to be made in order to begin to understand the uniqueness of the roles of the two types of agencies that service the home based visually handicapped. First let us look at a comparison of the number of individuals in each of several age groups of those serviced by the USD's and SFB.

Table No. 3

	AGE				
	5 and under	6 – 11	12 – 14	15 – 18	19 and older
USD's	28	130	56	57	3
SFB	47	* 0	* 0	31	64

Conclusions: 10. The results in Table No. 3 reflect that at present there is at least a somewhat unique role for the two agencies servicing the home based visually impaired. SFB primarily services pre-school aged children and young people about 15 years of age and older (Vocational Rehabilitation Program) . . . and the USD's primarily service school age young people (who are in school). Some extension into pre-school by the USD's is apparent and some extension into the 19 and older group is also suggested. Also, SFB is providing supplemental educational services to school aged children that are being primarily serviced by the USD's . . . although it doesn't show in the table. Again, however the uniqueness is apparent.

Now, let us examine the two types of agencies that service the home based visually handicapped along with the three residential settings. The examination and comparison will be centered around twelve selected characteristics.

* In order to obtain an unduplicated count, SFB did not report on school aged children (5 to 15) whose educational needs were being primarily met by USD's.

Table No. 4

Selected Characteristics of the Visually Impaired Populations Serviced by the Agencies and Residential Settings

	USD's	SFB	KSSVH	KNI	Winfield
Legally Blind	39%	96%	90%	59%	65%
No Appreciable Loss in Hearing	84%	82%	85%	60%	59%
Subject to Seizures	2%	4%	10%	50%	65%
Motor Difficulties	24%	41%	12%	66%	98%
Requires Direct Medical Supervision	9%	19%	23%	45%	83%
Sometimes or Usually Disturbed	29%	27%	34%	58%	82%
Physically Aggressive to Self	2%	2%	0%	7%	8%
Physically Aggressive to Others	2%	2%	0%	10%	0%
Subnormal IQ	38%	14%	46%	99%	100%
Totally Dependent—Dressing	9%	1%	4%	40%	89%
Totally Dependent—Eating	6%	1%	4%	37%	83%
Totally Dependent—Toilet	7%	3%	4%	34%	87%
Median Age	11	bimodal	13	15	10

Conclusion 11: An obvious conclusion from the comparisons in Table No. 4 is that the part of the total population under study that is presently at Winfield appears to be clearly unique in its overwhelmingly common mental, medical, psychological, and maintenance problems. The visual impairment problem is clearly compounded by other serious and handicapping problems.

Conclusion 12: Likewise, from Table No. 4 it can be seen that although the population at KNI also stands out from the populations of the other institution (KSSVH) and the home based population; it is similar to Winfield in dealing with the retarded exclusively (or almost so) . . . but it is different from Winfield in the lesser extent of other problems (medical, psychological, and maintenance characteristics).

13. As displayed by Table No. 4, it appears as though the populations served by the USD's and by SFB are distinguishable along certain characteristics in addition to age (Table No. 3). First, fewer of those in the USD's are legally blind as compared to the higher figure for SFB. Next, the SFB population is somewhat more characterized by people with motor (movement) difficulties and need for direct medical supervision than are those attending the schools. Finally, SFB is servicing fewer of those with subnormal I.Q.'s than are the USD's. Overall, there appears to be a general uniqueness in who is being served by SFB and the USD's and in what way (care vs. education).

14. Based on the figures in Table No. 4, it is clearly only a matter of extensiveness in a single dimension (legally blind/acuity) that distinguishes the groups served by KSSVH and the USD's. Here, the only clear difference is in the percentage who are considered "legally blind." This may or may not be a very distinct difference in terms of the part of the population served and needs to be examined more closely. It should be mentioned, however, that special education services are not completely related to legal blindness. Below are some data from the questionnaire that may be relevant.

Table No. 5

Acuity	USD's	KSSVH
Better than 20/200	4.4%	14%
20/200	15%	16%
Worse than 20/200	29.4%	7%
Can't Be Tested	7%	2%
No Vision	6%	35%
Light Perception Only	2%	4%
Counts Fingers Only	.4%	1%
No Information	22%	10%

Table No. 6

Type of Problem	USD's	KSSVH
Congenital Cataracts	17%	7%
Congenital Glaucoma	4%	3%
Retinoblastoma	3%	6%
RLF	6%	25%
Nystagmus	30%	14%
Optic Nerve Atrophy	7%	22%
Myopia	23%	7%
Injury	3%	3%
Other	42%	46%

Conclusion 15: Based on several comparisons (tables 2, 4, 5 and 6) presented in this report, there does appear to be a very close resemblance in the segments of the total population of visually impaired Kansas young people that are being served by the USD's and by KSSVH. These two do not appear significantly unique in terms of the individuals they serve except perhaps in degree (acuity).

THE ROLES OF THE VARIOUS AGENCIES AND RESIDENTIAL CARE SETTINGS — AN ANALYSIS OF THEIR EDUCATIONAL PROGRAMS —

Below is an analysis of the average number of hours in a structured educational program or training that are received by individuals involved across all the various types of education programs offered or supported (SFB) by the agencies and residential care settings.

Table No. 7

Average Weekly Hours in Structured Educational Program or Training					
	USD's**	KSSVH**	KNI**	Winfield**	SFB**
None*	12%	0%	44%	74%	58%
1–5	11%	0%	10%	2%	3%
6–10	3%	3%	9%	9%	0%
11–15	3%	0%	8%	6%	0%
16–20	0%	0%	9%	4%	0%
21–25	4%	0%	4%	0%	0%
26–30	46%	94%	7%	2%	0%
31–35	18%	0%	6%	0%	0%
36–40	1%	0%	2%	2%	39%
41 & Over	0%	3%	2%	0%	0%

* 18% of those receiving "none" are pre-schoolers 5 years of age and under. 17% of those in the 1–5 group are pre-schoolers, 22% in the 6–10, 17% in the 11–15, and 7% in the 16–20 are pre-school age. **May only include special education teacher or special materials.

Conclusion 16: Based on the analysis in Table No. 7, it appears as though the two agencies serving the home based population under study (SFB and the USD's) are relatively unique in respect to educational programming. The USD's appear to be more committed to academic educational offerings (although 12% indicated none), while SFB provides no education for 58% of their visually impaired clients and supports very extensive education training for their clients who cannot attend school, have graduated, or have dropped out of the public school programs.

17. From Table No. 7, and based on the data from this study, it can be concluded that the Winfield State Hospital is generally not involving the bulk (74%) of their visually impaired young people in

any traditional education programs or training. They are apparently oriented primarily to maintenance and their visually impaired young people participate in very few structured educational or training programs.

18: KSSVH appears (from the data in Table No. 7) to have a fairly standardized length program for their clients. The effort (26-30) hours per week appears to be a relatively heavy involvement in education and training of the visually impaired as compared with the two other residential settings (KNI and Winfield).

Next, and below, is an analysis of the extent of involvement of visually impaired young people by type of educational program offered by the different agencies and residential care settings.

Table No. 8

Extent of Involvement of Served Group in Types of Present Educational Program

Program Offered	USD's	KSSVH	KNI	Winfield	SFB
None*	3%	1%	47%	74%	22%
Home Program	2%	0%	1%	0%	10%
Readiness	5%	16%	20%	0%	2%
Academic	77%	68%	14%	0%	35%
Sheltered Workshop	3%	0%	0%	0%	12%
Vocational	0%	15%	10%	0%	2%
Other	10%	0%	8%	26%	17%

* 28% of all children receiving "none" are pre-school age. 81% of those in the home program are pre-schoolers, 22% of those in Readiness, 2% in Academic, and 11% in Other are pre-school age.

Conclusion 19: From the figures in Table No. 8, one can easily conclude that Winfield State Hospital is not educating or training their visually impaired young people in any of the types of programs asked about in this study.

Conclusion 20: The figures in Table No. 8 indicate that the programs at KSSVH and in the USD's are very similar but KSSVH is somewhat more heavily involved in the readiness and vocational areas than is characteristic of the USD's. There is more evidence of similarity in program type offering than differences.

21: SFB appears, from the data figures to be relatively more concerned with the use of home programs and sheltered workshops than either the USD's or the KSSVH and relatively less concerned with academic education. This may be because of the more extensive number of individuals with motor (movement) difficulties who might have trouble attending schools and the fact that more individuals that need direct medical supervision are serviced by SFB.

22: No conclusions about the relative quality of the various programs at the residential care settings or of the various programs provided by the agencies are possible from data collected by this study. Some examination of the adequacy of declared "programs," and an inventory of specific resources and objectives of each program is needed.

Because an individual's age is a significant consideration in providing educational programs and training, the table below is presented outlining the age distribution (by groupings) of individuals served by each agency and residential care setting. Generally, it is recognized that educational efforts at the very early ages are particularly important.

Table No. 9

	AGE				
	5 and under	6–11	12–14	15–18	19 and older
USD's	28	130	56	57	3
KSSVH	5	30	25	26	8
KNI	7	29	24	37	32
SFB	47	0*	0*	31	64
Winfield	7	18	10	11	2
Total	99(15%)	208(29%)	115(17%)	163(23%)	109(17%)

Conclusion 23: Data in Table No. 9 reveals that Winfield services a number of individuals in the younger age categories but from previous analysis it was indicated that no traditional educational or training programs are offered by Winfield.

Table No. 10

Analysis of Pre-school Age						
Program Type						
None	Home Program	Readiness	Academic	Sheltered Workshop	Vocational	Other
37%	19%	18%	10%	0	0	16%

Conclusion 24: Data in Table No. 10 indicates what is being done in the way of providing pre-school education or training for the visually impaired young people of Kansas.

* There are individuals being serviced by SFB but the primary responsibility for their education is with the USD's and only supplemental services are provided by SFB.

RECOMMENDATIONS

1. It is recommended that additional research be initiated that would allow a more specific and individualized needs analysis and as well, an evaluation of the nature and quality of all the present programs for the visually impaired in the state. This would include all agencies and institutions and would be an inventory of all types of courses, all types of personnel and their competence, all equipment, and program capabilities for various types of impairments. The inventory analyses could then be matched against the more specific needs analysis based on individual plans for the visually impaired.

2. It is recommended that individualized education programs based on professionally developed guidelines and a professional diagnosis be developed for each and every visually handicapped child in the state and that they, in the future, be developed as early as is possible (pre-school) and that they combine not only the needs related to education but also to the other handicapping characteristics that seem to frequently accompany visual impairedness (based on conclusion No. 4).

3. It is recommended that appropriate and high quality services and educational programs for the visually impaired be provided as close to the child's home as is possible. Whenever possible the problem should be diagnosed, an individual plan developed, and an educational program be provided within the child's own USD. When that is not possible, the efforts should be within a multi-district regional area, and only when this is not possible should the services and programs of a residential setting serving the entire state be utilized. (This general recommendation is based on (1) the emerging philosophy of delivering service, (2) the new law and (3) the data collected in this study that indicates a geographic maldistribution of services within the state.)

4. It is recommended that adequate programs be developed in the USD's that presently do not have educational programs for the visually impaired. These programs should either be comprehensive or a part of a special education cooperative (multi-district program) that is comprehensive.

5. It is recommended that special efforts be made to initiate programs in USD's in the Northern, Western, and North Central counties of Kansas.

6. It is recommended that Winfield State Hospital be used only in such cases where visual impairment is only a part of a cluster of very serious multiple handicaps (including very low level intellectual functioning) that render a child unable to progress in developmental areas other than simple socialization and self-maintenance. Also that children in the younger age grouping not be placed (whenever possible) at Winfield.

7. It is recommended that KNI be considered as the appropriate institution for the younger (including pre-schoolers and even the new born) mentally retarded visually impaired whenever residential care is needed.

8. It is recommended that additional educational programs for the visually handicapped be supported at KNI.

9. It is recommended that there be two plans for the use of KSSVH. The first plan would be an interim plan that recognizes that it will take some time to set up an adequate and coordinated delivery system for the visually impaired in the USD's. This plan should cover the years 1974 to 1979 (the deadline year under the new law) and adequate support should be provided to accomplish this plan.

   The second plan would be developed during the interim period and be based on the more detailed study of individualized educational and supportive needs that emerge from the plans and analyses and the progress of the USD's. The use of KSSVH would be consistent with the new law and with the suggested guidelines for providing services spelled out in recommendation number 3.

10. It is recommended that this study and any future study provide the basis for a comprehensive state plan for the visually impaired and that that plan should stress the central coordination of all state resources, the elimination of any unnecessary duplication, the use of professionally developed program standards, maximum educational efforts at the earliest possible age, serious attempts to work with the so called "uneducatables," and the use of a concept of "overriding disability" for placement when needed.

11. It is recommended that additional efforts be made to insure that normalization is optimized.

ADDITIONAL RECOMMENDATIONS FROM THE VISION TASK FORCE COMMITTEE

The previous report and recommendations were more strictly based on the data gathered but do not fully reflect the total conclusions of the Task Force. The following additional recommendations submitted are based on the professional judgment and consunsus of the Vision Task Force following the analysis of the results and is included here for consideration.

1. It is recommended that the position in the Special Education Section, Program Director for the Visually Handicapped, under the Kansas State Department of Education, assume the major responsibility for the development of educational programs for the visually handicapped, to recommend standards to the Board of Education and carry the responsibility for evaluating the progress of each visually handicapped child in all state supported educational programs; and that this person be responsible to the Director of Special Education.

2. It is recommended that all special education programming for visually handicapped children zero to twenty-one years of age be under the supervision of the Program Director for the Visually Handicapped and be in compliance with minimal state standards and guidelines.

3. It is recommended that the Psychologist for Visually and Hearing Impaired be responsible for coordinating diagnostic and evaluation services and placement recommendations for visually impaired and be assured adequate funds to contract for diagnostic services needed. This person will assume the responsibility for and eliminate the necessity of the present mandated Educational Clinical Team and Review Board.

4. It is recommended that an advisory council to the Program Director for Visually Handicapped, comprised of one representative from each agency that provides services from the public and/or private sectors be established. This group will be chaired by the Program Director for the Visually Handicapped.

5. It is recommended that statewide preschool educational programming for visually handicapped children be initiated by the Program Director for Visually Handicapped and that the Kansas State Board of Education earmark sufficient funds for such implementation.

6. It is recommended that the Kansas State School for the Visually Handicapped modify its program emphasis to specialize in providing services for the following visually handicapped children, to parents, and to teachers.

   a. Those children who are visually impaired and live in an area where there are no services available,

   b. Those children who are visually impaired and live in an area where there are services but live in a homesetting that fails to meet the needs of the child, and

   c. Those children who are visually impaired and have accompanying compounding handicapping conditions to the extent that they cannot adequately function in a public school program but are functioning at a level higher than is required to be accommodated in residential agencies for the retarded.

   d. Provide staff development for individuals working in the area of the visually impaired,

   e. Provide special parent-child training sessions,

   f. Provide post-secondary training for older members of the visually impaired population when not possible in the local areas; and

   g. Provide short term special training sessions when needed and not available locally.

7. It is recommended that the Kansas State Board of Education adopt the basic philosophy of placement and reveiw of placement indicated by the Cascade System of individualized educational programs. It is further recommended that adequate funding be allocated at all levels of educational service delivery throughout the state to implement this philosophy.

THE LIMITATIONS OF THE STUDY

As with many such studies, the present study did not answer all the questions and, in fact, in some instances served to point out some additional unknowns.

The committee felt that the lessons learned from this study should be made explicit so that future research efforts might benefit. After the study was well along the way it became apparent that additional background and supplemental material having to do with the definitions of terms was needed. Even the definition of an educational program would have contributed. Sometime other than September would have allowed more time and would have been more convenient for those filling out the questionnaire. Finally, some assurances should be sought, in any future study, that the questionnaire is filled out by the most qualified person.

QUESTIONNAIRE

STUDY OF PROGRAMS FOR EXCEPTIONAL CHILDREN AND YOUTH

— Kansas State Board of Education
— Kansas State Department of Social and Rehabilitation Services

Data for Visually Impaired
Agency Report as of
September 15, 1973

1. ☐☐☐☐ 1. Numerical code for individual.

2. ☐ 2. Sex
1. Male
2. Female
9. Info. not available

3. ☐☐ (Mo)
4. ☐☐ (Day)
5. ☐☐ (Yr) 3. Date of Birth (02-12-58 means Feb. 12, 1958).
99 - for month indicates info. not available.
[See Ques. 57.]

6. ☐☐☐ 4. Numerical code for residence (county) of parents or guardian.
999 - indicates info. not available

7. ☐☐ (Mo)
8. ☐☐ (Yr) 5. Date of most recent eye evaluation.
99 - for month indicates info. not available
[See Ques. 58.]

9. ☐ 6. Source of most recent eye evaluation
1. Routine School Screening
2. Optometrist
3. Other M. D.
4. Opthalmologist
5. Other
9. Info. not available

10. ☐ 7. Is individual legally blind?
1. Yes
2. No
9. Info. not available

11. ☐☐☐
12. ☐☐☐ 8. Distance acuity after correction — better eye. When possible, give info. as a ratio (e.g. 020-200); otherwise, code as indicated below, coding single most descriptive item.

600-000 - Other
500-000 - Counts fingers
400-000 - Notes hand movements
300-000 - Has light perception
200-000 - No vision
100-000 - Individual cannot be tested
900-000 - Info. not available

9. Eye evaluation diagnosis (Check all that apply)
13. ___ a. Congenital cataracts
14. ___ b. Congenital glaucoma
15. ___ c. Retinoblastoma
16. ___ d. RLF
17. ___ e. Nystagmus
18. ___ f. Optic nerve atrophy
19. ___ g. Myopia
20. ___ h. Injury
21. ___ Other - please note
_____
_____
22. ___ 9. Info. not available

23. ☐ 10. Eye evaluation prognosis.
1. Deteriorating
2. Stable
3. Capable of improvemen
4. Uncertain
9. Info. not available

24. ☐☐ (Mo)
25. ☐☐ (Yr) 11. Date of most recent hearing evaluation.
99 - for month indicates info. not available
[See Que 60.]

26. ☐ 12. Source of most recent hearing evaluation.
1. Routine school screenin
2. Audiologist
3. Other M. D.
4. Otologist
5. Other
9. Info.not available

27. ☐ 13. Results of hearing Evaluation
1. Deaf-Prelingual
2. Deaf-Postlingual
3. Partial Hearing
4. Hard of hearing
5. No appreciable loss
6. Unable to determine
9. Info. not available

40

14. Does the individual have a physical condition (other than vision and hearing) which inhibits normal school activities (motion)?

28. ☐ No (check only)

29. ☐ Yes - Gross motor
1. Partially inhibited
2. Totall inhibited
9. Info. not available

30. ☐ Yes - Fine motor
1. Partially inhibited
2. Totally inhibited
9. Info. not available

Note prosthesis if applicable

_____

_____

_____

31. ☐ 15. Is this child subject to seizures?
1. No
2. Grand mal - uncontrolled
3. Grand mal - controlled
4. Petit mal - uncontrolled
5. Petit mal - controlled
9. Info. not available

32. ☐ 16. Does this individual have a medical condition which requires direct supervision (e.g., diabetes, glaucoma, grand mal)
1. Yes
Please note condition

_____

_____

2. No
9. Info. not available

17. Behavior - characteristically observed (see directions for more detail).

Characteristic

33. ☐ Normal
1. Usually
2. Sometimes
3. Rarely or Never
9. Info. not available

34. ☐ Disturbed - frequency of observed behavior
1. Usually
2. Sometimes
3. Rarely or Never
9. Info. not available

35. ☐ Disturbed - source of notation
1. Stereotyped
2. Diagnosed
3. Observable - not diagnosed
8. Not applicable
9. Info. not available

Situational

36. ☐ Physically aggressive to self
1. Rarely or never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

37. ☐ Physically aggressive to others
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

38. ☐ Physically aggressive to objects
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

39. ☐ Verbally aggressive
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

40. ☐ Hyperactive
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

41. ☐ Passive
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

42. ☐ Withdrawn
1. Rarely or Never
2. Infrequently - not controlled
3. Infrequently - controlled
4. Frequently - not controlled
5. Frequently - controlled
9. Info. not available

43. ☐ 18. Primary communication medium
1. None
2. Gestural
3. Oral
4. Braille
5. Print
9. Info. not available

44. ☐ 19. Status of intelligence measure (there are two parts of this item)
1. No test given (individual cannot be tested)
2. No test given (individual could be tested)
3. Test attempted - no results
4. Individual has been tested
9. Info. not available

45. ☐ Results
1. Profound
2. Severe
3. Moderate
4. Mild
5. Borderline
6. Normal
7. Above Normal
8. Not applicable
9. Info. not available

46. ☐ 20. General level of academic achievement.
1. Pre-school
2. Primary
3. Intermediate
4. Junior High
5. Senior High
6. Post-Secondary
9. Info. not available

☐ 21. General level of basic skill development.

47. Dressing
1. Independent
2. Partially dependent
3. Totally dependent
9. Info. not available

48. Eating or Feeding
1. Independent
2. Partially dependent
3. Totally dependent
9. Info. not available

49. Toilet
1. Independent
2. Partially dependent
3. Totally dependent
9. Info. not available

50. ☐☐ 22. Average number of hours per week in a structured educational and/or training program (current month nearest whole hour)
98. No structured program
99. Info. not available

51. ☐ 23. Type of present educational program
1. None
2. Home Program
3. Readiness
4. Academic
5. Sheltered workshop
6. Vocational
7. Other - please note

_____

_____

9. Info. not available

52. ☐ 24. Parents' or guardian's attitude toward individual (enter most appropriate)
1. Overt rejection
2. Disguised rejection
3. Overprotective
4. Acceptance
8. Prefer not to answer
9. Info. not available

53. ☐ 25. Parents' or guardian's willingness to accept help from agency when needed (enter most appropriate)
1. Totally rejects help
2. Accepts help when coerced
3. Accepts help when prompted
4. Accepts help when offered
5. Seeks help
6. Actively seeks help (see directions)
8. Prefer not to answer
9. Info. not available

54. ☐ 26. Parent's or guardian's contact with agency
1. Rarely or Never
2. Infrequently
3. Frequently
4. Constantly (see directions)
8. Prefer not to answer
9. Info. not available

55. ☐ 27. Is this person currently in the most appropriate training setting?
1. Yes
2. No. Should be in a public school which has a special education program.
3. No. Should be in a residential setting for mentally retarded.
4. No. Should be in a residential setting for emotionally disturbed.
5. No. Should be in a residential setting for hearing impaired.
6. No. Should be in a residential setting for visually impaired.
7. No. Should have special training at home.
8. Uncertain
9. Info. not available

56. Agency.

57. Age in Years.

58. Years since last Eye Evaluation.

59. Acuity Ratio times 100.

60. Years since last Hearing Evaluation.

ATTACHMENTS

NORMALIZATION PRINCIPLE AND CASCADE SYSTEM

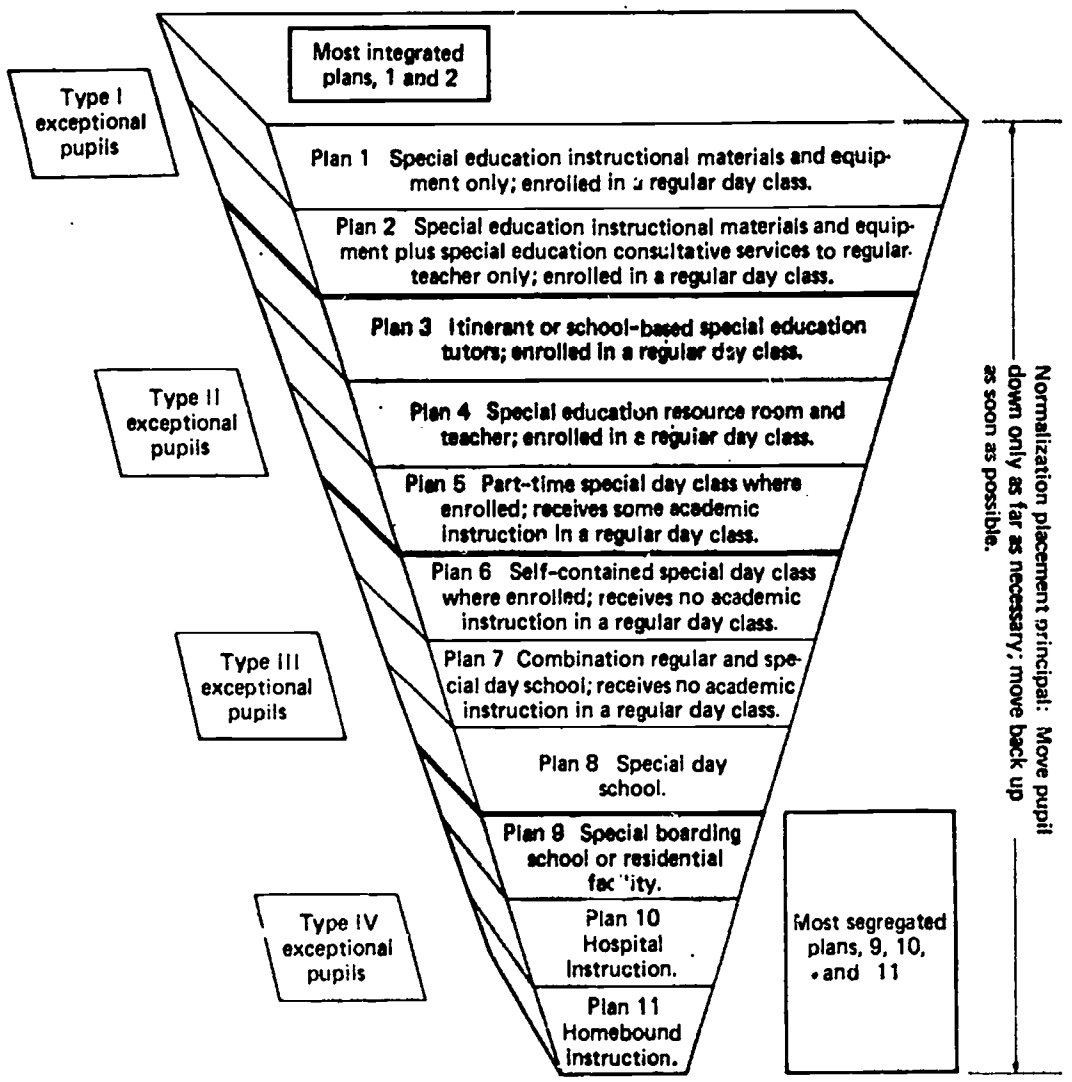
Decisions must be made about (1) the school in which a child is to be enrolled; (2) the homeroom placement; and (3) where and when the pupil is to receive various aspects of his instructional program. In all three areas, placement should always be on a trial basis, after having reached the best possible tentative decisions based on a study of the pupil's own characteristics, his home and community situation, and the educational resources (or options) available. A major guiding principle should be the concept of "normalization." The child should be integrated into his own home, community and neighborhood school to the maximum degree possible.

The cascade system is designed to make available whatever different-from-the-mainstream kind of setting is required to control the learning variables deemed critical for the individual case. It is a system which facilitates tailoring of treatment to individual needs rather than a system for sorting out children so they will fit conditions designed according to group standards not necessarily suitable for the particular case.

The cascade system (and the pyramid system adapted from it) has the following characteristics. First it projects an array of placement options. Second, it shows these options extending from the most integrated to the most segregated. Third, it points up that the largest number of pupils should be served in the most integrated programs and the smallest number in the most segregated plans.

In terms of special education placement within this system, the goal should be to move pupils as far upward as possible. Therefore there should be constant evaluation to determine if a pupil can be advanced. While some pupils will require one type of program for a school year or more, others may need it only for months. Furthermore, it should be possible to make large skips in placement. For example, a child may move from Plan 10 (hospital treatment) completely back into the general education mainstream, or vice versa. Some pupils will require certain services for only part of a day. The goal is to keep the program as little special as possible for the adequate education of the child.

Material taken from Exceptional Children in the Schools, Second Edition, by Lloyd M. Dunn, Editor



An inverted pyramid model to display 11 major administrative plans in special education from the most integrated to the most segregated, and from those that should serve the greatest numbers of pupils to those that should serve the least, classified for four types of exceptional children. Note: Plan 7 could shift up one category to serve Type II exceptional pupils when such children receive part of their academic instruction in a regular day class setting, as they often do.

The following pages contain a number of uninterpreted cross-tabulation analyses. These are but a very small proportion of what information is available from this study and were selected for presentation because they conform to the general thrust of the previously analyzed material.

*The "justified institutionalization" column refers to those visually impaired children who have one or more extreme rating or personal characteristic that would indicate a need for close care (health problems, medical problems, psychological problems, or social problems) or the need for a surrogate home based on present parental rejection. These are problems beyond their visual impairment and problems that have, in the past, been used to justify institutionalization. The decision to remove a young person from their home and community (even temporarily) is a difficult one and what might justify the decision in one instance might not in others (particularly if there are local health and social care resources that can assist).

* This refers to the second set of cross-tabulations. The first set are a simple analysis by residential setting or agency.

Sex	U.S.D.	KSVH	KNI	Winfield	SFB
Male	60% (168)	51% (48)	65% (82)	56% (25)	55% (77)
Female	40% (110)	49% (46)	35% (45)	44% (20)	45% (63)
Total No. of Responses	278	94	127	45	140
Number of No Responses	11	0	0	3	3

Number of Months from Most Recent Eye Evaluation	U.S.D.	KSVH	KNI	Winfield	SFB
1–6 months	33% (61)	11% (9)	61% (74)	26% (10)	9% (10)
7–12 months	32% (60)	81% (68)	24% (29)	18% (7)	16% (18)
13–18 months	10% (18)	5% (4)	5% (6)	5% (2)	10% (11)
19–24 months	13% (24)	2% (2)	6% (7)	0% (0)	10% (12)
25–30 months	2% (4)	0% (0)	1% (1)	5% (2)	16% (18)
31–36 months	5% (10)	0% (0)	3% (4)	5% (2)	7% (8)
37+ months	5% (10)	1% (1)	1% (1)	39% (15)	33% (38)
Total No. of Responses	187	84	122	38	115
Number of No Responses	102	10	5	10	28

Source of Most Recent Eye Evaluation	U.S.D.	KSVH	KNI	Winfield	SFB
Routine School Screening	20% (51)	0% (0)	0% (0)	2% (1)	0% (0)
Optometrist	12% (30)	1% (1)	40% (49)	0% (0)	0% (0)
Other M.D.	5% (12)	8% (7)	51% (63)	25% (11)	2% (3)
Opthamologist	62% (158)	91% (78)	10% (12)	66% (29)	96% (133)
Other	1% (2)	0% (0)	0% (0)	7% (3)	1% (2)
Total No. of Responses	253	86	124	44	138
Number of No Responses	36	8	3	4	5

Is Individual Legally Blind?	U.S.D.	KSVH	KNI	Winfield	SFB
Yes	39% (99)	90% (76)	59% (72)	65% (22)	96% (131)
No	61% (155)	10% (8)	41% (50)	35% (12)	4% (6)
Total No. of Responses	254	84	122	34	137
Number of No Responses	35	10	5	14	6

Distance Acuity After Correction, Better Eye	U.S.D.	KSVH	KNI	Winfield	SFB
Cannot Be Tested	6% (13)	2% (2)	14% (12)	7% (2)	10% (13)
No Vision	8% (17)	39% (33)	38% (33)	25% (7)	19% (24)
Has Light Perception	4% (9)	9% (8)	17% (15)	39% (11)	13% (17)
Notes Hand Movements	2% (5)	5% (4)	8% (7)	18% (5)	2% (3)
Counts Fingers	0% (1)	1% (1)	0% (0)	0% (0)	6% (7)
Other	7% (16)	0% (0)	10% (9)	11% (3)	2% (2)
20/20 or below	4% (8)	0% (0)	3% (3)	0% (0)	0% (0)
20/21 – 20/50	13% (27)	1% (1)	2% (2)	0% (0)	2% (2)
20/51 – 20/70	15% (33)	7% (6)	2% (2)	0% (0)	0% (0)
20/71 – 20/200	35% (75)	18% (15)	5% (4)	0% (0)	28% (36)
20/201 and above	6% (12)	18% (15)	1% (1)	0% (0)	18% (23)
Total No. of Responses	216	85	88	28	127
Number of No Responses	73	9	39	20	16

Eye Evaluation Diagnosis	U.S.D.	KSVH	KNI	Winfield	SFB
Congenital Cataracts	17% (36)	7% (6)	22% (22)	10% (4)	20% (28)
Congenital Glaucoma	4% (9)	3% (3)	0% (0)	2% (1)	7% (10)
Retinoblastoma	3% (6)	6% (5)	0% (0)	2% (1)	7% (10)
RLF	6% (13)	25% (22)	8% (8)	0% (0)	22% (30)
Nystagmus	30% (63)	14% (12)	40% (40)	27% (11)	37% (52)
Optic Nerve Atrophy	7% (14)	22% (19)	15% (15)	35% (14)	12% (16)
Myopia	23% (49)	7% (6)	13% (13)	7% (3)	4% (5)
Injury	3% (6)	3% (3)	1% (1)	5% (2)	1% (1)
Other	42% (89)	46% (40)	40% (40)	50% (20)	47% (65)
Total No. of Responses	212	87	100	40	139
Number of No Responses	77	7	27	8	4

Eye Evaluation Prognosis	U.S.D.		KSVH		KNI		Winfield		SFB	
Deteriorating	12%	(24)	16%	(14)	8%	(9)	18%	(6)	9%	(10)
Stable	55%	(110)	77%	(66)	50%	(55)	21%	(7)	71%	(82)
Capable of Improvement	4%	(9)	0%	(0)	14%	(15)	6%	(2)	4%	(5)
Uncertain	28%	(57)	7%	(6)	28%	(31)	55%	(18)	16%	(19)
Total No. of Responses		200		86		110		33		116
Number of No Responses		89		8		17		15		27

Number of Months from Most Recent Hearing Evaluation	U.S.D.		KSVH		KNI		Winfield		SFB	
1–6 months	22%	(27)	74%	(61)	80%	(65)	10%	(4)	24%	(12)
7–12 months	40%	(49)	22%	(18)	15%	(12)	3%	(1)	10%	(5)
13–18 months	4%	(5)	1%	(1)	5%	(4)	51%	(20)	16%	(8)
19–24 months	27%	(33)	0%	(0)	0%	(0)	0%	(0)	18%	(9)
25–30 months	1%	(1)	0%	(0)	0%	(0)	0%	(0)	14%	(7)
31–36 months	7%	(8)	0%	(0)	0%	(0)	3%	(1)	6%	(3)
37+ months	0%	(0)	2%	(2)	0%	(0)	33%	(13)	10%	(5)
Total No. of Responses		123		82		81		39		49
Number of No Responses		166		12		46		9		94

Source of Most Recent Hearing Evaluation	U.S.D.		KSVH		KNI		Winfield		SFB	
Routine School Screening	75%	(119)	66%	(54)	0%	(0)	3%	(1)	4%	(2)
Audiologist	16%	(25)	34%	(28)	13%	(11)	49%	(19)	20%	(10)
Other M.D.	3%	(5)	0%	(0)	71%	(61)	10%	(4)	4%	(2)
Otologist	5%	(8)	0%	(0)	0%	(0)	5%	(2)	8%	(4)
Other	1%	(2)	0%	(0)	16%	(14)	33%	(13)	65%	(33)
Total No. of Responses		159		82		86		39		51
Number of No Responses		130		12		41		9		92

Results of Hearing Evaluation	U.S.D.		KSVH		KNI		Winfield		SFB	
Deaf–Prelingual	2%	(4)	0%	(0)	0%	(0)	5%	(2)	0%	(0)
Deaf–Postlingual	0%	(0)	0%	(0)	0%	(0)	2%	(1)	0%	(0)
Partial Hearing	2%	(3)	10%	(8)	8%	(7)	7%	(3)	2%	(1)
Hard of Hearing	8%	(13)	1%	(1)	0%	(0)	7%	(3)	14%	(7)
No Appreciable Loss	84%	(135)	85%	(70)	60%	(52)	59%	(24)	82%	(42)
Unable to Determine	4%	(6)	4%	(3)	32%	(28)	20%	(8)	2%	(1)
Total No. of Responses		161		82		87		41		51
Number of No Responses		128		12		40		7		92

Physical Condition other than Vision and Hearing which Inhibits Normal School Activity (Motor)	U.S.D.		KSVH		KNI		Winfield		SFB	
No	76%	(215)	88%	(83)	34%	(43)	2%	(1)	59%	(75)
Gross Motor–Partially Inhibited	2%	(7)	5%	(5)	4%	(5)	0%	(0)	1%	(1)
Gross Motor–Totally Inhibited	0%	(0)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Has Gross Motor but information not available	0%	(0)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Fine Motor–Partially Inhibited	3%	(9)	1%	(1)	1%	(1)	0%	(0)	0%	(0)
Fine Motor–Totally Inhibited	0%	(0)	0%	(0)	0%	(0)	0%	(0)	1%	(1)
Has Fine Motor but information not available	0%	(1)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Gross Motor–Partially Inhibited & Fine Motor–Partially Inhibited	12%	(34)	4%	(4)	30%	(38)	19%	(9)	7%	(9)
Gross Motor–Partially Inhibited & Fine Motor–Totally Inhibited	0%	(1)	0%	(0)	0%	(0)	6%	(3)	1%	(1)
Gross Motor–Totally Inhibited & Fine Motor–Partially Inhibited	1%	(2)	1%	(1)	0%	(0)	0%	(0)	0%	(0)
Gross Motor–Totally Inhibited & Fine Motor–Totally Inhibited	2%	(5)	0%	(0)	30%	(38)	73%	(35)	0%	(0)
Gross Motor–Partially Inhibited & Fine Motor but information not available	0%	(1)	0%	(0)	0%	(0)	0%	(0)	3%	(4)
Gross Motor–Totally Inhibited & Fine Motor but information not available	0%	(0)	0%	(0)	0%	(0)	0%	(0)	1%	(1)
Gross Motor but information not available & Fine Motor–Partially Inhibited	0%	(0)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Gross Motor but information not available & Fine Motor–Totally Inhibited	0%	(0)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Gross Motor but information not availalbe & Fine Motor but information not available	3%	(8)	0%	(0)	0%	(0)	0%	(0)	28%	(36)
Total No. of Responses		283		94		125		48		128
Number of No Responses		6		0		2		0		15

Is Child Subject to Seizures?	U.S.D.	KSVH	KNI	Winfield	SFB
No	98% (237)	89% (84)	50% (63)	35% (17)	96% (71)
Grand Mal–Uncontrolled	0% (0)	0% (0)	6% (7)	4% (2)	0% (0)
Grand Mal–Controlled	1% (2)	7% (7)	38% (47)	44% (21)	0% (0)
Petit Mal–Uncontrolled	0% (1)	0% (0)	0% (0)	4% (2)	4% (3)
Petit Mal–Controlled	1% (3)	3% (3)	6% (8)	13% (6)	0% (0)
Total No. of Responses	243	94	125	48	74
Number of No Responses	46	0	2	0	69

Does this Individual Have a Medical Condition Requiring Direct Supervision?	U.S.D.	KSVH	KNI	Winfield	SFB
Yes	9% (24)	23% (22)	45% (49)	83% (40)	19% (16)
No	91% (232)	77% (72)	55% (59)	17% (8)	81% (70)
Total No. of Responses	256	94	108	48	86
Number of No Responses	33	0	19	0	57

Characteristic–Normal	U.S.D.	KSVH	KNI	Winfield	SFB
Usually	80% (202)	83% (78)	53% (58)	17% (8)	88% (83)
Sometimes	15% (38)	16% (15)	33% (36)	13% (6)	9% (8)
Rarely or Never	5% (13)	1% (1)	14% (15)	71% (34)	3% (3)
Total No. of Responses	253	94	109	48	94
Number of No Responses	36	0	18	0	49

Characteristic–Disturbed	U.S.D.	KSVH	KNI	Winfield	SFB
Usually	7% (17)	9% (8)	10% (11)	63% (30)	3% (3)
Sometimes	22% (53)	24% (23)	48% (54)	19% (9)	24% (21)
Rarely or Never	71% (169)	67% (63)	42% (47)	19% (9)	72% (62)
Total No. of Responses	239	94	112	48	86
Number of No Responses	50	0	15	0	57

Characteristic–Disturbed (Source of Notation)	U.S.D.		KSVH		KNI		Winfield		SFB	
Stereotyped	21%	(14)	6%	(2)	14%	(10)	11%	(1)	0%	(0)
Diagnosed	20%	(13)	16%	(5)	54%	(38)	11%	(1)	30%	(7)
Observable–Not Diagnosed	59%	(39)	78%	(25)	31%	(22)	78%	(7)	70%	(16)
Total No. of Responses		66		32		70		9		23
Number of No Responses		173		62		42		39		63

Situational–Physically Aggressive to Self	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	91%	(222)	96%	(90)	71%	(87)	77%	(37)	94%	(59)
Infrequently–Not Controlled	2%	(5)	1%	(1)	7%	(8)	2%	(1)	3%	(2)
Infrequently–Controlled	3%	(8)	3%	(3)	11%	(14)	10%	(5)	2%	(1)
Frequently–Not Controlled	2%	(6)	0%	(0)	7%	(8)	8%	(4)	2%	(1)
Frequently–Controlled	1%	(3)	0%	(0)	5%	(6)	2%	(1)	0%	(0)
Total No. of Responses		244		94		123		48		63
Number of No Responses		45		0		4		0		80

Situational–Physically Aggressive to Others	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	84%	(207)	88%	(83)	67%	(83)	94%	(45)	92%	(59)
Infrequently–Not Controlled	2%	(6)	2%	(2)	3%	(4)	0%	(0)	3%	(2)
Infrequently–Controlled	8%	(20)	7%	(7)	16%	(20)	4%	(2)	3%	(2)
Frequently–Not Controlled	2%	(5)	0%	(0)	10%	(12)	0%	(0)	2%	(1)
Frequently–Controlled	3%	(8)	2%	(2)	4%	(5)	2%	(1)	0%	(0)
Total No. of Responses		246		94		124		48		64
Number of No Responses		43		0		3		0		79

Situational–Physically Aggressive to Objects	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	91%	(220)	95%	(89)	78%	(97)	94%	(45)	98%	(58)
Infrequently–Not Controlled	2%	(6)	3%	(3)	2%	(3)	0%	(0)	0%	(0)
Infrequently–Controlled	4%	(10)	2%	(2)	9%	(11)	0%	(0)	2%	(1)
Frequently–Not Controlled	1%	(2)	0%	(0)	9%	(11)	2%	(1)	0%	(0)
Frequently–Controlled	2%	(4)	0%	(0)	2%	(2)	4%	(2)	0%	(0)
Total No. of Responses		242		94		124		48		59
Number of No Responses		47		0		3		0		84

Situational–Verbally Aggressive	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	81%	(198)	79%	(74)	81%	(102)	94%	(44)	87%	(53)
Infrequently–Not Controlled	2%	(6)	3%	(3)	3%	(4)	0%	(0)	3%	(2)
Infrequently–Controlled	8%	(19)	7%	(7)	4%	(5)	0%	(0)	2%	(1)
Frequently–Not Controlled	3%	(8)	6%	(6)	9%	(11)	2%	(1)	7%	(4)
Frequently–Controlled	6%	(14)	4%	(4)	3%	(4)	4%	(2)	2%	(1)
Total No. of Responses		245		94		126		47		61
Number of No Responses		44		0		1		1		82

Hyperactive	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	80%	(191)	85%	(80)	68%	(79)	72%	(34)	89%	(54)
Infrequently–Not Controlled	2%	(4)	3%	(3)	4%	(5)	0%	(0)	5%	(3)
Infrequently–Controlled	9%	(21)	9%	(8)	14%	(16)	13%	(6)	0%	(0)
Frequently–Not Controlled	3%	(6)	1%	(1)	8%	(9)	13%	(6)	5%	(3)
Frequently–Controlled	7%	(16)	2%	(2)	7%	(8)	2%	(1)	2%	(1)
Total No. of Responses		238		94		117		47		61
Number of No Responses		51		0		10		1		82

Passive	U.S.D.	KSVH	KNI	Winfield	SFB
Rarely or Never	71% (168)	81% (76)	39% (44)	36% (17)	79% (45)
Infrequently–Not Controlled	3% (8)	2% (2)	3% (3)	2% (1)	4% (2)
Infrequently–Controlled	9% (21)	5% (5)	17% (19)	15% (7)	7% (4)
Frequently–Not Controlled	8% (18)	11% (10)	20% (22)	34% (16)	11% (6)
Frequently–Controlled	10% (23)	1% (1)	21% (24)	13% (6)	0% (0)
Total No. of Responses	238	94	112	47	57
Number of No Responses	51	0	15	1	86

Withdrawn	U.S.D.	KSVH	KNI	Winfield	SFB
Rarely or Never	74% (175)	71% (67)	64% (65)	74% (34)	77% (46)
Infrequently–Not Controlled	3% (8)	3% (3)	2% (2)	4% (2)	8% (5)
Infrequently–Controlled	12% (29)	6% (6)	14% (14)	4% (2)	2% (1)
Frequently–Not Controlled	6% (14)	16% (15)	11% (11)	15% (7)	12% (7)
Frequently–Controlled	4% (10)	3% (3)	10% (10)	2% (1)	2% (1)
Total No. of Responses	236	94	102	46	60
Number of No Responses	53	0	25	2	83

Primary Communication Medium	U.S.D.	KSVH	KNI	Winfield	SFB
None	5% (13)	4% (4)	50% (63)	78% (36)	8% (6)
Gestural	2% (6)	0% (0)	12% (15)	13% (6)	9% (7)
Oral	51% (129)	13% (12)	37% (46)	9% (4)	21% (16)
Braille	5% (13)	44% (41)	0% (0)	0% (0)	41% (31)
Print	37% (93)	39% (37)	2% (2)	0% (0)	21% (16)
Total No. of Responses	254	94	126	46	76
Number of No Responses	35	0	1	2	67

Status of Intelligence Measure	U.S.D.		KSVH		KNI		Winfield		SFB	
No Test Given (Can't be tested)	2%	(5)	7%	(6)	6%	(8)	2%	(1)	10%	(8)
No Test Given (Could be tested)	13%	(31)	4%	(4)	1%	(1)	0%	(0)	5%	(4)
Test Attempted–No Results	1%	(3)	83%	(74)	6%	(8)	4%	(2)	1%	(1)
Individual Has Been Tested	83%	(192)	6%	(5)	86%	(108)	94%	(44)	84%	(69)
Total No. of Responses		231		89		125		47		82
Number of No Responses		58		5		2		1		61

Results of Intelligence Measure	U.S.D.		KSVH		KNI		Winfield		SFB	
Profound	3%	(5)	0%	(0)	66%	(77)	85%	(39)	0%	(0)
Severe	5%	(10)	1%	(1)	15%	(17)	13%	(6)	3%	(2)
Moderate	9%	(18)	5%	(4)	9%	(11)	2%	(1)	4%	(3)
Mild	7%	(13)	20%	(16)	9%	(10)	0%	(0)	1%	(1)
Borderline	14%	(27)	20%	(16)	0%	(0)	0%	(0)	6%	(4)
Normal	45%	(87)	44%	(35)	0%	(0)	0%	(0)	34%	(24)
Above Normal	13%	(26)	8%	(6)	0%	(0)	0%	(0)	27%	(19)
Not Applicable	0%	(0)	1%	(1)	1%	(1)	0%	(0)	3%	(2)
Information Not Available	4%	(7)	0%	(0)	0%	(0)	0%	(0)	21%	(15)
Total No. of Responses		193		79		116		46		70
Number of No Responses		2		0		0		0		0

General Level of Academic Achievement	U.S.D.		KSVH		KNI		Winfield		SFB	
Pre-School	17%	(45)	12%	(11)	70%	(57)	97%	(31)	25%	(25)
Primary	31%	(84)	16%	(15)	24%	(20)	3%	(1)	2%	(2)
Intermediate	21%	(57)	35%	(32)	2%	(2)	0%	(0)	4%	(4)
Junior High	13%	(34)	20%	(18)	1%	(1)	0%	(0)	1%	(1)
Senior High	18%	(47)	17%	(16)	2%	(2)	0%	(0)	32%	(32)
Post-Secondary	0%	(1)	0%	(0)	0%	(0)	0%	(0)	35%	(35)
Total No. of Responses		268		92		82		32		99
Number of No Responses		21		2		45		16		44

Dressing	U.S.D.	KSVH	KNI	Winfield	SFB
Independent	85% (217)	93% (87)	16% (20)	2% (1)	91% (61)
Partially Dependent	7% (17)	3% (3)	44% (55)	9% (4)	7% (5)
Totally Dependent	9% (22)	4% (4)	40% (51)	89% (42)	1% (1)
Total No. of Responses	256	94	126	47	67
Number of No Responses	33	0	1	1	76

Eating or Feeding	U.S.D.	KSVH	KNI	Winfield	SFB
Independent	87% (230)	94% (88)	34% (43)	11% (5)	91% (64)
Partially Dependent	7% (18)	2% (2)	29% (36)	6% (3)	7% (5)
Totally Dependent	6% (15)	4% (4)	37% (47)	83% (39)	1% (1)
Total No. of Responses	263	94	126	47	70
Number of No Responses	26	0	1	1	73

Toilet	U.S.D.	KSVH	KNI	Winfield	SFB
Independent	89% (235)	93% (87)	32% (38)	6% (3)	91% (63)
Partially Dependent	3% (9)	3% (3)	34% (41)	6% (3)	6% (4)
Totally Dependent	7% (19)	4% (4)	34% (40)	87% (41)	3% (2)
Total No. of Responses	263	94	119	47	69
Number of No Responses	26	0	8	1	74

Average Number of Hours per Week in Structured Education and/or Training Program	U.S.D.		KSVH		KNI		Winfield		SFB	
No Structured Program	12%	(30)	0%	(0)	44%	(55)	74%	(35)	58%	(18)
1–5 hours	11%	(28)	0%	(0)	10%	(12)	2%	(1)	3%	(1)
6–10 hours	3%	(8)	3%	(3)	9%	(11)	9%	(4)	0%	(0)
11–15 hours	3%	(8)	0%	(0)	8%	(10)	6%	(3)	0%	(0)
16–20 hours	0%	(1)	0%	(0)	9%	(11)	4%	(2)	0%	(0)
21–25 hours	4%	(10)	0%	(0)	4%	(5)	0%	(0)	0%	(0)
26–30 hours	46%	(115)	94%	(88)	7%	(9)	2%	(1)	0%	(0)
31–35 hours	18%	(45)	0%	(0)	6%	(8)	0%	(0)	0%	(0)
36–40 hours	1%	(3)	0%	(0)	2%	(3)	2%	(1)	39%	(12)
41 or more hours	0%	(0)	3%	(3)	2%	(2)	0%	(0)	0%	(0)
Total No. of Responses		248		94		126		47		31
Number of No Responses		41		0		1		1		112

Type of Present Education Program	U.S.D.		KSVH		KNI		Winfield		SFB	
None	3%	(8)	1%	(1)	47%	(59)	74%	(34)	22%	(20)
Home Program	2%	(6)	0%	(0)	1%	(1)	0%	(0)	10%	(9)
Readiness	5%	(13)	16%	(15)	20%	(25)	0%	(0)	2%	(2)
Academic	77%	(210)	68%	(64)	14%	(18)	0%	(0)	35%	(33)
Sheltered Workshop	3%	(7)	0%	(0)	0%	(0)	0%	(0)	12%	(11)
Vocational	0%	(0)	15%	(14)	10%	(12)	0%	(0)	2%	(2)
Other	10%	(27)	0%	(0)	8%	(10)	26%	(12)	17%	(16)
Total No. of Responses		271		94		125		46		93
Number of No Responses		18		0		2		2		50

Parents' or Guardian's Attitude Toward Individual	U.S.D.		KSVH		KNI		Winfield		SFB	
Overt Rejection	1%	(2)	0%	(0)	10%	(11)	8%	(4)	3%	(3)
Disguised Rejection	7%	(15)	10%	(9)	15%	(16)	0%	(0)	8%	(8)
Overprotective	12%	(28)	7%	(7)	7%	(7)	0%	(0)	24%	(25)
Acceptance	76%	(173)	83%	(78)	67%	(72)	75%	(36)	66%	(69)
Prefer Not to Answer	4%	(9)	0%	(0)	1%	(1)	17%	(8)	0%	(0)
Total No. of Responses		227		94		107		48		105
Number of No Responses		62		0		20		0		38

Parents' or Guardian's Willingness to Accept Help from Agency When Needed	U.S.D.		KSVH		KNI		Winfield		SFB	
Totally Rejects Help	4%	(8)	1%	(1)	13%	(13)	0%	(0)	1%	(1)
Accepts Help when Coerced	6%	(13)	15%	(14)	12%	(12)	4%	(2)	8%	(8)
Accepts Help when Prompted	10%	(23)	48%	(45)	10%	(10)	6%	(3)	10%	(10)
Accepts Help when Offered	50%	(113)	12%	(11)	44%	(44)	21%	(10)	23%	(24)
Seeks Help	22%	(50)	22%	(21)	20%	(20)	56%	(27)	56%	(59)
Actively Seeks Help	2%	(5)	2%	(2)	2%	(2)	0%	(0)	3%	(3)
Prefer Not to Answer	5%	(12)	0%	(0)	0%	(0)	13%	(6)	0%	(0)
Total No. of Responses		224		94		101		48		105
Number of No Responses		65		0		26		0		38

Parents' or Guardian's Contact with Agency	U.S.D.		KSVH		KNI		Winfield		SFB	
Rarely or Never	13%	(28)	11%	(10)	31%	(36)	23%	(11)	12%	(12)
Infrequently	43%	(94)	43%	(40)	32%	(38)	17%	(8)	49%	(48)
Frequently	40%	(87)	47%	(44)	37%	(43)	48%	(23)	39%	(38)
Constantly	0%	(1)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
Prefer Not to Answer	4%	(8)	0%	(0)	0%	(0)	13%	(6)	0%	(0)
Total No. of Responses		218		94		117		48		98
Number of No Responses		71		0		10		0		45

Is this person currently in the most appropriate training setting?	U.S.D.		KSVH		KNI		Winfield		SFB	
Yes	83%	(219)	99%	(93)	91%	(108)	96%	(46)	75%	(75)
No–Should be in public school special education	2%	(5)	0%	(0)	3%	(3)	0%	(0)	1%	(1)
No–Should be in residential setting for mentally retarded	0%	(1)	0%	(0)	1%	(1)	0%	(0)	1%	(1)
No–Should be in residential setting for emotionally disturbed	0%	(0)	0%	(0)	1%	(1)	0%	(0)	0%	(0)
No–Should be in residential setting for hearing impaired	0%	(0)	0%	(0)	0%	(0)	0%	(0)	0%	(0)
No–Should be in residential setting for visually impaired	3%	(8)	1%	(1)	3%	(3)	0%	(0)	0%	(0)
No–Should have special training at home	0%	(1)	0%	(0)	1%	(1)	2%	(1)	0%	(0)
Uncertain	12%	(31)	0%	(0)	2%	(2)	2%	(1)	23%	(23)
Total No. of Responses		265		94		119		48		100
Number of No Responses		24		0		8		0		43

Institution	* Total of Visually Impaired Population	* Justified Institutionalization
U.S.D.	41% (289)	33% (120)
KSVH	13% (94)	10% (37)
KNI	18% (127)	33% (121)
Parsons	1% (4)	1% (3)
Winfield	7% (48)	13% (48)
SFB	20% (143)	10% (37)
I.L.	0% (3)	0% (1)
Total No. of Responses	100% 708	100% 367
Number of No Responses	0	0

* These columns take the total number of visually impaired young people in Kansas (708) and also the portion of the total group that has one or more characteristics that might justify institutionalization (367 of the 708), and it indicates the proportion of both of these groups that are associated with each of the variables (institutions) located in the far left column.

Sex	Total of Visually Impaired Population	Justified Institutionalization
Male	59% (405)	60% (217)
Female	41% (286)	40% (144)
Total No. of Responses	691	361
Number of No Responses	17	6

Number of Months from Most Recent Eye Evaluation	Total of Visually Impaired Population	Justified Institutionalization
1 – 6 months	30% (166)	41% (121)
7 – 12 months	33% (182)	31% (90)
13 – 18 months	8% (43)	7% (20)
19 – 24 months	9% (47)	6% (17)
25 – 30 months	5% (25)	3% (9)
31 – 36 months	4% (24)	4% (12)
37+ months	12% (65)	9% (26)
Total No. of Responses	552	295
Number of No Responses	156	72

Source of Most Recent Eye Evaluation	Total of Visually Impaired Population	Justified Institutionalization
Routine School Screening	8% (53)	4% (15)
Optometrist	12% (80)	18% (63)
Other M. D.	15% (96)	24% (82)
Opthamologist	64% (415)	52% (180)
Other	1% (8)	1% (4)
Total No. of Responses	652	344
Number of No Responses	56	23

Is Individual Legally Blind	Total of Visually Impaired Population	Justified Institutionalization
Yes	63% (401)	62% (200)
No	37% (237)	38% (123)
Total No. of Responses	638	323
Number of No Responses	70	44

Distance Acuity After Correction, Better Eye	Total of Visually Impaired Population	Justified Institutionalization
Cannot Be Tested	8% (42)	13% (35)
No Vision	21% (114)	25% (69)
Has Light Perception	11% (60)	15% (40)
Notes Hand Movement	5% (25)	8% (21)
Counts Fingers	2% (9)	0% (1)
Other	6% (33)	7% (18)
20/20 or below	2% (11)	1% (2)
20/21 – 20/50	6% (32)	4% (11)
20/51 – 20/70	7% (41)	6% (16)
20/71 – 20/200	24% (131)	.0% (43)
20/201 or above	9% (52)	6% (16)
Total No. of Responses	550	272
Number of No Responses	158	95

Eye Evaluation Diagnosis	Total of Visually Impaired Population	Justified Institutionalization
Congenital Cataracts	17% (100)	17% (51)
Congenital Glaucoma	4% (23)	3% (8)
Retinoblastoma	4% (22)	2% (7)
RLF	12% (73)	10% (31)
Nystagmus	31% (181)	31% (93)
Optic Nerve Atrophy	13% (78)	15% (46)
Myopia	13% (78)	15% (44)
Injury	2% (13)	2% (7)
Other	44% (257)	44% (133)
Total No. of Responses	585	301
Number of No Responses	123	66

Eye Evaluation Prognosis	Total of Visually Impaired Population	Justified Institutionalization
Deteriorating	11% (63)	13% (38)
Stable	59% (327)	51% (151)
Capable of Improvement	6% (31)	7% (20)
Uncertain	24% (131)	29% (85)
Total No. of Responses	552	294
Number of No Responses	156	73

Number of Months from Most Recent Hearing Evaluation	Total of Visually Impaired Population	Justified Institutionalization
1–6 months	45% (173)	50% (113)
7–12 months	22% (85)	22% (49)
13–18 months	10% (39)	12% (27)
19–24 months	11% (42)	6% (13)
25–30 months	2% (8)	1% (2)
31–36 months	3% (12)	2% (5)
37+ months	6% (22)	7% (16)
Total No. of Responses	381	225
Number of No Responses	327	142

Source of Most Recent Hearing Evaluation	Total of Visually Impaired Population	Justified Institutionalization
Routine School Screening	42% (176)	30% (77)
Audiologist	23% (99)	27% (69)
Other M.D.	17% (72)	26% (66)
Otologist	3% (14)	3% (7)
Other	15% (63)	14% (35)
Total No. of Responses	424	254
Number of No Responses	284	113

Results of Hearing Evaluation	Total of Visually Impaired Population	Justified Institutionalization
Deaf—Prelingual	1% (6)	2% (5)
Deaf—Postlingual	0% (1)	0% (1)
Partial Hearing	5% (23)	7% (17)
Hard of Hearing	6% (26)	4% (11)
No Appreciable Loss	76% (325)	70% (179)
Unable to Determine	11% (46)	16% (42)
Total No. of Responses	427	255
Number of No Responses	281	112

Is Child Subject Seizures?	Total of Visually Impaired Population	Justified Institutionalization
No	81% (477)	68% (219)
Grand Mal—Uncontrolled	2% (10)	3% (10)
Grand Mal—Controlled	13% (77)	22% (70)
Petit Mal—Uncontrolled	1% (6)	2% (5)
Petit Mal—Controlled	4% (21)	6% (19)
Total No. of Responses	591	323
Number of No Responses	117	44

Physical Condition other than Vision and Hearing which Inhibits Normal School Activity (Motor)	Total of Visually Impaired Population	Justified Institutionalization
No	61% (418)	47% (169)
Gross Motor–Partially Inhibited	3% (18)	4% (13)
Gross Motor–Totally Inhibited	0% (0)	0% (0)
Has Gross Motor but information not available	0% (0)	0% (0)
Fine Motor–Partially Inhibited	2% (11)	1% (3)
Fine Motor–Totally Inhibited	0% (2)	1% (2)
Has Fine Motor but information not available	0% (1)	0% (0)
Gross Motor–Partially Inhibited & Fine Motor–Partially Inhibited	14% (97)	20% (74)
Gross Motor–Partially Inhibited & Fine Motor–Totally Inhibited	1% (5)	1% (4)
Gross Motor–Totally Inhibited & Fine Motor–Partially Inhibited	0% (3)	1% (2)
Gross Motor–Totally Inhibited & Fine Motor–Totally Inhibited	12% (79)	22% (79)
Gross Motor–Partially Inhibited & Fine Motor but information not available	1% (5)	1% (3)
Gross Motor–Totally Inhibited & Fine Motor but information not available	0% (1)	0% (1)
Gross Motor but information not available & Fine Motor–Partially Inhibited	0% (0)	0% (0)
Gross Motor but information not available & Fine Motor–Totally Inhibited	0% (0)	0% (0)
Gross Motor but information not available & Fine Motor but information not available	6% (44)	4% (13)
Total No. of Responses	684	363
Number of No Responses	24	4

Does this Individual Have a Medical Condition Requiring Direct Supervision?	Total of Visually Impaired Population	Justified Institutionalization
Yes	25% (152)	38% (120)
No	75% (447)	62% (196)
Total No. of Responses	599	316
Number of No Responses	109	51

Characteristic—Normal	Total of Visually Impaired Population	Justified Institutionalization
Usually	72% (433)	49% (163)
Sometimes	17% (103)	31% (101)
Rarely or Never	11% (66)	20% (66)
Total No. of Responses	602	330
Number of No Responses	106	37

Characteristic—Disturbed	Total of Visually Impaired Population	Justified Institutionalization
Usually	12% (69)	21% (69)
Sometimes	28% (163)	47% (154)
Rarely or Never	60% (354)	33% (108)
Total No. of Responses	586	331
Number of No Responses	122	36

Characteristic—Disturbed (Source of Notation)	Total of Visually Impaired Population	Justified Institutionalization
Stereotyped	13% (27)	13% (27)
Diagnosed	32% (65)	32% (65)
Observable—Not Diagnosed	54% (109)	54% (109)
Total No. of Responses	201	201
Number of No Responses	385	130

Situational—Physically Aggressive to Self	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	86% (498)	76% (255)
Infrequently—Not Controlled	3% (19)	5% (18)
Infrequently—Controlled	6% (33)	10% (32)
Frequently—Not Controlled	3% (19)	6% (19)
Frequently—Controlled	2% (10)	3% (10)
Total No. of Responses	579	334
Number of No Responses	129	33

Situational—Physically Aggressive to Others	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	83% (481)	72% (242)
Infrequently—Not Controlled	2% (14)	4% (13)
Infrequently—Controlled	9% (53)	14% (46)
Frequently—Not Controlled	3% (18)	5% (18)
Frequently—Controlled	3% (17)	5% (17)
Total No. of Responses	583	336
Number of No Responses	125	31

Situational—Physically Aggressive to Objects	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	90% (515)	83% (273)
Infrequently—Not Controlled	2% (12)	4% (12)
Infrequently—Controlled	4% (25)	7% (22)
Frequently—Not Controlled	2% (14)	4% (14)
Frequently—Controlled	1% (8)	2% (8)
Total No. of Responses	574	329
Number of No Responses	134	38

Situational—Verbally Aggressive	Total of Visual Impaired Population	Justified Institutionalization
Rarely or Never	82% (477)	72% (243)
Infrequently—Not Controlled	3% (16)	4% (13)
Infrequently—Controlled	6% (32)	8% (26)
Frequently—Not Controlled	5% (30)	9% (30)
Frequently—Controlled	4% (25)	7% (25)
Total No. of Responses	580	337
Number of No Responses	128	30

Hyperactive	Total of Visually Impaired Population	Justified Institutionalized
Rarely or Never	79% (443)	67% (214)
Infrequently—Not Controlled	3% (15)	4% (12)
Infrequently—Controlled	9% (51)	12% (40)
Frequently—Not Controlled	4% (25)	8% (25)
Frequently—Controlled	5% (30)	9% (30)
Total No. of Responses	564	321
Number of No Responses	144	46

Passive	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	64% (356)	43% (135)
Infrequently—Not Controlled	3% (16)	4% (13)
Infrequently—Controlled	10% (56)	12% (38)
Frequently—Not Controlled	13% (72)	23% (72)
Frequently—Controlled	10% (55)	18% (55)
Total No. of Responses	555	313
Number of No Responses	153	54

Withdrawn	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	72% (391)	56% (171)
Infrequently–Not Controlled	4% (21)	6% (18)
Infrequently–Controlled	10% (53)	12% (35)
Frequently–Not Controlled	10% (55)	18% (55)
Frequently–Controlled	5% (25)	8% (25)
Total No. of Responses	545	304
Number of No Responses	163	63

Primary Communication Medium	Total of Visually Impaired Population	Justified Institutionalization
None	20% (123)	36% (119)
Gestural	6% (37)	9% (30)
Oral	35% (210)	35% (116)
Braille	14% (85)	9% (30)
Print	25% (148)	12% (40)
Total No. of Responses	603	335
Number of No Responses	105	32

Status of Intelligence Measure	Total of Visually Impaired Population	Justified Institutionalization
No Test Given (Can't be tested)	5% (29)	6% (21)
No Test Given (Could be tested)	7% (40)	6% (19)
Test Attempted–No Results	15% (88)	12% (39)
Individual Has Been Tested	73% (424)	76% (257)
Total No. of Responses	581	336
Number of No Responses	127	31

Results of Intelligence Measure	Total of Visually Impaired Population	Justified Institutionalization
Profound	24% (122)	41% (122)
Severe	7% (37)	13% (37)
Moderate	7% (38)	9% (27)
Mild	8% (42)	7% (22)
Boderline	9% (48)	7% (20)
Normal	29% (146)	16% (48)
Above Normal	10% (51)	4% (11)
Not Applicable	1% (4)	0% (1)
Information not available	4% (22)	2% (7)
Total No. of Responses	510	295
Number of No Responses	2	1

General Level of Academic Achievement	Total of Visually Impaired Population	Justified Institutionalization
Pre-School	30% (175)	49% (137)
Primary	21% (122)	22% (62)
Intermediate	16% (95)	13% (33)
Junior High	9% (54)	5% (13)
Senior High	17% (97)	10% (28)
Post-Secondary	6% (36)	1% ((4)
Total No. of Responses	579	282
Number of No Responses	129	85

Dressing	Total of Visually Impaired Population	Justified Institutionalization
Independent	65% (388)	41% (138)
Partially Dependent	15% (89)	23% (75)
Totally Dependent	20% (120)	36% (120)
Total No. of Responses	597	333
Number of No Responses	111	34

Eating or Feeding	Total of Visually Impaired Population	Justified Institutionalization
Independent	71% (433)	51% (170)
Partially Dependent	11% (68)	18% (59)
Totally Dependent	17% (106)	32% (106)
Total No. of Responses	607	335
Number of No Responses	101	32

Toilet	Total of Visually Impaired Population	Justified Institutionalization
Independent	71% (428)	49% (162)
Partially Dependent	11% (65)	18% (60)
Totally Dependent	18% (106)	32% (106)
Total No. of Responses	599	328
Number of No Responses	109	39

Average Number of Hours per Week in Structured Education and/or Training Program	Total of Visually Impaired Population	Justified Institutionalization
No Structured Program	25% (138)	34% (113)
1–5 hours	8% (42)	9% (31)
6–10 hours	5% (27)	8% (26)
11–15 hours	4% (23)	5% (16)
16–20 hours	3% (14)	4% (13)
21–25 hours	3% (15)	4% (12)
26–30 hours	39% (216)	24% (80)
31–35 hours	10% (53)	7% (22)
36–40 hours	4% (20)	3% (11)
41 or more hours	1% (5)	2% (5)
Total No. of Responses	553	329
Number of No Responses	155	38

Type of Present Education Program	Total of Visually Impaired Population	Justified Institutionalization
None	19% (122)	31% (107)
Home Program	3% (16)	3% (11)
Readiness	9% (55)	12% (43)
Academic	52% (328)	32% (110)
Sheltered Workshop	3% (18)	2% (8)
Vocational	4% (28)	5% (18)
Other	11% (69)	14% (50)
Total No. of Responses	636	347
Number of No Responses	72	20

Parents' or Guardian's Attitude toward Individual	Total of Visually Impaired Population	Justified Institutionalization
Overt Rejection	3% (20)	6% (20)
Disguised Rejection	8% (48)	12% (38)
Overprotective	12% (68)	14% (46)
Acceptance	74% (433)	63% (205)
Prefer Not to Answer	3% (18)	5% (16)
Total No. of Responses	587	325
Number of No Responses	121	42

Parents' or Guardian's Willingness to Accept Help from Agency when Needed	Total of Visually Impaired Population	Justified Institutionalization
Totally Rejects Help	4% (23)	6% (20)
Accepts Help when Coerced	8% (49)	11% (34)
Accepts Help when Prompted	16% (94)	15% (47)
Accepts Help when Offered	35% (205)	35% (110)
Seeks Help	31% (178)	27% (84)
Actively Seeks Help	2% (12)	3% (8)
Prefer Not to Answer	3% (18)	4% (13)
Total No. of Responses	579	316
Number of No Responses	129	51

Parents' or Guardian's Contact with Agency	Total of Visually Impaired Population	Justified Institutionalization
Rarely or Never	17% (97)	20% (66)
Infrequently	40% (232)	36% (118)
Frequently	41% (238)	41% (134)
Constantly	0% (1)	0% (1)
Prefer Not to Answer	2% (14)	3% (11)
Total No. of Responses	582	330
Number of No Responses	126	37

Is this person currently in the most appropriate training setting?	Total of Visually Impaired Population	Justified Institutionalization
Yes	86% (547)	84% (288)
No—Should be in public school special education	2% (10)	1% (5)
No—Should be in residential setting for mentally retarded	0% (3)	1% (2)
No—Should be in residential setting for emotionally disturbed	0% (1)	0% (1)
No—Should be in residential setting for hearing impaired	0% (0)	0% (0)
No—Should be in residential setting for visually impaired	2% (12)	3% (9)
No—Should have special training at home	0% (3)	1% (3)
Uncertain	9% (57)	10% (33)
Total No. of Responses	633	341
Number of No Responses	75	26