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ABSTRACT

Information on identifying handicapped children was collected and analyzed, in order to evaluate Illinois-required case study components and assessment procedures. A literature review chapter discusses assessment of health, academic status, and individual strengths/weaknesses, and provides summaries of best practices. In regard to method, a survey of state departments of education found that all states require assessment of achievement data, followed in order of required frequency by: consideration of child's physical condition, child's social/cultural condition, adaptive behavior, and so on. Also analyzed were types of personnel required in identification procedures, consistency with nondiscriminatory guidelines of federal education legislation, and placement criteria for specific categories of children. Twenty-six Illinois institutions of higher education were surveyed regarding training in student assessment procedures, to evaluate the amount of instructional emphasis given to each of the case study components and perceptions of graduate preparedness to complete case study components. In addition, 549 Illinois professionals involved in special education evaluation were asked to rate usefulness of the various case study components. Components receiving highest rankings of usefulness were: evaluation of learning processes, medical history, level of educational achievement, hearing screening, vision screening, and speech and language. Respondents were also asked how case study requirements should be modified and which professional should have primary responsibility for each case study component. Results of each survey are described and discussed, and 13 recommendations are presented. Forty references are listed and three appendixes contain copies of the survey forms. (JDD)

IDENTIFICATION OF HANDICAPPED CHILDREN

An Analysis of Illinois Case Study

Evaluation Procedures

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Table of Contents

List of Tables

Identification of Handicapped Children:
An Analysis of Illinois Case Study Evaluation Procedures

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Introduction

Two previous studies (Swartz, Koenig-Jerz & Mosley, 1987; Swartz & Mosley, 1988) which examined regulatory requirements of states for special education assessment purposes arrived at several findings. Both found that requirements vary enormously across the states with little or no consensus among them regarding policy or procedure. Another study (Swartz, Mundschenk & Mosley, 1989) which examined school psychologists assesment of mental retardation in Illinois again found great variation among this group within the state. A surprising finding was the importance, or lack of importance, the majority of Illinois school psychologists placed on impairments in adaptive behavior as a major factor in arriving at a diagnosis of mental retardation. The definition of mental retardation is very clear on the point that in order to arrive at a diagnosis of mental retardation, the individual being assessed must show (1) subaverage intellectual functioning and (2) impairments in adaptive behavior. Both these conditions must be met. Yet the

responses received from school psychologists indicated that subaverage intellectual functioning was the primary factor leading to a diagnosis of mental retardation.

The assessment process which led to the diagnosis, insofar as the sample of Illinois school psychologists was concerned, was essentially a single criterion approach. This approach violates federal legislation and Illinois special education rules and regulations. It was clear from these three studies that the assessment process in general, is both irregular and uneven. This is the case nationally as well as in Illinois. Since special education assessment has been a source of controversy for well over two decades, and especially with respect to minorities, it would seem that more stringent attempts should be made to regulate the process of assessment in special education.

In Illinois a case study approach is used to evaluate children for special education consideration. 23 Illinois Administrtative Code (226.535) requires, for most special education referrals, a case study evaluation with a least nine separate components. These include: child interview, parent consultation, social developmental study, medical history, vision screening, hearing screening, academic history, evaluation of learning processes, assessment of learning environment and specialized evaluations (i.e., psychological, speech and language).

Since general evidence of student assessment problems has been reported in recent studies which suggest that special education proceaures used in Illinois are unnecessarily diverse and inconsistently applied (Swartz et al., 1987, 1988b, 1989), it seemed particularly important to evaluate the required case study components and student assessment procedures used to complete the case study for referrals to special education. The project reported was designed to collect information regarding the process of identifying handicapped children in Illinois. A variety of data bases were employed to examine present practices in using the prescribed case study. In addition, information regarding best practices for the identification of handicapped children was collected and reviewed.

Research Literature Review

A special education case study is a form of assessment - a purposeful activity by more than one educational professional where relevant information about a child is gathered from a number of sources for clarification of presenting problems, which leads to decision-making about possible psychoeducational interventions. It is comprehensive in that a number of methods are used by individuals of varying professional perspectives to examine the developmental, behavioral, medical, and environmental aspects of the child's life - factors within the child, such as intelligence and motivation; factors in the instructional environment, such as methods and curriculum; and factors in the child's out-of-school environment, such as family economics and parenting.

The present Illinois case study is defined as "in-depth multidisciplinary diagnostic procedures designed to provide information about a child, the nature of the problem(s) affecting educational development, and the type of intervention/assistance needed" (23 Illinois Administrative Code 226.35) and encompasses the following components:

Child interview
Parent consultation
Medical history and current health status
Vision and hearing screening
Academic history and current educational functioning
Social developmental study (adaptive behavior and cultural background)
Specialized evaluations such as speech/language and psychological

Evaluation of the learning environment
Evaluation of learning processes

The Case Study Survey has sampled Illinois Practitioners' opinions regarding the relevance of these components and which members of the multidisciplinary assessment team should assume responsibility for each (see Tables 8 and 9). To provide a broader perspective to the appropriateness of these components, information about practices in other states was gathered (see Tables 1,2,3 and 4). A selected review of the research literature has been done through a review of school psychology, school social work, and special education journals published recently, as well as a look at current textbooks on assessment used in training programs for those disciplines.

For ease of discussion and clarity, the present case study assessment components have been arranged as follows:

(A) Health Information
(Medical history and current health status, vision and hearing status)

(B) Academic Status
(History and current functioning, learning environment)

(C) Individual Strengths/Weaknesses
(Specialized evaluations, learning processes, social development data)

Child interview and parent consultation are not included in the arrangement because they are not areas of assessment, but rather aspects of assessment methodology. In order to gather adequate information for decision-making, some member of the evaluation team should have personal contact with the child in question for

direct assessment purposes and also for gathering information as to the child's perspective of his/her problems (to the extent the child can communicate this). "A perusal of the literature on child interviewing reveals the extent empirical and conceptual foundation for conducting these interviews is not well developed" (Hughes, 1989, p. 247). Best practices available would take into consideration the child's stage of development in language, understanding of emotions, and person perception.

Likewise, adequate assessment of social development and medical history require contact with a parent/guardian in order to gather relevant information. The professional literature provides little empirical validation of parent assessment methods as they pertain to the comprehensive case study, though increasing parent involvement in education is a topic emphasized in general education at present, as well as the nature of the changing American family and parent training. P.L. 94-142 does require the full participation of parents in the evaluation and placement process for special education services. . ." (Constable & Flynn, p. 231), with the best practices intent being that parents should be sources of information about children, along as well as co-decision-makers about educational needs. Training texts do include both parent and child interviewing as a vital tool in the collection of important data and all disciplines (school psychology, school social work, and special education) include them in their training repertoire. Murphy (1985) provides a best practices in interviewing framework:

A. Interviewer attitudes which lead to effective interviews
   1. Acceptance
   2. Positive regard
   3. Nonjudgmental
   4. Empathy

B. Skills/abilities which facilitate effective interviews
   1. Interviewer self-awareness
   2. Interview management
   3. Questioning techniques
   4. Probing and topic control

Before discussion of these assessment components, a reference to Public Law 94-142 is in order. This legislation mandated certain fair, equitable, and nondiscriminatory assessment procedures. The components of the Illinois special education case study reflect these procedures:

1. Tests used are to be selected and administered in a racially and culturally nondiscriminatory manner (Social Developmental Study).

2. Native language and/or primary mode of communication is to be accomodated during assessment activities (Social Developmental Study).

3. Decisions about students need to be based on data from more than one single test.

4. Evaluations are to be made by a multidisciplinary team.

5. Children are to be assessed in all areas related to their presenting problems, including health, vision, hearing, social and emotional status, general intelligence, academic performance, communication skills, and motor development - as appropriate to each case (specialized evaluations, medical, vision and hearing, academic, learning processes).

These procedures are almost exclusively related to test instruments and assessment methodology. The current concern in the area of nondiscriminatory assessment lies not with

instrumentation and data gathering methods, but rather within the decision-making process. That is, the process of determining eligibility and program placement may contain the discriminatory elements (Tucker, 1977) more so than the assessment tools. The Tucker model (1980) presents a best practices approach to nondiscriminatory assessment in a nineteen level hierarchy from preferral problem identification, through intervention trial(s), to referral and eligibility determination (if warranted). Each level of this assessment-intervention hierarchy raises critical questions about possible bias in decision-making at that level, as well as approaches to reduce or eliminate such bias.

HEALTH INFORMATION

Current professional literature contains little reference to assessment of health status. There is considerable research in neuropsychology, but not as a mandatory aspect of comprehensive educational assessment. Omission in the current literature appears to suggest a noncontroversial status and accepted practice rather than disregard for its importance. Training texts note the necessity of determining general health status of referred children and of the impact of sensory acuity losses. "The first thing to check when a child is having academic or social difficulties is whether that child is receiving environmental information adequately and properly" (Salvia and Ysseldyke, p. 214). A member of the multidisciplinary team is not usually the one to assess the adequacy of vision and hearing, persons outside the school do. Therefore, team members need to

be aware of the kinds of vision and hearing difficulties children can experience and how to go about securing adequate evaluation by appropriate specialists in those fields. In addition, good communication skills are necessary in order to receive and convey diagnostic information between the school and nonschool specialist. It would appear from training texts that all three disciplines -- special education, school social work, and school psychology - provide training in those needed communication skills.

ACADEMIC STATUS

The historic foundation of special education lies in children's learning problems and testing of academic achievement has been the basis for special and remedial services since its inception. But testing is not assessment and the growth of the field of special education has been accompanied by increasing dissatisfaction with the norm-referenced testing that has dominated the field of assessment. Cresham (1983) summarized the major problems in norm-referenced testing as: (1) obtaining insufficient assessment information, (2) using technically inadequate testing, and (3) relying on measures that yield inappropriate or educationally irrelevant information. Therefore, the current school psychology and special education literature is replete with a new direction in academic assessment - functional assessment or curriculum-based assessment. Shapiro and Lentz (1985) outlined the assumptions underlying this methodology:

1. Assessment reflecting an evaluation of behavior in its natural environment (the classroom);

2. Idiographic (individual) rather than nomethetic (group or norm-referenced) assessment;

3. Testing that reflects what is taught;

4. Strong links between assessment results and behaviors targeted for intervention;

5. Assessment methods capable of providing ongoing evaluation;

6. Empirically validated assessment measures; and

7. Examination of both performance and skill deficits.

Gerken (1985) elaborates on best practices in the academic assessment process:

I. Analysis of Referral

- A. Special academic concern(s)
- B. Intervention efforts attempted
- C. School related variables of significance
- D. Non-school related variables of significance

II. Determination of Academic Expectations

- A. Textbook scope and sequence charts or lists of objectives/goals by grade level
- B. Instructional programs available
- C. Access research on factors influencing academic skills

III. Determination of Appropriate Assessment Techniques

- A. Interdisciplinary planning of questions to be answered (and time table for completion of activities)
- B. Division of responsibilities via individuals' skills
- C. Selection of techniques
  1. Formal instruments of technical adequacy
     a. Significant behavior samples
     b. Link with curriculum
  2. Observation
     a. Informal
     b. Formal
  3. Interview

4. Informal analysis techniques
   a. Error-pattern analysis
   b. miscue analysis
   c. Task analysis

Norm-referenced achievement testing is the most frequently used testing in all educational settings. Such academic achievement testing can also be a part of the case study evaluation. It is a measure of the extent to which a child has benefited from life experiences/schooling compared to others of the same age or grade. Best practices to guide the assessor in selection and use of academic achievement instruments are summarized from Salvia and Ysseldyke (1985):

1. Instrument valid for your assessment purposes
2. Adequate sampling of area/domain being tested
3. Adequate reliability and standardization sample
4. Use instrument both quantitatively and qualitatively
5. Consideration of testing format versus any limitatiaons in child responding
6. Appropriate interpretation and usefulness of results

INDIVIDUAL STRENGTH/WEAKNESSES

Specialized evaluations constitute another component of the Illinois case study. These evaluations, done on a need basis determined by consensus of the case study team, include psychological, medical, speech/language, audiological, vocational, OT/PT, and others if necessary. Those who assess students in these areas require specialized training and need to be aware of certain assumptions underlying all assessment. Newland (1971) identified them as:

1. A skilled examiner who knows how to select assessment techniques, use them appropriately, and make accurate interpretations,

2. The ever-presence of a certain amount of error and/or bias;
3. Awareness that acculturation is a matter of experiential background rather than race, color, or ethnic background; and if comparisons are to be made between a child's performance on a test and that of a particular group performance, comparable acculturation should exist for valid interpretations;
4. Behavior sampling adequate in amount and representative of the area being assessed; and
5. Realization that observation of present behavior provides only the opportunity for inference of future behavior.

The specialized evaluations at issue for best practices in the field of case-study assessment are the psychological and the vocational evaluation -- the inclusiveness of the former and appropriate approaches in the latter. Does the psychological component of the case study refer to the assessment of any/all aspects of the mind or mental functioning of a referred child (personality, emotional status, problem-solving abilities, level of motivation) or merely an estimate of intellectual functioning (IQ range)? The professional literature and current training texts divide psychological assessment into intellectual, personality, neuropsychology and behavioral assessment. This approach directs practitioners to a more comprehensive definition of the psychological component of the case study. It also suggests the need for comprehensive evaluation teams to view intelligence testing as only one dimension of a multifaceted assessment. Guidelines for psychoeducational best practices in these areas come primarily from the disciplines of special education and school psychology, except for behavioral assessment, which is a focus also of school social work training.

Specific to intellectual assessment, Sattler (1982) provides guidance in using intelligence and special ability tests.

1. These tests are samples of behavior.
2. They do not reveal traits/capacities directly
3. Tests used should have demonstsrated adequate reliability and validity.
4. Test interpretation should take into account the child's primary language, cultural background and any handicapping condition at variance to the standardization group.
5. Test performance can be adversely affected by temporary states of fatigue or stress; by disturbances in personality, and by the level of the child's cooperation/motivation.
6. Tests should never be interpreted in isolation.

Sattler (1982) further elaborates that intelligence tests measure success in school quite well, are value-laden, representing such societal values as schooling, verbal abilities and abstraction. But when used wisely and cautiously by skilled and knowledgeable assessors, they assist in helping children.

Psychological assessment can include evaluation of personality, and like intelligence testing, is a controversial area of assessment. Barnett and Zucker (1985) outline best practice guidelines:

A. Use of many and varied sources of information

   1. Interviews
   2. Observations
   3. Rating scales
   4. Review of school records
   5. Developmental and social histories
   6. Projective techniques
   7. Objective techniques

B. Focus on gathering data that will lead to positive plans for change

1. Possibility for psychosocial change
2. Sensitivity to minority issues and cultural differences.

Neuropsychological functioning can also be part of a psychological assessment and it has been historically included in comprehensive psychoeducational assessment due to the assumption that learning disorders have a neurological basis. During the last twenty years in special education, three different definitions of learning disabilities, now the largest categorical special education program, have included some reference to minimal brain dysfunction. But "only limited evidence exists that documents neuroanatomical abnormalities in the brain of severely learning disabled children" (Rosen & Galaburda, 1984). And since the major consideration in assessment of learning disabilities is documentation of discrepancy between ability and achievement, some feel that neuropsychological dysfunctioning is irrelevant (Hynd & Snow, 1985). Others would place value on a neuropsychological exam as helping to differentiate learning disorders due to neurological dysfunction from those not due to neurological dysfunction in order for the most productive interventions to be formulated. Training in the area of neuropsychological assessment is limited for school psychologists and non-existent in school social work. In the special education field, there is much controversy as to its relevance and empirical-based assessment approaches are minimal. Hynd and Snow (1985) offer these best practice guidelines for assessing neuropsychological functioning:

1. Working knowledge in areas of neuropsychology, such as functional neuroanatomy and cerebral vascular systems.

2. Understanding of basic principles of psychometrics, such as construct validity.

3. Awareness of the relative infancy of the field and the complexity of assessment.

Behavioral assessment is another aspect of psychological assessment. The school psychology, school social work, and special education literature supports the importance of this component for comprehensive educational evaluation and textbooks provide training in appropriate methodology. The preferred assessment approach is an ecological one as described by Berdine and Meyer (1987). Major assumptions upon which this approach is based are:

1. Behavioral repertoires - behavior problems stem primarily from faulty learning experiences, so assessment of children's social and behavior problems needs to sample their behavioral assets and liabilities across settings.

2. Expectations of significant others - significant individual's in the child's environment determine the appropriateness or inappropriateness of behavior; therefore assessment needs to identify expectations set by significant others.

3. Internal and external variables -- problem behaviors are usually maintained by particular variables within the child, as well as within the child's environment, and assessment needs to identify both and then design viable interventions involving both sets of variables.

4. Observation-based information from direct observation is more useful and reliable in planning for, implementing, and evaluating behavioral change programs.

The Behavioral-Ecological Assessment Methods include use of:

1. Behavior Rating Scales
2. Ecological Survey
3. Direct-Observation Procedures
4. Ecological Interviewing

Vocational education is assuming a much greater role in career training for special education students, thus vocational assessment may be a specialized evaluation component of case studies for students at junior high ages and above. P.L. 98-524 provides that the assessment of handicapped students for vocational needs should include interests, abilities, and special needs. There is a paucity of literature in school psychology and school social work on vocational assessment and only a little more in special education literature and in special education training texts. Hohenshill, Levinson, and Heer (1985) offer guidelines for best practices in such assessment. They propose an experential continuum for assessment that includes paper/pencil psychometric techniques, behavioral observation and interviews, work sampling, and simulated (or actual) work experience. The suggested components of a quality vocational appraisal should include:

1. Mental ability
2. Academic achievement
3. Fine and gross motor coordination
4. Personality and social maturity
5. Vocational interest and aptitude surveys
6. Vocational adaptive behavior
7. Career maturity

Those who conduct vocational assessment should be aware of the limited number of quality vocational interest, aptitude, and adaptive behavior measures available, and that those available, as well as career maturity inventories, may not contain normative data for various handicapped students or were not standardized for use with junior and senior high school students.

Under the category of Individual Strengths/Weaknesses, the Illinois case study presently requires evaluation of learning processes, i.e., learning style and/or behavioral patterns such as attention, discrimination, memory, multiple sensory integration, concept formation, and problem-solving (23 Illinois Administrative Code 226). This component stems directly from the P.L. 94-142 learning disability definition - ". . . a disorder in one or more of the basic psychological processes. . ." (U.S. Office of Education, 1977, p. 65083). Special education and school psychology research studies have shown that learning disabled students differ from normally achieving children on assessment of attention, linguistic skills, working memory and metacognition (Bryan, Bay, & Donahue, 1988). This abundant literature on distinctions between learning disabled and nondisabled children has generated few fundamental principles for theoretical foundation of, what is currently labeled, information processing. Without a solid theoretical base, theorists and practitioners disagree on the assessment of these learning processes (or information processing components)

and it is most difficult to provide best practices guidelines. Examples of this "assessment dilemma" can be found in the assessment of perceptual-motor skills and in learning styles research.

According to Salvia and Ysseldyke (1985), educators and others have assumed for a long time that adequate perceptual-motor development is important in and of itself and as a prerequisite to academic skill development. But the majority of the research does not support this hypothesis. For example, children with visual-perceptual disabilities, a component of perceptual-motor development, are likely to be rated as problematic in the school setting. What the research has shown is that tests of perceptual-motor performance are unreliable, technically inadequate, and not psychometrically sound. This makes for problematic assessment of perceptual-motor skills. The assessment of other aspects of cognitive behavior - memory, sustained attention, multiple sensory integration, for example also suffer from technically inadequate assessment tools and a lack of empirical support for their usefulness in planning effective interventions.

An "assessment dilemma" exists in evaluation of learning styles, as well. There are few researchers in the area of learning styles (Dunn, 1988). Reading is the primary area of research interest (Carbo, 1983). Specific, separate learning styles appear common to all children and not just to children

with learning disabilities (Shinn-Stricker, 1986). The school psychology and special education literature and assessment texts provide little assessment guidance in this area. Carbo (1983) suggests use of the Reading Style Inventory (Carbo, 1982) and Shinn-Stricker (1986) utilized the Lyon and Associates test battery (Lyon, 1983).

Assessment of adaptive behavior is the central component of the social development study, another component of the present case study evaluation. The definition used in Illinois is: the effectiveness with which an individual functions independently and meets culturally imposed standards of personal and social responsibility (23 Illinois Administrative Code 226). Its definition may be influenced by distinctive norms of an individual's racial and/or ethnic group (therefore the need for adequate cultural background information) and are also dependent upon the individual's progress through the life cycle (Horn and Fuchs, 1987). Its inclusion in case study evaluation stems from the inclusion of adaptive behavior in the current definition of mental retardation - significantly subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior. . . (AAMD, 1983).

Allen-Meares and Lane (1983) suggest an ecological approach to the assessment of adaptive behavior. Reschley (1985) states that adaptive behavior assessment should be guided by the assessor's considerations regarding concept, purpose, and target

population. Several common features in adaptive behavior concepts are - developmental criteria, environmental/cultural conditions, and specific domains such as self-help skills. Further, the purposes for adaptive behavior assessment need to be considered - classification/placement or program planning/intervention decisions. Finally, adaptive behavior assessment needs to consider the target population of one's efforts -- mildly handicapped versus more severly handicapped individuals. Reschley (1985) warns that "adaptive behavior measures are not as technically adequate nor as well developed as measures of cognitive functions" (p. 359). Recent authoritative commentary urges caution in selection/interpretation of adaptive behavior information and the importance of sound clinical judgment and a variety of sources of information. Reschley further offers the following best practices for adaptive behavior assessment of the school-aged child:

ADAPTIVE BEHAVIOR: SCHOOL BASED

Rationale:
1) Mastery of literacy skills is a key developmental task for persons between the ages of 5 and 17.
2) The expectation for and emphasis on educational competencies is common to most if not all major socio-cultural groups.

Assessment:
1) Collection and consideration of a broad variety of information including teacher interview, review of cumulative records, examination of samples of classroom work, classroom observation, results of group standardized achievement tests, results of individual achievement tests, diagnostic achievement tests, and other informal achievement measures.

ADAPTIVE BEHAVIOR: OUTSIDE OF SCHOOL

Rationale:
1) Mastery of a variety of non-academic competencies also is expected, and a key developmental task between the ages of 5 and 17.

2) the expectations for and opportunities to develop non-academic competencies may vary among sociocultural groups.

Assessment:
1) Collection of information on social role performance outside of school in areas such as: peer relations, family relationships, degree of independence, responsibilities assumed, economic/vocational activities

2) Method of collecting data may include informal measures, interviews with parents, interview with student

SUMMARY

The components of the present Illinois case study were organized topically for clarity of discussion and a summary of best practices in assessment was provided for each. The only case study components not supported in the literature were assessment of the learning environment and evaluation of learning processes.

These two components are plagued by little agreement by theorists and practitioners as to theoretic bases, and subsequently, appropriate assessment. There are few technically adequate assessment tools available and best practices guidelines have been difficult to formulate.

Child and parent interviews were not included in the topical organization of case study components, not because they lack significance, but because they are approaches categorized under methodology, not assessment domains. The components of the Illinois case study would be more in line with appropriate assessment practices if those two were expected avenues of methodology, and so documented, but not listed as an assessment component.

Method

Various methodological strategies were employed to collect data addressing the major research questions of this study. Each procedure and data base has been described separately.

A selected literature review was conducted to evaluate assessment of handicapped children procedures research. In addition, best practices publications and position statements from major professional organizations were collected and reviewed.

Survey of the States

State departments of education, including the District of Columbia, (N=51) were asked to submit official documentation of their procedures for identifying handicapped children. Response rate was 100 per cent. The information supplied was analyzed using a meta-analysis process looking at each states requirements relative to: 1) types of assessment data used, 2) personnel involved in the evaluation process, 3) consistency of state procedures with federal guidelines, 4) use of prereferral systems, and 5) types of assessment instruments required.

Higher Education Survey

Illinois institutions of higher education were surveyed regarding training in student assessment procedures (see Appendix A). Institutions training special education teachers (N=18),

school psychologists (N=4), and school social workers (N=4) responded to questions of extent of training for each case study component.

Illinois Districts Survey

Data specific to the Illinois case study was collected by surveying professionals involved in special education evaluation throughout the state (see Appendix B). Directors of special education (N=90) were asked to distribute surveys to the following personnel: 1) regular teacher, 2) regular administrator, 3) special teacher, 4) special administrator, 5) school psychologist, 6) school social worker, 7) speech and language therapist, 8) school nurse, 9) counselor, 10) audiologist, 11) occupational therapist, and 12) physical therapist. Districts reported forty positions not employed and there were 549 useable returns for a 53 per cent return rate. Respondents were asked to rate usefulness of the various case study components and what professional should have primary responsibility for component completion. In addition, respondents were asked to report whether case study requirements should be changed for different ages and/or handicapping conditions.

Results

Survey of the States

All states require a variety of data for the assessment of special needs children (see Appendix C). The only assessment component required by all fifty-one states (see Table 1) was achievement data. Eighty-eight per cent of the states required some form of social/cultural assessment while 82 per cent required regular education teacher assessment. Data on the child's current physical condition was required by 96 per cent of states and adaptive behavior assessment by 88 per cent. Slightly over three-fourths of the states required aptitude testing (78%), psychologicals (82%) and observations (70%). Communication status was required by 58 per cent and developmental history was required by 56 per cent.

Forty-one per cent of the states required some form of academic history. Vocational assessment for secondary students was required by a little more than one-fourth (27%) while assessment of the learning environment was required by a little less than one-fourth of the states (21%). Eight states required a review of the child's current academic performance (15%) while only three states (6%) considered the child's learning style to be an important part of the assessment process. One state required performance measures on the state required basic skills test. Of the fifty-one states, seven gave specific recommendations concerning instruments to be used in the

TABLE 1

Assessment Data Required by States
(N=51)

	N	%
Aptitude measures	40	78
Achievement measures	51	100
Regular classroom teacher assessment	42	82
Physical condition of the child	49	96
Social/cultural condition of child	45	88
Adaptive behavior measures	45	88
Developmental history	29	56
Academic history	21	41
Learning styles of child	3	6
Learning environment of regular classroom	11	21
Communication status of child	30	58
Vocational measures	14	27
Current academic performance	8	15
Performance on state required basic skills tests	1	1
Observations	36	70
Psychological	42	82
Use of state specified instruments	7	14
Parent interviews	42	82
Child interviews	6	12

assessment process (14%). None of these states suggested the best instruments to be used with any one area of disability but each listed suggested instruments. Including parents in the assessment process through interviews was required by 82 per cent of the states and child interviews were required by only 12 per cent of the states. Table 2 summarizes this data as it compared to Illinois case study components.

Relatively few specific personnel were required by the states to participate in the identification process (see Table 3). Only the collective category of "specialized personnel" was required by all of the states. These personnel ranged from audiologists and medical doctors to opthamologists. Because this group encompassed such a variety of personnel and was based upon specific disability areas, it was decided to remove it for comparison purposes. When this category was removed, regular educators and psychologists were evenly distributed as required personnel to be involved in the data collection or evaluation process (82%, 84%). More than half of the states required the involvement of the speech and language therapist (58%). Five states (9%) suggested that schools could use trained paraprofessionals to administer various tests including psychological, vision and hearing tests and academic tests.

State procedures and federal guidelines for nondiscrimination in testing were not entirely uniform (see Table 4). All of the

TABLE 2

State Required Case Study Components
(N=51)

	%
Child interview	12
Parent consultation	82
Social developmental study	56
adaptive behavior	88
cultural background	88
Medical history	
current health status	96
Academic history	41
current educational functioning	100*
Evaluation of learning processes	6
levels of educational achievement	100*
Assessment of learning environment	21
Specialized evaluations	
psychological	82
medical	39
speech and language	57
audiological	41
vocational	29

*undifferentiated item

TABLE 3

Personnel Required by States in Identification Procedures
(N=51)

	N	%
Regular class teacher	42	82
Speech and language therapist	30	58
Psychologist	43	84
Other specialized personnel	51	100
Use of trained paraprofessionals	5	9

Table 4

States Consistent with P.L. 94-142
Nondiscriminatory Guidelines
(N=51)

	N	%
Reevaluation system	51	100
Primary language testing	48	94
Nondiscrimination of instruments	48	94
Notification in primary language	45	88
Multidisciplinary teams	49	96
Validity of instruments	47	92
Use of mutifaceted procedures	50	98
Assessment in related areas	48	94

states required a three year reevaluation with one requiring this reevaluation every two years (Pennsylvania). In all but one state (98%), the use of multifaceted evaluations was required while 96 per cent of the the states required multidisciplinary teams.

Nondiscriminatory procedures in testing and in the tests used were required by 94 per cent of the states. Only 88 per cent required notification in the parents' primary language. Ninety-two per cent of the states (46/50) provided written requirements concerning the validity and reliability of the instruments being used while 94 per cent (47/50) required that these instruments assess all areas related to the suspected handicapping condition.

Due to the increased emphasis on the use of various types of prereferral systems and the focus on adapting regular education curriculum and teaching methods before placement in special education, state requirements in this area were reviewed. Over one-half of the states reporting either suggesting the use of modifications in the regular classroom or requiring their use (57%). Of these 28 states, most required regular classroom modifications for children with learning disabilities or behavior disorders (18). A few provided examples of modifications that could be done at both the elementary and secondary level.

Four of the fifty states required some form of team meeting prior to referral for special education (8%). Of these,

Louisiana requires the use of Teacher Assistance Teams involving the student's regular classroom teacher and two additional staff members. Vermont requires a Basic Staffing Team made up of the regular teacher and specialists in the area of disability. South Dakota requires the use of building level Teacher Assistance Teams made up of the regular classroom teacher and two members of the school staff.

Many states had placement criteria specific to categories of children. For example, Georgia requires prior intervention techniques for mentally handicapped and behavior disordered children. They also require a complete adaptive behavior evaluation for mentally handicapped children, including parent interviews, teacher interviews, observations, and standardized and informal adaptive behavior rating scales. For learning disabled children they require an examination of the students' regular classroom work.

Washington requires an observation of the child by at least two people at separate times and places. Each must cite and corraborate specific behavior problems as part of the assessment of children referred for behavior disorders. The school must also show evidence of at least two attempted intervention techniques. These strategies must be done along with a social history, current academic assessments, vision and hearing screening and a current psychiatric or psychological evaluation.

Idaho sets out their requirements for adaptive behavior with mentally handicapped children by listing the following requirements: motor, communication, self-help, socialization, academic, daily living skills, and vocational skills, along with intelligence testing.

Louisiana utilizes teacher assistance teams that must include the student's regular teacher and two additional staff

members. There must be evidence of communication between the regular teacher and the child's parents before any referral can be initiated. All referrals are made through the building principal who is responsible to the evaluation coordinator. These coordinators can be the educational assessment teacher, school psychologist, speech clinician, educational consultant, social worker, audiologist, occupational therapist. physical therapist or nurse. I.Q. scores cannot be recorded or reported in the individual report and the SOMPA is required if it cannot be proven that the students background is representative of the majority population used in standardizing intellectual measurement instruments. The three year reevaluation must include an interview with the child's family, observations of the child, interview with the child, a vision and hearing screening, interview with the child's classroom teacher and a review of the Individualized Education Program. Idaho also outlines specific evaluation procedures for each handicapping condition.

The State of Montana uses a Case Study Team for the multifaceted evaluation process. This team must consist of an administrator, regular teacher, special education teacher, the parents, a school psychologist (for LD & MR), and medical doctor (for orthopedics), visual consultant for visually impaired, audiologist (hearing impaired), speech pathologist for children with speech impairments and a psychiatrist or psychologist for chidren with behavior disorders.

In Vermont, the Basic Staffing Team, consisting of the regular teacher and a specialist in the handicapping area must collect the typical assessment data and also examines the child's "current life circumstances" including support from peers, family and teachers, and environmental factors that might influence learning and motivation (family, community and school).

Missouri allows diagnostic teaching to be used as a supplement to standardized instruments. The diagnostic teaching process has to describe the information being obtained, how the data will be collected, over what time period and who will do the testing. For each child a diagnostic summary is written and must include the existence and nature of the handicapping condition, the basis for determination (using categorical eligibility requirements), relevant behaviors obtained through an observation, relationship of behaviors to academic functioning, any educational relevant medical findings, effects of environmental, social and economic disadvantages and a signature of the team indicating agreement to the findings.

North Dakota also uses diagnostic teaching as another form of assessment. The use of criterion and curriculum based assessment is strongly recommended as well as the use of ecological based assessments.

Higher Education Survey

More than one-half of the special education teacher training programs in Illinois (N=18) responded to the case study survey (see Appendix A). Table 5 summarize both the amount of instructional emphasis given to each of the case study components and perception of student preparedness to complete case study components.

Highest ratings for instructional emphasis were given to levels of educational achievement (4.63), current educational functioning (4.59), speech and language (4.47), and parent consultation (4.41). Ratings of three or more were given to adaptive behavior, assessment of learning environment (both 3.88), child interview (3.71), cultural background (3.67), psychological (3.5), current health status (3.33), hearing screening (3.17) and vision screening (3.05). Ratings of two or more were given to audiological (2.93), medical (2.88), and occupational therapy and physical therapy (both 2.4).

Ratings of preparedness of students to complete case study components ranged from 1.71 to 4.44. Ratings of four or more were given to current educational functioning and levels of educational achievement (both 4.44). Ratings of three or more were given to parent consultation (3.92), assessment of the learning environment (3.87), cultural background (3.86), child interview (3.8), and adaptive behavior (3.75). Ratings of two or more were given to hearing screening (2.76), current health status (2.75), vision screening (2.53), psychological (2.47), and

TABLE 5

Instructional Emphasis and Graduate Preparedness for Case Study Procedures Reported by Special Education Training Programs (N=18)

	Instruction		Preparedness	
	$\bar{X}$ rating	SD	$\bar{X}$ rating	SD
Child interview	3.71	1.28	3.8	1.11
Parent consultation	4.41	.91	3.99	.86
Social developmental study				
adaptive behavior	3.88	.86	3.75	.97
cultural background	3.67	.94	3.86	.91
Medical history				
current health status	3.33	1.2	2.75	1.08
Vision screening	3.05	1.51	2.53	1.33
Hearing screening	3.17	1.5	2.76	1.35
Academic history				
current educational functioning	4.59	.69	4.44	1.06
Evaluation of learning processes				
levels of educational achievement	4.63	.59	4.44	1.12
Assessment of learning environment	3.88	1.23	3.87	.88
Specialized evaluations				
psychological	3.5	1.32	2.47	1.29
medical	2.86	1.32	1.94	1.18
speech and language	4.47	1.26	2.39	1.22
audiological	2.93	1.39	1.71	.96
occupational therapy	2.4	.88	1.75	.83
physical therapy	2.4	1.08	1.75	.83

speech and language (2.38) Low ratings were given to medical (1.94), occupational therapy and physical therapy (both 1.75) and audiological (1.71).

Two-thirds of the school social work training programs in Illinois (N=4) responded to the survey (see Appendix A) and provided course information Table 6 summarizes both the amount of instructional emphasis given to each of the case study components and perception of program graduates preparedness to take responsibility for completion of case study components.

Highest ratings for instructional emphasis included: adaptive behavior, cultural background and levels of educational achievement (all 4.5). Other high ratings included: assessment of the learning environment (4.25) and current educational functioning (4.0). Ratings of three or more included: child interview and parent consultation (both 3.75), and psychological (3.5). Ratings in the two or more range included: current health status, speech and language, and audiological (all 2.5), and medical (2.25). Low ratings were given to vision screening and hearing screening (both 1.5), and occupational therapy and physical therapy (both 1.25).

Ratings of preparedness of students to complete case study components ranged from 1.5 to 4.5. High ratings (4.0 or more) were given to child interview and parent consultation (4.5), adaptive behavior and cultural background (both 4.25).

TABLE 6

Instructional Emphasis and Graduate Preparedness for Case Study Procedures Reported by School Social Work Training Programs (N=4)

	Instruction		Preparedness	
	$\bar{X}$ rating	SD	$\bar{X}$ rating	SD
Child interview	3.75	.83	4.5	.87
Parent consultation	3.75	.83	4.5	.87
Social developmental study				
adaptive behavior	4.5	.87	4.25	.83
cultural background	4.5	.87	4.25	.83
Medical history				
current health status	2.5	.87	2.25	.83
Vision screening	1.5	.87	1.5	.5
Hearing screening	1.5	.87	1.5	.5
Academic history				
current educational functioning	4.0	0	3.75	.43
Evaluation of learning processes				
levels of educational achievement	4.5	.49	3.75	1.08
Assessment of learning environment	4.25	1.29	3.75	.83
Specialized evaluations				
psychological	3.5	1.5	3.5	1.5
medical	2.25	.43	1.75	.43
speech and language	2.5	.87	1.75	.43
audiological	2.5	.87	1.75	.43
occupational therapy	1.25	.43	1.5	.87
physical therapy	1.25	.43	1.5	.87

Ratings of three or more included: current educational functioning, levels of educational achievement, and assessment of learning environment (all 3.75), and psychological (3.5). Lower ratings were given to current health status (2.25), medical, speech and language, and audiological (all 1.75), vision screening, hearing screening, occupational therapy and physical therapy (all 1.5).

A review of course syllabi and program plans showed specific training in the case study components: social developmental study, academic history, child interview and parent consultation. However, though ranked high by training programs, evidence of training in evaluating learning processes or environments was not found.

More than 40 per cent of the school psychology training programs in Illinois (N=4) responded to the request for information. However, only two programs completed the survey. Ratings for both programs are listed in Table 7.

Highest ratings for instructional emphasis were given to current educational functioning, levels of educational achievement, and psychological (all 5). Next highest ratings were given to parent consultation (5,4), adaptive behavior (5,4), and current health status (4,4). Other ratings included: child interview (5,2), cultural background (4,3), and assessment of the learning environment (5,2). Lower ratings were given to vision screening and hearing screening (both 4,1), speech and language

TABLE 7

Instructional Emphasis and Graduate Preparedness for Case Study Procedures Reported by School Psychology Training Programs (N=2)

	Instruction		Preparedness	
	1	2	1	2
Child interview	5	2	5	4
Parent consultation	5	4	5	5
Social developmental study				
adaptive behavior	5	4	4	4
cultural background	4	3	4	4
Medical history				
current health status	4	4	3	3
Vision screening	4	1	3	1
Hearing screening	4	1	3	1
Academic history				
current educational functioning	5	5	5	5
Evaluation of learning processes				
levels of educational achievement	5	5	5	5
Assessment of learning environment	5	2	5	2
Specialized evaluations				
psychological	5	5	5	5
medical	3	1	2	1
speech and language	3	2	2	2
audiological	3	1	2	1
occupational therapy	3	1	2	1
physical therapy	3	1	2	1

(3,2), and medical, audiological, occupational therapy and physical therapy (all 3,1).

Ratings of preparedness of students to complete case study components ranged from 1.5 to 5.0. High ratings were given to parent consultation, current educational functioning, levels of educational achievement and psychological (all 5,5). Other high ratings included: child interview (5,4), adaptive behavior and cultural background (both 4,4). Lower ratings were given to assessment of the learning environment (5,2) and current health status (3,3). Low ratings were given to vision screening, hearing screening (both 3,1), and speech and language (2,2), medical, audiological, occupational therapy and physical therapy (all 2,1).

A review of syllabi and other course related materials indicated that school psychology training programs included training in some form for all case study components rated high by respondents.

Illinois Districts Survey

School district personnel (N=549) were asked to rate the usefulness of each of the Illinois case study components (see Table 8). These personnel included: regular teacher (33), regular administrator (53), special teacher (49), special administrator (58), school psychologist (59), school social worker (59), speech therapist (50), school nurse (48), school counselor (42), audiologist (22), occupational therapist (33), and physical therapist (43). Mean ratings for usefulness on a 1 (low) to 5 (high) scale ranged from a low of 3.61 for vocational evaluation to a high of 4.63 for current educational functioning. Highest rankings (4.5 or higher) were received by: current educational functioning (4.63), psychological (4.62), parent consultation (4.52), current health status and academic history (both 4.5). Rankings of 4.25 -4.49 were received by: evaluation of learning processes (4.46), medical history (4.45), level of educational achievement (4.44), hearing screening (4.4), vision screening (4.38), and speech and language (4.35). Rankings of 4.0-4.24 were received by: social developmental study (4.24), adaptive behavior and medical (specialized) (both 4.14), and audiological (4.08). Rankings of lower than 4.0 were received by: cultural background (3.94), child interview (3.87), assessment of learning environment (3.81), physical therapy (3.8), occupational therapy (3.77), and vocational (3.61).

Respondents were also asked to indicate which professional or group of professionals should have primary responsibility for

TABLE 8

Rating of Case Study Usefulness
(N=549)

	$\bar{X}$ rating	SD
Child interview	3 87	1.29
Parent consultation	4.52	.88
Social developmental study	4.24	1.04
adaptive behavior	4.14	1.08
cultural background	3.94	1.14
Medical history	4.45	.88
current health status	4.5	.86
Vision screening	4.38	.96
Hearing screening	4.4	.96
Academic history	4.5	.85
current educational functioning	4.63	.82
Evaluation of learning processes	4.46	.95
levels of educational achievement	4.44	.94
Assessment of learning environment	3.81	1.19
Specialized evaluations		
psychological	4.62	.85
medical	4.14	1.16
speech and language	4.35	.97
audiological	4.08	1.15
vocational	3.61	1.27
occupational therapy	3.77	1.28
physical therapy	3.8	1.27

each of the separate case study components (see Table 9). Those groups indicated by at least 10 per cent of respondents were, child interview: psychologist (55%), social worker (44%), regular teacher (26%), and speech therapist and counselor (both 20%). Parent consultation: social worker (61%), psychologist (30%), regular teacher (25%), special teacher (17%), counselor (15%) and regular administrator (10%). Social developmental study: social worker (71%) and psychologist (10%). Adaptive behavior: social worker (62%) and psychologist (18%). Cultural background: social worker (65%) and psychologist (10%). Medical history: nurse (65%), physician (27%) and social worker (12%). Current health status: nurse (58%) and physician (23%). Vision screening: nurse (83%) and physician (14%). Hearing screening: nurse (65%) and audiologist (27%). Academic history: regular teacher (48%), special teacher (25%), psychologist (18%), counselor (13%) and regular administrator (10%). Current educational functioning: regular teacher (53%), special teacher (31%) and psychologist (22%). Evaluation of learning processes: psychologist (56%), special teacher (32%) and regular teacher (25%). Levels of educational achievement: psychologist (44%), special teacher (30%) and regular teacher (28%). Assessment of learning environment: psychologist (38%), special teacher (29%), regular teacher (26%), regular administrator (17%), social worker (14%) and special administrator (11%). Specialized evaluation

TABLE 9

Primary Responsibility for Case Study Component Completion (N=549)

	%												
	Regular Teacher	Regular Admin.	Special Teacher	Special Admin.	Psychologist	Social Worker	Speech & Lang.	Nurse	Counselor	Audiologist	OT	PT	Physician
Child interview	26	3	20	3	55	44	9	4	20	4	4	4	3
Parent consultation	25	10	17	9	30	61	5	7	15	3	3	3	3
Social developmental study	4	0	3	1	10	71	1	2	6	0	0	0	0
adaptive behavior	0	1	6	1	18	62	1	2	5	0	2	1	1
cultural background	4	1	2	1	10	65	2	5	6	0	0	0	1
Medical history	1	0	1	1	3	12	2	65	1	4	3	4	27
current health status	2	1	1	1	2	8	1	58	1	2	1	1	23
Vision screening	1	0	1	1	0	0	2	83	5	4	0	5	14
Hearing screening	1	0	1	0	1	0	4	65	0	27	0	0	9
Academic history	48	10	25	4	18	5	1	0	13	0	0	0	0
current educational functioning	53	4	31	3	22	2	2	0	6	0	0	0	0
Evaluation of learning processes	25	2	32	5	56	2	2	4	3	1	1	1	0
levels of educational achievement	28	1	30	4	44	2	1	0	5	1	1	0	1
Assessment of learning environment	26	17	29	11	38	14	2	0	6	1	2	1	4
Specialized evaluations													
psychological	1	0	2	1	87	1	0	3	1	0	3	0	2
medical	1	4	1	0	1	2	2	37	1	2	2	2	63
speech and language	1	0	3	1	1	1	83	2	0	7	0	0	2
audiological	1	0	1	1	0	0	7	11	1	74	1	4	4
occupational therapy	0	0	1	0	0	1	0	1	0	1	82	4	3
physical therapy	0	0	1	0	1	0	0	1	0	1	5	76	6

and professionals indicated included, psychological: psychologist (87%). Medical: physician (63%) and nurse (37%). Speech and language: speech therapist (83%). Audiological: audiologist (74%) and nurse (11%). Occupational therapy: occupational therapist (82%). Physical therapy: physical therapist (76%).

Respondents were also asked how case study requirements should be modified by handicapping condition, severity of handicap and age of the handicapped child. Forty-four individuals did not respond to this item and 47 indicated that all components should be required without modification (both approximately 1%). Table 10 summarizes the responses of those who indicated the need for case study modifications (N=459). Suggested modifications for mild speech/language: no social developmental study (43%), no assessment of the learning environment (42%) and no psychological (specialized evaluation) (58%). For mild LD: no social developmental study (15%) and no psychological (23%). For severe/profound mental retardation: no levels of educational achievement (19%) and no assessment of the learning environment (20%). For physical/sensory handicaps (visual, hearing, physical and health impairments): no social developmental study (18%), no levels of educational achievement (13%) and no psychological (32%). For early childhood (all categories): no child interview (25%). For vocational evaluation (specialized evaluation): secondary (high school) only (11%).

TABLE 10

Modifications of Case Study Requirements
(N=459)

	Regular Teach	Regular Admin	Special Teach	Special Admin	Psychologist	Social Worker	Speech & Lang	Nurse	Counselor	Audiologist	OT	PT	All
	N=22	42	43	51	54	49	46	36	25	18	26	34	
Mild speech and language													
no social/developmental	59	62	37	63	44	43	37	39	37	28	8	35	43
no learning environment	32	45	37	69	48	39	43	50	34	28	15	29	42
no psychological	55	67	56	86	65	61	70	56	60	61	31	32	58
Mild LD													
no social/developmental	27	19	19	31	11	4	15	25	14	6	0	15	15
no psychological	23	33	19	37	17	16	35	22	17	28	15	15	23
Severe MR													
no achievement	23	14	9	49	17	18	26	11	11	17	8	6	19
no learning environment	23	26	16	49	17	12	24	14	11	6	12	6	20
Physical/Sensory													
no social/developmental	41	21	12	35	9	8	22	14	17	11	0	24	18
no achievement	9	20	16	37	7	8	13	8	6	11	0	3	13
no psychological	27	29	19	39	26	37	41	39	43	28	15	26	32
Early childhood													
no child interview	9	26	30	31	46	24	15	17	9	28	19	24	25
Vocational evaluation													
secondary only	32	7	9	16	13	10	9	11	0	11	8	6	11
Specialized evaluations													
as needed basis	86	90	67	92	81	53	67	39	26	39	58	50	66

The overall category of specialized evaluation was targeted on an as needed basis (66%).

Questions and concerns regarding the case study process not addressed by the questionnaire were developed for inclusion in the survey by both members of the research team and the technical advisory committee (see Appendix B). Responses using a 1 (strongly agree) to 5 (strongly disagree) scale are found on Table 11. Statements that parents have an important role in the evaluation process and that the case manager should be responsible for monitoring case study completion received the highest positive ratings (1.55 and 1.92). High agree ratings were given the statement that a school psychologist should always be involved in the case study (2.05) and the statement that verified the important difference between a psychological examination and a case study evaluation (2.08).

Medium agree ratings were given to the statements: 1) my training was adequate for evaluation responsibility (2.20), 2) ISBE compliance review procedures are clear (2.23), 3) multidisciplinary team members should have equal say in evaluation decisions (2.28), and 4) special education entrance/exit requirements should be prescribed by ISBE (2.28). Lower agree ratings were given to the statements: 1) the school social worker should always be involved in the case study (2.41), 2) a multidisciplinary evaluation is needed by all special education referrals (2.47), 3) case study components should be specified by ISBE (2.52), 4) adaptive behavior should

TABLE 11

Evaluation Procedures Questions
(N=549)

	$\bar{X}$ rating*	SD
Adequacy of evaluation training	2.20	1.14
Clear compliance review procedures	2.28	1.02
Multidisciplinary evaluation for all referrals	2.47	1.39
Equal say for team members	2.28	1.23
School social worker always involved	2.41	1.25
School psychologist always involved	2.05	1.15
Case study components specified by ISBE	2.52	1.20
Entrance/exit criteria prescribed by ISBE	2.28	1.19
Staff evaluation training district responsibility	2.72	1.18
Parents important in evaluation process	1.55	.74
Curriculum based assessment needed alternative	2.58	1.01
Standardized adaptive behavior instrument use	2.52	1.02
Cultural background of child/professional match	3.56	1.01
Nondiscriminatory evaluation to safeguard minorities	2.53	.96
Evaluation practices well defined and consistent	3.12	1.07
Psychological and case study significantly different	2.08	.99
Case manager responsible for case study completion	1.92	.91

*Rating scale: 1-strongly agree, 2-agree, 3-undecided, 4-disagree, 5-strongly disagree

be measured using a standardized instrument (2.52), 5) the importance of nondiscriminatory evaluation procedures to safeguard minority students (2.53), 6) curriculum based assessment is an important evaluation alternative (2.58), and 7) staff training in evaluation procedures should be a local district responsibility (2.72). Lowest agree ratings were given to the statements, evaluation practices are well defined and consistently applied (3.12) and children should be evaluated by someone with a similar cultural background (3.56).

Discussion

Survey of the States

Of the fifty-one states (including the District of Columbia) contacted, all returned the information requested. The most often used assessment data (75% or more of the states) included criterion-referenced assessment, grades, curriculum based assessment), assessment of the child's current physical condition including vision and hearing screening, adaptive behavior assessment, aptitude measures, and psychologicals.

The least used assessment measures (30% or less of the states) involved state required basic skills tests, learning style assessment, current academic performance, assessment of the learning environment and vocational assessment.

From the data analyzed relative to the types of assessment information required by the states it would seem that the traditional psychoeducational system used for assessing the needs of handicapped children is still a strong force in the data collection field. Less than half the states required information on the child's learning environment, learning style, home environment, communication status, vocational status, current academic performance or developmental history. The emphasis is on achievement, classroom performance, adaptive behavior, physical condition and social/cultural background. States that require pre-referral systems have broadened their assessment

requirements to include more of the learning environment and learning style data on the child.

P.L. 94-142 was designed to provide parents with more input concerning their child's educational program, however, only 42 of the 51 states required parent interviews at the assessment stage. Only 6 of 51, required some form of child interview. Obviously, the assessment focus remains with the professionals involved in the educational process. Specialized personnel were required by all the states with the type of personnel depending on the type of suspected condition. The two most often found groups were the school psychologist and the speech/language therapist. However, five states did allow the use of trained paraprofessionals in the assessment process. Based on this data, the personnel most often making up the assessment team are: special education teacher, regular education teacher, school psychologist and speech/language therapist, with specialized personnel as needed.

It is interesting to note that not all states met the federal requirements relative to nondiscriminatory procedures in testing. While all the states did have requirements in the areas of re-evaluation 49/51 had written information regarding the use of multidiciplinary teams for assessment. No requirements were found for administering tests in the child's primary language in three of the fifty one states nor was information found for instruments that did not discriminate in three of the fifty. While all but one state had requirements for using multifaceted

evaluation procedures, only 48 of the fifty-one had requirements specifically indicating the need to assess related areas. Also of importance is the information concerning notification in the primary language of the home. In six of the fifty-one states no information was found to indicate an requirements for making sure the written notification concerning evaluation was in the primary language of the child's parents. Since these nondiscriminatory procedures are part of the federal approval process for state plans, we would hope the documents reviewed for this study were not inclusive for these six states.

In light of the increased awareness of the need to make adjustments in a child's regular curriculum before referral to special education evaluation it would seem important that states require or at least recommend pre-referral systems to the school districts serving children in that state. However, the data analysis does not support this. Only four of the fifty-one states had required pre-referral team meetings. While 57 percent of the states (29/51) required some form of modification of the regular classroom most of these were in the area of learning disabilities and behavior disorders and were left up to the discretion of the regular classroom teachers. Numerious researchers have referred to the difficulties that regular educators have in choosing appropriate intervention techniques to use with special needs children (Kauffman, Gerber & Semmel, 1988; Reynolds, 1988; Shinn, Tindal & Spira, 1987), attitudes towards

pre-intervention (Stephens & Braun, 1980), and the need for competencies to successfully implement pre-intervention procedures (Larrivee & Vacca, 1962). In an analysis of prereferral interventions used by teachers with behavior disordered children Sevcik and Ysseldyke (1988) found that while teachers did use direct intervention (i.e., measuring progress to plan intervention, providing feedback on expectations and planning contingency programs) there was a heavy reliance on the use of specialists for information and services (p.110). Only four of the fifty-one states (18%) required or recommended prereferral teams to assist the regular educator in developing these intervention strategies. While states are moving towards requiring regular educators to plan prereferral interventions, they do not seem to be providing regulations that would assist these teachers with the support they need in developing and implementing these techniques.

While none of the states mandate specific tests to local school districts, seven of the states (14%) did make strong suggestions concerning which tests to use in measuring various conditions. These suggestions usually took the form of a menu of suggested instruments from which assessment personnel could choose.

In summary, the following profile could be developed from the data provided by the states. Special education evaluation still relies heavily on psychoeducational methods. While some

states are recommending curriculum based assessment and criterion referenced testing, most still rely on traditional psychoeducational evaluations with an emphasis on achievement testing. Measures of adaptive behavior are becoming more prevalent but still not required in 12 per cent of the states. The background of the child relative to social and cultural influences is seen as important by a majority of the states as well as the child's current health status.

The use of parent and child input is still not seen as a vital component in the assessment process. While a few states are looking at the use of trained paraprofessionals for collecting assessment data, there is still a heavy reliance on input from the regular education teacher and the school psychologist.

With this heavy reliance on the regular educator for providing assessment information to the evaluation team, many of the states also require the regular educator to modify current classroom procedures and curriculum before complete a can take place. Yet with this requirement, few states require the establishment of teacher assistance teams to help these teachers perform appropriate classroom modifications and to moniter those modifications.

Higher Education Survey

Special education training programs indicated that special education teachers are best prepared to assess educational functioning and levels of educational achievement. This report is not surprising and this role for the special education teacher in the assessment process is consistent with their role in programming. Likewise, school social work training programs reported the social developmental study (including both adaptive behavior and cultural background), an area associated with social work services, as the appropriate function of their graduates. School psychology training programs claimed a broader array of activities for their graduates: child interview, parent consultation, educational functioning and levels of achievement and the psychological examination. This claim is a match with the perception that the role of the school psychologist is basically one of assessment and diagnosis. That each group claims some special expertise is expected. There was, however, considerable overlap in program report.

All three groups rated preparedness of graduates as above average in the areas of: child interview, parent consultation, social developmental study, current educational functioning, levels of educational achievement and assessment of the learning environment. This overlapping training suggests the possibility of considerable flexibility in assigning multidisciplinary team

members to specific case study components. It is also possible that representatives from each of these groups would not be necessary for each special education referral.

It is also of interest to note that all of the groups indicated some preparedness for case study components that are not traditionally associated with their profession. Ratings of more than one were recorded for vision and hearing screening, and some of the medically related specialized evaluations. There can be no question that these evaluations should be included in the list of topics in assessment coursework. However, considerable concern should be expressed when higher education training programs in special education, school social work and school psychology begin to suggest abilities that are not corraborated by either professionally developed best practices or by the report of practitioners.

Illinois Districts Survey

The survey data collected from professionals in the field were reported along four distinct lines. While each of these could be discussed separately it is useful to discuss the results in an integrated fashion taking those case study components that received higher ratings and progressing downward to those with lower ratings. It is important to note that all of the components were perceived as useful when ratings were compared.

The most useful components of the case study seemed to center around the more traditional assessment approaches which was consistent with data from the states survey. Assessment of current educational functioning, psychological evaluation, levels of educational achievement and evaluation of learning processes were all four perceived as highly useful. Of these four components, current educational functioning and evaluation of learning processes were considered to be important for all categories and ages of handicaps. There was indication that psychological evaluation is not needed for children and youth with mild speech/language delays, mild learning disabilities, and physical/sensory impairments. Of these three categories the lack of need was seen most in the speech/language and sensory/physical areas. In the latter of these two, the respondents also saw little need for achievement data. It may be that, at least for the two areas referred to, practitioners view the problems as not

related to academic and/or learning but rather to physical problems and thus intelligence and achievement are not perceived as crucial to the assessment profile. Interestingly enough, there were a percentage of respondents indicating no need to conduct psychological evaluations with mild learning disabled children. The operative word here might well be "mild". Perhaps the continued flux relating to the definition of learning disabilities is causing professionals to move away from intelligence assessment for children in such an open ended category.

It is interesting to note that of these four components (current educational functioning, psychological, educational achievement and learning processes), three were perceived to fall under the jurisdiction of the school psychologist. Evidently there is still a strong belief that information relative to those areas is best obtained by school psychologists. Only current educational functioning was perceived to be an area where regular educators and special educators could collect information.

This traditional psychoeducational approach to evaluation is probably deeply rooted in the current concept of assessment. While many authors and some states are suggesting criterion based and curriculum-based assessments, professionals still perceive the need for specialized diagnostic services to be provided by the school psychologist. It seems obvious that professionals want information that not only accesses academic aptitude and

achievement but also feel the data concerning how a child learns is important. However, either they do not feel competent in the collection of such data and thus rely heavily upon the school psychologist or there is still a strong belief in the value of intelligence testing as a measure of academic or school based performance.

The impact of P.L. 94-142 can be seen through the high rating of parent consultation. Not only did this component rank high in usefulness but it was also perceived as being important to the evaluation process. Again, while many professionals rated this component as useful and important, the onus for collecting this data was placed upon the social worker and the school psychologist. It may well be that parent consultation is not really perceived as a cooperative sharing experiences but rather as an assessment of the home environment. The intent of consultation as outlined in 94-142 is to provide parents with input into their child's educational program and to develop a partnership between home and school. The heavy reliance on specialized personnel to obtain data from parents may not necessarily provide this. Of the direct educational service personnel involved in a child's program the special education teacher was perceived as the least responsible, behind the regular education and special education administrators. Perhaps special education teachers perceive themselves and are perceived by others as being too involved in the child's educational

program to discuss parent input relative to assessment or, perhaps, as alluded to earlier, parent involvement is not perceived as an assessment collection process as intended in 94-142 but as a means to access the child's home environment. It is important to note that the special education teacher was not perceived as having strong primary responsibility for any of the case study components. It seems, at least within the State of Illinois, special education teachers are perceived as having a job description that does not include the collection of assessment data.

Two other case study components that rated high were those of medical and academic history. As with two of the previous components, both of these were seen as important for all categories and ages. The emphasis on these two areas would seem to support earlier contentions that the trend is still towards the more traditional evaluation methods. Special education and related service personnel still have a heavy reliance on the need to view the history of a child being referred. It was not surprising to find that the nurse was seen as the primary person responsible for collecting the medical data even though this could be supplied by the family physician. Also not unusual was the focus on the regular educator to provide information on the academic history of the child. This reliance on the nurse for medical history and the regular teacher for academic history appears to be a simple case of assigning data collection responsibility to the professional closest to the data.

interpretation by the nurse is obvious, but what about the reliance on the regular teacher for interpretation of academic history. Perhaps, special education professionals perceive that the regular teacher is more of an expert on the regular education curriculum and that he/she is needed to interpret this information.

Four components that were rated high but lower than the five perviously discussed were those of social developmental study, adaptive behavior, cultural background and specialized evaluations.

Social development was not considered important for mild speech/language, mild learning disabled and physical/sensory problems, while adaptive behavior and cultural background were perceived as not needing modifications. It would seem that the collection of social development data is useful except in mild cases or in the case of physical/sensory impairments. This might indicate a lack of understanding of just what is involved in the social developmental component. Certainly, knowledge of developmental history would be important for a child with a language delay. This type of confusion does not seem to stop with social development but seems to permeate the whole domain of

what could be referred to as out-of-school factors, including adaptive behavior and cultural background.

The area of adaptive behavior has long been one of concern for professionals. Questions arise in the literature relative to quantitative and qualitative measurements of a students behavior. Concerns over cultural considerations, environmental constraints and validity/reliability measures often cause confusion and hesitation over the use of standardized measures for assessing adaptive behavior. These concerns are reflected in the survey results. Indeed, while the mean ranking for usefulness was high, twelve other components ranked higher. Sixty-two per cent of the respondents indicated that the social worker had primary responsibility for collecting adaptive behavior information. This was also the case for cultural background and parent consultation. These three areas when linked to social development form the core of primary responsibility in the case study for the social worker. Respondents, while agreeing (4) that social workers should always be involved in the case study process, did not strongly agree (5) to this. And yet, four major components of the case study, one of which ranked within the top group and two of which also held mean rankings above 4.0, were perceived as falling under the domain of the social worker in over 60 per cent of the respondents views. It would certainly seem that aspects of the child that are considered outside the schools domain (i.e., community) are perceived as not being best evaluated by persons based in the school.

Two of the case study components rated lower than the others in terms of their usefulness; assessment of learning environment and child interview. Of these two, learning environment assessment was seen as not needed in two categories, mild speech/language and severe mental retardation. However, it must be pointed out that the percentages in the mental retardation category were low and may have been impacted by the high ratings of the regular education administrators who indicated that the case study needed modification across all categories. It seems that the regular education administrator sees little value in many of the components. This lack of perceived need may be due to the inadequate training received in programs that provide administrators to the public schools. Few, if any, training programs provide information on special education assessment for regular administrators. This lack of knowledge would certainly affect perceptions of need.

While the child interview also rated lower that other case study components in usefulness, it was only recommended for ommission in one area (early childhood). The school psychologist and social worker were perceived as the most likely professionals to conduct the interview showing again the reliance on specialists to collect data.

In summary, while all the components of the case study were rated as useful, those that were psychoeducational and medical ranked as more useful than those that were sociological/

environmental. The reliance on specialists, especially the school psychologist and social worker, for collecting and interpreting assessment data was obvious. The apparent lack of inclusion of special educators in the assessment process was disconcerting Apparently, special education teachers are not perceived as an important part of the diagnostic team as it relates to the case study. Also obvious was the distinct lack of inclusion of the administrators in the case study process. Given their perceptions of what is or is not needed, perhaps including these personnel is more important than was previously suspected.

Recommendations

1. The present "state of the art" in assessment of learning processes and evaluation of the learning environment is problematic at best. Though it has been suggested that data from these areas would be helpful in the overall assessment process, the supporting research base is sparse and inconclusive. There is presently only theory to recommend assessment in these areas. These components should be eliminated from the case study until such time as there is more empirical support for the concepts and reliable methods of assessment in these two domains.

2. The child interview is seen in the literature and by Illinois practitioners as an important aspect of the case study. Likewise, parent consultation is viewed as an important case study component. These two activites should be retained but it is important that they be considered as methods of assessing rather than as case study components. To ensure their inclusion in the case study, it is suggested that the child interview and parent consultation be required methods of data collection during the case study of a child referred for special education services.

3. Nearly three-quarters of the states require observation of the referred child. Best practices guidelines and research literature support this practice. An observation of the child referred for special education should be a requirement in the case study evaluation process.

4. The remaining case study components - social developmental study (adaptive behavior and cultural background), medical history, vision and hearing screenings, academic history and specialized evaluations - should be reorganized into three assessment domains:

a. Health status

history
current status
vision and hearing
specialized evaluations

b. Academic information

history
current levels of functioning
learning environment

c. Individual strengths/weaknesses

language
psychological
intelligence
social development

Though the importance of any particular piece of information is not debated, it is important to remember that only information that is needed to plan an appropriate educational program is required. The decision about what information should be collected should be left to those knowledgeable professionals who make up the multidisciplinary evaluation team

5. The determination of who on the assessment team does what should be based on the individual skills of the team members and accessibility to the student, records, family and the school setting. It was apparent from the various data sources used for this study that all three disciplines (special education, school psychologists and social workers) are being prepared to do adaptive behavior assessment, health history and status, and behavioral assessment. Some disciplines have clear specialties, such as intellectual and psychological assessment by school psychologists, academic performance by special educators, and social development by social workers. Assignment of role and responsibility in the case study should ignore discipline territoriality and instead utilize the various strengths of team members on a case-by-case and need basis.

6. There is strong support in this state for a case study manager. Those professionals currently best prepared to assume this role include the special education teacher, school psychologist and school social worker. Others, with appropriate training, could reasonably be expected to serve as a case study manager. The consultation skills needed for effective management are usually acquired. To ensure effective case management in the special education assessment process, the State Board of Education should initiate the necessary training activities.

7. Data from the survey of Illinois school district personnel suggests an apparent lack of knowledge on the part of regular education administrators about the case study process. There is no question that this situation can impede the successful implementation of a strong case study model. Both preservice and inservice training in case study components and quality assessment issues is recommended for regular education administrators with supervisory responsibility for special education programs.

8. The data supports the existing modification of the case study for children with speech and language impairments. A thorough evaluation of speech and language skills would be an appropriate substitute for the full case study. A rating of classroom functioning through use of a behavior rating scale completed by the teacher should also be included, along with some information from the family regarding history of speech language history.

9. Regular classroom teachers in a vast majority of states are involved in the assessment process. The literature supports their inclusion in curriculum-based assessment of student need. It is recommended that the regular teacher be an assessment team member, not merely an information source.

10. Consistent with regular teacher membership on the assessment team and one of the aims of the Regular Education

Initiative is the concept of prereferral interventions. It is recommended that Illinois initiate in-service programs on the teacher assistance team model as well as classroom instructional adaptations.

11. In the assessment of adaptive behavior, the literature supports both norm-referenced and informal assessment. The survey indicated that practitioners are asking for guidance. It is recommended that adaptive behavior assessment be required to include an appropriate norm-referenced measure and supportive informal assessment from both in-school and out-of-school sources. Gathering of such adaptive behavior information can be done by either the school social worker, school psychologist, the special education teacher, or some combination of the three.

12. It is apparent from the review of social work programs that ISBE lacks rules regarding the specific coursework required for an approved training program in school social work. This made an evaluation of the programs somewhat difficult. No documentation was available to substantiate school social work trainers ratings that their graduates were prepared to assess learning environment and processes and current academic functioning. The material shared by the training programs did not substantiate training in basic measurement and assessment concepts. It is recommended that ISBE establish required coursework, to include a basic graduate level course in measurement, for all approved school social work training programs.

13. Practitioners in Illinois indicated strong support for state mandated entrance and exit criteria for the special education categories. Developing these criteria would place Illinois with the vast majority of states who have established criteria for learning disabilities, behavior disorders and mental retardation. A state-wide standard for special education program entrance and exit would, in great measure, ensure equal access to special education services.

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Appendices

A. Higher Education Survey

B. Local District Survey

C. Survey Results of State Departments of Education

CASE STUDY SURVEY
HIGHER EDUCATION

Does your training program provide instruction on completing the case study evaluation as prescribed in the Illinois Rules and Regulations?

___YES ___NO

If you answered yes, please complete the following items:

1. Please rate the amount of instructional emphasis given each component of the case study from 1(mild emphasis) to 5(strong emphasis);

2. Also, please indicate whether this instruction is provided in your evaluation of handicapped children course or whether instruction on the case study evaluation is provided within other courses.

	1	2	3	4	5	Eval. Course	Other Course
1. Child Interview							
2. Parent Consultation							
3. Social Developmental Study							
adaptive behavior							
cultural background							
4. Medical History							
current health status							
5. Vision Screening							
Hearing Screening							
6. Academic History							
current educ. functioning							
7. Eval. of Learning Processes							
levels of educ. achievement							
8. Assessment of Learning Envir.							
9. Specialized Evaluations							
psychological							
medical							
speech and language							
audiological							
10. Vocational							
OT							
PT							
Other (specify)_____							

CASE STUDY SURVEY
HIGHER EDUCATION
PAGE 2

Based on the type and amount of instruction your students receive on the case study evaluation, please indicate those components your students are best prepared to take responsibility for.
(1 = least prepared to 5 = best prepared)

	1	2	3	4	5
1. Child Interview					
2. Parent Consultation					
3. Social Developmental Study					
adaptive behavior					
cultural backgrou					
4. Medical History					
current health status					
5. Vision Screening					
Hearing Screening					
6. Academic History					
current educ. functioning					
7. Eval. of Learning Processes					
levels of educ. achievement					
8. Assessment of Learning Envir.					
9. Specialized Evaluations					
psychological					
medical					
speech and language					
audiological					
10. Vocational					
OT					
PT					
Other (specify)_____					

Please attach a sample syllabus for your evaluation of handicapped children course.

Thank you.

CASE STUDY SURVEY

WIU 1989

Position	Education	Certification	Years of Experience
	BA__ MA__ Doctorate__	__regular teaching __special teaching __administrative __pupil personnel services	0-2 __ 3-5 __ 5+ __

I. Illinois requires a case study evaluation for each special education placement. Please rate the usefulness of each component (1 - low to 5 - high).

	1	2	3	4	5	RETAIN	DELETE	
1. Child Interview								(1)
2. Parent Consultation								(2)
3. Social Developmental Study								(3)
adaptive behavior								
cultural background								
4. Medical History								(4)
current health status								
5. Vision Screening								(5)
Hearing Screening								
6. Academic History								(6)
current educ functioning								
7. Eval of Learning Processes								(7)
levels of educ achievement								
8. Assessment of Learning Envir								(8)
9. Specialized Evaluations								(9)
psychological								
medical								
speech and language								
audiological								
vocational								
OT								
PT								
Other (specify) _____								

Are there additional evaluations that you think should be included?
Please specify _____

II. What professional group should have a primary (P) role in completing each component? Who should have secondary (S) roles? More than one group can be marked primary and/or secondary for each component. Please mark P or S for each component/group.

	Reg Teacher	Reg. Admin	Special Teacher	Special Admin	Psychologist	Social Worker	Speech Ther	Nurse	Counselor	Audiologist	OT	PT	Physician	
1. Child Interview														(1)
2. Parent Consultation														(2)
3. Social Developmental Study														(3)
adaptive behavior														
cultural background														
4. Medical History														(4)
current health status														
5. Vision Screening														(5)
Hearing Screening														
6. Academic History														(6)
current educ functioning														
7. Eval of Learning Processes														(7)
levels of educ achievement														
8. Assessment of Learning Envir														(8)
9. Specialized Evaluations														(9)
psychological														
medical														
speech and language														
audiological														
vocational														
OT														
PT														
Other (specify) _____														

CASE STUDY SURVEY

III Should case study requirements be modified by handicapping condition, severity, and age (EC-early childhood, EL-elementary, JH-junior high, HS-high school)? Mark those components you think necessary for evaluating each group

	Mild SLD				Severe SLD				Mild BD				Severe BD				Mild MR				Mod MR				Severe/ Profound MR			
	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS
a. Child Interview																												
b. Parent Consultation																												
c. Social Developmental Study																												
adaptive behavior																												
cultural background																												
d. Medical History																												
current health status																												
e. Vision Screening,																												
Hearing Screening																												
f. Academic History																												
current educ functioning																												
g. Eval of learning Processes																												
levels of educ achievement																												
h. Assessment of learning envir																												
i. Specialized Evaluations																												
psychological																												
medical																												
speech and language																												
audiological																												
visual																												
OT																												
PT																												
Other (specify) __																												

(1) (2) (3) (4) (5) (6) (7) (8) (9)

CASE STUDY SURVEY

III. Should case study requirements be modified by handicapping condition, severity, and age (EC-early childhood, EL -elementary, JH-junior high, HS-high school)? Mark those components you think necessary for evaluating each group

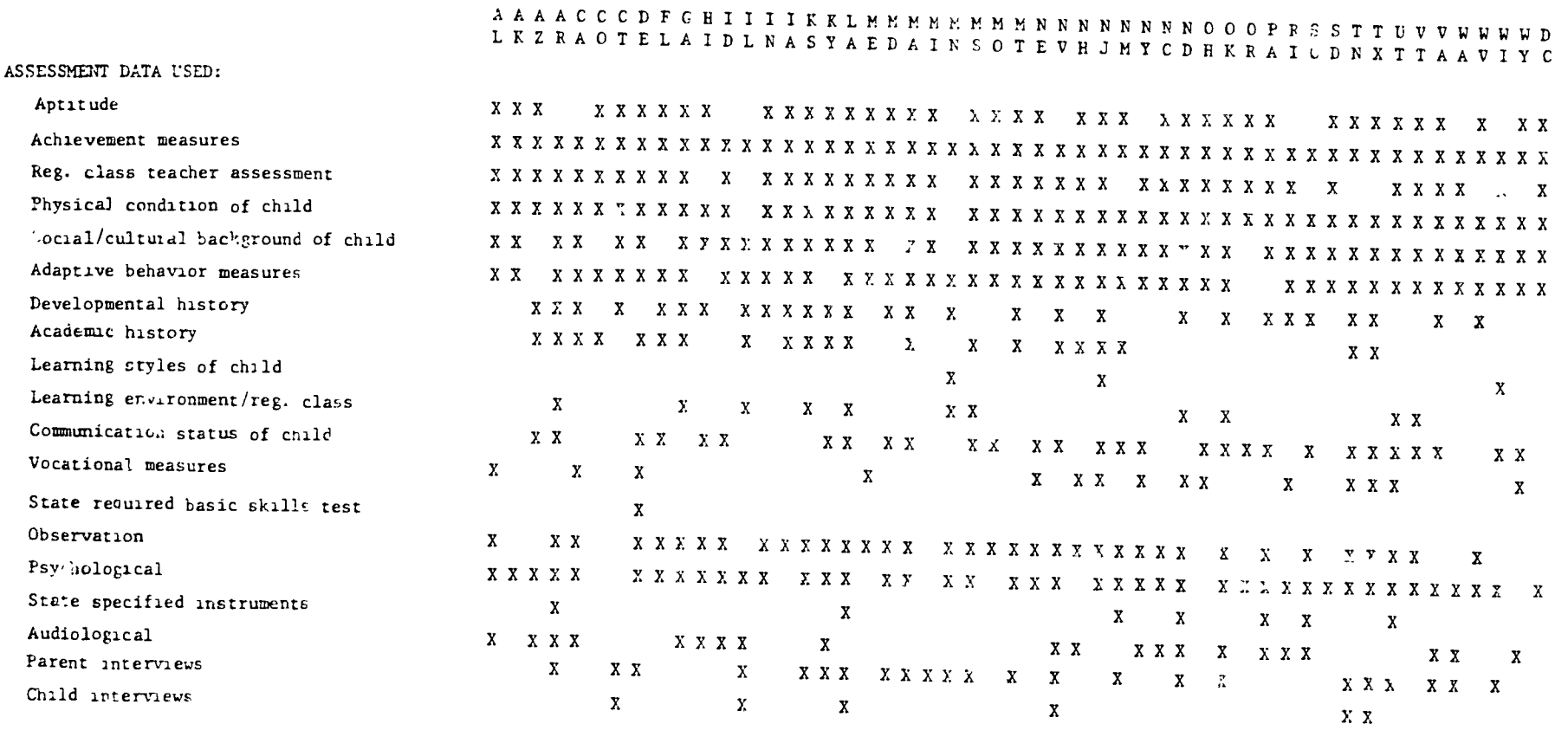
	Mild Speech/ Lang				Severe Speech/ Lang.				Visual Impair				Hearing Impair				Phys & Health Impair.				Multiple Impair				
	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	EC	EL	JH	HS	
1 Child interview																									(1)
2 Parent Consultation																									(2)
3 Social Developmental tudy																									(3)
adaptive behavior																									
cultural background																									
4 Medical History																									(4)
current health status																									
5 Vision Screening																									(5)
Hearing Screening																									
6 Academic History																									(6)
current educ functioning																									
7 Eval of Learning Processes																									(7)
levels of educ achievement																									
8 Assessment of learning Envir																									(8)
9 Specialized Evaluations																									(9)
psychological																									
medical																									
speech and language																									
audiological																									
vocational																									
OT																									
PT																									
Other (specify) _____																									

CASE STUDY SURVEY

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1 The assessment and evaluation sequence of my professional training was adequate to my responsibilities in the case study evaluation	1	2	3	4	5
2 Illinois State Board of Education (ISBE) compliance review procedures for the case study evaluation are clear.	1	2	3	4	5
3 A multidisciplinary evaluation should be completed for all special education referrals	1	2	3	4	5
4 All members of the multidisciplinary evaluation team should have an equal say in the decision-making process	1	2	3	4	5
5 A school social worker should always be involved in the case study evaluation.	1	2	3	4	5
6 The ISBE should specify the specific components to be completed for each case study	1	2	3	4	5
7 The ISBE should adopt clear entrance/exit criteria for each handicapping condition	1	2	3	4	5
8 Local districts should have the primary responsibility for staff training in evaluation procedures	1	2	3	4	5
9 Parents have an important role in the case study evaluation process	1	2	3	4	5
10 Curriculum-based assessment is an important alternative to traditional psychoeducational evaluation procedures.	1	2	3	4	5
11 A school psychologist should always be involved in the case study evaluation.	1	2	3	4	5
12 Adaptive behavior should be assessed using a standardized instrument	1	2	3	4	5
13 The evaluation of cultural background should be completed by a professional with the same background as the child being evaluated	1	2	3	4	5
14 Nondiscriminatory evaluation requirements and procedures are adequate to insure appropriate identification and placement of minority handicapped children	1	2	3	4	5
15 Best practices for evaluating handicapped children are well defined and consistently applied	1	2	3	4	5
16 A psychological examination is significantly different from a case study evaluation	1	2	3	4	5
17 The case manager should be responsible for monitoring the completion of the case study	1	2	3	4	5

COMMENTS

STATE MANDATED ASSESSMENT DATA



STATE MANDATED IDENTIFICATION PROCEDURES