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ABSTRACT

Intended as a reference guide for early childhood special education personnel in North Dakota, this guide addresses required and recommended practices related to the delivery of services to children with disabilities, ages 3 through 5, and their families. The guide was developed by 50 specialists including parents and reflects all segments of the state service delivery system, guidelines from other states, and the position statements and recommendations of the Division for Early Childhood Education of the Council for Exceptional Children and the National Association for the Education of Young Children. Each of the three main sections is designed as an independent stand-alone chapter, dealing respectively with: (1) evaluation and assessment, (2) program planning, and (3) staff/facilities. Each section provides subheadings referring to the primary components of the service delivery system, a listing of appropriate state regulations relating to children requiring special education, guidelines that provide operational objectives related to each activity, recommended practices and procedures, and supplemental information in appendices.

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EARLY CHILDHOOD SPECIAL EDUCATION FOR CHILDREN WITH DISABILITIES, AGES THREE THROUGH FIVE

Published by

ADAPTIVE SERVICES DIVISION
NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
Wayne G. Sanstead, Superintendent
1996

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FOREWORD

Approximately 1200 preschool and kindergarten children (ages three through five) who have disabilities are assisted each year through programs and services provided by North Dakota's local school districts. The North Dakota Department of Public Instruction is committed to these early intervention initiatives to decrease the effects of disabling conditions and reduce the need for special education when these children reach school age.

Within the context of the Goals 2000 State Plan, this document represents an important element for the Department of Public Instruction. Goal One states that "all children in America will start school ready to learn". The practices required under state regulations, together with the recommendations from constituent state and national agencies and organizations, are provided in an easy-to-use format.

Eight objectives are considered central to the philosophy that pervades this document. These include: (1) providing opportunities for young children with disabilities to be educated with same-age peers without disabilities; (2) providing services in a variety of settings with an emphasis on utilizing the least restrictive learning environment for each child; (3) providing services that reflect interagency and interdisciplinary cooperation and coordination; (4) actively involving parents in every aspect of the educational process; (5) providing services that are developmentally appropriate and address how the child's disability impacts access to those activities; (6) providing services that value cultural diversity; (7) promoting interagency collaboration to ensure smooth transitions; and (8) utilizing comprehensive program evaluation models to assess anticipated and unanticipated outcomes of local programs.

Some 50 specialists, including parents, worked to make this document a reality. All segments of the service delivery system are represented including universities, local school districts, special education units, state agencies, and the North Dakota Interagency Coordinating Council along with several of its subcommittees. The commitment of these individuals to the many youngsters who have disabilities is reflected throughout. They have brought to the task the best possible thinking and writing in the field of early childhood special education.

We welcome feedback on this resource from personnel in local school district programs and other agencies as they work to develop, expand and enhance educational opportunities for young children with disabilities in North Dakota communities and schools.

Gary Gronberg, Ed.D.
Assistant Superintendent
North Dakota Department of Public Instruction

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PREFACE

Early Childhood Special Education for Children with Disabilities Ages Three Through Five is designed as a reference guide for special education personnel. It addresses required and recommended practices related to the delivery of services to children, ages three through five, with disabilities and their families. Public Law 101-476, the Individuals with Disabilities Education Act, and policies adopted by the North Dakota Department of Public Instruction are used as a foundation for the recommendations contained in this guide.

The required and recommended practices contained in this document will invariably be outdated in a short period of time. Each reauthorization of IDEA has the potential for significant impacts necessitating revisions. To accommodate future revisions, a loose-leaf notebook format was selected for the guide. Each of the sections is designed as an independent chapter that can stand alone. This will allow for revisions to be made to single chapters. It will also permit users to store additional handouts and material within the guide itself.

Key components of a comprehensive service delivery system have been identified and organized under five major sections: Assessment; Program Planning; Staff/Facilities; Transition; and Program Evaluation. Each section is organized to provide the reader with:

- a table of contents
- an introduction
- subheadings referring to the primary components of the service delivery system
- a listing of appropriate state regulations relating to children requiring special education
- guidelines that provide operational objectives related to each activity
- recommended practices and procedures
- supplemental information regarding early childhood special education practices in the appendices for each chapter

The position statements and recommendations proposed by the Division for Early Childhood (DEC) of the Council for Exceptional Children (CEC), the National Association for the Education of Young Children (NAEYC), and guidelines from other states have served as valuable resources in this project.

This document acknowledges the uniqueness of services to preschool children with disabilities in a very rural state, particularly as these services relate to parent participation, least restrictive environment, and transition. The role of families is central to planning, coordinating, and implementing activities and services for preschool children with disabilities. Special education personnel are encouraged to share the contents of this document with parents. Rather than address family participation separately, issues relating to parents and families are integrated into each chapter. Efforts to increase

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opportunities for integration with preschool peers without disabilities as well as efforts to improve procedures for transition planning are relatively new endeavors. The guidelines and recommended practices within this document offer a framework for addressing concerns regarding integration and transition. Local school districts and other agencies serving preschool children with disabilities are encouraged to use these guidelines and recommended practices in their planning and implementation efforts.

Keith H. Gustafson
Section 619 Coordinator
North Dakota Department of Public Instruction

ACKNOWLEDGEMENTS

The Department of Public Instruction, Office of Special Education, gratefully acknowledges the involvement of numerous groups of individuals who participated in the development of these guidelines. Their efforts provided critical input through regularly scheduled meetings over the course of several years. Their expertise and advice regarding the concepts in this document will enhance the quality of early childhood special education services in North Dakota. Individuals who were involved in some aspect of the development of this document are listed below.

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Special acknowledgement is give to Alan Ekblad for his involvement in this project from its inception. He coordinated the initial preparation of the individual sections of this guide while employed at the Department of Public Instruction as the Preschool Coordinator. He continued with the final editing and publication of the guide in a consultative capacity after accepting a position at Minot State University. Alan attended numerous committee meetings at which countless drafts of each section were reviewed and edited. His determination and support of this project are greatly appreciated.

Recognition is extended to Lori Anderson who coordinated all aspects of the editing, printing, and dissemination. The process was greatly facilitated by her experience and excellent organization and management skills.

Special acknowledgment is also given to Jean Newborg for her diligence and commitment in the final editing, review and formatting of the guide. Her publishing and technology skills made final editing and printing of this document a reality.

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INTRODUCTION

The purpose of these guidelines, *Early Childhood Special Education for Children with Disabilities Ages Three Through Five*, is to provide direction for program growth in the state. Historically, North Dakota has recognized the importance of providing services to young children with disabilities since special education services were mandated in the state in 1973. In 1977 the North Dakota legislature added foundation aid support for early childhood special education programs. In 1985 early childhood special education was included as a area of disability covered by North Dakota state statute. More recently North Dakota's commitment is evidenced by the state's intent to provide a unified approach for children of ages birth through five, and their families. Various efforts have been initiated to establish a seamless system, such as the establishment of an Interagency Coordinating Council representing agencies serving children birth through five, the development of a state level interagency agreement among numerous agencies and programs serving young children, and the development of transition agreements and procedures between infant development and early childhood special education programs.

Services to infants and toddlers with disabilities were created as a result of the Association for Retarded Citizens (ARC) class action lawsuit against the State of North Dakota in the early 1980s. The state's Department of Human Services (DHS), through its Developmental Disabilities Division, became the funding source for services to this population. Additionally, the DHS contracted with other agencies within each regional Human Service Center of the state so that eight regional infant development programs provided statewide services to infants and toddlers with developmental delays.

P.L. 99-457 was passed in 1986. This law, later included as Part H of IDEA, mandated services nationwide for preschoolers with disabilities, three through five years of age, and provided permissive legislation with funding for states to develop programs for infants and toddlers with disabilities. Each state was required to have a lead agency assigned as the primary administrative agent for the program. An option given to states was to split the responsibility and have one agency serve as lead agency for infants and toddlers with disabilities birth through two years, and another agency serve as lead agency for preschoolers with disabilities, three through five years. North Dakota chose to utilize two lead agencies, since statewide services were in place at that time for both populations. This resulted in a continuation of the precedent set earlier: the North Dakota Department of Public Instruction (NDDPI) was responsible for programs for preschooler children with disabilities, ages three through six years, and the Department of Human Services was responsible for services to infants and toddlers with disabilities, ages birth through two years. Although the programs are separated administratively at the state and local levels, both adhere to interagency collaborative approaches at these levels. Both are coordinated through a state level Interagency Coordinating Council (ICC), which serves an advisory function to the lead agencies.

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These guidelines have been prepared for use by personnel involved in services to preschool age children with disabilities. The principal audience for this guide is professionals in public school programs and supervisory personnel. Although the majority of the sections of the guidelines address only content applicable to services for preschoolers with disabilities, some of the sections address the same parameters for both the infant and toddler programs (referred to as Part H) and preschool programs (Part B). This is true of the evaluation and assessment chapter and references infused throughout other chapters. This serves a training purpose for preschool teachers who are unfamiliar with the experiences that are provided by the infant/toddler services prior to the child's enrollment in a preschool. This also provides a single resource guide to professionals who are working in programs that serve both populations.

It is also expected that the guide will provide parents, personnel in health, human services and other child service agencies with an understanding of the scope and purpose of educational services for young children with disabilities and their families.

This guide is intended to outline a process for the provision of services for young children with disabilities. It is not intended to set all special education units on a course of providing identical programs. Rather, it is intended to offer suggestions and alternatives from which personnel may choose as they develop the services that best fit the needs of the individual children.

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A PHILOSOPHY

Providing services for young children with disabilities has long been recognized as sound planning in North Dakota schools. Efficacy data in early intervention have demonstrated the benefits of providing services early in the life of a child to significantly reduce the impact of a disability during school years. In some cases, the need for special education can be prevented. To implement major goals of intervention, it is necessary to identify the disability very early in the life of the child. This entails a collaborative approach with all community agencies and professionals providing services to families with young children including doctors, nurses, social workers, and other community and business leaders. Once a child has been identified, it is necessary to create programs that provide the essential support to the child and the family unit to facilitate the goals of intervention.

Community early intervention programs have provided the needed education and habilitation services to children with known disabilities. North Dakota serves this population through various state level agencies. The Department of Human Services (DHS), through the Developmental Disabilities Program, coordinates services to infants and toddlers with disabilities ages birth through two years. The Department of Public Instruction (DPI) has the responsibility for local school programs that serve students with disabilities from age three through five. The North Dakota Department of Health and Consolidated Laboratories is also involved in collaborative interactions with DHS and DPI at the state and local levels to implement a comprehensive system of early intervention in North Dakota.

Recent trends in research findings and best practices have indicated the need to develop early intervention programs for the at-risk population of children. These children are not currently identified as having a disability but are at high-risk of developing a disability because of variables within their home environment and/or community. This is the group of children who are served through splintered services in our communities. There is no comprehensive statewide program to systematically address the needs of this group of children. Gaps exist in our service delivery system for identification and location and in intervention to meet the identified needs. There are a few pilot programs in some communities in our state that are designed to address the needs of these children and their families on a small scale. However, there are no programs that have the funding for preventative programs on a community-wide scale. The only means for serving this population at the present time is through interagency collaboration at the local and state levels. The sharing of staff, finances, facilities, and other resources is needed to address the needs of this group of children.

Quality indicators must be utilized to assess services and ensure that the needs of the consumers in our state are met. Service availability alone is not enough. Services must make a difference in the lives of the children and family members as well as benefit society. They must be cost-effective, well monitored and evaluated to assure fiscal and programmatic responsibility. They must also be valued by parents and community members. Quality indicators that should be considered by programs

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in the state in their quest to enhance the qualitative aspects of their service delivery system are presented and discussed below.

1. Provide opportunities for young children with disabilities to be educated with same-age peers without disabilities.

There are many early childhood services within each community in our state. Local services designed to meet the needs of young infants, toddlers, and preschool children with disabilities should collaborate with existing providers to maximize the outcomes for all. Duplication of services is often the result of a lack of collaboration such as when budgets are utilized to provide similar services at the expense of providing new services that are needed. By pooling resources at the local level, the needs of preschool children with disabilities can be served in a more effective and meaningful way. This would also enable the provision of services to an expanded population of students through the incidental benefit of co-location.

Obstacles imposed by bureaucracies of local service providers must be eliminated or minimized. Obstacles that are more difficult to address, such as the need for autonomy, control, and ownership of programs by professionals, must be eliminated through the continued lobbying efforts of parents, professional organizations, and supervisory personnel at the regional and/or state level. Since the primary goal for early intervention is to decrease and, when possible, prevent the need for subsequent placement in special education at a later time, it is not justifiable to isolate these children into segregated, self-contained programs to receive the intervention services. The outcomes of early intervention can be realized through utilizing childcare facilities, Head Start programs, community preschool programs, and other locations where young children who are not disabled receive services. There will always be a need for more intensive and specialized early intervention programs for children requiring a more restrictive learning environment. The majority of the children who need early intervention services, however, could be appropriately served utilizing sites already available within each community in our state.

2. Provide services in a variety of settings with an emphasis on utilizing the least restrictive learning environment for each child.

Diversity is a hallmark of most communities. In addition to alternative settings for shopping, socializing, and worshiping, communities attempt to meet the needs of citizens by providing alternative support programs or services that address specialized needs. Family members will traditionally have had vast experiences in exploring community options and will have selected the settings, programs, and services that best meet their needs as residents of that community. They will have a preferred set of stores for shopping, a preferred church, social clubs, and childcare facilities or arrangements. When a child is identified as having a disability, family members are often asked to accommodate to an entirely new service involving new personnel, new concepts, and in many cases, a new location for the service. They will invariably retain their existing community connections for meeting the existing needs of the family and add the new service and location to their already busy schedules. An option that would certainly assist many busy families would be to

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have the preschool special education services built into one of the existing community supports currently utilized by that family. It would not require adding a new routine to the parents' busy schedule; an existing location or service would be adapted to meet the new need of one of the family members. An existing routine would be adapted, rather that creating a new routine.

As local programs begin utilizing family-focused approaches, it will require offering the services in a greater variety of community environments. This will require that the family be extensively involved in the process of balancing the elements required by law, and in selecting the least restrictive learning environment in which to achieve the specified outcomes delineated for the child. Programs are being asked to redefine themselves. Rather than to conceptualize the programs as *locations*, they must be thought of as *services* or *support personnel* who go to different locations to provide services and supports to the child in the naturally occurring environments that constitute the least restrictive learning environments.

3. Provide services that reflect interagency and interdisciplinary cooperation and coordination.

As programs begin serving children and families in new locations within the community, they will come into contact with other agencies, disciplines, and services. Working together with these agencies will be a natural progression. It will facilitate the coordination of schedules and services for the children enrolled in the early intervention program and will also result in incidental benefit to other children and families. There are many services available in most communities. Service providers co-located and working together will be in a much better position to maximize the services to meet the needs of the community members as well as identify unmet needs within the community.

4. Actively involve parents in every aspect of the educational process.

The model of tailoring services to meet the unique community routines of the family unit will require far more extensive involvement of parents in the planning process. They will be involved in a more professional capacity than just being invited to attend planning meetings. They will be instrumental in the assessment process, identifying community locations utilized by their family members, and inventorying those environments and services to determine the feasibility of adapting or tailoring the services to meet the new need of the family. Their input will also be essential in prioritizing modifications that would be the least intrusive to the family and yet most beneficial to the child. The family members must be more involved in selecting the intervention outcomes, methodologies, and evaluation paradigms. Since the skills will be taught within the existing routines and locations used by the family, they must facilitate the selection of outcomes that will be valued by the family and considered valid by other community members. They must assist in selecting the methodologies since they will be involved extensively in the implementation of the activities. The evaluation criteria selected by the team will be dictated by the perceived value attached to that outcome by the family. Different families utilizing the same facility for a variety of purposes (different programs) should be working together to provide comprehensive evaluation input to the array of a-

gencies and programs or services represented in that location.

5. Provide services that are developmentally appropriate and address how the child's disability impacts access to those activities.

This will be a natural outcome of the co-location process. Personnel who have worked with preschool children with disabilities in isolation from other early childhood programs often lose their perspective of developmentally appropriate practices. Programs are so busy providing intensive remedial and habilitation services and addressing deficit skills only, that the larger picture - how the ability to participate in regular education is impacted by the disability - is lost. A step back is needed. The children need to be returned to the naturally occurring community environments or to the locations in which they would be living and learning if they had no disability. They would be found in child care facilities, at the babysitter's or grandparent's house, with the parents at home, or with siblings in the park.

The focus must be placed on how the disability impacts the child's ability to participate and learn or develop from the activities within those locations. Interventions should not separate the child from the normalized daily living activities. The child should be supported in those environments and activities to assure equal assess and opportunity for developing the "regular education" skills that nondisabled peers are developing.

6. Provide services that value cultural diversity.

Cultural diversity should be valued in our programs. Rather than tolerating differences in the cultural backgrounds of community members and ethnic groups, the differences should be celebrated and receive preferential consideration in program planning activities. Cultural variables should be considered when addressing family diversity. Cultural, ethnic, and language preferences and differences should be viewed as features unique to each family unit. The alternative behaviors and symbols that family and other community members utilize in their daily living habits, holiday celebrations, and other interactions should be valued. People of diverse cultural heritage should be encouraged to share their traditions. In addition to cultural exposure, there are many incidental outcomes in the lives of the children and parents. Self-esteem is built and there is an increased sense of community belonging and being valued by the community.

7. Promote interagency collaboration to ensure smooth transitions.

Intervention programs should be designed and implemented to minimize the need for transition. Transition involves movement from one location to another, from one activity to another, or from one service to another. The more separate and isolated our services, the greater is the need for planning transition activities. Programs that are co-located and operated together will have fewer transition needs. Those that have reduced bureaucratic obstacles find minimal need for transition. Promoting interagency collaboration to ensure smooth transitions must begin with encouraging and supporting professionals to plan, practice, and serve the community members together. The community members will view intervention as one program, with different facets. Transition planning can

then be integrated into the daily operations of the constituent providers. Smooth transitions will occur at every critical juncture.

8. Utilize comprehensive program evaluation models to evaluate the local programs in terms of standards for program quality.

Concurrent with establishing community-based services for preschool children that have specified outcomes, the effectiveness of the interventions offered should be examined carefully. There should be an emphasis placed on program improvement over time. Essential questions to address in a program evaluation model are stated below.

- Does the program make a difference in the life of this child?
- Will this child do better in school because of our efforts?
- Does the family feel empowered to better address the educational and community living needs of this child because of an intervention?
- Does the community value and support the intervention processes utilized?
- Is there an increase in the capacity of other service providers to adequately meet the needs of the child with a disability and the child's family?
- What other support services are needed in our community to meet the needs of the community residents or to improve the quality of life in the community?

It is readily observable that program evaluation must be comprehensive. It will require input from the children themselves, their parents, siblings, and extended family members. It will require involving community business and service sector leaders. Data must be collected over time for determining long term impact and cost savings to society. Services should be modified immediately as a result of evaluation data. Above all, program evaluation must be a collaborative venture with other service providers. The programs and services should be monitored and evaluated in the same manner as they are operated. Professionals from different programs must work together to improve the quality of community life for the residents of that community.

9. Provide ongoing staff development inservice training opportunities.

Opportunities for comprehensive staff development are a critical aspect of assuring quality in the process of implementing early intervention services. Staff should be provided with support and inservice training to learn new methods for evaluating young children, provide comprehensive interventions in the least restrictive learning environments, involve parents, apply technology, and participate in interagency collaboration. Staff training should be directed to all participants in the early intervention process: parents, teachers, related service providers, administrators, and other community service personnel including child care providers and preschool teachers. Training should not be limited to the initial presentation of skills or materials. Alternative models of staff support, such as peer mentoring, parent-to-parent support programs, and collaborative planning, should also be utilized. In addition to facilitating the acquisition of a high level of quality in program outcomes, interventionists will develop a feeling of competence and efficacy. Staff development activities should be planned and evaluated through the local and state Compre-

hensive System for Personnel Development programs and should be aligned with the program evaluation process or program improvement plan.

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EARLY CHILDHOOD SPECIAL EDUCATION FOR CHILDREN WITH DISABILITIES, AGES THREE THROUGH FIVE: EVALUATION AND ASSESSMENT GUIDELINES FOR YOUNG CHILDREN WITH SPECIAL NEEDS

Prepared By

North Dakota Interagency Coordinating Council
Evaluation and Assessment Subcommittee

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Young Children with Special Needs

Evaluation and Assessment Subcommittee

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FOREWORD

The Evaluation and Assessment Subcommittee of the North Dakota Interagency Coordinating Council was established in the fall of 1992 to develop guidelines for the assessment of young children with special needs. The work of the subcommittee, which is represented by this document, covers both the Infant Development Program, administered by the North Dakota Department of Human Services, and the Early Childhood Special Education Program (ECSE), administered by the North Dakota Department of Public Instruction.

Creating one document that applies to both programs presented special challenges to the subcommittee due to inherent differences and legislation that supports each program. It is the expectation of the subcommittee members that this document will be useful as a resource and guide to assessment practices in infant and early childhood special education programs in North Dakota.

Mary McLean and Mary Stammen, Co-chairs

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INTRODUCTION

Public Law (P.L.) 99-457 as re-authorized by P.L. 102-119 (known as Part H of the Individuals with Disabilities Education Act - IDEA) mandates each state system to ensure that each public agency establishes and implements procedures that meet the requirements for evaluation as identified in IDEA. Such evaluations must take place prior to initial placement of a child with disabilities in a program providing special education and related services. The evaluations must be timely, comprehensive, and multidisciplinary in nature. In addition, evaluation and assessment procedures should:

1. respect the unique developmental nature and characteristics of the child and his or her family,
2. include the active participation of parents and other significant caregivers,
3. be sensitive to cultural and ethnic differences, and
4. utilize appropriate assessment procedures and instruments.

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OVERVIEW OF THE INFANT DEVELOPMENT AND EARLY CHILDHOOD SPECIAL EDUCATION (ECSE) PROGRAMS: FEDERAL LAW APPLIED TO NORTH DAKOTA

In North Dakota, early intervention services for children with disabilities ages birth through five and their families occur through state programs of two agencies, the Department of Public Instruction and the Department of Human Services. State formula grants for infants and toddlers with disabilities (Part H of Individuals with Disabilities Education Act - IDEA) and preschoolers with disabilities (Part B, Section 619 of IDEA) are used to facilitate the statewide systems developed to address these respective populations.

Although Part H and Part B, Section 619 are similar in intent and serve populations with similar needs, their focus differs. Part H of the law addresses service provision to infants and toddlers, with disabilities ages birth through 2 years. It views the family unit as the recipient of the service. The family centered-approach contained in Part H includes a provision for the assessment of family needs and results in an intervention plan addressing not only the needs of the infant with disabilities, but also the needs of the family unit. This plan is referred to as an Individualized Family Service Plan (IFSP). Part B, Section 619 of IDEA, addresses service provision to disabled children, ages three through five years. It is consistent with the approach used throughout the remaining sections of IDEA and includes a child-focused approach. The Individualized Education Program (IEP) is designed to provide intervention directed to the child. Although this section of the law also contains provisions for parent involvement, the family unit is not viewed as the recipient of the intervention.

The terminology contained in the two sections of the law relevant to the assessment process, also varies. This was necessitated by the differences in focus-family-focused versus child-focused.

In contrast to Part H, Part B regulations utilize the terms *identify*, *locate*, and *evaluate*. The terms *identify* and *locate* refer to child find, screening, and referral processes, while evaluation refers to all of the procedures used to determine whether or not a child has a disability and to identify the individual programming needs of the child.

Congress, in enacting Public Law 101-476 (IDEA), demonstrated the clear intent that all children in need of special services *be identified, located, evaluated and served*. The intent is further enhanced through strengthened coordination of child evaluation, assessment and services regulated under Part H and Part B. This promotes a seamless system of services for children with disabilities from birth through five years of age and their families.

North Dakota meets the federal intent with its unified approach for children ages birth through five. Various efforts have been initiated to establish a seamless system in North Dakota. One such effort has been the establishment of an

Under Part H, *evaluation* refers to the information gathered to determine eligibility, while *assessment* addresses the information gathered to determine intervention and support needs. The assessment process under Part H also specifically addresses family resources, priorities and concerns. In North Dakota, the term assessment process is used to encompass both evaluation and assessment activities for preschool and school-age populations.

Interagency Coordinating Council representing agencies serving children birth through five. Other efforts include the development of a state level interagency agreement among numerous agencies and programs serving children from birth through five, the development of transition agreements and procedures between infant development and early childhood special education programs, a community approach to selective screening, and the establishment of a regional North Dakota Early Childhood Tracking System -NDECTS).

These efforts have identified a set of tasks and opportunities immediately relevant to evaluation and assessment that need to be addressed and resolved in maintaining a statewide seamless approach. These tasks include:

- identifying young children with disabilities, ages birth through 5 years of age;
- planning evaluation and assessment strategies for young children with disabilities using a multidisciplinary approach;
- conducting the evaluation utilizing parent input; and
- preparing a written report including an integrated summary.

The reader will notice that these tasks, with their unique programmatic differences, are addressed throughout each section of the document.

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IDENTIFICATION OF YOUNG CHILDREN WITH DISABILITIES

Identification of young children with disabilities can be undertaken for a multiple of purposes through various activities. Activities such as locating, screening, evaluating, and assessing can be distinguished as serving definite purposes in the identification of young children with disabilities. Each activity has a focused purpose and strategies for implementation, although the overall philosophy of evaluation and assessment will be consistent throughout all activities.

CHILD FIND

The term *Child Find* refers to North Dakota's system of procedures for locating children who are in need of early intervention. Child Find encompasses the age range birth through 21 years, although the emphases in this document is the birth through five year age range.

The Child Find system encompasses all efforts aimed at identification of children with disabilities including public awareness/education activities, screening programs, and interagency efforts. Education of the general public is an integral part of identification efforts.

The North Dakota Department of Human Services, through the Interagency Coordinating Council, Child Identification Subcommittee, has developed a campaign designed to supplement the activity of the Department of Public Instruction that targets families of children ages birth through five years. The purpose of this campaign is to educate parents and the general public regarding typical development in young children. The campaign is multifaceted and includes the development of a universal logo, brochures, and informational packets. The campaign material may be used by clinics, hospitals, public health centers, human service agencies, educational agencies, and early childhood programs. Implementation of the campaign is facilitated by the North Dakota Early Childhood Tracking System, which consists of teams of local and regional agencies serving children ages birth through five. (See Resources section of this document.)

Child Find is an ongoing process that operates on a daily basis rather than as a once or twice a year effort. The potential for locating unidentified children with disabilities is maximized through all public awareness and interagency collaborative efforts. Certain times during the year may be designated for special recognition of the Child Find system, as is the case during the third week in September when the Department of Public Instruction coordinates activities with local agencies in publicizing Child Find efforts.

Ongoing public awareness/education is critical to the success of Child Find procedures. Activities aimed at increasing public awareness of infant and early childhood special education services for children with disabilities may take many forms. Formats that may be used include the printed media, radio, television, and public presentations. The State Health Department operates a toll-free telephone number for individuals who have questions or concerns relevant to referrals. Ongoing planning and evaluation of public awareness/education efforts will ensure an effective Child Find system.

SCREENING

Community Screening. The purpose of screening is to identify children who may be in need of further assessment. Screening yields only a general evaluation of the child's functioning and answers the question, "Does a problem exist?" Because of reliance on gross estimates of performance, screening measures do not provide adequate information for eligibility or placement decisions.

Some community early intervention teams provide large-scale, community wide mass screening activities. These activities are sponsored for all children of a targeted age group within that community. Agencies commonly involved include public health, social services, and education. The targeted ages vary across communities. Some communities attempt to identify three year old children with disabilities; others screen those who are four years old. Some communities provide mass screening to all children who will be enrolling in kindergarten. Although special education personnel may be involved in these screening activities, they should be viewed as supplemental contributions to the community's responsibility. The mass screening cannot replace existing selective screening procedures and cannot be supported by federal funds earmarked for special education children.

Selective Screening. Selective screening is the process of screening only those children suspected of having a disability who are referred due to identified risk factors. This screening will determine the significance of the risk conditions to the child's growth and development or academic performance. The result of the screening process is a systematic collection of information for each child that helps determine whether there is a need for further evaluation by a multidisciplinary team.

In all cases, two procedures must be followed. First, parents must be notified that their child has been referred for screening and must provide written consent for the child to participate in the selective screening process. The notice must include a description of the concern, the procedures to be used, the date, time and location of the screening, and who will be involved (See *Guidelines: Parent Rights, Prior Notice, and Parent Consent Procedures,* July 1993). Parents must provide written consent for the child to participate in the selective screening process.

Second, parents must also receive a written summary of the screening results. The team that reviews the results of the screening will determine whether the child should be referred for a complete evaluation by school, other agency or medical personnel, should be rescreened at a later date, or does not need further evaluation. If the results of the screening indicate the need for an evaluation because of a suspected disability, parent consent must be obtained and an explanation of procedural safeguards given before proceeding with further evaluation and assessment.

Many agencies that provide services to young children (e.g., Head Start and Early Periodic Screening Diagnosis and Treatment (EPSDT) program), have responsibility for screening children ages birth through five years. Local programs are encouraged to work together to reduce duplication in screening activities for families by providing community or multi-agency screenings.

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EVALUATION FOR ELIGIBILITY

The process of identifying children with disabilities consists of two components: evaluation and assessment. Part H regulations (IDEA, or 34 CFR §303.322 of Part H) define the evaluation process as separate from the assessment process. Part B regulations (IDEA, 34 CFR §300.-530) do not differentiate between evaluation and assessment; rather both are addressed under "Preplacement Evaluation" regulations.

> As defined in IDEA, *evaluation* is the procedure used by appropriate qualified personnel to gather information that will be used to determine a child's initial and continuing eligibility, consistent with the legal definition of infants and toddlers or preschoolers with disabilities. Additionally, Part H includes in the definition the procedures for determining the status of the child in each developmental area. Evaluation can be described as a systematic process of collecting information on a child's health status, medical history, and current level of functioning, which is used in the determination of eligibility.
> **(IDEA, 34 CFR §303.322 of Part H, and IDEA, 34 CFR §300.530 of Part B)**

Table A1 presents a comparison of Part B and Part H language and requirements relative to evaluation and assessment.

For infants and toddlers ages birth through two years, information gathered through the evaluation process is compiled in a written report and presented to the regional Human Service Center Eligibility Determination Team. This team determines eligibility for Developmental Disabilities case management services. The information gathered from evaluation procedures is also used during the assessment process. When a child has been determined eligible for early intervention services, assessment procedures can be continued to identify child and family needs for intervention.

> For children ages birth through two, the evaluation and assessment of each child must:
>
> - be conducted by personnel trained to utilize appropriate methods and procedures;
> - be based on informed clinical opinion;
> - include a review of pertinent records related to the child's current health status and medical history;
> - include an evaluation of the child's level of functioning in each of following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive skills;
> - include an assessment of the unique needs of the child in each of the above developmental areas, including the identification of services appropriate to meet those needs.
>
> **(IDEA, 34 CFR §303.322 of Part H)**

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Table A1. Comparison of IDEA Part B and Part H with regard to Evaluation and Assessment

IDEA 34 CFR §300.322 OF PART H
INFANT TODDLER, BIRTH THROUGH TWO YEARS

§303.322 Evaluation and assessment.

(a) General.
(1) Each system must include the performance of a timely, comprehensive, multidisciplinary evaluation of each child, birth through age two, referred for evaluation, including assessment activities related to the child and the child's family.
(2) The lead agency shall be responsible for ensuring that the requirements of this section are implemented by all affected public agencies and service providers in the State.

(b) Definitions of evaluation and assessment. As used in this part --
(1) "Evaluation" means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of "infants and toddlers with disabilities" in §303.16, including determining the status of the child in each of the developmental areas in paragraph (c)(3)(ii) of this section.
(2) "Assessment" means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify --
(i) The child's unique strengths and needs and the services appropriate to meet those needs; and
(ii) The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

(c) Evaluation and assessment of the child. The evaluation and assessment of each child must --
(1) Be conducted by personnel trained to utilize appropriate methods and procedures;
(2) Be based on informed clinical opinion; and
(3) Include the following:
(i) A review of pertinent records related to the child's current health status and medical history.
(ii) An evaluation of the child's level of functioning in each of the following developmental areas:
(A) Cognitive development.
(B) Physical development, including vision and hearing.
(C) Communication development.
(D) Social or emotional development.
(E) Adaptive development.
(iii) An assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c)(3)(ii) of this section, including the identification of services appropriate to meet those needs.

(d) Family assessment.
(1) Family assessments under this part must be family-directed and designed to determine the resources, priorities, and concerns of the family related to enhancing the development of the child.
(2) Any assessment that is conducted must be voluntary on the part of the family.
(3) If an assessment of the family is carried out, the assessment must --
(i) Be conducted by personnel trained to utilize appropriate methods and procedures;
(ii) Be based on information provided by the family through a personal interview; and
(iii) Incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development.

(e) Timelines.
(1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in §303.321(e).
(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will --
(i) Document those circumstances; and
(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with §303.345(b)(1) and (b)(2). (Approved by the Office of Management and Budget under control number 1820-0550)
(Authority: 20 U.S.C. 1476(b)(3); 1477(a)(1), (a)(2), (d)(1), and (d)(2))

Note: This section combines into one overall requirement the provisions on evaluation and assessment under the following sections of the Act: (1) section 676(b)(3) (timely, comprehensive, multidisciplinary evaluation), and (2) section 677(a)(1) and (2) (multidisciplinary and family-directed assessments).

The section also requires that the evaluation-assessment process be broad enough to obtain information required in the IFSP concerning (1) the family's resources, priorities, and concerns related to the development of the child (section 677(d)(2)), and (2) the child's functioning level in each of the five developmental areas (section 677(d)(1)).

IDEA 34 CFR §300.530 OF PART B
PRESCHOOL THREE THROUGH FIVE YEARS

Before any action is taken with respect to the initial placement of a child with a disability in a program providing special education and related services, a full and individual evaluation of the child's educational needs must be conducted in accordance with the requirements of §300.532.
(Authority: 20 U.S.C. 1412(5)(C))

§300.532 Evaluation procedures.

State educational agencies and LEAs shall ensure, at a minimum, that:
(a) Tests and other evaluation materials --
(1) Are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so;
(2) Have been validated for the specific purpose for which they are used; and
(3) Are administered by trained personnel in conformance with the instructions provided by their producer.
(b) Tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient.
(c) Tests are selected and administered so as best to ensure that when a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (except where those skills are the factors that the test purports to measure).
(d) No single procedure is used as the sole criterion for determining an appropriate educational program for a child.
(e) The evaluation is made by a multidisciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of suspected disability.
(f) The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. (Authority: 20 U.S.C. 1412(5)(C))
Note: Children who have a speech or language impairment as their primary disability may not need a complete battery of assessments (e.g., psychological, physical, or adaptive behavior). However, a qualified speech-language pathologist would (1) evaluate each child with a speech or language impairment using procedures that are appropriate for the diagnosis and appraisal of speech and language impairments, and (2) if necessary, make referrals for additional assessments needed to make an appropriate placement decision.

§300.533 Placement procedures.

(a) In interpreting evaluation data and in making placement decisions, each public agency shall --
(1) Draw upon information from a variety of sources, including aptitude and achievement tests, teacher recommendations, physical condition, social or cultural background, and adaptive behavior;
(2) Ensure that information obtained from all of these sources is documented and carefully considered;
(3) Ensure that the placement decision is made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data, and the placement options; and
(4) Ensure that the placement decision is made in conformity with the LRE rules in §§300.550-300.554.
(b) If a determination is made that a child has a disability and needs special education and related services, an IEP must be developed for the child in accordance with §§300.340-300.350.
(Authority: 20 U.S.C. 1412(5)(C); 1414(a)(5))

Note: Paragraph (a)(1) of this section includes a list of examples of sources that may be used by a public agency in making placement decisions. The agency would not have to use all the sources in every instance. The point of the requirement is to ensure that more than one source is used in interpreting evaluation data and in making placement decisions. For example, while all of the named sources would have to be used for a child whose suspected disability is mental retardation, they would not be necessary for certain other children with disabilities, such as a child who has a severe articulation impairment as his primary disability. For such a child, the speech-language pathologist, in complying with the multiple source requirement, might use (1) a standardized test of articulation, and (2) observation of the child's articulation behavior in conversational speech.

§300.534 Reevaluation.

Each SEA and LEA shall ensure --
(a) That the IEP of each child with a disability is reviewed in accordance with §§300.340-300.350; and
(b) That an evaluation of the child, based on procedures that meet the requirements of §300.532, is conducted every three years, or more frequently if conditions warrant, or if the child's parent or teacher requests an evaluation.
(Authority: 20 U.S.C. 1412(5)(c))

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For preschoolers ages three through five years, the local school gathers information using the state assessment process for determination of a disability (see *Guidelines: Assessment Process*). This information, along further further assessment data, is used to identify further programming needs.

ASSESSMENT FOR PROGRAM PLANNING

Assessment is defined as the ongoing procedure used by appropriately qualified personnel throughout the period of a child's eligibility to identify the child's unique needs and the nature and extent of intervention services that are needed by the child and family. The outcome of assessment activities is the identification of special services needed by the child and family and the delineation of intervention objectives as specified in the Individualized Family Service Plan (IFSP) for children birth through two years of age, and the Individualized Education Program (IEP) for children who are three through five years of age. In the Infant Development Services, as indicated previously, the evaluation process will precede the assessment process. However, in Early Childhood Special Education Services, evaluation and assessment are included in the same process.

TIMELINES

Part H and Part B of IDEA identify specific, but different, timelines for the completion of certain activities when a child is being evaluated and assessed. Under Part H, a referral source has two working days to refer a child to the regional Human Service Center. The evaluation, assessment, and the Individualized Family Service Plan (IFSP) must be completed within 45 days of the referral to the Human Services Center. This timeline is to protect children and their families from undue delay that could be harmful and to make the process responsive to families. If an initial or interim IFSP is postponed beyond the 45 days at the request of the family, this should be documented by the service coordinator and is acceptable under the law. However, a postponement due to a shortcoming on the part of the service delivery system is legally unacceptable.

Part B states that a public agency has 30 days from point of determination of a disability to hold a meeting to develop the written Individualized Education Program (IEP) for a child. Service must begin "as soon as possible" following the IEP meeting. Although federal regulations do not address the time span between date of referral and completion of the evaluation, the North Dakota Department of Public Instruction recommends that the evaluation be completed within 30 days from receipt of the referral. In exceptional circumstances, such as when the child/family cannot be reached, the total assessment process may go beyond the specified timeline. To justify this extended timeline, public agencies must document the circumstances that make meeting the deadline impossible. Upon completion of the assessment process and determination of a disability, an IEP is developed. At the conclusion of the IEP, a placement decision will be made and the child may begin receiving special education services, if appropriate. If further assessment needs are identified, additional information can be gathered and the results considered in revision of the IEP as appropriate.

Table A2 summarizes the location, identification, evaluation and assessment process for young children.

TABLE A2. The Process of Location, Identification, Evaluation and Assessment of Children, Birth Through Five, Who Are Eligible for Services

Activity	Purpose	Personnel	Activities
Child Find	To create awareness of typical and atypical child development among the general public	State personnel, public health professionals, volunteers, community members, early childhood personnel, parents, caregivers	Census taking, posters, brochures, media publicity, referral to tracking
Selective Screening	To identify children suspected of having a disability who may need further diagnostic assessment	Professionals, parents, paraprofessionals	Administration of screening instruments, medical screenings/examinations, hearing and vision testing, parent questionnaires, and review of records
Evaluation for Eligibility	To determine existence of delay or disability.	Multidisciplinary team of educators, psychologists, parents, clinicians, physicians, social workers, therapists, nurses, caregivers	Formal and informal testing, parent interview, home or school observation, team meetings
Assessment for Program Planning	To determine/identify child and family strengths and needs, individual education/family services needed intervention activities, and awareness of program setting options.	Parents, teachers, assessment team personnel, other professionals	Home and/or program observation, informal assessment, development of intervention objectives

Adapted from Meisels and Provence (1989)

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TEAM PROCESS

Both Part B and Part H require that evaluation and assessment be multidisciplinary team efforts. The manner in which team members organize themselves to accomplish the evaluation is most important. Best practice suggests that evaluation should be a collaborative team process. The individuals involved should coordinate their efforts and function as a team rather than as separate individuals. The family is an integral part of the team.

Multidisciplinary Model. According to IDEA, "multidisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities." (IDEA, 34 CFR §303.17 of Part H). Variations of this model of team functioning that have been recommended for early intervention include both the interdisciplinary and transdisciplinary model.

Interdisciplinary Model. Under the interdisciplinary model the child is assessed individually by members of several disciplines. A meeting is then held so that the evaluation summary and recommendations will reflect a team consensus.

Transdisciplinary Model. Under the transdisciplinary model, the child is evaluated simultaneously by multiple professionals. A common sample of behavior is the basis from which all members of the team complete the evaluation. A team meeting is held to formulate an integrated report that represents the consensus of the team.

The transdisciplinary team approach is a model that is highly recommended for evaluation and assessment of young children. Further information on this approach can be found in the section conducting the Evaluation and in Appendix E.

Training for those who serve on evaluation/assessment teams for young children must include the skills necessary for coordinated, informed teamwork. One single source of information and/or expertise cannot provide a complete picture of the young child's characteristics. It is essential that professionals develop the skills necessary to work along with the family as members of a team.

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EVALUATION/ASSESSMENT PLANNING PROCESS

The purpose of an evaluation/assessment plan is to identify questions that will assist in the determination of whether a child has a disability as well as to describe the child's unique needs. Planning should also incorporate the family's priorities and concerns.

The evaluation/assessment plan cannot be developed by one individual. Input must be obtained from persons who, because of their expertise or their relationship or position in the child's life, can observe, gather data, and evaluate all aspects of the child's functioning. The plan will be developed by the evaluation team that is composed of the family and professionals from each of the disciplines from which information is needed about the child's development and current level of functioning.

The steps involved in evaluation/assessment planning include:

- obtaining all background information to develop a child profile;
- determining family goals and involvement for evaluation/assessment; and
- formulating the evaluation/assessment plan.

BACKGROUND INFORMATION/ CHILD PROFILE

The team should begin the process by gathering all pertinent information already known about the child by each of its members. With this information, the team will develop a profile of the child. Information can be gleaned from a variety of sources including health records, teacher reports, information from a cumulative file, and parent information. In addition, those factors that precipitated the referral should be noted as a significant part of the child's profile. Evidence of abilities and strengths as well as patterns of weakness provide information relevant to a child's developmental pattern, but the same information raises new questions as well. Such information reflects the child's learning characteristics and will provide direction for the evaluation plan. Early Childhood Special Education Services will follow reference guides put forth by the Department of Public Instruction (see *Guidelines: Assessment Process*).

FAMILY INVOLVEMENT

Family Involvement in the Planning Process. Family involvement assumes a partnership between the family and the professionals serving that family. For the partnership to be successful there must be an understanding that each member will contribute to the final outcome in a different way, and each contribution will be valued. Family involvement will differ with each family based on the family's perception of their role, the knowledge level of the family regarding child development, and cultural factors. For example, many American Indian families prefer to involve the grandparents and other extended family members in the evaluation process.

Family involvement in the evaluation planning process is very important. The evaluation process itself, as well as the test instruments and procedures selected, should be based on input from the family. Families should be invited to

contribute information to the planning process in the following areas:

- questions or concerns family members have about the child's development;
- preferred times and locations for the evaluation (i.e., times when the child will be most alert and locations where the child will be most comfortable);
- special toys or materials which might help in comforting or motivating the child; and
- the manner in which the family members would like to be involved (i.e., participating in the evaluation by holding the child; providing information to the team about the child's behavior, etc.).

When the evaluation procedures and instruments have been identified, the family should be fully informed about the instruments that will be used and the procedures to be followed. The family can greatly facilitate the evaluation by making sure the child is comfortable and by providing the team with information. To assist in the evaluation process, however, the family must be informed about what to expect during the evaluation. Options should be presented giving the family suggestions on how they might become involved. Families should then be allowed to determine the extent of their involvement in the evaluation process. Some families may opt for a family-directed process in which they have a leadership role, whereas others may prefer a collaborative process with shared decision-making.

Assessment of Family Concerns, Resources and Priorities. Under Part H, the family will be involved in an assessment to identify the resources, priorities, and concerns of the family that relate to enhancing the development of the child. This assessment must be voluntary on the part of the family and must be directed by the family. Personnel involved should be trained to conduct the assessment through a family interview process.

It is suggested that family members be invited to share their concerns about the child's development during the evaluation process to determine eligibility. More indepth information on family priorities for intervention and resources related to enhancing the child's development may be obtained during the assessment process as information is gathered to plan intervention.

FORMULATION OF AN EVALUATION/ ASSESSMENT PLAN

The evaluation process is utilized to gather and synthesize information for a variety of purposes. Although in the past a disproportionate emphasis was placed on evaluation for program eligibility purposes, the focus appears to be shifting to include a more comprehensive model of assessment. Areas that should receive equal emphasis include evaluating program implementation variables such as how the child learns best, what is reinforcing to the child, and whether the child maintains and generalizes skills. Ecological variables include family support needs and community environments to include as settings for service. Instructionally relevant information that should be determined through the evaluation process consists of problem solving strategies the child has learned to utilize, psychological processing strengths and

discrepancies, responsiveness to instructional styles and materials, and the child's learning curve. Other topical areas might consist of curriculum referenced assessment across domains, effectiveness of prior interventions, responsiveness to intervention techniques and formats, efficacy data collection, and program evaluation.

Considering the potential comprehensiveness or scope of an evaluation process, it is important to articulate clear purposes for individual evaluations. When evaluation/assessment is to determine whether the child has a disability, one of the purposes must be to obtain relevant child data for this decision. Actual benefits of child evaluation, however, are much broader. Even those children who are determined not to have a disability will benefit from the process since information obtained may lead to other services that might be provided.

In the evaluation planning process, questions regarding the child's development will be formulated. Questions should relate to the suspected disability, the child's style of learning and the learning environment. It is also important to focus questions on the areas of health, social-cultural background, sensory functioning, and emotional development to assure non-biased assessments. The more specific the questions are, the greater the likelihood that assessment procedures will be selected that will provide developmentally and educationally relevant data. Based upon the questions asked, the team constructs a plan for gathering relevant information and outlines specific procedures to be followed in gathering the information. The list of questions that have been formulated and still need to be answered will also determine who will gather the data, and whether additional persons need to be added to the evaluation team.

The content of the evaluation plan will be determined by the kind of data already available and the information that still needs to be gathered. The assessment plan will vary from child to child. In addition, the range of concerns reported, the complexity of those concerns, and the age of the child will determine the type and amount of evaluation required. If during the evaluation process the team determines that information in any area is incomplete, a plan to gather the missing information should be outlined and carried out as part of the assessment process. Skillful and careful observations are required to recognize clues in the child's performance signaling that not all of the pertinent information is known.

For children ages three through five, the team's plan must be documented. A written plan will become a working document for each team member and will serve as a reference for accountability purposes. The *Guidelines: Assessment Process* document prepared by DPI should be followed by preschool teams.

The evaluation planning process will culminate in a written document that specifies instruments and procedures to be used, family members, caregivers and professionals to be involved, toys or other materials to be used, and the location and times for conducting the evaluation. It's important to remember that evaluation and assessment planning is an ongoing process because new questions may arise during evaluation which call for additional procedures.

In deciding on the instruments and procedures to be used, the team will review the background information available on

the child and consider the questions and concerns identified by the family and the professionals on the team. Specific instruments and procedures will be individually selected to determine whether the child has a disability and to answer the questions that have been identified.

There are at least three other aspects of evaluation which should also be considered at this time:

- evaluation and assessment procedures must be nondiscriminatory;
- instruments and procedures used should be reliable and valid; and
- evaluation procedures should be culturally appropriate.

Each of these aspects will be discussed below.

Nondiscriminatory Procedures. Each state agency is required to adopt nondiscriminatory evaluation and assessment procedures for children birth through five years of age.

The law requires that tests and other evaluation materials:

- be provided and administered in the child's native language or other mode of communication;
- be validated for the specific purpose for which they are used;
- be administered by trained personnel in conformance with the instructions provided by the producer of the materials;
- include instruments tailored to assess specific areas of educational needs, and not merely those that are designed to provide a single general intelligence quotient; and
- be selected and administered to best ensure that when a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level, or whatever other factors the test purports to measure, rather than simply reflecting the child's disability (except, of course, in cases in which the effects of the disability are the specific factors that are being measured).

No single procedure may be used as the sole criterion for determining an appropriate educational program for a child, and the evaluation must be done by a multidisciplinary team that includes at least one specialist with knowledge in the area of suspected disability. Additional information is contained in Appendix A and B.

Reliability/Validity. Standardized and criteria-referenced or curriculum-referenced tests should have been developed by test publishers through a process of development, field-testing, and refinement. Unfortunately, some instruments are published and advertised which have not been adequately field-tested. Therefore, the professional must be skilled in judging the quality of instruments and knowledgeable about the characteristics of the instruments used.

Tests are typically evaluated according to reliability and validity. (Refer to Appendix D for information on reliability and validity.) A test is *reliable* if it consistently yields the same or similar results. A test is *valid* if it actually measures what it purports to measure.

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Culturally Sensitive Evaluation. Richard N. Roberts in the *Workbook for Developing Culturally Competent Programs for Families of Children With Special Needs* (1990), views cultural competence as "a program's ability to honor and respect those beliefs, interpersonal styles, attitudes, and behaviors both of families who are clients and the multicultural staff who are providing services" (page 1). This well-rounded definition takes into account influences of both the family and the service provider and will be used throughout the following discussion focusing on evaluation and assessment as a process that is culturally sensitive.

The influence of the culture on family functioning and child rearing practices is not easily separated from the impact of a disability on a child and family members. Family members often can best identify how a child functions in a variety of natural settings and can describe the impact of the child's disability on skill acquisition and general growth and development. Eliciting this information often becomes pivotal in facilitating the gathering of comprehensive information about the child. This becomes more complex when the family is of another culture.

The evaluation and assessment process, therefore, must acknowledge and recognize the critical roles of the family and their cultural and linguistic background. Cultural variables to be acknowledged include:

- language and communication in the home, such as who speaks what language, when, and for what purpose;
- child rearing practices of the family;
- how family is defined within a particular culture; and
- cultural beliefs regarding what is considered healthy and what is considered a disability.

The cultural effects on a child's learning style, values, and self-concept must also be taken into account.

Children with multicultural backgrounds often appear to be acculturated to the dominant culture. However, they may have multiple cultural biases that are masked by the influences of the dominant culture. It is important to understand how closely the family is adhering to and is influenced by a traditional culture. Even when the child shows adequate use and understanding of the dominant culture, one must consider the amount of experience and practice the child/family has had with the dominant culture in relation to their traditional culture.

Standardized assessment tools are not normed to accommodate diverse cultural populations. Use of such instruments is extremely limited and fails to reflect accurate developmental information for those from diverse backgrounds. Modifications of standardized tools negates the norming value of the tools, making them situation specific. Information gathered from formalized tests, to be valuable, must be reinforced and augmented by other information gathering methods.

For diverse populations, evaluation and assessment cannot be defined merely as gathering standardized information that can be used to project future growth and development. To most adequately identify the special needs of a child and his/-her family, the process must be unique

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to the situation. Within this context, the assessment approach becomes an individualized, comprehensive view of the child's environment, rather than being an exercise in formal testing. This approach to evaluation and assessment, because of its individualized nature, will promote the use of developmentally appropriate practices throughout the process.

When a myriad of family and cultural factors are evident, evaluation/-assessment planning is imperative and vital in making the process culturally sensitive. Planning activities include a thorough analysis of background information, observations in the natural setting, interactions with culturally significant others to determine what adaptations and modifications will provide accurate information regarding other possible culturally relevant factors that may affect the assessment of the child and family.

Accurate information for the previously mentioned areas may be gathered in one or more of the following ways:

- talking directly to individuals of a particular culture;
- reviewing written material pertaining to certain cultures;
- observing family interactions and activities; and
- participating in other cultural activities.

Professionals need to accept that their understanding of culture is influenced by their own basic core beliefs and values. Every individual is rooted in a culture that sets core beliefs and values and serves as the primary influencer of attitudes toward other cultures. To effectively work with other cultures, not only must one neutralize one's own biases, but gather actual information about other cultures, discarding stereotypes and biased beliefs.

To establish credibility within the minority culture, the professional must become culturally competent, accept parents as equal team members and advocates for their child, and show a strong belief in a truly integrated society with equal opportunity for all. One must show a genuine sensitivity to and appreciation for the uniqueness of each child, the child's family and their needs. In doing so, communication between the cultures is enhanced and respect from the minority culture attained.

On an individual basis, professionals will need to evaluate their own level of cultural competence. To do so, the following questions must be critically pondered.

- To what extent do I accept and value diversity of beliefs, behavior, and values?
- Do I have the capacity for cultural self-assessment?
- To what degree am I aware of the dynamics that occur when cultures interact?
- How much cultural knowledge have I gained or do I have for the minority cultures with which I interact?
- What adaptations have I developed to accommodate diversity when working with young children and their families?

The answers to these questions will give insight into how impartial and unbiased one's system is for working with others from diverse backgrounds.

There may be times when, due to circumstances or limited cultural competence, it may be beneficial to use cultural mediators or interpreters. Often they are better able to make language adaptations during communication efforts, and they may be able to gain a sense of the proficiency the child holds for both languages to which he/she may be exposed. Interpreters or cultural mediators are often viewed as neutral by the family, gain the family's trust quickly, and establish a good working relationship with the family.

Appendix A of this guidebook is a fact sheet entitled "Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups." The ten strategies discussed will assist professionals in working effectively with children and families of other cultures.

Appendix B of this guidebook is a fact sheet entitled "Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment." The ten questions will assist professionals in making the screening and assessment process culturally sensitive.

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CONDUCTING THE EVALUATION

> *"The best way to understand the development of children is to observe their behavior in natural settings while they are interacting with familiar adults over a prolonged period of time" (Bronfenbrenner, 1977).*

The above statement should serve as a guide for conducting evaluation and assessment procedures with infants, toddlers and preschoolers. Although standardized instruments may need to be used, the child's involvement should be as natural and nonthreatening as possible. Procedures that can facilitate this process are the arena evaluation, play-based evaluation, and using parents and caregivers as a source of information.

ARENA EVALUATION

Arena evaluation is the simultaneous evaluation of the child by multiple professionals of differing disciplines (Foley, 1990). This procedure is representative of a transdisciplinary model of team functioning. An example is when a physical therapist, an occupational therapist, an educator, and a speech therapist all evaluate the child simultaneously. Instead of each professional working with the child separately, the team of professionals works together with the child observing a common sample of behavior and immediately sharing expertise and information. The rationale for arena evaluation is based on the relative difficulty of separating physical, cognitive and sensory domains of development in the young child. The advantages of this approach extend to everyone involved - child, family and professionals. Since all professionals are working together, the amount of actual time spent in evaluation by the child and family is reduced. Family members can provide information once rather than possibly having to provide the same answers to each professional in turn. Professionals have the advantage of immediate access to the skills and knowledge of their teammates. In addition, consensus building is facilitated since a common sampling of behavior has been the basis of evaluation for all team members. Further information on arena evaluation is included in Appendix E.

PLAY-BASED EVALUATION

Procedures have also been identified for evaluation procedures based on observation of the child in more informal, play-based situations. Toni Linder has developed a system for evaluating child functioning across developmental domains in an arena format which involves the child in informally structured activities. *The Transdisciplinary Play-Based Assessment* (TPBA) method (Linder, 1990) relies on clinical observation and interpretation of these observations by the team of professionals to determine eligibility and to guide the development of the IFSP or IEP. The TPBA provides useful guidelines for the clinical observation of child behavior and may be used in addition to other instruments.

PARENTS AND CAREGIVERS AS A SOURCE OF INFORMATION

In recent years, there has been increased interest in involving family mem-

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bers and caregivers in the evaluation and assessment process. The importance of involving families in decision-making is emphasized in the most recent legislation - P.L. 99-457 and P.L. 102-119. Professionals also realize the importance of gaining information from the family about the child's behavior in a variety of situations.

Information from family members and caregivers can be obtained by interviews or by asking parents or caregivers to complete standardized measures, rating scales, or checklists. Many pre-screening instruments, such as the Infant Monitoring Questionnaire (IMQ) (Bricker, 1987), are completed by parents. The recently published *Ages and Stages* (Bricker, 1995), which is used for program planning, includes a scale called The Family Report which is completed by families.

WRITING THE REPORT

Upon the completion of the evaluation/assessment process, the team will jointly develop a written integrated summary. The purpose of the written report may differ between infant development and early childhood special education programs; however, a thorough and complete written integrated report is necessary to ensure an appropriate interpretation of the assessment information.

The written integrated summary should be written in terms families can understand. If educational or medical terms must be used, definitions should be given. The summary should include:

- identifying information;
- reason for referral and referral source;
- medical and developmental history;
- evaluation/assessment procedures;
- interpretation of evaluation/assessment results; and
- conclusions including statement of disability and need for specialized instruction.

INFANT DEVELOPMENT REPORT

At the conclusion of an assessment of infants and toddlers with disabilities, an evaluation report will be written and forwarded to the Regional Human Service Center Eligibility Determination Team. This team determines eligibility for Developmental Disabilities Case Management System Services which may include Infant Development Services if the parent chooses. In the written report the evaluation team will make a recommendation regarding services in the infant development program. It is necessary for the report to include a rationale for this recommendation based on both qualitative and quantitative information derived from the evaluation. Information regarding a physical or mental diagnosis and a percentage of delay in any of the five developmental domains (cognition; receptive and expressive communication; gross and fine motor, physical; social-emotional; or adaptive)) must be included in this report.

Other issues that may not be directly related to eligibility determination may also be addressed in the evaluation process. For instance, information that would be helpful in planning the intervention program should be included. Furthermore, questions about the child's functioning that may have been identified during evaluation and require further assessment should also be included.

The evaluation report should be the result of team discussion. Information from tests, observations and interviews should be synthesized to present a comprehensive picture of the child's needs.

The term "informed clinical opinion" is part of the regulatory requirements of eligibility determination under Part H. The use of informed clinical opinion refers to the process of making a clinical judgment in those cases where test scores do not provide a comprehensive picture of a child's development. It is used as a safeguard against eligibility that is determined solely on test scores or isolated information. Informed clinical opinion is used by the evaluation team to make a

recommendation relative to eligibility for services. It makes use of qualitative and quantitative information in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. The training and previous experience of the evaluation team, including the parents, form the basis for assuring an informed clinical opinion in the evaluation process. According to the National Early Childhood Technical Assistance System, cited in Biro, Daulton and Szanton (1991), this opportunity to integrate observations, impressions, and evaluation findings of the team facilitates a "whole child" approach to evaluation and assessment that goes beyond a reporting of test scores. In this way, the functional impact and the implications of noted delays or differences in development can be discussed and considered by the team in determining eligibility and developing the intervention plan.

Adjusting for Prematurity. When Infant Development Program staff are evaluating an infant who was born prematurely, the child's chronological age is adjusted to reflect the expected date of birth rather than the actual date. This adjustment is made if the infant is born more than four weeks prematurely and continues to be made until the chronological age of twelve to eighteen months (based on actual date of birth).

EARLY CHILDHOOD SPECIAL EDUCATION INTEGRATED WRITTEN ASSESSMENT REPORT

The team will write a report that integrates findings from all sources. The report will verify agreement that all current data have been gathered to make disability determination decisions. The integration of all assessment data ensures that attention has been given to observations and other information shared by each team member. In addition, the integration process protects the child from being labeled inappropriately. Decision-making by one person or on the basis of one procedure or situation increases the chance of inappropriate labeling and is prohibited by regulations. The report needs to be written in a manner that is understandable to parents and other professionals; a reiteration of test scores is not meaningful to parents and others.

Each of the areas listed below should be considered during the team's analysis of the assessment findings and is discussed further in the pages that follow:

- determination of disability;
- input from all assessment team members that reflects all areas of the child's functioning;
- observational information relating to child's learning;
- impact of disability on education;
- nondiscriminatory procedures;
- relationship between the assessment summary and strategies for individual program development;
- attention to immediate needs;
- signatures of all team members/ agreement; and,
- statement of disagreement (if applicable).

Determination of Disability. At the conclusion of the meeting to review the assessment results, the team will determine whether the unique educational needs of the child are due to a disability as defined by IDEA or Section 504 of the Vocational Rehabilitation Act of 1973. The report must include a statement as to whether the child has a disability and what that disability is as defined in IDEA or Section 504. The categories used in North Dakota are: specific learning disability, hearing impairment, deafness, visual impairment including blindness, deaf-blindness, mental retardation, serious emotional disturbance, orthopedic impairment, other health impairment, traumatic brain injury, autism, and speech or language impairment. If the child is not eligible under IDEA, the assessment report will determine if the child is considered "handicapped" under Section 504 of the Vocational Rehabilitation Act of 1973. This assures the provision of parental rights, procedural safeguards, and an individual accommodation plan, which are afforded under Section 504.

Section 504 applies to preschoolers when:

- they are enrolled in a Head Start program
- they are in a kindergarten program
- the public school sponsors a program for all 3, 4, or 5 year olds.

For children not requiring special education or services under Section 504 but for whom the existing regular education curriculum has not fostered successful learning, the school will need to plan for satisfactory changes in the regular educational program.

The written findings need to reflect the relationship of observational information to the child's learning/functioning. At least one professional other than the child's regular teacher shall observe the child's performance in the preschool setting or in an environment appropriate and familiar to the child, such as home. A summary report based on team analysis ensures that observations are not only recorded and shared but that attention is given to the effect these observations have on the child's ability to process information, express an idea, or perform a skill. Since observational data may either support or conflict with conclusions based on other assessment procedures, the inclusion of such data is critical.

An integrated written report enables all assessment team members, including the parents, to know whether the observation and other assessment information that they shared was considered. A child's unique patterns of functioning, particularly for children whose problems are complex, will emerge only after the team's joint analysis of *all* input rather than individuals drawing conclusions in isolation.

The conclusions drawn by the team are derived from the assessment data and recorded in the written report. Input from all assessment team members and all parameters of functioning must be considered. If some interfering factors are due to disabilities in addition to the *primary* disability, the written report ensures that such secondary disabilities are identified and addressed.

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Assessment findings from evaluators outside the school district or special education unit should be given equal consideration. Their findings should be discussed by the team in conjunction with all other findings and integrated into the written report. All information gathered during the assessment process is important, whether conducted by school personnel or outside evaluators.

Evaluation data generated by Infant Development Programs should be utilized. The transition process (see section on transition) addresses the roles of multiple agencies during the evaluation process or the transition from Infant Development to public school preschool programs.

Nondiscriminatory Procedures. Careful consideration should be given to nondiscriminatory assessment procedures to assure that the child is not identified as having a disability when the child's educational concerns are primarily related to cultural, environmental, sensory, or economic issues. These considerations must be included in the written report so that they can be considered when making decisions regarding the determination of disability.

Information for Program Development. The integrated written assessment report should serve as a resource document for all planning teams. Recommendations regarding instructional needs may be included in the report as further explanation of the child's performance within areas of strength or need. Such recommendations may be implemented regardless of whether there is an identified disability.

The report will not establish whether special education or related services are required or who is responsible for any resulting services; it will only determine whether the child has a disability and if it is appropriate to develop an IEP. *It is important to remember that when a child has been determined to have a disability, the IEP process (rather than the assessment process) determines whether the child in is need of special education and related services.* When the assessment findings have been adequately analyzed by the assessment team and the significant information summarized in the report, the IEP team will be able to draw directly from the report in preparing the present level of functioning statements for the IEP.

It is important to provide immediate attention to areas in need of modifications or adaptations that may not be relevant to eligibility or placement decisions. Examples of such situations are given below.

- Medical and other health-related problems as well as environmental circumstances that are physically threatening or otherwise affect a child's physical well-being need to be addressed. Response to such needs often requires a referral to specialists or other agencies.

- Classroom situations that impair learning or achievement and require attention regardless of placement can be addressed immediately. For instance, if a hearing impairment is reported and preferential seating is necessary, a change in seating arrangement should not be delayed until the development of the IEP. Any immediate changes implemented at this time will benefit the child and be advantageous to the assessment and program planning process.

- The assessment report should indicate needs that are specifically setting-related. Examples include: physical accessibility; distractions (e.g., auditory, visual, spatial) that interfere with functioning; teacher style; classroom climate; number of personnel with whom the child will be expected to relate; and number and age of children in classroom. When assessment shows that setting-related factors make a critical difference, the observations should be noted in the report.

The sharing and analysis of the assessment data occur separate from and preceding the IEP meeting. However, procedures in local schools may be such that many of the same persons function on the multidisciplinary team for both assessment and IEP development. If so, the sharing and analysis of assessment information may precede IEP development during the same meeting.

Consensus Statement. The team needs to gain consensus on how all findings, including those from evaluators outside the district or special education unit, relate to the questions asked during the assessment planning process as well as if there is a significant impact on the child's learning. The procedures require that team members sign the report to verify that the report reflects their conclusions. If a team member disagrees with the report, that team member must attach a dissenting statement to that effect.

DISSEMINATION OF INFORMATION

Immediate feedback should be given to the family following an evaluation or assessment, if possible. A face-to-face conference at a later time would be an alternative as would a telephone conference. A last choice would be a letter to the family reporting results. The first two alternatives allow questions to be answered and misconceptions to be resolved. Every effort should be made to respond to the family's questions with honesty and conciseness and without the use of educational or medical jargon. The child's family should be made aware of the factors that form the basis for making a recommendation.

Personally identifiable information concerning a child, the child's parent, or other family members is confidential. Program staff must receive parental consent before sharing information about the family and the child with other agencies or professionals in private practice unless authorized to do so under the Family Educational Rights and Privacy Act.

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APPENDICES

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APPENDIX A

APPENDIX A-A. Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups

APPENDIX A-B. Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment

APPENDIX A-C. Selected Evaluation and Assessment Instruments for Early Intervention

APPENDIX A-D. Types of Test Reliability and Validity

APPENDIX A-E. Arena Evaluation

APPENDIX A-A

Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups

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1. Individualize the screening and assessment process for parents as well as for children. Children and other family members may be at various levels of acculturation and may require similar or varying degrees of modifications, adaptations, or support, such as language interpretation.

2. Do a self-assessment of your own cultural background, experiences, values, and biases. Examine how these factors may impact your interactions with people from other cultural groups.

3. Begin the screening and assessment process with the parents - their concern, reasons for coming to you, and expectations of what you can provide.

4. Take time to establish the trust needed to fully involve the family in the screening and assessment process.

5. Use bilingual and bicultural staff, or mediators and translators whenever needed. Try to maintain a consistency of providers to allow the family to establish an ongoing communication.

6. Allow for flexibility of the process and procedures. Meet with parents at their job site, or call them when they return home from their job, if necessary. Modify test items to ensure cultural relevancy.

7. Conduct observations and other procedures in environments familiar to the child. These may be at the home of his/her grandmother, outdoors, or at the parents' work site.

8. Provide assistance and be flexible in establishing meetings with parents. This might include providing for childcare of the siblings, transportation to a meeting site, or meeting the family in their home.

9. Participate in staff training on cultural competence skills in screening and assessment. Strive to achieve standards for professional cultural competence.

10. Conduct ongoing discussions with practitioners, parents, policymakers, and members of the cultural communities you serve.

APPENDIX A-B

Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment

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1. With what cultural group was this screening or assessment tool normed? Is it the same culture as that of the child I am serving?

2. Have I examined this screening and assessment tool for cultural biases? Has it been reviewed by members of the cultural group being served?

3. If I have modified or adapted a standardized screening or assessment tool, have I received input on the changes to be certain is it culturally appropriate? If using a standardized tool or one to which I have made changes, have I carefully scored and interpreted the results in consideration of cultural or linguistic variation? When interpreting and reporting screening and assessment results, have I clearly referenced that the instrument was modified and how?

4. Have representatives from the cultural community met to create guidelines for culturally competent screening and assessment for children from that group? Has information about child-rearing practices and typical child development for children from that community been gathered and recorded for use by those serving the families?

5. What do I know about the child-rearing practices of this cultural group? How do these practices impact child development?

6. Am I aware of my own values and biases regarding child-rearing practices and the kind of information gathered in the screening and assessment process? Can I utilize nondiscriminatory and culturally competent skills and practices in my work with children and families?

7. Do I utilize parents and other family members in gathering information for the screening and assessment? Am I aware of the people with whom the child spends time, and the level of acculturation of these individuals?

8. Do I know where or how to find specific cultural or linguistic information that may be needed for me to be culturally competent in the screening and assessment process?

9. Do I have bilingual or bicultural skills, or do I have access to another person who can provide direct service or consultation? Do I know what skills are required of a quality interpreter or mediator?

10. Have I participated in training sessions on cultural competence in screening and assessment? Am I continuing to develop my knowledge base through additional formal training and by spending time with community members to learn the cultural attributes specific to the community and families I serve? Is there a network of peer and supervisory practitioners that is addressing these issues, and can I become a participating member?

APPENDIX A-C

SELECTED EVALUATION AND ASSESSMENT INSTRUMENTS FOR EARLY INTERVENTION

Developmental Screening

Assessment Instrument	Domains/ Component	Age	Description	Publisher
Battelle Developmental Inventory Screening Test	Personal-social Adaptive Motor Communication Cognitive	birth - 8 years	Nationally standardized screening test; abbreviated version of full scale	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Denver Developmental Screening Test - Revised (DDST)	Gross motor Fine motor Personal-social Language	1 month - 6 years	Screening instrument that assesses 4 areas (including a pre-screening form)	DDM, Inc. PO Box 20037 Denver, CO 80220
Minnesota Preschool Inventory	Developmental Scales Adjustment Scales	2 - 6 years	Screening instrument profiles current functioning levels	Behavior Science PO Box 1108 Minneapolis, MN 55440
Developmental Indicators for the Assessment of Learning - Revised (DIAL-R)	Gross motor Fine motor Concepts Communication	2 1/2 - 5 1/2 years	Standardized; identifies potential learning problems	Mardell-Czudnowski & Goldenberg Childcraft Education Corp. Edison, NJ 08818
Comprehensive Identification Process (CIP)	Cognitive-verbal Motor Language Sensory Social Medical history	2 1/2 - 5 1/2 years	Standardized; identifies potential learning problems in children in need of special services	Scholastic Testing Services 480 Mayer Road Bensonville, IL 60106
Developmental Activities Screening Inventory, II (DASI)	Fine motor Initiative behavior Identification Classification Matching Number concepts Response to commands	6 months - 5 years	Assesses sensory motor behavior across 55 uncategorized developmental tasks	Testing Resources Corp. 50 Pond Park Rd. Illingham, MS 02025
Developmental Profile II	Physical Self-help Social Academic Communication	birth - 12 years	Estimates current level of performance in 5 areas	Psychological Development 7150 Lakeside Dr. Indianapolis, IN 46278

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APPENDIX A-C (continued)

Standardized Developmental and Intellectual Assessments

Assessment Instrument	Domains	Age	Description	Publisher
Wechsler Preschool and Primary Scales of Intelligence (WPPSI)	Verbal Skills Performance Skills	4 years - 6 1/2 years	Yields verbal, performance and full scale deviation IQ's	Psychological Corporation 757 Third Ave. New York, NY 10017
Stanford-Binet Intelligence Scale	Vocabulary, Comprehension Absurdities, Quantitative, Pattern Analysis, Copying, Bead Memory, Memory for Sentences	2 - 18 years	Yields mental age and IQ useful for predicting academic achievement	Riverside Publishing Co. 1919 S Highland Ave. Lombard, IL 60148
Kaufman Assessment Battery for Children (K-ABC)	Sequential processing Simultaneous processing Mental processing Achievement	2 1/2 - 12 years	Yields scores in five areas; norm-referenced/ standardized; Sensitive to minorities; Assesses 5 areas	American Guidance Svcs., Inc. Publishers Bldg. Circle Pines, MN 55014
Leiter International Performance Scale and the Arthur Adaption	Generalization Discrimination Analogies Sequencing Pattern Completion	2 - 18 years	Yields mental age and IQ; Measures intelligence through nonverbal, block pattern-matching response; Assesses 5 areas	Western Psychological Services 12031 Wilshire Ave. Los Angeles, CA 90025
McCarthy Scales of Children's Abilities	Verbal Perceptual-performance Quantitative Motor memory	2 1/2 - 8 years	Yields mental age, standard score, and percentile;. Determines general intellectual levels, strengths, and weaknesses; Norm-referenced/ standardized	Psychological Corporation 757 Third Blvd. New York, NY 10017
Battelle Developmental Inventory	Personal-social Adaptive Motor Communication Cognitive	birth - 8 years	Nationally standardized; Yields age equivalent scores standard scores; Determines relative developmental strengths and weaknesses; Assesses 5 areas; Spanish version available	Riverside Publishing Company 8420 Bryn Mawr Avenue Chicago, IL 60631
Griffiths Mental Developmental Scales	Locomotor Personal-social Learning & Speech Eye & hand performance Practical reasoning	birth - 2 years 2 - 8 years	Offers an infant and a preschool scale; Standard scores in developmental areas and a total score	High Wycomb England

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APPENDIX A-C (continued)

Behavioral/Social Emotional

Assessment Instrument	Domains	Age	Description	Publisher
Vineland Adaptive Behavior Scales,	Self-help Self-direction Occupation Communication Locomotion Socialization	birth - adult	Assesses progress toward social-maturity, competence or independence; Interview format; Yields social age, social quotient; Assesses 6 areas	American Guidance Svcs., Inc. Publishers Bldg Circle Pines, MN 55014
Burk's Behavior Rating Scale	18 categories of behavior	birth - 6 years	Identifies behavior problems and patterns of problems shown by children; Standardized; Assesses 18 categories of behavior	Western Psychological Services 12031 Wilshire Blvd Los Angeles, CA 90025
Topeka Association for Retarded Citizens Assessment Instrument for Severely Handicapped Children (TARC)	Self-help Motor Communication Social	3 - 16 years	Measures adaptive behavior; Appropriate for the more severely disabled; Assesses 4 areas	II & II Enterprises Box 3342 Lawrence, KS 66044
AAMD Adaptive Behavior Scale	13 categories of behavior	birth - adult	Measures adaptive behaviors; Assesses 13 areas of behavior	Edmark Corp PO Box 3903 Dellevue, WA 98009-3503
Balthazer Scales of Adaptive Behavior	Self-help Adaptive and coping behavior	5 - adult	Measures adaptive behavior; Assesses 6 areas of behavior	Research Press Co CFS Box 3327 Champaigne, IL 61820

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APPENDIX A-C (continued)

Communication

Assessment Instrument	Domain / Components	Age	Description	Publisher
Receptive Expressive Emergent Language Scale (REFEL)	Receptive, expressive language	birth - 3 years	Standardized test that yields 3 scores: expressive, receptive and combined	Paul II. Brookes PO Box 10624 Baltimore, MD 21285-0634
Test of Language Development (TOLD)	Receptive, expressive language	4 - 8 years	Standardized test that yields language age, percentiles, subtest standard scores	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Language Development Scale (LDS)	Receptive, expressive language	birth - 60 months	Standardized test that yields language age equivalent; Appropriate for hearing impairment	Ski Hi Outreach Utah State University Logan, UT 84322
Peabody Picture Vocabulary Test Revised (PPVT)	Receptive language	2 1/2 - 40 years	Standardized test that yields a standard score and age equivalents	American Guidance Service Publisher's Bldg Circle Pines, MN 55014
Clinical Evaluation of Language Fundamentals - Revised (CELF-R)	Oral expression	K - 12	Standardized test that yields age equivalents and percentiles	Psychological Corp 757 Third Ave New York, NY 10017
Carrow Elicited Language Inventory (CELI)	Oral expression	3.0 - 7.11 years	Standardized test that assesses language problems	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Preschool Language Scale	Verbal ability Auditory comprehensive Language	1 - 7 years	Evaluates strengths and deficiencies in each area; Provides "language age" description of performance; Spanish version available	Charles E. Merrill Publ. 1300 Alum Creek Drive Columbus, OH 43216

APPENDIX A-C (continued)

Listening Comprehension

Assessment Instrument	Domains/ Components	Age	Description	Publisher
Test of Auditory Comprehension of Language (TACL-R)	Receptive language	3.0 - 9.11 years	Standardized; Assesses auditory comprehension of language	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Test of Early Language Development (TELD)	Receptive language	3.0 - 7.11 years	Standardized; Assesses language content, form and development; Yields language quotients and ages	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Boehm Test of Basic Concepts - Preschool Version	Basic concepts Understanding	K - 2	Assesses child's beginning school knowledge of basic concepts	Psychological Corporation 757 Third Ave New York, NY 10017
Boehm Test of Basic Concepts - Revised	Basic concepts Understanding	3 - 5 years	Assesses child's knowledge of concepts	Psychological Corporation 757 Third Ave New York, NY 10017

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APPENDIX A-C (continued)

Criterion-Referenced Instruments

Assessment Instrument	Domains/ Concepts	Age	Publisher
Learning Accomplishment Profile	Fine & Gross Motor, Language Cognition, Self - help, Personal-Social	birth - 72 months	Kaplan Press 600 Jonestown Road Winston - Salem, NC 27108
The Portage Curriculum	Infant stimulation, Socialization, Language, Self-help, Cognitive Motor	birth - 72 months	Portage Project 412 East Slifer Street Portage, WI 53901
Preschool Developmental Profile	Cognition, Perceptual-Fine Motor, Gross Motor, Social-emotional, Self-care, Language	3 - 6 years	U of Michigan Press Ann Arbor, MI 48109
Carolina Curriculum for Preschoolers with Special Needs	Cognition, Communication, Social skills-Adaptation, Self-help, Fine and Gross Motor	2 1/2 - 5 years	Paul Brookes Publishers P O Box 10624 Baltimore, MD 21285
Uniform Performance Assessment System	Preacademic/Fine Motor, Communication, Self-help/Social, Gross Motor, Inappropriate Behaviors	birth - 72 months	Charles Merrill Publishers 1300 Alum Creek Drive Columbus, OH 43216
Oregon Project for Visually Impaired and Blind	Fine-Gross Motor, Communication, Social-emotional, Self-help, Cognition	birth - 72 months	Jackson Co Ed Service District 101 N Grape Street Medford, OR 97501
Individualized Assessment & Treatment for Autistic and Developmentally Delayed Children	Integrated Assessment and Curricular Objectives	birth - 8 years	Pro-Ed 5341 Industrial Oaks Austin, TX 78735
Help for Special Preschoolers	Cognition, Language, Gross & Fine Motor, Social-emotional, Self-help	3 - 6 years	VORT Corporation PO Box 11132 Palo Alto, CA 94306
The Callier-Azusa Scale: Assessment of Deaf/Blind Children	Motor Development, Perceptual Development, Daily Living Skills, Cognition, Communication & Language, Social Development	birth - 9 years	Callier Center for Communication Disorders U of Texas 1966 Inwood Road Dallas, TX 75235
The H/COMP Preschool Curriculum	Communication, Own-Care, Motor, Problem Solving	birth - 60 months	Charles Merrill Publishers 1330 Alum Creek Drive Columbus, OH 43216
The Programmed Environments Curriculum	Functional Living Skills, Cognitive Skills, Motor Skills, Self-help Skills	birth - 60 months	Charles Merrill Publishers 1330 Alum Creek Drive Columbus, OH 43216
Brigance Diagnostic Inventory of Early Development	Pre-speech, General Knowledge, Comprehension, Fine motor, Pre-ambulatory	birth - 7 years	Curriculum Associates North Billeria, MA

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Assessment Instrument	Domains/ Concepts	Age	Publisher
Peabody Developmental Motor Scales	Neuromotor Fine Motor; grasping, hand use, eye-hand coordination, manual dexterity Gross motor; reflexes balance nonlocomotor, receipt, propulsion of objects	birth - 83 months	Riverside Publishing Company 8420 Bryn Mawr Avenue Chicago, IL 60631
Evaluation & Programming System for Infants & Young Children (Gentry & Bricker)	Sensorimotor Skills; Physical Development, Gross & Fine Motor; Social, Self-care; Communication	birth - 2 years	Dept of Special Education U of Idaho Moscow, ID
Play Assessment Scale - R. Fewell, 1986	Toy Play	birth - 4 years	College of Education U of Washington Seattle, WA
Functional Vision Inventory for the Multiple & Severely Handicapped (M.B.Langley)	Functional Vision	All ages	Stoelting Co 1350 S Kosten Avenue Chicago, IL 60623
The Integrated Preschool Curriculum (Odom, et al, 1987)	Social Interaction	birth - 5 years	U of Washington Press U of Washington Seattle, WA
Pre-Feeding Skills (Evans-Morris & Klein, 1987)	Oral Motor Develop-ment/Feeding	birth - 5 years	Therapy Skill Building 3830 E Bellevue P O Box 42050 Tuscon, AZ 85733
Transdisciplinary Play-Based Assessment (Toni W. Linder)	Play, Cognition, Social-Emotional Communication, Sensorimotor	birth - 5 years	Paul H. Brookes Co P O Box 10624 Baltimore, MD 21285-0624
Assessment in Infancy: Ordinal Scales of Psy-chological Development (I. Uzgiris & I. M. Hunt)	Cognition	birth - 24 months	U of Illinois Press Urbana, IL
A Clinical & Educational Manual for Use with the Uzgiris & Hunt Scales (C. Dunst)	Cognition	birth - 24 months	Pro-Ed 5341 Industrial Oaks Blvd Austin TX 78735

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APPENDIX A-D

Types of Test Reliability and Validity

Types of reliability include, but are not limited to:

- *Interrater reliability* - the extent to which two raters will get similar results.
- *Test-retest reliability* - the extent to which the test will yield similar results over time.

Information on reliability should be included in the test manual. Levels of .80 or greater are typically considered to be adequate.

Types of validity include, but are not limited to:

- *Content validity* - the extent to which the content of the test sufficiently covers the area it purports to measure.
- *Concurrent validity* - the extent to which a test yields the same results with a population of children as another, well-established, test.
- *Predictive validity* - the extent to which the results of a test are predictive of the future performance of a population of children.

Levels of .80 or greater are typically considered to be adequate for concurrent validity and predictive validity. Content validity can be judged by a review of the behavior that is measured by an instrument. For example, the content validity of an intelligence test which only measures receptive vocabulary would be questionable, since there is certainly more to intelligence than receptive vocabulary.

APPENDIX A-E

Arena Evaluation

The organization of an arena evaluation is based on the concept of a primary facilitator. One member of the team is designated to serve as primary facilitator by interacting with the child and eliciting the main sample of structured behavior. This does not mean that other team members are forbidden to interact with the child. For example, the physical therapist may need to "lay hands" on the child to assess muscle tone even though another team member is the primary facilitator. It does mean, however, that if there is an instrument or instruments that serve as the more structured part of the evaluation, all team members may need to become proficient at administration. The primary facilitator may be designated as such because the needs of the child best match his or her discipline, because of a relationship established with the child or family, or because of other considerations which may arise. A parent facilitator may also be designated to record parents' input and answer their questions throughout the evaluation. The following has been suggested by Foley (1990) as a possible sequence to follow during the arena evaluation:

Greeting and Warm Up
: Family and team members visit, child is allowed to explore and get to know team members.

Formal Task-Centered Sequence
: The main assessment instrument is administered by the primary facilitator. Other team members observe and may score discipline-specific instruments or make clinical notes.

Snack Break and Refueling
: Snack and bathroom break provides an opportunity to observe self-help skills and parent-child interaction.

Story Time and Teaching Samples
: A story time format may be used to expand the language sample or a brief teaching sequence might be used to observe how the child processes new information and generalizes learning to new materials.

Free Play
: The child's spontaneous movement and interaction with toys will be observed. With older children, bringing in a peer at this point may allow observation of social interaction skills as well.

Brief Staffing and Feedback
: The team members pause to formulate impressions while the parent facilitator collects the parents' comments about the session. Parents and other team members will then come together to share initial impressions so the parents have some closure and do not go away with undue anxiety. A formal staffing with results of the evaluation will be held at a later time.

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Whether or not formal evaluation instruments are used, the advantages of the arena evaluation method described above are many. The evaluation is conducted in an environment where the child feels comfortable with a primary facilitator who has established rapport with the child. The sequence of evaluation tasks and activities is flexible and can be made to fit the pace and interests of the child. The parent can remain with the child to reduce anxiety and facilitate the child's involvements and motivation. The professional members of the team will witness the same sampling of child behavior, each adding expertise from his/her discipline to build a holistic impression of the child's development.

Appendix C includes a list of instruments commonly used in evaluation and assessment of infants, toddlers and preschoolers. Most of these instruments can be utilized in the arena evaluation format.

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EARLY CHILDHOOD SPECIAL EDUCATION FOR CHILDREN WITH DISABILITIES, AGES THREE THROUGH FIVE: PROGRAM PLANNING

Prepared By

North Dakota Interagency Coordinating Council
Program Standards Subcommittee

Published By

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INTRODUCTION

This section includes distinct but interrelated components. First, the North Dakota program guidelines are presented, including eligibility of students, a description of the service delivery system, and recommendations regarding caseload and use of support personnel. Following the program guidelines is a discussion of services to families - both required and supplementary options. Finally, guidance in the individualized education program (IEP) planning process is described, with emphasis given to those components that differ from the IEP that is developed for children who are of school age. Directions for completing a SPECIS Record Entry Data Form is included. An extensive discussion of team decision-making relative to service in the least restrictive environment is presented, with alternative procedures and examples offered to the reader.

NORTH DAKOTA PROGRAM GUIDELINES

1.0 **ELIGIBILITY OF STUDENTS:** A comprehensive, multidisciplinary assessment must be completed for each child suspected of having a disability under Individuals with Disabilities Education Act (IDEA). This assessment will provide information from all areas of a child's functioning (e.g., medical, cognitive, developmental, social/emotional). Relevant family and environmental information will also be gathered. This information will be used to identify a disability under IDEA and establish the need for specially designed instruction.

1.1 Disability categories are identified in IDEA (34 C.F.R. 300.5(a)) and NDCC 15-59-01(2). Disability categories are: autism, deafness, deaf-blindness, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, serious emotional disturbance, specific learning disability, speech or language impairment, traumatic brain injury and visual impairment. The definitions of the disability categories are contained in Appendix A.

1.2 Identified children with disabilities are eligible for services under IDEA beginning on their third birthday. (NDCC 15-59-01(2), definition of a child with disabilities.)

1.3 Children receiving Early Childhood Special Education (ECSE) services must be three years of age through five years of age. (NDCC 15-59-01(2), definition of a child with disabilities.)

1.3.1 Children who turn age six after the current school term has begun may receive ECSE services throughout the school year, as determined by the individualized education program (IEP) team's decision that such services are appropriate.

1.3.2 Children who are six years of age enrolled in kindergarten programs and in need of special education and related services will receive those services from personnel serving the school-aged students.

1.3.2.1 Special education and related services that are coordinated by a school case manager may be implemented in an ECSE setting if determined appropriate by the IEP team.

1.4 Children receiving ECSE services must have verification of updated immunizations in their special education student file (NDCC 23-07-17). It is recommended that this information be placed in the child's cumulative file housed at the school of residence.

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2.0 **APPROVAL OF SERVICES:** A request to the Department of Public Instruction (DPI) for annual approval must be made for any ECSE services in the same way as for any other special education services.

2.1 An approved program of services must employ a teacher holding a North Dakota credential in the area of ECSE.

3.0 **SERVICE DELIVERY SYSTEM:** Individualized education services for young children with disabilities must be implemented in a variety of community, home and school settings. Least Restrictive Environment (LRE) decisions will be based on specific needs identified in the child's IEP as determined by the IEP team. The identification of the child's typical environment (place the child would be if he/she did not have a disability) serves as the point of reference as LRE options are addressed and decisions made. The following list of options, along with a variety of possible combinations, are all acceptable means to deliver a ECSE service within the context of LRE.

3.1 Services will be implemented according to strategies identified as most appropriate in meeting a child's individual needs. Service options fall under one of three categories:

3.1.1 **Direct Instructional Services** include children who receive special education and related services in individual, small group and large group instructional services implemented within targeted instructional settings by credentialed teachers, paraprofessionals, child care providers, and parents. The "characteristics of service" section of the IEP is used to determine which activities in the child's day within the home or preschool environments qualify for the total number of hours per week. The following criteria must be addressed.

3.1.1.1 In center programs where a child is being taught through large or small group instructional activities in preschool, kindergarten, or child care facilities, there must be specific educational outcomes for the child concurrent with his/her involvement in that specific activity. These outcomes must be delineated in the child's IEP and.

3.1.1.2 When the parent, child care provider or paraprofessional works directly on activities as identified in the IEP, inservice training must have occurred.

3.1.1.3 Home programs, in cases where the parent is implementing activities within the home environment which are to qualify as direct service interventions, must be described in the IEP to involve adapted routines or specially designed instructional procedures and contain specific educational outcomes for the child in the targeted instructional areas.

3.1.2 **Indirect Services** include the amount of time spent by educational and related service personnel in observing the child in any of the targeted instructional environments, assessing the child, providing inservice training to parents and other team members, and providing consultation with parents and other team members.

3.1.3 **Related Services** include the amount of time spent in individualized and small group therapy sessions within any of the targeted learning environments. This includes physical therapy, occupational therapy, communication therapy, and itinerant instructional services by credentialed personnel in targeted area(s) of the child's disability. Such services may be appropriate when supportive therapies are needed to enable a child to gain from special education services.

3.2 Service delivery settings are determined according to the child's needs. The following settings are options to be considered.

3.2.1 **Homebased Services** include children who receive special education and related services in the principal residence of the child's family. These services provide direct intervention to the child in the home environment through the use of daily functional activities and routines. Therefore, serving children in a homebased setting involves both parent training and direct interventions with the child. Homebased services may be appropriate because of the specific nature of the disability, the young age of the child, or family needs.

3.2.2 **Early Childhood Settings** include children who receive at least 80 percent of their special education and related services in community-based settings designed primarily for nondisabled children. This may include, but is not limited to, public or private preschools, child care centers, family day care, preschool classes offered to the entire 3-4 year old population by the public school system, or combinations of early childhood settings. These services provide direct intervention to the child in his/her typical day-to-day environment through the use of daily activities adapted to meet the child's developmental needs. Community-based services may be appropriate when a child lacks the ability to interact in an age-appropriate

setting because of weaknesses in socialization, interaction and language development.

3.2.3 **Combined Early Childhood/ECSE Services** include children who receive 40 to 79 percent of their special education and related services in educational programs designed primarily for non-disabled children. This may include, but is not limited to, home/clinic combinations, pull-out programs, or any other dual placements in which the child receives 40 to 79 percent of special education services in the home or in an early childhood setting with non-disabled peers, and the remainder of special education services in a setting apart from non-disabled peers. Combinations of services may be appropriate when the child has complex developmental needs requiring direct instruction including related therapies.

3.2.4 **Early Childhood Special Education Classroo**m includes children who receive 61 to 100 percent of their special education and related services in a separate class that is housed in a public or private school building, and in which the children are in a non-integrated program.

3.2.5 **Separate Day School** includes children who are served in publicly or privately operated programs set up primarily to serve children with disabilities who are not housed in a facility with programs for children without disabilities. Children must receive special education and related services in the separate day school for 50 percent or more of the time served.

3.2.6 **Residential Services** include children who are served in publicly or privately operated programs in which children receive care for 24 hours a day. This could include placement in public nursing home care facilities or public residential schools.

3.2.7 **Homebound/Hospital Services** include children who receive special education and related services in their home or in a residential medical facility. This placement is required because of the medical and health concerns that limit the child's ability to attend a school or community based program.

3.2.8 **Itinerant Services Outside the Home** includes children who receive all of the special education and related services at a school, clinic, or other location for a short period of time in individual or small group formats.

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3.2.9 **Reverse Mainstream Setting** include children in programs utilizing reverse mainstreaming, the general education portion of the day can consist of that time of the day during which non-disabled peers are brought into the special education preschool classroom as long as the ratio consists of 50 percent or greater of nondisabled peers.

4.0 **TRANSITION:** There are two critical transition phases for children in ECSE services. Individual child needs are reviewed through a transition process to determine the most appropriate services when they are referred for ECSE services from Infant Development Programs or other community early intervention programs. The other transition process occurs as children move out of ECSE programs and are enrolled in school programs. There transition processes are described in detail in the Transition Section of this guide.

5.0 **SIZE OF ENROLLMENT/CASELOAD:** The multiplicity of needs of the individual child and the additional support services necessary for each child will determine the number of children served in any particular setting by any one case manager. Actual time allotted for services will be identified on a per child basis on the individualized education program.

5.1 The Department of Public Instruction recommends the following:

5.1.1 Special education personnel providing services to children shall consider setting options including homebased, community, individual/small group and/or a combination of these. Individual teacher caseloads will vary depending upon the nature of the setting(s). Caseloads may range from 6 to 20 children. It is important to remember that caseloads are based on number of contact hours and not the number of children.

For example, a child in direct instructional services receives approximately 2 to 2 1/2 hours of service per day. Using this as a basis for homebased services, a case manager would be able to serve a minimum of two children per day, five days a week, equaling 10 children.

A teacher serving children in combined settings will need to consider the range of indirect contact time needed. Time must also be allotted for collaborative planning, team teaching, observation, and data collection. In a combined setting where both direct and indirect services are implemented, teacher case load size will increase in relation to the amount of indirect service (the more direct service, the fewer children on each caseload). If all children on a teacher's caseload

received indirect services, a typical caseload may range from 15 to 20 children.

5.2 If a child enters services needing more than the minimum of contact hours, a case manager's caseload would need to be decreased or personnel added.

5.3 Support services personnel qualified in one or more area of disability will be required to assist in the provision of appropriate services as identified in the child's IEP.

5.4 Aides may be employed dependent upon the service needs of individual children.

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SERVICES TO FAMILIES

Parent involvement in the young child's educational program is essential. Parents and siblings have provided and will continue to provide for the child's needs before, during, and after placement in the preschool program. Bronfenbrenner noted that "the family is both the most effective and economical system for fostering the development of the child." This is true in that (1) family members are the primary teachers during the child's first years of life, (2) interventions by family members occur in the natural environment and across settings in that environment, thus improving chances that learning will generalize, and (3) family members are the only persons who will remain members of the child's intervention team during subsequent transitions. It is imperative that parents be offered opportunities to develop intervention skills that will empower them to adequately address their child's educational needs over the years in the areas of growth and development, advocacy, exercise of rights, assuring appropriateness of educational programs, decision-making, and home and community integration.

FAMILY INVOLVEMENT

The Individuals with Disabilities Education Act, Part D (IDEA-D) guarantees parent participation in decision-making regarding the child with disabilities. This basic level of involvement assures parents the right to participate as active team members in the multidisciplinary team decision-making regarding the child's eligibility for special education services and in developing the child's individualized education program (IEP). (See Figure PP-1.) This involvement begins with the first contacts made with the family either by the referring source (e.g. a physician or agency personnel) or by the program staff when a referral is received. Sensitivity and support on the part of professionals can set the tone for an effective and successful program for the child as well as a positive working relationship with the family's participation in the multidisciplinary team's decision-making process. Empowering parents of diverse backgrounds is critical. The parents are in the best position to clarify for staff members whether assessment results are typical patterns of behavior, to give information about medical or other relevant factors in the child's development, and to provide other observations of the child not available to the staff in assessment situations.

In the development of the child's individualized education program (IEP), parents and other family members will provide input on priority targets for programming, assist in determining methods that might work, suggest interventions to be carried out in the home, or provide information on motivational, health, and social-emotional variables.

In addition to planning for the child's individual needs, *plans for individual families* may be developed in the IEP planning process based on the family's goals and needs. An individualized plan for a family's involvement should incorporate the unique needs of the family and recognize that the family's role is central to the child's development. An individualized plan for the family may involve goals that relate to the child with

FAMILY INVOLVEMENT

Multidisciplinary Team Membership
- providing assessment information
- planning the child's IEP
- making eligibility decision

Individualized Family Program

Ongoing Communication

Participation in intervention activities
- observing child's behavior
- monitoring child's progress
- implementing intervention strategies
- evaluating child's progress

Supplementary Options

FAMILY EDUCATION SERVICES

Information Exchange
- about the child's disability
- about the program
- about parent rights, laws, regulations

Education Program for Families
- knowledge needs (information on disabilities, available community services, parenting issues, etc.)
- skill needs (e.g. how to carry out specific interventions in the home, how to access agency services and resources, etc.)

FAMILY SUPPORT SERVICES

Ongoing communication

Support Groups
- for parents
- for siblings
- for extended families
- community

Counseling

Agency Services
- medical
- social
- economic
- educational
- respite care

Figure PP-1. Services to Families

disabilities and goals that relate to the family's meeting other needs. For example, a family's goals might be (1) to integrate an intervention into the family's daily routine, such as reinforcing language and fine motor skills while bathing the child; (2) to access resources to obtain an alternative communication system for the child; (3) to find a more rewarding part-time job for the mother; or (4) to enroll siblings in a workshop on play with a brother or sister with a disability.

An important aspect of family involvement is ongoing communication among team members. Ongoing communication is critical for a young child whose physical health may be unstable or who is undergoing rapid developmental changes that necessitate program changes. Family involvement in the child's program may also be encouraged through parent participation throughout all aspects of a child's intervention plan.

SUPPLEMENTARY OPTIONS IN FAMILY SERVICES

Basic levels of family involvement in the young child's educational program include family education and family support services.

Family education provides information that addresses the family's knowledge and skill needs. Information directed at the family's knowledge needs might cover topics such as characteristics of the disability, available community resources, parenting issues, organizations for parents of children with disabilities, and so on. Topics in the area of skill needs might address how to access agency services and resources, carry out specific interventions, set up a trust fund for the young child, or manage specific behaviors. Knowledgeable parents may act as resources to other parents as they share their own experiences and what they have learned about having a young child with disabilities.

The second type of supplementary service, family support services, may be provided as part of the program's family services component or may be accessed through other agencies or programs. Ongoing communication, as previously described, provides a basic level of support to families. In addition, family support services may be provided through group activities for family members (e.g. siblings, parents, or grandparents), the natural support system of extended family members and friends, counseling services, or agency services (i.e. medical, social, economic, or educational services or respite care).

GUIDELINES FOR FAMILY SERVICES

The addition of a child with disabilities to a family has a significant impact on the entire interactional system of the family. Consideration of some basic guidelines in serving families can enhance the quality of services provided to the young child and the family, and facilitate communication between the program staff and the family.

In communicating with a family, professionals need to listen and support the family members, keeping in mind that families may react in different ways at different times. They must be sensitive to the parents' fluctuating emotions and responses regarding their child.

There are many societal expectations and pressures on the family to raise their child to conform to cultural patterns. The culturally different family may require

special support as they face systems that do not acknowledge these differences.

Parents may appear disinterested, overprotective, rejecting, or guilt ridden, but it is extremely important that professionals reserve judgment until they have a clear understanding of situations, especially when economic or cultural factors distinguish parents from professionals. Making assumptions may hinder communication and development of a trust relationship between the family and professionals. Parents can often sense that they are being negatively evaluated even though this is not communicated verbally.

Professionals need to communicate clearly using everyday language. Parents should be encouraged to clarify their understanding of what is being conveyed and to ask questions when something is ambiguous. Parents need time and assistance to understand the significance of information presented to them by professionals.

The family's specific knowledge about the child should be solicited and utilized. They should be involved in assessing the child's strengths, in setting goals and determining intervention methods, and in evaluating success.

The extended family and immediate community can be educated about disability conditions through printed materials, media, support groups, or agency programs. Encouraging extended family members and friends to offer practical and emotional support can help families of children with disabilities reduce social isolation and enhance community understanding of the needs of children with disabilities and their families.

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PROGRAM SERVICES

In programs for young children with disabilities, critical consideration must be given to providing the following services: assessment, educational programming, related services, parent education, family support services, transitional services, and consultation. Program staff must have competencies in each of these areas as well as the ability to work effectively on a team in assessment, planning, daily service delivery, and ongoing program evaluation and planning. An effective team effort leads to a better integrated program for the child, with all personnel aware of and working toward the same objectives.

PROVISIONS FOR THE LEAST RESTRICTIVE ENVIRONMENT

To ensure that a child's placement will always be made in the least restrictive environment (LRE), procedures must be developed to address the following requirements.

1. Alternative settings and delivery modes must to be made available so that each child's education will be appropriate to his or her individual needs. The alternatives must include whatever is needed to carry out the agreed upon individualized education program for each child enrolled in early childhood special education services.

2. Safeguards to take into account in determining the appropriate setting and service delivery mode for each child include:

   a. alternative settings and delivery modes are determined at least annually.

   b. alternative settings and delivery modes are based on the child's IEP.

   c. the setting for the program/service is as close as possible to the home of the child.

   d. before concluding that the child requires a special setting, all possibilities should be considered for engaging supportive services that would enable the child to receive services in a setting with children who do not have disabilities. If the nature and severity of the disability is such that the child must be served in a setting apart from children who do not have disabilities, provisions that enable the child to interact as much as possible with age-appropriate peers must be identified.

SERVICE DELIVERY SYSTEM

Individualized education services for young children with disabilities may be implemented in a variety of community, home and school settings. The identification of the child's typical environment (place the child would be if he/she did not have a disability) serves as the point of reference as LRE options are considered and decisions made.

Within the LRE context, services may be direct or indirect. A full continuum of direct preservice options includes:

- homebased
- community based
- combined Early Childhood/Early Childhood Special Education
- individualized, small group, direct intervention
- residential
- in-patient hospital

Indirect services includes:

- observation
- assessment
- inservice training
- consultation
- technology based services

In situations where child care services, preschool programs or other early childhood services are not available or considered inappropriate within the local community, special education units may choose to develop reverse integration programs to assure that children with disabilities interact with age appropriate peers without disabilities.

In establishing reverse integration programs, specific administrative and programming considerations will be addressed by the local special education unit. These will result in written local policies and procedures. Programming considerations should include identification of a curricular approach appropriate for all children, ratio of children with disabilities to children without disabilities, registration procedures for children without disabilities and length of program day. Administrative considerations include but are not limited to additional fiscal factors, child care licensing issues, liability concerns, transportation responsibilities, staffing patterns, and program setting concerns.

When setting up a reverse integration program, school districts need to be sensitive to existing community child care programs, keeping in mind competition and variability in child care costs to families. It is important that school districts work with all community services to enhance collaborative programming.

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INDIVIDUALIZED EDUCATION PROGRAM PLANNING PROCESS FOR EARLY CHILDHOOD SPECIAL EDUCATION

The North Dakota Department of Public Instruction has published a comprehensive guide that addresses the process that should be utilized for documenting the deliberations of the multidisciplinary team. In addition, it provides the recommended format for the Individualized Education Program (IEP). This manual, *Guidelines: Individualized Education Program Planning Process,* published in February 1995, contains the recommended process to use with preschool children with disabilities as well as school age students. Modifications pertinent to preschool children are addressed in this section. A one page alternative form for documenting the IEP form is attached as Appendix B.

This section highlights factors that must be addressed when preparing an IEP for a child in an Early Education Special Education Program. *Only those components that differ from the standard IEP are presented and discussed.* They include sections:

C. IEP Information - Federal Child Count Setting

D. IEP Planning Meeting

E. Present Levels of Educational Performance

F. Annual Goals, Short-term Instructional Objectives, and Characteristics of Services

J. Least Restrictive Environment

SECTION C. IEP INFORMATION - FEDERAL CHILD COUNT SETTINGS

Federal Child Count settings are listed in the IEP *Guidelines* document. They are also included on the alternative page five form for preschool IEPs. When completing the SPECIS Record Entry Form (Appendix B) for Child Count purposes, *note that the service settings do not match.* Although the IEP *Guidelines* document contains the service settings appropriate for use with preschool children, the SPECIS Record Entry Form contains only the service settings considered appropriate for students who attend school. A crosswalk must be used to facilitate the correct selection of the SPECIS service setting. A crosswalk describes new definitions for existing categories. The new definitions for reporting the preschool service setting selected on the alternative page five of the IEP form are then superimposed on the old categories contained on the SPECIS form. The crosswalk is contained in Appendix B and is also included on the back of the alternative page five of the IEP.

SECTION D. IEP PLANNING MEETING

Team members who must be involved include the administrator of the school the child will attend when he/she becomes school age, the child's current special education teacher(s), the parents, and a general education representative. It is imperative that consideration be given to selecting a general education

representative who is providing services to the child and to other children who do not have a disability. In the event that the child is not receiving any services outside the home, an early childhood professional providing services for other same age children who do not have disabilities should be identified and included as the general education teacher. This procedure will ensure that the curricular input from the general education teacher is maximized.

It is also vital to involve in the IEP process an administrator from the school the child will be attending when he/she is old enough to start kindergarten. The responsibility for the child's education is immediately placed on the neighborhood school. This ensures that the school personnel become knowledgeable about the educational and developmental needs of the preschool child. It affords the parents an opportunity to become familiar with the administrators of the neighborhood school and allows them to feel much more comfortable with the eventual transition process.

SECTION E. PRESENT LEVELS OF EDUCATIONAL PERFORMANCE

The present levels of educational performance (PLP) component addresses the child's unique patterns of functioning. It lays a foundation for the succeeding components of the IEP. Statements in the PLP should (a) address significant strengths and deficits, (b) be understandable to the parents and general educators, and (c) give the reader a clear picture of how the student is functioning in all relevant areas at the time the IEP is being written.

A critical concept relating to PLP that must be considered for the preschool age child is the counterpart to a general education curricular framework. The child's unique patterns of functioning should be compared against the prerequisite skills required, and the anticipated outcomes expected from the curricular source being utilized. Although there are many curricular sources available commercially, it is important to select a recognized system based on developmentally appropriate practices. Examples of widely used sources include the National Child Development Associate (CDA) credentialing curricular standards for child care settings, Head Start curriculum, preschool curriculum such as that sponsored by the Association for the Education of Young Children (AEYC), or, for older preschool children, an accepted kindergarten curriculum. This curricular framework is the basis for comparing the preschooler's performance with that of a chronologically same-aged peer without a disability.

Two components must be addressed relative to the curriculum reference that has been selected. The first consideration is how the impairment or developmental delay affects the child's ability to participate and make progress in the general education curriculum. The second consideration is how the impairment or developmental delay impacts the child's access to other developmentally appropriate activities. The curricular framework selected should serve as an outline in deriving the present level of performance. Assessment considerations, observational data, and parent input should then be included to provide the explanation and validation of the impact of impairments or developmental delays.

The reference to a developmentally based curriculum framework is always

required. When a home-based intervention program is most appropriate for a young preschool child, a standardized curriculum for home-based care should be selected. Although the critical components of these curricular sources vary somewhat, all contain essential curricular offerings such as the following examples from the National CDA in the following domains.

CDA Goals:
- Safe Environment
- Healthy Environment
- Creative Environment
- Cognitive Development
- Physical Development
- Communication Development
- Social Development
- Guidance
- Self Development
- Learning Environment
- Family Involvement

SECTION F. ANNUAL GOALS, SHORT-TERM INSTRUCTIONAL OBJECTIVES, AND CHARACTERISTICS OF SERVICES

The format for writing the annual goals and short-term objectives of the IEP is identical to that addressed in the *Guidelines* document. The characteristics of service sections will vary, however, since the service settings and educational needs are different. It is important to remember that the early childhood curricular focus must be retained. The characteristics of service section must address the parameters of the behavior or skill to be taught and the supports, modifications, and adaptations that are necessary for the child to develop the skill. The characteristics of service section provides the rationale for the service setting selected.

SECTION J. LEAST RESTRICTIVE ENVIRONMENT

A two page worksheet included in this guide can be utilized in identifying the learning environment that is most appropriate for instruction of a particular skill. The worksheet is designed as an outline to guide discussion during the IEP process. It facilitates an analysis of the instructional content and appropriate methodology. Completing the worksheet on every goal and supporting objectives is a time consuming process; therefore, it is intended as a training tool only. The thinking process will generalize after being utilized on a variety of content outcomes for children of various ages. Before discussion on the least restrictive learning environment can occur, teachers must have a thorough understanding of *what they intend to teach* and *why they want to teach* that skill. The IEP process does not require documentation of the logic and rationale. However, the methodology that is selected for designing the instructional program including the goal, objectives, and characteristics of service has direct implications for the service settings that will be necessary and appropriate to accomplish the goal. (An alternative procedure is contained in Appendix B.)

When the goal is established, a sequence of questions should be asked before writing the behavioral objectives. The four questions that should be considered initially are:

1. *What behavior or skill do I intend to teach?*

2. *Why is instruction in this skill necessary?*

This "why" question should be addressed by comparing the child's performance of the skill to that of other children of the same chronological age. The reference to the curricular framework is used to substantiate the child's need for instruction in that area. The discrepancy should be reported in the present level of educational performance so that it relates directly to the skill or behavior that is being taught.

3. *What are the parameters of the behavior or skill that is being taught?*

This third question addresses rationale or intent for teaching the skill. The property of the skill that is critical for instruction will determine the *type* of service necessary and consequently impact on the *location* of that service. There are three different properties of skills that must be considered:

a. **Topography** refers to the actual muscle movements necessary to perform the skill. When the child requires direct instruction on the basic movement patterns necessary to perform a skill, the instruction required is intensive, must be carefully graded, and must be implemented consistently. Usually one-to-one instruction is required.

b. **Force** refers to increasing the intensity or consistency of a skill. After a child has learned the topography of a skill, the next step is to increase the frequency, shape the quality, or build the strength of a skill. This is accomplished through reinforcing the skill when it is demonstrated utilizing a variety of different reinforcement strategies. A critical concept to consider when force is being addressed is the importance of utilizing naturally occurring learning environments that are motivating for the child. This will increase the likelihood that the skill will be performed independently.

c. **Locus** refers to the appropriate utilization of a skill. Pragmatics is a classic example of locus. For example, after a child has learned to ask questions, the next step is learning to ask questions for a variety of purposes: to seek clarification, initiate conversation, gather information, obtain daily living essentials, etc. Locus addresses the utility of a skill and the ability to transfer and generalize.

4. *In what service setting can the behavior be most appropriately taught?*

After thoroughly analyzing what the teacher intends to teach, why they need to teach it, and the parameters of the behavior, the next step is to address alternative service settings in which the instruction can be appropriately provided. To assist in identifying the learning environment that is most appropriate for each goal, another sequence of questions should be addressed for each of several alternative service settings:

a. What are the elements within this setting that make it an appropriate environment in which to teach this skill?

b. What are the variables that impact the appropriateness of that environment?

c. Would this environment be appropriate with the necessary supports?

d. Of all of the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching the skill?

The sequence should be completed for each of the subsequent alternative service settings until the team has arrived at the learning environment that appears to be the least restrictive and is the most appropriate for that skill.

The characteristics of service section provides the basis for the justification of the least restrictive environment selected for each outcome. The subsequent LRE section (page five) is a composite summary of the constituent environments selected.

To illustrate how this planning process occurs, a case study is provided in the following pages.

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LRE PLANNING WORKSHEET: AN EXAMPLE

Behaviors of Concern:

Jonny, age 4, does not initiate interaction with other children, either verbally or nonverbally, and does not reciprocate interaction when other children approach him.

Curriculum Reference:

These skills are contained in the development checklist of social behaviors used for 3 and 4 year old children in the community child care facility. They are normally occurring skills in all children of 3 and 4 years of age with the topography and the locus of the response fully developed in its final form. The emphasis at this age is on force or expanding the quality of the response (longer length of verbalizations, more complexity, etc.) and to embed within the responses the targeted social and emotional behaviors such as politeness, sharing, empathy, etc.

Basis in Present Level of Educational Performance:

Jonny currently does not engage in interactive behaviors with other students while playing. He stands and watches others or engages in parallel play with objects but does not approach them or initiate interaction. Although he utilizes intelligible verbalizations while playing alone, he discontinues all verbalizations when other children approach him or are near him. When they approach him, he often just stands still and ignores them. If they offer him a toy, he reaches out, grabs it and then walks away. If the other children persist in their attempts to interact, he either tries to hit them or runs away.

Parameter of the Behavior Being Addressed:

Jonny demonstrates the required constituent components of the response (topography) including smiling, nodding, verbalizations, etc. He now needs to develop the locus of the response or utilization of the behaviors within the interaction paradigm. After he begins utilizing these behaviors appropriately to initiate and reciprocate interactive turns, the force or intensity, duration, and consistency can be shaped through reinforcement schedules.

Goal:

"Jonny will demonstrate age-appropriate interactive and communicative behaviors, utilizing appropriate verbal and nonverbal initiation and reciprocation skills while playing with other children of the same chronological age. This will enhance his life long communication and socialization skills across all environments."

Objectives:

"During a 15 minute free play opportunity, Jonny will initiate 5 contacts with peers utilizing an approach behavior such as walking up to another child, calling their name as an attention-getting mechanism, or establishing eye contact while simultaneously verbalizing...."

"During a 15 minute free play opportunity, Jonny will reciprocate interactions

initiated by others 90% of the time by establishing eye contact and either smiling at them or verbalizing a response ....."

Types of Activities That Will Be Needed:

Jonny will require opportunities to first learn the skills and then to practice the skills in normalized settings with other 3 and 4 year olds. Activities involving free play, sharing, and structured game time appear most appropriate.

Optional Service Settings: (address at least three)

There are a variety of service settings in which these activities normally occur. They include (a) the home environment; (b) child care setting; (c) Early Childhood Special Education classroom; and (d) a combination of Early Childhood Special Education classroom and child care facility. A discussion of each is provided.

a. Home Environment

What are the elements within this setting that make it an appropriate setting in which to teach this skill?

Jonny's parents spend a great deal of time with him on play activities and sharing activities.

What are the variables that impact the appropriateness of that environment?

The difficulty encountered in this setting is that Jonny's only sibling is 16 years older and an adult. There are no other children who are regularly available to interact with him. The discrepancy in interaction is very significant and appears to be attributable to the disability in contrast to limited prior opportunities. This appears to be a skill that will require direct instruction rather than just reinforcing occurrences of the behavior. Although his parents are wonderful in providing him with opportunities, they have not been able to teach him these skills.

Would this environment be appropriate with the necessary supports?

To provide the needed instruction in this setting, several modifications to the environment would be required and then extensive support would be necessary. The first requirement would be a specialized teacher with experience in teaching interaction. This could be arranged by enrolling Jonny in the home-based component of the preschool program and having the qualified teacher teach the skills in the home. Another consideration is that other children of the same chronological age would have to visit on a regular basis to provide Jonny with the normalized interactive opportunities in which he will subsequently be expected to perform these skills. This would not be realistic considering that his parents both work outside the home and would be unavailable to assist with the implementation of this outcome. Another factor is that Jonny demonstrates the most limited interaction skills within his regular child care environment in contrast to within the home. This pattern is also reported in other similar environments with other children such as at birthday parties, Sunday School, and family reunions. Although Jonny would be most responsive to instruction within the home with his parents

present, providing the instruction within this setting would constitute circumvention of the discrepancy rather than providing an optimal setting for directly teaching and reinforcing the skill.

Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

The team finds this alternative unrealistic and inappropriate because of the potential for circumvention and the extent of supports required (creating a classroom setting within the home)

b. Child Care Setting

What are the elements within this setting that make it an appropriate setting in which to teach this skill?

Jonny spends 8 hours a day, 4 days a week, in a child care setting. There are ample opportunities for interacting with other children in this setting because of the nature of the social curriculum for 3 and 4 year olds.

What are the variables that impact the appropriateness of that environment?

Although this setting provides an abundance of opportunities for this skill to be demonstrated, the child care facility staff do not feel comfortable in teaching this skill. Jonny obviously has not learned this skill with the instructional opportunities present in that environment. He has been attending the center for over a year and has made very little progress in developing interactive behaviors. Although abundant reinforcement is provided when children demonstrate appropriate social skills, Jonny is at an instructional level in this area and not at a practice level. With the exception of the need for specialized instruction, this environment would be very appropriate since it contains many opportunities to teach these skills including initial AM free play, sharing time, structured play time, motor activities, snack, afternoon free play, social skills instruction, and afternoon motor skills time.

Would this environment be appropriate with the necessary supports?

To provide the needed instruction in this setting, preschool staff would be required to go into the center. The child care provider is very interested in assisting but feels uncomfortable about providing the initial instruction. After an effective instructional routine has been developed, she would be very willing to provide practice and reinforcement throughout the day. Although a specialized instructor would be necessary on a daily basis for a 1/2 to 1 hour block of time to develop effective instructional strategies, no other supports would be necessary. The duration and frequency of the direct instruction visits can be faded out over time for these objectives as Jonny's skills in this area develop.

Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

This setting would be very appropriate with instructional support. Selection as the LRE is contingent on no other option discussed being more appropriate.

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c. Early Childhood Special Education Classroom

What are the elements within this setting that make it an appropriate setting in which to teach this skill?

Jonny could attend the early childhood special education classroom at Harlow Elementary School. The classroom is very structured and contains several opportunities to interact with other children. It utilizes reverse-mainstreaming for a part of each morning or afternoon session. This would allow Jonny an opportunity to work on these skills in a normalized play setting with other preschoolers who are not disabled. The teacher in this classroom is trained in the area of early childhood special education and has had extensive experience with other students with similar discrepancies.

What are the variables that impact the appropriateness of that environment?

One of the disadvantages to this setting is that Jonny already has all of the cognitive and fine motor skills that are stressed in the curriculum. In fact, the limited cognitive stimulation, in contrast to what is provided in the child care facility, would be viewed as a potential risk. Jonny's needs in the areas of language development and social skills development could not be as appropriately met in the early childhood setting as in the child care facility.

Would this environment be appropriate with the necessary supports?

To make all aspects of the program appropriate for Jonny's needs, modifications would be required. The number of peer models and the duration of their time in the program would need to be increased. The curriculum would have to be enhanced to include more challenging activities for Jonny's level of cognitive development and his language stimulation needs. Transportation would also be necessary to teach the targeted skills in this environment.

Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

The decision is contingent upon whether or not there are other needs best matched to the curricular focus of this setting. Although the setting could be made appropriate for this goal, it would require extensive modifications if this were to be the only setting used for intervention.

d. Combination of Early Childhood Special Education Classroom and Child Care Facility:

What are the elements within this setting that make it an appropriate setting in which to teach this skill?

Jonny could attend the early childhood special education classroom at Harlow Elementary School in either the morning or afternoon and continue in the child care center for the remainder of the day. This would provide him with the instruction in the interaction skills and access to normalized preschool activities in an age appropriate setting.

What are the variables that impact the appropriateness of that environment?

Although a combination of service setting options would appear appropriate, there are difficulties with this model. When considering the modifications required (transporting Jonny to Harlow Elementary for an hour a day of instruction or having him attend a half-day and then altering the curriculum and including more students who do not have disabilities), neither would appear to be the most expedient method. If he were to go to Harlow Elementary, he should be scheduled only for the duration of those activities stressing interaction. This schedule would not allow the child care provider an opportunity to observe the instruction and then provide opportunities to practice these skills across the curriculum and throughout the day.

Would this environment be appropriate with the necessary supports?

Supports which would be necessary to ensure appropriateness of this model would be to transport Jonny to Harlow Elementary School for 1 hour of instruction a day, and then provide consultation services to the child care provider. Video taping of instructional sessions could be used. This would have to be done in conjunction with some altering of routines within the early childhood classroom since none of the current interaction activities last more than 15 or 20 minutes. They would have to be clustered to give Jonny experiences in at least two of these activities. The impact of the appropriateness of the curriculum to the other students would then have to be addressed.

Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

The combination approach would not appear to address any of the difficulties effectively and creates additional problems. To make this approach appropriate, there would have to be two or three trips to Harlow Elementary per day with Jonny or the curriculum and schedule for the classroom would have to be changed.

LRE Setting most appropriate to the implementation of this goal/objectives when considering the total needs of the child:

Jonny's educational needs consist of support and specialized instruction in two critical domains of development: socialization and communication. His needs in all other areas (fine motor, gross motor, cognitive and preacademic) can best be met through continued involvement in his current community based child care facility. After a review of options for both targeted areas, the team agreed that the least restrictive setting appropriate to meeting the needs was the child care facility with specialized instruction provided by two special education teachers. The Early Childhood Special Education Teacher will spend 1/2 to 1 hour daily in the center initially. She will provide direct instruction on socialization skills using the normalized routines within that setting. After an effective instructional paradigm has been identified, the child care provider will be involved in the instruction and implement similar activities across the day. Subsequent program revisions will

determine the schedule and timelines for fading out the specialized instruction when and if that becomes appropriate. The Speech Language Therapist will spend 1/2 hour with Jonny, 3 times per week, for direct instruction in language concepts, pragmatics, and articulation. Consultation will also occur with the child care provider and parents on generalizing these skills across settings. Since Jonny does so well in other preacademic activities, no other supports appear necessary at this time.

The characteristics of service section, then, must address the critical parameters of the intervention including how the instruction will be delivered or how the behavior will be taught, reinforced, and shaped. Questions referenced in the IEP *Guidelines* as being necessary to address will have been answered as the result of completing this process.

Can the performance specified in this objective be met in the child's current preschool classroom without modifications or adaptations?

No

Can the performance specified in this objective be met in regular classroom activities if appropriate modifications are made?

Yes

Can the performance specified in this objective be met if the content difficulty is altered or if specially designed instruction (totally different) is provided?

Yes

Can the performance specified in this objective be met if supportive training related to the disability is provided (e.g. functional communication training, orientation and mobility, fine/gross motor development, etc.)?

Yes

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LRE Planning Worksheet

Behaviors of Concern:	Goal:
Curriculum Reference:	Objectives:
Basis in Present Level of Performance:	
Parameters of the Behavior Being Addressed:	Types of Activities That Will be Needed:

Alternative Service Settings: (address at least three)	
Home Based Model	**Early Childhood Setting**
What are the elements within this setting that make it an appropriate setting in which to teach this skill?	What are the elements within this setting that make it an appropriate setting in which to teach this skill?
What are the variables that impact the appropriateness of that environment?	What are the variables that impact the appropriateness of that environment?
Would this environment be appropriate with the necessary supports?	Would this environment be appropriate with the necessary supports?
Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?	Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

Alternative Service Settings: (address at least three)	
Early Childhood Special Education Setting	**Part-time Early Childhood/Part-time Early Childhood Special Education**
What are the elements within this setting that make it an appropriate setting in which to teach this skill?	What are the elements within this setting that make it an appropriate setting in which to teach this skill?
What are the variables that impact the appropriateness of that environment?	What are the variables that impact the appropriateness of that environment?
Would this environment be appropriate with the necessary supports?	Would this environment be appropriate with the necessary supports?
Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?	Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

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Alternative Service Settings: (address at least three)	
Itinerant Services Outside the Home	
What are the elements within this setting that make it an appropriate setting in which to teach this skill?	What are the elements within this setting that make it an appropriate setting in which to teach this skill?
What are the variables that impact the appropriateness of that environment?	What are the variables that impact the appropriateness of that environment?
Would this environment be appropriate with the necessary supports?	Would this environment be appropriate with the necessary supports?
Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?	Of all the learning environments considered, does this appear to be the least restrictive environment that is appropriate for teaching this skill?

LRE setting most appropriate to the implementation of this goal/objectives when considering the total needs of the child:

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APPENDICES

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APPENDIX A

APPENDIX PP-A. Crosswalk for Reporting Service Settings and Amount of Time by Service Setting on the SPECIS Record Entry Form and IEP

APPENDIX PP-B. Definitions for Eligibility

APPENDIX PP-C. An Alternative Procedure to Identify the Most Appropriate Learning Environment

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APPENDIX PP-A

CROSSWALK FOR REPORTING SERVICE SETTINGS AND AMOUNT OF TIME BY SERVICE SETTING ON THE SPECIS RECORD ENTRY FORM AND IEP

To acquire funding, as well as for planning and program improvement purposes, information about children with disabilities is reported annually to the Department of Public Instruction. The original source of the information is typically the first page of the child's individualized education program (IEP), which includes an item for "Federal Child Count Setting." This item is completed after the IEP team has decided the most appropriate service setting(s) for the child. Each special education unit verifies these data and reports them to the Department of Public Instruction using the Special Education Child Information System (SPECIS). Children who are receiving services as documented on an individualized education program (IEP) on December 1 of each year are included.

Because service settings for young children may be somewhat different from those typical for school-age children, there is need to carefully define the criterion for each service setting so that persons providing the data do so in a consistent and accurate manner. This section describes how early childhood service settings must be coded using the existing SPECIS record entry form. In addition, it provides guidance in recording on the IEP form the amount of time a child is served in each setting.

Reporting Service Settings for Young Children with Disabilities on the IEP and the SPECIS Record Entry Form

The individualized education program (IEP) for a school district or special education unit typically includes an item on the first page that looks like this:

Federal Child Count Setting
A B C D E F G H I

The information recorded for this item is used to complete item 14 on the SPECIS Record Entry form (SFN 14054 (4-95), which appears as follows:

Use the following table to determine how an early childhood service setting will be coded on the IEP and on the SPECIS form.

	If the child's services are delivered in this Early Childhood Service Setting and meet this criterion on the IEP, Section J	Then use this Federal Child Count Code to complete IEP, Section C (page 1), and SPECIS
A.	**Early Childhood Setting:** includes sites such as general education kindergarten classes, public or private preschools, Head Start centers, child care facilities, etc. Children with disabilities are educated in these sites with nondisabled peers for 80%-100% of the day.	Code as ***A. Regular Class***
B.	**Early Childhood Special Education Setting:** includes segregated settings where children with disabilities are educated separately for 61% - 100% of the day, and are educated with nondisabled children for 0%-20% of the day.	Code as ***C. Separate Class*** if the child spends 61%-100% of the day in a self-contained setting
C.	**Homebased Early Intervention:** includes home or hospital settings. It does not have a percent of time component. This category also includes young children receiving special education or related services in home settings because the team has identified that environment as the most normalized setting for the needed intervention. Note on the IEP (Section J) whether this is a homebound placement or an early intervention home-based setting	Code as ***I. Homebound/Hospital***
D.	**Part-Time Early Childhood/Part-Time Early Childhood Special Education Setting:** Includes a combination of service sites, involving some amount of integration with nondisabled peers, with part-time placement in A. and part-time placement in C.	Code as ***B. Resource Room*** if the child spends 21% to 60% of the day in an integrated setting; **OR** Code as ***C. Separate Classroom*** if the child spends less than 21% of the day in an integrated setting.
E.	**Public Residential:** This column includes children who are served in publicly operated programs in which children receive care for 24 hours a day. This could include placement in public nursing home care facilities or public residential schools.	Code as ***F. Public Residential Facility***
E.	**Private Residential:** This column includes children who are served in privately operated programs in which children receive care for 24 hours a day. This could include placement in private nursing home care facilities or private residential schools.	Code as ***G. Private Residential Facility***

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	If the child's services are delivered in this Early Childhood Service Setting and meet this criterion on the IEP, Section J	Then use this Federal Child Count Code to complete IEP, Section C (page 1), and SPECIS
F.	**Public Separate Day School:** This column includes children who are served in publicly operated programs set up primarily to serve children with disabilities that are not housed in a facility with programs for children without disabilities. Children must receive special education and related services in the public separate day school for 50% or more of the time served.	Code as ***D. Public Separate Day School***
F.	**Private Separate Day School:** This column includes children who are served in privately operated programs set up primarily to serve children with disabilities that are not housed in a facility with programs for children without disabilities. Children must receive special education and related services in the private separate day school for 50% or more of the time served.	Code as ***E. Private Separate Day School***
G.	**Itinerant Services Outside the Home:** This column includes children who receive all of their special education and related services at a school, clinic, or other location for a short period of time in individual or small group formats. On the IEP (Section J), use a footnote to indicate the type of therapy being received.	Code as ***I. Homebound/Hospital***
H.	**Reverse Mainstream Setting:** In programs utilizing reverse mainstreaming, the general education portion of the day can consist of that time of the day during which nondisabled peers are brought into the special education preschool classroom as long as the ratio consists of 50% or greater of nondisabled peers. See **A. Early Childhood Setting** and **B. Early Childhood Special Education Settings** (above) for the percentage of time during which the peers are present in the program.	Code as ***A. Regular Class*** if criteria describe Early Childhood Setting; **OR** Code as ***C. Separate Class*** if criteria describe Early Childhood Special Education Setting

Recording Service Time for a Young Child with Disabilities on the IEP

Section J (Least Restrictive Environment Justification: Setting) of the IEP is used to record service time for each service setting. The "Setting" item for young children with disabilities will differ from that used for school age children, and is shown at the bottom of this page.

Identify the amount of time the child is served in each of the following service settings. If the child's schedule is the same every day, calculations can be made on the basis of a day. If each day of the week is somewhat different, but each week is the same, calculations should be done on the basis on a week. If there is variation in the child's schedule over a two week period (e.g., the child receives occupational therapy every second Tuesday), calculations should be made on a two week basis. Review the child's schedule to determine the block of time that is appropriate.

Next, identify the amount of instruction and related services time that is provided to the child **and that are paid for** by the school system. This will include time spent in general education, special education, or child care. Use the total time as the denominator in calculating the percentage of time the child is served in each of the service settings.

The following is offered as an example: The child receives, across all settings, a total of 15 hours of instruction and related services each week for which the school system pays. Of the 15 hours, the child receives twelve hours of service each week in a self contained setting in which he is educated with other children with disabilities. Therefore, *80%* (12/15 = 80%) should be entered for *Early Childhood Special Education Setting* under section J of the IEP.

In the above example, the Federal Child Count Code would be entered on the front page of the IEP and on the SPECIS Record Entry form as *C. Separate Class.* This was determined by using the crosswalk table provided earlier in this section to identify the appropriate Federal Child Count Code for a child who is served 80% of his service time in a self contained setting.

SETTING		Percent of Time/Week
	Regular education	
	Special education (select of not %100 regular education)	
	☐ limited special services (less than 21% of time/week)	
	☐ resource room services (21-60% of time/week)	
	☐ separate class services (more than 60% of time/week)	
	Integrated community	
	Other ______	
	TOTAL	100%

Note:
Please use this setting and site information to determine the federal child count placement category and enter in Part C, on front page of IEP.

APPENDIX PP-B

DEFINITIONS FOR ELIGIBILITY

According to North Dakota Guide I - Laws, Policies, and Regulations for Special Education for Children with Disabilities a child is eligible for early childhood special education services if he/she has been diagnosed as having a disability in one of the 13 recognized categories and requires specially designed instruction. Any preschool child enrolled in an approved program must have a diagnosed disability to a degree constituting a developmental barrier that requires special education to benefit from early childhood experiences. Services are available to children ages three through five. A child becomes eligible for special education services on his/her third birthday.

The categories used in special education as outlined under Part B, §300.7, of the Individuals with Disabilities Act are:

Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term does not apply if a child's educational performance is adversely affected primarily because the child has a serious emotional disturbance, as defined in this section.

Deafness means a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects educational performance.

Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that cannot be accommodated in special education programs solely for children with deafness or children with blindness.

Hearing impairment means an impairment in hearing, whether permanent or fluctuating, which adversely affects a child's educational performance but which is not included under the definition of "deafness" in this section.

Mental retardation means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance.

Multiple disabilities means concomitant impairments (such as, mental retardation-blindness, mental retardation-orthopedic impairment, etc), the combination of which causes such severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blindness.

Orthopedic impairment means a severe orthopedic impairment which adversely

affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc), and impairments from other caused (e.g., cerebral palsy, amputations, and fractures or burns which cause contracture).

Other health impairment means having limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.

Serious emotional disturbance is a term that means:

(i) a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, that adversely affects educational performance:

(A) an inability to learn which cannot be explained by intellectual, sensory, or health factors;

(B) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

(C) inappropriate types of behavior or feelings under normal circumstances;

(D) a general pervasive mood of unhappiness or depression;

(E) a tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have a serious emotional disturbance.

Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not apply to children who have learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

Speech or language impairment means a disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance.

Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's education performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as: cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem-

solving, sensory perceptual and motor abilities, psychosocial behavior, physical function, information processing, and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.

Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects the educational performance of the child. The term includes both partial sight and blindness.

Young children with disabilities may have an identified primary and/or secondary disability as determined through the assessment process. Refer to the Assessment section of this document.

APPENDIX C

AN ALTERNATIVE PROCEDURE TO IDENTIFY THE MOST APPROPRIATE LEARNING ENVIRONMENT

Modification/Addition to Individual Education Plan Process and Form

The IEP team will follow the steps described below.

1. In developing the goals and objectives, review and consider the skills necessary to succeed at age three, four, or five whichever is the appropriate age for this child.

2. After developing the goals and objectives, review and consider the environments in which the skills can be acquired. Examples of a range of options is included in the first column of Table 1 (attached).

3. List the child's current environment(s). List this information in column 2 of Attachment PP-C1.

4. Answer the following question:

   > *Is it likely that this child will achieve his/her goals and objectives with special education and related services provided in his/her current environment(s)?*

   Document this information on the child's IEP. See Item 1 in Attachment PP-C2 for a sample item that could be added to existing IEP forms. In answering this question, consider, at a minimum, the elements of the child's current environment(s) listed in Attachment PP-C3.

5. If it is not probable that in the current environment(s), for the child to master the goals and objectives identified in the IEP, discuss whether the current environment(s) could be modified. See Attachment PP-C4 for a sample list of factors that should be considered in making this decision.

6. Document the results of this decision in the IEP. See Item 2 in Attachment PP-C2 for a sample item which could be added to existing IEP forms.

7. After these decisions have been made, determine if it will be necessary to remove the child from his/her current environment(s) for the provision of special education and related services. Document this decision in the IEP. See Item 3 in Attachment PP-C2 for a sample item that could be added to existing IEP forms.

8. Discuss and identify the elements that must be present in any proposed environment. See Attachment PP-C5 for a sample list of factors that should be considered in making this decision.

9. Record elements of the environment of particular need and/or significance to this child on the IEP. This record is one of the most important steps in identifying and verifying the least restrictive environment in which this child can receive an appropriate special education and related services. See Item 4 in Attachment PP-C2 for a sample item which could be added to existing IEP forms. Alternatively, the IEP team could use the checklist from Attachment PP-C5 and append this to the IEP form.

10. After the team has identified the needs of the child; his/her goals and objectives; strategies to reach these goals and objectives; and the elements of the environment which are necessary for the implementation of the IEP, then the IEP team is ready to suggest specific environments in which special education and related services can be provided to the child. The team should consult the list in Column 1 of Attachment PP-C1 for a sample of the options which might be appropriate. More than one option should be discussed by the team. See Attachment PP-C6 for a sample that could be incorporated into existing IEP forms the IEP team should list specific environments that should be considered options for this child. This can be done by listing them in Column 3 of Attachment PP-C1 or by writing them into the IEP.

11. The IEP team should summarize the discussion regarding options considered, options rejected and options recommended. This summary should be written on the IEP. Appropriate selection of environments, and monitoring and verifying the appropriateness of environments selected, is dependent on the quality of the information contained in this documentation. Any minority or dissenting views should also be recorded with this information. A sample summary is provided in Attachment PP-C7.

12. The IEP team should identify the fiscal responsibilities of each party, e.g., by filling in Column 4 of Attachment PP-C1.

13. The LEA shall use its established policies and procedures for selecting placement options based upon the information and recommendations contained in the IEP.

ATTACHMENT PP-C1

SELECTION OF APPROPRIATE ENVIRONMENTS

Column 1 Potential Environments for Children Birth through Age 5	Column 2 Child's Current Environment(s)	Column 3 Recommended Options to Implement IEP	Column 4 Funding Sources
1. Community child development programs (nursery school and/or day care center)			
2. Self-contained preschool class located in community preschool facility allowing significant interaction between these classes.			
3. Combination placement where child receives some services in a community facility and some at a campus location.			
4. LEA/IEU operated program in the community with spaces available for community children on a tuition basis.			
5. LEA/IEU operated program in the community with spaces available for school faculty as an employee benefit or on a tuition basis.			
6. Head Start program.			
7. Recreation program in the community (e.g., "Gymboree", YMCA/YWCA, libraries, community "camps", etc.)			
8. Home			

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Column 1 Potential Environments for Children Birth through Age 5	Column 2 Child's Current Environment(s)	Column 3 Recommended Options to Implement IEP	Column 4 Funding Sources
9. Babysitter's or family member's home			
10. Self-contained class in a regular elementary school, including significant interactions with preschool children who do not have disabilities			
11. Self-contained class with regular, frequent, & systematic (i.e., "significant") interactions with peers from other preschool programs			
12. Self-contained class on campus where other preschool programs also operate classes and there is significant interaction between the two programs			
13. Campus-based program for children with special needs with a reserved percentage of slots for faculty or community children			
14. Slots in programs operated under other federal, state, and/or local initiatives (e.g. protection services, workfare, daycare, drop-out prevention programs, etc.)			

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ATTACHMENT PP-C2

MODIFICATION/ADDITION TO IEP FORM:

1. Is it likely that this child will achieve his/her goals and objectives with special education and related services provided in his/her current environment(s)? (Consider such factors listed in Attachment PP-C3.)

   Decision: ____ Yes ____No

   Rationale for this decision: ____

   ____

2. Can the current environment be modified/adapted to meet the child's needs?

   Decision: ____ Yes ____No

   Rationale for this decision: ____

   ____

3. Does appropriate implementation of this child's IEP require any/some removal of this child from the child's typical environment?

   ____ Yes ____No

   Rationale for this decision: ____

   ____

4. If the typical environment cannot be reasonably adapted so that the IEP can be implemented, what elements are necessary to implement the IEP? (Consider such factors listed in Attachment PP-C5.)

   Elements: ____

   ____

   ____

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ATTACHMENT PP-C3

ANALYSIS OF CHILD'S CURRENT ENVIRONMENT

Factors to consider:

- interaction with peers who do not have special needs
- language/social/physical/cognitive/adaptive stimulation
- capabilities of this environment (as appropriate to each child's needs)
- equipment available
- availability of personnel (therapists and teachers)
- adult interaction and supervision

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ATTACHMENT PP-C4

OPTIONS TO CONSIDER TO ADAPT CURRENT ENVIRONMENT

- Can staff be added?
- Can experiences with peers who do not have special needs be added?
- Can equipment be bought/provided?
- Can physical environment be modified?

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ATTACHMENT PP-C5

ELEMENTS OF ENVIRONMENTS THAT SHOULD BE CONSIDERED

A. Meets minimum standards (check those items of relevance):

- ____ Health code
- ____ Safety and fire codes
- ____ Child care requirements
- ____ Other program requirements: ______________________________
- ____ NAEYC or other certification/endorsement

B. Qualifications of available/potential personnel: ______________________________

____

C. Travel time/location of program relative to child's home: ______________________________

____

D. Accessibility of program/environment: ______________________________

____

E. Ratio of children/staff: ______________________________

____

F. Number of children with special needs/children with no identified special needs: ____

____

G. Schedule: ______________________________

H. Age range of children in proposed environment: ______________________________

____

I. Equipment available/possible: ______________________________

____

J. Parent involvement activities: ______________________________

____

K. Identified preschool curriculum (if applicable): ______________________________

____

L. Signed agreement that environment will comply with Part B requirements: ________

____

M. Other: ______________________________

____

____

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ATTACHMENT PP-C6

CONSIDERATION OF SPECIFIC ENVIRONMENTS

1a. Option Considered:____________________

1b. Advantages:____________________

Disadvantages:____________________

2a. Option Considered:____________________

Disadvantages:____________________

3a. Option Considered:____________________

3b. Advantages:____________________

Disadvantages:____________________

4. **OPTION(S) RECOMMENDED:**____________________

Rationale for recommended options:

ATTACHMENT PP-C7

SAMPLE SUMMARY OF RATIONALE FOR RECOMMENDATIONS

Three settings were considered as possible options for the delivery of the special education and related services needed by Marcus: his home, his family day care home, and a play group. Since Marcus lives in a remote area where there are no day care centers or center based nursery schools, these options were not considered. Because implementation of his IEP requires interaction with peers in his community who do not have disabilities, self-contained options were also ruled out.

- The social worker and parents felt that modifying his home environment to provide opportunities for interactions with typical peers and other adaptations necessary would cause unnecessary disruption for other members of the family.

- Based on a visit to the day care home, the therapists thought that this would not be the most appropriate setting in which to implement the IEP. There are too many children to ask the child care provider to address the goals and there are different children coming each day. However, the speech pathologist recommended that she meet periodically with the child care provider to reinforce certain communication strategies.

- The play group has four children led by a mother with child development training and is held in the 4-H building twice a week, in the morning. The school early childhood specialist and Marcus' father visited the play group and reported that the social, language, and motor goals can be addressed in this setting. They also reported that the play group leader is willing to work with the team in implementing the IEP.

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EARLY CHILDHOOD SPECIAL EDUCATION FOR CHILDREN WITH DISABILITIES, AGES THREE THROUGH FIVE: STAFF/FACILITIES

Prepared By

North Dakota Interagency Coordinating Council
Program Standards Subcommittee

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INTRODUCTION

This section presents requirements related to staff and facilities. Teachers qualifications are stated, along with a description of staffing pattern options involving teachers, related services personnel, paraeducators, and volunteers. In addition, a number of administrative considerations are addressed.

QUALIFICATIONS

6.0 **QUALIFICATION OF TEACHERS:** Teachers of Early Childhood Special Education (ECSE) must hold a North Dakota Educator's Professional Certificate and a special education credential in early childhood special education.

6.1 Credential Requirements - Courses in the areas listed below must be at the graduate level unless otherwise specified.

6.1.1 A valid North Dakota Educator's Professional Certificate in elementary education or kindergarten education is required.

6.1.2 One Required: (Undergraduate or graduate)

Education of Exceptional Children
Psychology of Exceptional Children

6.1.3 Assessment in Early Childhood Special Education

6.1.4 One Required:

Developmental Psychology
Infant Behavior and Development
Language Development and Disorders

6.1.5 One Required:

Home-School Relations
Parents, the School, Community Agencies

6.1.6 Practicum in Early Childhood Special Education (required)

6.1.7 Early Childhood Special Education

Introductory Course, or Characteristics of Young Children with Disabilities; Methods and Materials in Teaching Young Children with Disabilities; and at least one other course in the Education of Young Children with Disabilities

or

Training in other areas of exceptionality will be reviewed. A full sequence in one area of exceptionality will be considered as an alternative to the Early Childhood Special Education sequence:

Introductory Course for this area of exceptionality; Methods and Materials in this area of exceptionality; Practicum in this area of exceptionality; and at least one other course in area of exceptionality.

6.2 Teachers who do not have a credential in ECSE may receive a Letter of Approval to teach in the area of early childhood special education after having completed eight (8) semester hours of coursework in Early Childhood Special Education. The approval is valid for one year (12 calendar months) and renewable for up to three years. Renewal status is dependent on completion of eight (8) semester hours of coursework per year as identified on an approved university program of study. Teachers must fully qualify for a credential within three years.

6.3 A restricted certificate in the area of ECSE may be granted to teachers completing a full program of study from a university program that has been approved through the North Dakota State Program Approval process and by the Department of Public Instruction.

7.0 **FACILITIES:** Classrooms within a school setting will be equal to or larger than a regular classroom, have self-contained bathrooms or facilities that provide private changing areas located within easy access of the classroom. Classrooms must be located within easy access to other age-appropriate classrooms (i.e., kindergarten and primary grades) within the building. The classrooms must also meet minimum standards of heat, light, and ventilation.

7.1 Community-based settings will meet minimum state child care licensing standards or other agency licensing standards, as appropriate.

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8.0 **REQUIRED INSTRUCTIONAL TIME IN PROGRAM TO BE ELIGIBLE FOR FUNDS:** Federal preschool special education funds are available for children who are on an active individualized education program (IEP). The amount of funds available is determined by the number of children on active IEPs at the time of the annual December 1 Child Count. State per pupil foundation aid is available for children receiving a minimum of twelve hours per week of a combination of direct and indirect instruction as identified in the IEP. Indirect instruction may include parent training, home interventions, consultation with parents and/or other agency personnel regarding intervention programming.

9.0 **EQUIPMENT AND MATERIALS:** All educational equipment needed for provision of special education and related services and identified in the student's individualized educational program must be provided.

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STAFFING PATTERNS

A number of options staffing patterns options exist to support the team planning process for the education of young children with disabilities. The development of job roles and responsibilities that reflect the services needed will ensure that responsibilities of various staff members and related personnel are clear.

Early Childhood Special Education Teacher

Roles and Responsibilities:

- Coordination of children's programs, parent involvement, team planning.
- Team participation in planning, implementing and evaluating children's services.
- Screening and assessment of referred children, including documentation of results.
- Development and implementation of program services to children and to families.
- Consultation to program staff and to other community programs.
- Knowledge of child development, disability conditions, working with parents, regulations and guidelines that apply to serving young children with disabilities.
- Record keeping and documentation.

Related Service Personnel

- Screening and assessment of referred children, including documentation of results.
- Team participation in planning, implementing and evaluating children's services.
- Assistance in development of individualized education programs and implementation or training of others to implement the child's program.
- Consultation with parents and other team members or other community programs concerning the child's progress.

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- Provision of information regarding child development, disability conditions, working with families, and regulations and guidelines that apply to serving young children with disabilities.

- Recordkeeping and documentation.

- Determining need for special adaptive equipment, assistance in design and/or acquisition of equipment such as alternate communication systems or prosthetic devices, and training others in using specialized materials.

Federal regulations describe related services as "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training" (34 CFR§300.16).

Related services personnel are part of the multidisciplinary team who assist in assessment planning and evaluating the child in their areas of specialization and assist in planning and implementing the child's program. Related services may be provided through contractual arrangements with other public and private agencies within the community.

Aides (Paraeducators)

An individual child with very specific needs that require a highly individualized program may necessitate the assistance of an aide. The aide would assist in the implementation of each child's individual education program to meet the special needs of individual children.

Roles and Responsibilities:

- Carry out instructions for children's programs or provide teacher support as designated by supervisor.

- Provide to supervisor observational information obtained while carrying out assigned activities.

- Assist in child management.

- Record keeping/data collection as prescribed.

- Team participation and effective communication with team members.

Volunteers

Volunteers may be utilized as additional supports for intervention services. They require the same training procedures as aide (paraeducators) although the intensity will vary with the role they assume. Potential volunteers include parents, high school students, senior citizens, university or college students who may or may not be practicum students, or members of community service organizations or religious groups.

Volunteers may assume some of the same responsibilities as aide or they may choose a nonteaching task such as construction of materials, organizing field trips, or raising money for special projects such as purchasing new equipment for the classroom.

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ADMINISTRATIVE CONSIDERATIONS

As a program for young children with disabilities is planned, a number of decisions relating to program administration must be made. Some of these decisions are based on options that the program administrator has selected. The provision of services within the least restrictive environment will reflect the continuum of options in service delivery and staffing patterns that dictate needs for intervention facilities, transportation and funding. Needs of children to be served must be considered as decisions are made regarding emergency procedures necessary in serving young children with disabilities. The sections that follow -- Classroom Facilities, Emergency Precautions, Interagency Collaboration, Transportation, Funding, and Evaluation -- address considerations in making appropriate programming.

Classroom Facilities

Classrooms within a school setting will be equal to or larger than a regular classroom, have self-contained toilet facilities or facilities that provide private changing areas located within easy access of the classroom. Classrooms should be located within easy access to other age-appropriate classrooms (i.e., kindergarten and primary grades) within the building. The classrooms must also meet minimum standards of heat, light, and ventilation. Community-based settings will meet minimum state child care licensing standards or other agency licensing standards, as appropriate.

An accessibility checklist for assuring compliance with the Americans with Disabilities Act (ADA) is essential for facilities serving both adults and children. Some of the key considerations that refer specifically to young children with disabilities are identified below.

- Ramps should have a handrail 32 inches above the ramp surface for adults and a lower set appropriate to the size of the children served.
- Stairs should have two sets of handrails available on each side of the stairs at a height of 32 inches for adults and at an appropriate lower height for children.
- Water fountains should be accessible to young children with disabilities at a height of 26 inches from the floor.
- The heights of toilet seats should be appropriate for young children with orthopedic disabilities at 12 to 17 3/4 inches.
- The heights of the sinks should be 29-34 inches from the floor to accommodate young children with orthopedic disabilities.
- Pull-up bars should be located near the toilet and sink for young children with disabilities.

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- A towel dispenser or hand dryer should be located beside each sink no higher than 30 inches from the floor.

Other considerations in designing a barrier-free environment for the education of young children with disabilities include:

- well-lighted corridors and classrooms
- location away from loud noises, excessive odor, or heavy traffic
- no free-standing columns or pipes blocking access to any part of the room that would decrease the mobility of children with a visual impairment
- no permanent structures that could prevent children with an auditory impairment from seeing the teacher from all parts of the classroom
- adjacent play area, drinking fountains, and sinks
- direct access to bus loading/unloading or parent drop-off areas
- location of the classroom near other age appropriate classrooms to control unstructured interactions between older and younger students
- carpeted areas where children will be participating in floor activities
- a nonslip floor surface that will not impede the locomotion of a child with a physical disability in a wheelchair in traffic areas within the classroom. (Brooks and Deen, 1981)

Safety Standards

Certain "childproofing" precautions should be adhered to in the learning environment:

- covered electrical outlets
- cleaning products stored in locked cabinets
- tap water not hot enough to scald children
- furniture free of protrusions and stabilized to prevent toppling
- furniture resistant to scratching, chipping, or staining
- furniture of the appropriate height, that is functional and comfortable

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- flooring in areas used for toileting, eating, or art activities made of a dense resilient material resistant to damage by toileting accidents, and spillage of food, paint, and water

- appropriate use of hard surface versus carpet flooring for children with physical disabilities.

Playground Facilities

The playground facilities for the young child with disabilities should be located so as to provide ease in transition in and out of the building. Adaptive playground equipment may be necessary for some children. For example, adaptive swings, a hammock, or a rubberized cement ramp leading up to a low-pitched and high-sided slide may be appropriate.

Emergency Precautions

Fire or Other Emergencies. In case of fire or other emergencies, an evacuation plan must be developed and practiced to ensure the safe exit of each child with disabilities and staff members. Staff members should be assigned certain children to guide out of the building.

Local, state, and federal fire codes and guidelines have provisions for emergency exits. Facilities serving young children with disabilities must meet these minimum standards.

Medical/Health Considerations. Written policies and procedures should be in place regarding medical emergencies, dispensing medication and other health considerations (i.e., immunizations, food allergies or dietary restriction, special positioning, or programming classroom sanitation and infectious illness).

Interagency Collaboration. Interagency collaboration refers to efforts on the part of separate service providers to work together to share ideas, information, and resources. The broad goal underlying such collaborative efforts is improvement of comprehensive service delivery to the population served, including improved access to services, greater consistency in services, and better coordination of services. No single agency provides services for all needs - health, economic, social, education - so interagency collaboration and cooperation become vital when a child and family require more than one type of service.

Another issue addressed by interagency collaboration is fragmentation of services. This is particularly true where either there may be duplications or gaps in services to meet

identified needs. The current economic and social climate of declining resources along with increased social advocacy for providing new or expanded services has put many agencies in the difficult position of determining how to continue to provide or expand services with fewer financial resources. Interagency collaborative efforts can assist agencies as they address fragmentation while maximizing resources in light of current economic and social pressures.

Special education programs can serve a key role by facilitating collaboration between the school and other agencies serving young children with disabilities. This is true because most of the identified young children will have educational needs while the child-family needs for health, social services or economic assistance will vary. Since other agencies will often make first contacts with families of young children with disabilities, they can serve as major referral sources to school programs indicating the need for a close working relationship. The special education personnel can identify those agencies likely to have contact with young children, establish contacts with key personnel, and inform the agency of referral procedures.

A logical starting pint for collaboration among agencies is location and identification of children needing services. A major goal of agencies working together is to ensure that children are identified and referred to appropriate agency services. This matching process can be facilitated when agencies (including the school) are aware of one another's services and referral procedures. The process can be further enhanced when agencies share responsibilities for location, identification, or evaluation through cooperative financial and/or personnel sharing arrangements. An example of such cooperation is a joint selective screening program in which several agencies contribute financial and personnel resources and use the resulting information to channel referrals to appropriate agencies.

The North Dakota Early Childhood Tracking System (NDECTS) was established to identify and monitor children birth through five who are considered at risk for developmental delays. Regional NDECTS teams bring together representatives from several agencies to deal with common concerns relating to identification, location, and evaluation of young children at risk for developmental delays/disabilities. In promoting comprehensive services to young children, NDECTS teams may address more complex issues such as gaps or duplication in services.

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Transportation

If transportation is a related service as determined by the IEP planning team, the school district of the child's residence and the special education unit in which the district participates are responsible for arranging and providing transportation (or boarding care in lieu of transportation) for children who must be transported or live away from home in order to receive special education services that meet LRE criteria. (North Dakota Century Code 15-59-02.1).

The district of residence may use any reasonably prudent and safe means of transportation at its disposal. Such means may include, but are not limited to, a regularly scheduled school bus, or transportation provided by a parent of a child with disabilities or other responsible party at school district expense.

Special precautions need to be considered when transporting young children; these may make transportation provided by a parent or other responsible adult a more viable solution in some situations. Lengthy rides, adequacy of supervision, and safety and comfort for the child must be considered. Often carpools can be arranged among the parents of the children. The number of children transported at a given time should be based on safety and supervision considerations. Children should ride in car seats when appropriate or wear safety belts. North Dakota Century Code 39-21-42.2 requires that such restraint devices be used for children through ten years of age when the passenger vehicle is operated by the child's parent. The adult should escort the children into the classroom when dropping them off and return to the classroom to pick them up. This will control accidents that may occur if children are left to cross a street by themselves or enter the school building unattended.

If young children with disabilities ride a bus, the child's condition should be considered in determining the length of the bus ride. Another adult in addition to the bus driver should ride the bus to supervise the children. A separate bus may be used to transport young children to minimize unstructured physical interactions with older children that might result in injury.

Individual disabilities need to be considered in determining the type of vehicle most appropriate for transporting a child. The vehicle transporting children in wheelchairs, for example, must be equipped with fastening devices that hold wheelchairs in a secure and fixed position. Children may also be transferred in and out of wheelchairs if they are able to sit well-balanced on a regular bus seat. Such considerations will require that a bus driver be given training in the handling and positioning of physical disabilities. The vehicles providing transportation for young children should be equipped with a two-way radio and special emergency equipment such as a first aid kit, blankets, or flares.

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Funding

Special education programs in public schools are funded through combination of federal, state, and local outlays. The federal funds come from entitlement programs such as P.L. 89-313 or P.L. 101-476 and are distributed according to the number of children enrolled in the special education program. Funds flow through the state education agency to the local education agency.

An additional revenue source is provided by the state. North Dakota Century Code, Section 15-59-06, provides state per pupil foundation aid that is available when children are enrolled in an approved program. Based on a percentage of the state foundation payment per school-age pupil. State special education funds also provide reimbursement to programs qualifying for program approval.

Section 15-59-08 of the North Dakota Century Code allows school districts to levy a tax for special education. These local funds pay excess costs in providing special education services to all children with disabilities within the local district or unit.

Evaluation

Ongoing planning and evaluation are crucial components of a program for young children with disabilities. As a program is implemented, situations will arise that were not accounted for in the original planning process. The administrator and members of the program staff are responsible for developing problem solving procedures that may be used when such situations arise.

In addition to ongoing problem solving and subsequent changes in planning, personnel responsible for the ECSE program need to evaluate the effectiveness of the program. Programs are evaluated to determine strengths, deficiencies, gaps and duplications in services to children with disabilities and their families.

Each local special education unit is required to identify policies and procedures that address on-going program evaluation as a part of the unit's three year plan submitted to the North Dakota Department of Public Instruction. The effectiveness of each unit's program is determined through an evaluation of services provided, how those services are delivered, at what frequency and duration they are provided, and their quality.

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Technology-Based Options

In some areas where transportation is a major obstacle to the delivery of direct services, consideration can be given to alternative forms of information sharing.

Media-based options include utilizing closed circuit television to transmit training and technical information and self-contained instructional packages designed for use by parents or paraeducators. Videotapes may be used to provide information on child development and management techniques or on assessing and teaching techniques when consultants are not available. Likewise, computers have been used in rural areas for assessment and teaching. A checklist of skills is sent to the family and other community-based personnel such as a public health nurse or social agency representative and that person administers the checklist. The information gained from the checklist is programmed into a computer which delineates those skills that should be targeted. Videotapes are then mailed for use in teaching the targeted skills. Telephone services and special frequency radios can also serve as communication links to provide consultative skills to remote areas.

In some rural communities, mobile resource centers provide assessment and instructional services. Assessment teams consisting of multidisciplinary staff in coordination with various local community agencies travel from one rural community to another providing needed assessments. The mobile unit can also be fitted as a classroom to conduct classes in the morning while the afternoons are spent working with parents and children in the home. Toy lending and parent/child take-home libraries are also incorporated into the mobile unit.

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