
MINNESOTA DEPARTMENT OF

*Children,
Families &
Learning*

Promising Practices for the Identification of Individuals with Autism Spectrum Disorders

Minnesota Autism Project



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Preface

This document has been developed to assist the educational field in applying the new eligibility criteria for Autism Spectrum Disorders. These are promising practices in identification and they are offered as an aid for teams as they determine and document whether a student may be eligible under this category. Permission is granted for Minnesota school districts and cooperatives to duplicate this publication for nonprofit educational uses.

In 1999 the Minnesota Legislature directed DCFL to “amend Minnesota Rules, part 3525.1325, to revise the eligibility criteria for autism to reflect professional standards.” The Autism Criteria Work Group was convened to draft a proposal for revision of the criteria reflecting current research. That research asserts that autism is now more accurately described and understood as including a range or spectrum of related pervasive developmental disorders. During the past six years, three separate groups have studied the autism criteria and the issues regarding its use in Minnesota. The groups that have worked on the criteria include: 1) the Minnesota Department of Education’s Task Force on Education for Children with Disabilities II (Task Force II Report 1995); 2) the Legislative Task Force 1999, a joint task force between Department of Human Services and Department of Children Families & Learning (Legislative Report) and 3) the Department of Children, Families & Learning, Autism Criteria Work Group 1999. The work of all three of these groups contributed to the development of the eligibility criteria for the category of Autism Spectrum Disorders. The current criteria were adopted June 12, 2000.

The rationale to “revise the eligibility criteria for autism to reflect professional standards” was supported by several critical concerns about the prior 1992 criteria. That criteria was outdated and limited because it was based upon the narrower DSM-III-R “autistic disorder.” There was confusion in the field with inconsistent application of the criteria between districts and frequent use of overrides was reported. In addition, professional and parental input indicated concern with interpretations of the criteria that were “too restrictive” and excluded students that demonstrated significant educational needs but had not met the older and more limited DSM-III-R standard.

This new eligibility criteria was developed with the expertise of the Work Group members and supported with input and rationale from a variety of professional sources (see page 45 for a partial listing). As research from the fields of education, psychology and medicine have continued to progress, our understanding of autism has increased since the past criteria was established in 1992. We now better understand the disorder of autism as a spectrum of related pervasive developmental disorders also known as Autism Spectrum Disorders (ASD).

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Purpose of the Manual

This manual has been developed to assist the educational field in understanding and applying the new eligibility criteria for Autism Spectrum Disorders. This document contains promising practices in identification and the determination of eligibility under this Special Education category. The information, processes described and the materials contained in this document are current promising practices. The forms are optional and may assist teams in documenting the eligibility of these students. This manual is provided as an aid for teams as they plan and conduct evaluations to determine and document whether a student meets eligibility requirements.

The manual is organized in two main sections with supporting Appendices.

Part I – An Overview of Autism Spectrum Disorders provides background, definitions and general information about the disability category.

Part II – Using the New Autism Spectrum Disorders Criteria contains a copy of the new criteria along with more specific and detailed materials that will assist teams in the process of educational evaluation; first, in determining that a disability exists and second, in the identification of individual needs that will form the foundation of the IEP/IFSP.

The Appendices include a sample evaluation report, resources for assessment, and information on other promising practices. A question and discussion/answer format is also utilized throughout. The answers provided are not intended to be legal interpretations, rather to provide guidance-based promising practices. This format and all materials are intended to contribute to a broader understanding of the issues and application of the new eligibility criteria for ASD.

The developers of this manual have incorporated the work of many others with permission. While the information provided here reflects many current promising practices, it should not be considered an exhaustive collection of possible practices. Practitioners are encouraged to improve upon these or utilize other approaches that are consistent with current professional standards. It is expected that these methods and materials will evolve as research in the field continues to develop and methods of identification and assessment are improved.

Training or technical assistance is available through DCFL, Division of Special Education Low Incidence Project and the Minnesota Autism Network.

Copies of this manual are available at cost, by completing the order form at the back of the manual or contacting the Metro ECSU at (612) 706-0801 ext.110

An Overview of Autism Spectrum Disorders (ASD)

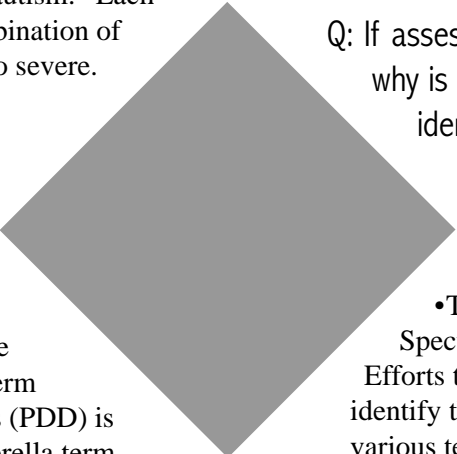
History and Background of Autism Spectrum Disorders

The term Autism Spectrum Disorders (ASD) is used in Minnesota and, now more frequently throughout the country, to refer to this range of related conditions also known as Pervasive Developmental Disorders (PDD). Autism and these related conditions are lifelong developmental disabilities that usually begin during the first three years of a child's life. They are neurologically based disorders and affect the way a child communicates, interacts with other people, and perceives and reacts to the world.

Patterns of behavior characteristic of ASD include impairment of reciprocal social interactions, impaired communication skills, and a restricted range of interests or repetitive behaviors. *Not all children with autism behave in the same way.* This is what is meant by the "spectrum of autism." Each child might display a different combination of characteristics, ranging from mild to severe.

Many professionals have defined autism and the PDD's based upon a diagnostic manual published by the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders or DSM. According to the most recent version, DSM-IV, the term Pervasive Developmental Disorders (PDD) is not a specific diagnosis, but an umbrella term under which the specific diagnoses in the diagram

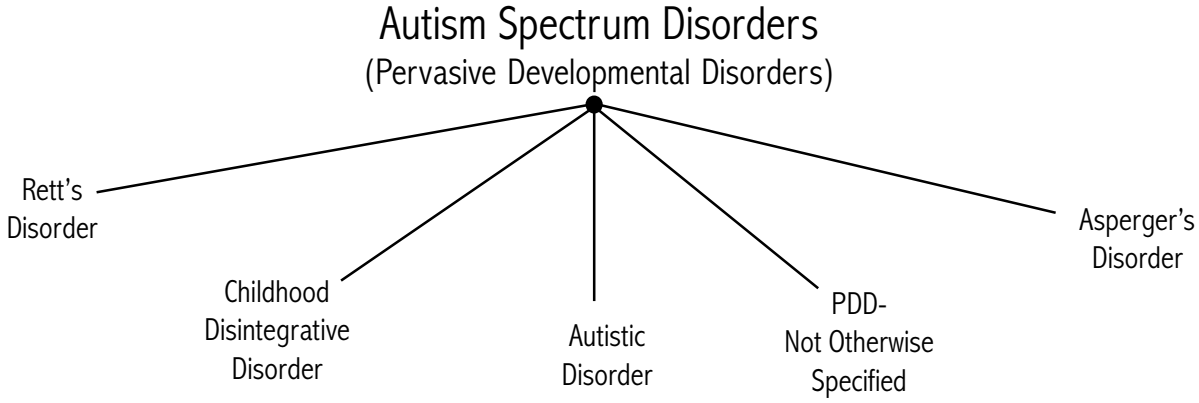
below are defined. Since 1943, when autism was first described, the professional and public understanding of this complex disorder has grown. Leo Kanner first described this condition in a small group of young children. At the same time, Hans Asperger was describing a similar and seemingly related condition in a different group of children. Kanner coined the term "autism" to describe his group; Asperger's group carried his name. Children in both groups demonstrated difficulties in their ability to communicate, play or relate to others, and had a narrow range of interests. In the years that followed, professionals have attempted to more clearly understand the differences and similarities in the types of children that Kanner and Asperger had described.



Q: If assessment methods have improved, why is there still confusion about identification of ASD?

There are several factors that contribute to possible confusion.

- The terms used to identify Autism Spectrum Disorders often change. Efforts to more clearly describe and identify these children have resulted in various terms and criteria being established and revised as well as subgroups being

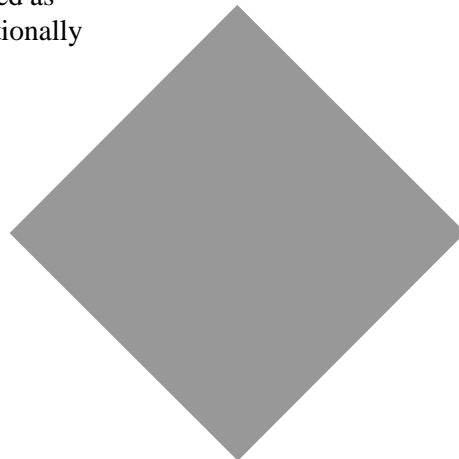


added. Various terms used historically in medicine, psychiatry and education have included Childhood Autism, Atypical Autism, Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), Autistic Disorder, Childhood Schizophrenia, High Functioning Autism, Low Functioning Autism, Asperger's Syndrome and others.

- Individual differences occur along a continuum or spectrum. Research and professional experience supports the fact that the clinical picture of autism varies across individuals, especially in preschool years. There often is a lack of understanding or misidentification of the disability. Children with Autism Spectrum Disorders are sometimes misdiagnosed as oppositional, defiant, emotionally

disturbed, obsessive compulsive, learning disabled, speech delayed or mentally retarded.

- Autism can occur in association with other disorders and disabilities such as mental retardation, sensory impairments, Fragile-X Syndrome, obsessive-compulsive disorders, epilepsy or other medical conditions. Proper identification can be difficult but is critical for obtaining appropriate information and services.
- Diagnosticians lacking experience may not identify the critical features and needs associated with the disorder and thus delay effective early interventions.



Definitions of Autism Spectrum Disorders

Minnesota definition from Educational Criteria for Eligibility (2000)

*Minnesota Rules, Chapter 3525.1325 –
Adopted June 12, 2000*

“Autism spectrum disorders (ASD)” means a range of pervasive developmental disorders that adversely affect a pupil’s functioning and result in the need for special education instruction and related services. ASD is a disability category characterized by an uneven developmental profile and a pattern of qualitative impairments in several areas of development: social interaction, communication, or restricted repetitive and stereotyped patterns of behavior, interests, and activities, with onset in childhood. Characteristics can present themselves in a wide variety of combinations from mild to severe, as well as in the number of symptoms present, for example Autistic Disorder, Childhood Autism, Atypical Autism, Pervasive Developmental Disorder: Not Otherwise Specified, Asperger’s Disorder, or other related pervasive developmental disorders.

Federal Definition of Autism (1997)

*IDEA Reauthorization 1997
CFR 300.7 (c)(1)(i)*

“Autism” means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, that adversely affects a child’s 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 an emotional disturbance.

Autism Society of America Definition (2000)

Autism is a complex developmental disability that typically appears during the first three years of life. The result of a neurological disorder that affects the functioning of the brain, autism and its associated behaviors have been estimated to occur in as many as 1 in 250 individuals (Center for Disease Control and Prevention, 2000). Autism is four times more prevalent in boys than girls and knows no racial, ethnic, or social boundaries. Family income, lifestyle, and educational levels do not affect the chance of autism’s occurrence.

Autism interferes with normal development of the brain in the areas of social interaction and communication skills. Children and adults typically have difficulties in verbal and non-verbal communication, social interactions and leisure or play activities. The disorder makes it hard for them to communicate with others and relate to the outside world. They may exhibit repeated body movements (hand flapping, rocking), unusual responses to people or attachments to objects, and they may resist changes in routines.

Over one half million people in the U.S. today have some form of autism. Its prevalence rate now places it as the third most common developmental disability- more common than Down syndrome.

Questions About the Incidence of Autism Spectrum Disorders in Minnesota

Q: Has there been an increase in the Minnesota Child Count?

In Minnesota the incidence rate for the ASD category has annually increased an average of 32 percent for the last nine years. This increase is consistent with international and national figures and trends.

Q: How many students are identified in Minnesota?

The child count data reported to DCFL for Dec. 1, 1999 indicates that 2,242 students (Birth-21 years of age) presently meet the educational criteria for the ASD category and receive special education services.

Q: Are these figures complete?

This figure does not reflect a complete count due to several factors. Young children with ASD may be counted and receive services when they meet criteria under the Early Childhood Special Education category (ECSE now the Developmental Delay category). In addition, very young children are sometimes difficult to identify or others may be incorrectly identified but counted and served under other categories (e.g., EBD, MSMI, SL).

Q: Are we over-identifying students in this category?

There is no data to suggest that any students found eligible under this category were inappropriately identified. Data collected by the DCFL, Division of Accountability and Monitoring, have found no students inappropriately identified in this category

over the past three years.

Q: Are other states seeing the same increase and what are the national incidence rates?

Data reported from other states and countries indicate this increase is present nationally and internationally. The National Institute of Child Health and Human Development (NICHD) reported new incidence figures in 1998. Projected incidence rates now range anywhere from 7-48 per 10,000 births, when considering the broader spectrum of the disorder. Marie Bristol-Powers, Ph.D., reported the following figures to the Autism Society of America.

- 1 in 666 individuals with “classic” Autism
- 1 in 500 individuals with Autism and Pervasive Developmental Disorder: Not Otherwise Specified (PDD-NOS)
- 1 in 200 individuals with Autism, PDD-NOS and Asperger’s Disorder

Q: What forecast or estimates can be made about this trend in Minnesota?

It is predicted that we will continue to see this count increase as we are only now reaching the levels suggested by nationally reported incidence rates. By applying the most recent NICHD rates to Minnesota, estimates can be made of the number of individuals within this disability category in the state. Based on the total student enrollment reported Dec. 1, 1999, Minnesota is home to 942,317 individuals Birth-21 years. At an estimated rate of 1 in 666 for “classic” autism, there are potentially 1415 students in this age range. If we consider the incidence rate of 1 in 500 for autism and PDD-NOS, the potential number of students identified increases to 1885. And if we include individuals with Asperger’s Syndrome and use the 1 in 200 incidence rate, the estimated number reaches

4711 students from birth to 21 years.

Q: Why are we seeing these dramatic increases?

While there is general agreement that Autism Spectrum Disorders are on the rise, it is unclear why. Better identification methods and better-trained professionals contribute to some of the increase, but many speculate that there may be some undetermined causal factors that continued research could identify. Many theories exist and promising research is focused on a possible combination of genetic and environmental factors. The National Center for Disease Control currently is funded to study this issue in greater detail.

Q: How will Minnesota address this increasing need for appropriate services?

The Legislative Task Force on Autism—1999, jointly convened by DCFL and DHS, reported recommendations that can build upon a foundation begun in partnership between DCFL, school districts, families and other public agencies. The legislative directive requires that recommendations be implemented “within the current available funding.” These ‘budget-neutral’ recommendations are:

- A single intake process should be developed and used by all agencies serving children with Autism Spectrum Disorders (ASD).
- The Department of Children, Families and Learning’s entrance criteria for ASD eligibility should be revised to reflect current research and

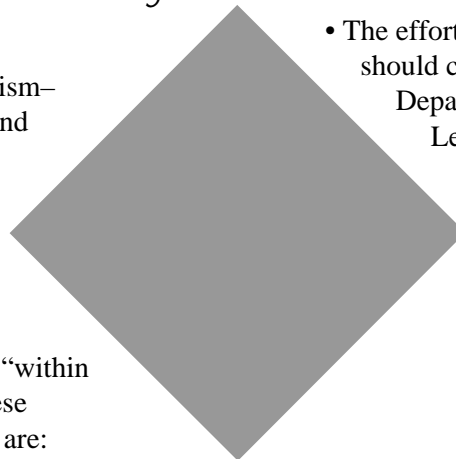
practice.

- Access to Child and Teen Check-Up funding (EPSDT) should be clarified by the Department of Human Services to enhance treatment options.

- Training and technical assistance on Autism Spectrum Disorders and how to access available funding should be provided to county personnel by the Department of Human Services.

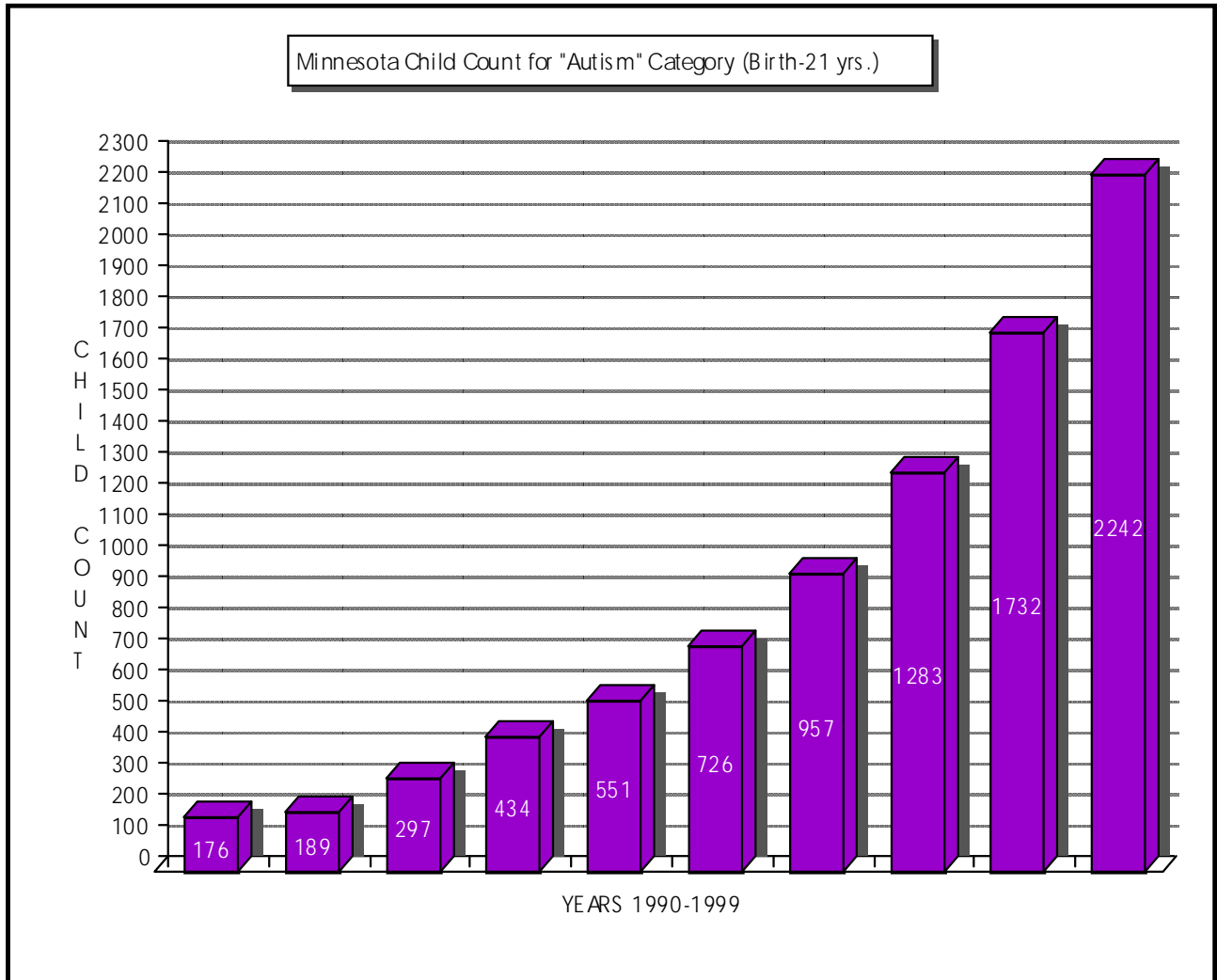
- A jointly convened state work group that includes family, advocate, and professional representation should be formed to develop best practices and personnel standards relating to services and treatments for children with Autism Spectrum Disorders.

- The efforts of the Minnesota Autism Network should continue to be supported by the Department of Children, Families and Learning.



Minnesota Child Count for "Autism" Category

December 1 Unduplicated Child Count



Who are the kids with Autism Spectrum Disorder?

These vignettes illustrate the range of behaviors that may be seen in children with Autism Spectrum Disorder. They are composite sketches and do not refer to a specific child.

Adam, age 4, seemed different from other infants from the day he was born. Instead of exploring his environment and interacting with people, Adam spent time sitting motionless in his crib or playpen. He didn't seem to respond to voices, toys, rattles, etc., and his parents thought he "appeared deaf." He rarely made eye contact with those around him. Developmental milestones did not occur in the typical sequence, for Adam was one who stood up before crawling, and when he walked, it was on tiptoes. He used screaming and grabbing to get what he wanted, and by age 3 still was not talking. He showed intense interest in visually stimulating items, such as the spinning wheels of his toy trucks, and the motion of the fan spinning across the room. For no apparent reason, Adam will rock and bang his head against the wall, and does not respond to his parent's attempts to comfort him. Changes in routine and activity brought intense episodes of screaming and tiptoe running around the perimeter of the room. Because of these unusual behaviors, Adam has been asked to leave several daycare settings. His pediatrician has referred Adam to his local ECSE team to determine his eligibility for Special Education services.

Jonathon is a 6-year-old boy diagnosed with autism by his primary physician and meets state educational criteria for Autism Spectrum Disorders. He is functioning in the developmentally delayed range in cognitive and adaptive behaviors. He is physically active, but spends much of his free time wandering aimlessly around and playing repetitively with a few select toys. He appears disinterested in playing with others or in interacting with adults. He is not using words to communicate, but will bring an object to an adult to indicate his wants, such as handing someone a cup to indicate wanting a drink.

Sarah is an energetic 10-year-old girl with fairly average communication skills. She has difficulties making and keeping friends and often wanders alone on the playground or talks with an adult. She has an excellent memory for math facts and does well on daily worksheets. Her vocabulary and spelling skills are average but she doesn't appear to comprehend what she reads. She takes things very literally and is considered a concrete thinker. She does not understand classroom jokes or abstract concepts presented in stories and is not able to relate to another person's perspective. She has somewhat poor coordination and is not interested in participating in organized sports activities. At home, Sarah spends most of her free time building towers with legos and playing games on the computer. Sarah recently has been diagnosed with Asperger's syndrome by her physician and meets state educational criteria for ASD.

Amanda is a 16-year-old who has had many labels. She qualified for Early Childhood Special Education services during preschool due to delays in social skills and communication. In elementary school, her primary disability was listed as EBD with Speech and Language secondary. She exhibited many "oddities" in social interactions with peers, insisted on routine and order, was easily upset by changes, and over the years had several periods of fixation on one topic. Her mother frequently has questioned the doctor about possible anxiety disorder, obsessive compulsive disorder, and oppositional defiant disorder and wondered if medications would benefit Amanda. The educational team, along with Amanda and her mother, is looking at the state educational criteria for ASD to more accurately identify Amanda's primary needs and concerns.

Myths about individuals with ASD

Myth: Parents cause their child to have autism.

Fact: Parents do not cause “autism.” The Autistic Spectrum Disorders are a developmental disability resulting from various genetic, metabolic, and biochemical conditions affecting development and functioning of the central nervous system.

Myth: ASD is a form of emotional disturbance.

Fact: Autism is an organic disorder resulting in unusual patterns of development. Just like anyone else, people with ASD *can* experience emotional problems, either chronically or intermittently.

Myth: Professionals can't seem to agree on a diagnosis of ASD.

Fact: The Autism Spectrum Disorders can be difficult to diagnose and professionals sometimes disagree. Different professionals sometimes assign different diagnostic terms to nearly identical descriptions of characteristics. This is very confusing for parents and service providers. Professionals are now much more aware of the wide variety of ways that the core social, communication and behavioral deficits may be evidenced by individuals. Thus, agreement on diagnosis is more common while terms such as autistic-like, childhood schizophrenia, childhood psychosis, and pervasive developmental disorder are used less frequently.

Myth: People can be cured or grow out of ASD.

Fact: ASD are lifelong disabilities and, at present, there is no known cures. As an individual moves from childhood through adolescence and into adulthood, the characteristics of ASD will change. Although individuals with ASD can learn to be successful in a number of areas, difficulties with socialization and communication often may remain.

Myth: Children with ASD are never cuddly or affectionate.

Fact: Children with ASD often like to be hugged and cuddled. They may want to be in control of physical displays of affection and may feel smothered by physical closeness imposed by others. They may need to give permission to be hugged and to have control of how they are held or cuddled. Or, they may not discriminate among people with whom they should and should not be affectionate. Sensory, social and communicative issues all affect an individual's patterns of physical interaction.

Myth: Children with autism are more intelligent than scores from IQ tests indicate.

Fact: IQ scores are accurate, stable, and predictive when appropriate instruments and assessment strategies are used by skilled professionals.

Myth: People with ASD never make eye contact.

Fact: People with ASD may avoid eye contact or use it in atypical ways. They may engage in prolonged staring and/or avoid eye contact with people who are talking with them. They sometimes use peripheral vision in ways that make it difficult to determine whether they are paying attention. People with ASD often have great difficulty with “reading” subtle messages commonly conveyed through eye contact.

Myth: All people with autism are alike.

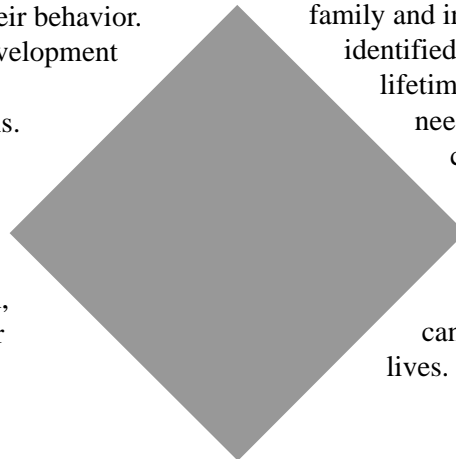
Fact: All people with ASD are different. Individuals vary immensely in ways the disorder is manifested in their thinking and their behavior. Individuals vary widely in their development in sensory, cognitive, social, communication, and motor domains. They vary widely in how areas of strength and impairment interact. All people with ASD do experience difficulty in the areas of social awareness and interaction, communication, and sensory/motor functioning.

Myth: People with autism need to be in special programs for “the autistic” if they are to benefit.

Fact: People with ASD need to be taught age-appropriate, real-life skills. They need to learn to participate and interact in age-appropriate community settings. Systematically planned, comprehensive, individualized programs that provide for the flexibility needed to build on strengths and compensate for deficits are most beneficial. If individuals with ASD are to learn to participate, interact, and communicate, they need to be in inclusive settings with peer models and friends who are sociable and supportive.

Myth: ASD is such a severe and hopeless disability that little can be done to help persons with the disorder.

Fact: ASD is a severe and complex disorder, but all individuals with the disability can learn to function in the community to some degree. Many develop very satisfying and productive lives. Children who have the disorder need to be identified as early as possible. Early intervention is critical to problem prevention and positive progress. Positive individualized programs should focus on systematic teaching and reinforcement of situation-appropriate behaviors in natural settings, on provision and use of functional communication strategies, and on fostering social participation and interaction in real-life community events. Networks of available family and individual services need to be identified early and kept current over the lifetime of the person with ASD. Services need to be expanded to fill gaps that can result in frustration and failure. Given ongoing positive instruction, needed supports, and natural opportunities to use developed skills, people with ASD can live satisfying and productive lives.



Common Questions about Children with ASD

Q: How does a child qualify for special education services and related services?

Students who meet eligibility criteria for ASD are entitled to a free and appropriate public education. A clinical or medical diagnosis is not required to meet this criteria. The educational team, which includes the parents, is responsible for determining if a child meets criteria and for identifying their educational needs through the educational evaluation process. The multi-disciplinary team must include a professional with experience and expertise in the area of ASD and knowledge of typical development. The Evaluation Summary Report is the foundation for an appropriate program and leads to the development of an IEP/IFSP that addresses the individual needs identified for the child.

Q: Is this a clinical diagnosis of autistic disorder?

Minnesota's state criteria for ASD is not a medical diagnosis. ASD is a disability category and has specific criteria used to determine eligibility for special education services as determined by educational teams upon review of the state criteria. A medical diagnosis made by a licensed psychologist or physician is not necessary in determining educational eligibility.

Parents may choose to go to a medical facility to seek further information and diagnoses. Physicians and neurologists can rule out or confirm other contributing medical conditions such as seizure disorders, chromosomal abnormalities, sensory disabilities, etc.

Q: How is ASD clinically diagnosed?

There are no medical tests for diagnosing any of the Autism Spectrum Disorders. In order to be diagnosed accurately, a child must be observed by professionals skilled in determining communication, social, behavioral, and developmental levels. A brief observation in a single setting cannot present a true picture of an individual's abilities and behavior patterns. At first glance, the child may appear to have mental retardation, a learning disability, or problems with hearing or vision.

Diagnosis is difficult for a practitioner with limited training or exposure to ASD due to its low incidence rate and because ASD's characteristics vary so widely. This can be a source of frustration for families seeking a clinical diagnosis or referrals to specialists.

While a clinical diagnosis is not required for Special Education services, families may choose to consult with medical personnel to discuss such possibilities as chromosomal testing, EEGs, metabolic tests, etc.

Q: Must an IQ test be completed as part of the initial evaluation or reevaluation?

A team decision determines the need for an evaluation in this area of development. A cognitive assessment is not necessary for making decisions regarding the verification of ASD or in making educational programming and evaluation decisions. In fact, the validity of any standardized cognitive assessment with a child with ASD is questionable given that standardized assessments require specific prerequisite skills that often are missing or less developed in children with ASD (i.e., functional receptive and expressive language abilities and social interaction skills). Also, the behavior of a

Continued on next page

child with ASD can be extremely variable, which can affect evaluation results. Research further suggests there is no evidence that children with ASD exhibit a unique profile of intelligence as measured by an intellectual test.

Skilled professionals may use intellectual assessment when ruling out mental retardation, but only if the child has communication skills, is able to attend to the testing materials, and is able to engage in appropriate testing behavior. The results from a cognitive assessment also may provide the team with descriptive baseline information about the child's present levels of performance on tasks measuring specific intellectual abilities. The observation data obtained by attempting the assessment may further provide useful information in terms of providing insights to his/her learning style, of how s/he functions in a one-to-one situation, and of how s/he approaches new situations and materials. (This and further information is found in *School Psychology Review*, Volume 28 (4), 1999.)

Q: Aren't school districts eager to label children with Autism Spectrum Disorders so they get more money for serving the child?

No. School personnel conduct thorough evaluations in order to make the most appropriate decisions about serving children in special education programs. School districts **do not** receive more money for serving a child with an Autism Spectrum Disorders label than for any other category of special education.

Q: Why is early identification so important?

According to the Autism Task Force Report (March 1999) to the Minnesota Legislature, the following recommendations were made by the Department of Children, Families and Learning and the Department of Human Services:

“Autism is a complex and treatable disorder. The identification of Autism Spectrum Disorders, whether made medically or educationally, should be shared with the parent and/or guardian and Individualized Family Service Plan (IFSP) team members as soon as possible. Early diagnosis is critical for appropriate intervention and meaningful outcomes for children with Autism Spectrum Disorders.”

Since schools often see young children first and for extended periods of time, the identification of toddlers and young children with this disorder should become standard practice for Early Childhood Special Education Programs throughout the state using this educational criteria.

Older children, who have not previously been identified as having Autism Spectrum Disorders, should be considered using this criteria as soon as the team recognizes the possibility of this pattern of symptoms.

More questions on next page

Q: Are there special considerations for learners of diverse cultures?

When assessing children for the educational category of ASD, the impact of diverse cultures and languages must be considered. Areas for team discussion as to individual or cultural differences may occur in the following areas:

- expectations for eye-to-eye gaze and amount of eye contact
- reactions to physical touch and acceptable areas for touch
- social games/ interactions used to evaluate reciprocity
- social play routines and toys used to evaluate imagination and interaction responses
- reactions and responses to an interpreter’s language/behaviors
- cultural reactions in “warming up” to new situations and issues of anxiety regarding authority figures
- presentation of material regarding Autism Spectrum Disorders given to parents in the language spoken in the home.

The Autism Society of America provides information in various languages. Their phone number is 1-800-AUTISM.

Q: What are coordinated services?

Multiple agencies and programs have roles and responsibilities in the provision of services for children with ASD and their families. With the reauthorization of IDEA, children who qualify for special education services may be eligible for coordinated services based upon their level of need and the number of agencies involved with the family. Coordinated services is a collaborative effort where schools, county programs, and other community agencies work together to provide a continuum of services to children and families based upon their needs. The purpose of coordinated services is to ensure families are connected with various resources in the community and that services are not duplicated.

If a student has more than one agency working with him/her, the educational team will be required to design and implement a coordinated service plan based upon the implementation timeline set by the state.

Q: What county services are available?

Local social service agencies can provide case management, allocate services and funding from the Family Support Fund, facilitate child protection activities, and oversee in-home support services as well as out-of-home placement activities. County public health agencies play a key role in health related activities. Specifically, they have the responsibility to evaluate the need for and authorize personal care assistant services. Both health and social services are responsible for administering as well as providing and funding a variety of services for eligible children with ASD. *(Information from the Task Force Report to the State Legislature.)*

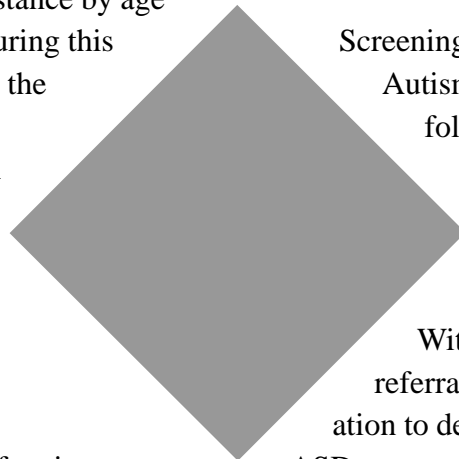
Screening and Early Identification

Many experts now agree that screening for autism spectrum disorders should become a routine part of well-child visits beginning in infancy. Recent research and advances in the screening tools and early detection of ASD have made it possible to begin identifying these children at even younger ages. The American Academy of Neurology and experts from 12 professional organizations recently released their recommended guidelines for autism screening. In their recent survey of 1,300 families, the average age of diagnosis of autism was 6 years, despite the fact that most parents felt something was wrong by 18 months of age and had usually sought medical assistance by age 2 years. The role of educators during this critical time was emphasized by the data that “almost half of these families reported that the school system and other parents were the major source of assistance over time rather than the medical health care community”.

A clinical diagnosis of autism often is not made until two or three years after the symptoms or behavioral indicators are recognized, primarily because of concerns about labeling or incorrectly diagnosing the child. Identifying these children earlier can facilitate earlier educational planning, provisions for family

supports and education, management of family stresses and delivery of appropriate interventions. Screening to identify very young children at risk for any type of atypical development and then followed by identifying those specifically at risk for Autism Spectrum Disorders is critical to earlier identification and intervention.

The interagency efforts of schools and communities can improve screening and referral for further evaluation. This can assist families in their attempts to understand their child’s developmental difficulties and provide a free and appropriate public education.



Screening tools such as the Checklist for Autism in Toddlers (CHAT) and the following information can assist Birth to Three teams and other providers in identifying young children with possible Autism Spectrum Disorders. With this screening information, referrals can be made for further evaluation to determine eligibility under the ASD category, identification of specific educational needs and appropriate programming can be planned and implemented sooner.

Characteristics of Autism in Children Under 36 Months*

Social Interactions/Reciprocity

Young children with autism are less likely to:

- Respond to social bids (e.g., “hard to reach”)
- Smile responsively (e.g., in response to praise or a smile)
- Reciprocate affection (e.g., return a hug)
- Establish eye contact during interactions
- Imitate the actions of others (e.g., wave good-bye)
- Engage in reciprocal, back-and-forth play
- Repeat actions that produce attention or laughter (e.g., “show off;” attempt to please parents)
- Show interest in other children (e.g., play near or with them)

Restricted/Repetitive Activities

Young children with autism are less likely to:

- Engage in a broad repertoire of functional play activities
- Create simple play schemes or sequences with toys
- Engage in functional play with dolls
- Engage in imaginative play

Young children with autism may:

- Engage in repetitive play activities (e.g., lining up toys; opening and closing doors on toy cars)
 - Demonstrate repetitive motor behaviors (e.g., spinning; finger posturing)
 - Respond inconsistently to sounds (e.g., “seems deaf”)
- Show unusual visual interests (e.g., spinning objects; “studying” objects)

Communication

Young children with autism are less likely to:

- Use gestures to communicate (e.g., point to request; shake head “no” to protest)
- Communicate to direct another person’s attention (e.g., hold up an object to show; point to indicate interest)
- Use eye contact during communicative acts
- Understand language or gestures



* From a handout by Wendy Stone, Ph.D., University of Vanderbilt

What do Special Education Administrators and Service Providers need to know about ASD?

Adapted from material provided by Renae M. Ouillette, Special Education Coordinator, Lakeville Public Schools. Used with permission.

What is Autism Spectrum Disorder?

1. Neurological disorder that affects brain functioning
2. Lifelong developmental disability, usually appearing prior to 36 months of age
3. Occurs in 1 of every 200-250 births
4. Symptoms can range from mild to severe
5. Characterized by:
 - a. severe deficits in understanding social relationships
 - b. severe deficits in communication development
 - c. marked restriction of activity and interests
 - d. uneven patterns of intellectual development
6. Types are listed as Autism, Pervasive Developmental Disorder—Not Otherwise Specified, Asperger's Syndrome, Rett's Syndrome, and Childhood Disintegrative Disorder

5. Often unaware of others' feelings
6. Unable to carry on a "give and take" conversation
7. Easily upset by changes in routine
8. Literal in speech and communication
9. Fixated on one subject
10. Overly sensitive to certain stimuli

Why is Autism Spectrum Disorder so Challenging?

1. Social deficits make it difficult for adults to make attachments
2. Considered a "hidden" disability
3. Behavior often viewed as willful, manipulative
4. Adults fail to understand sensory and neurological issues
5. School staff lack knowledge of effective strategies

What causes Autism?

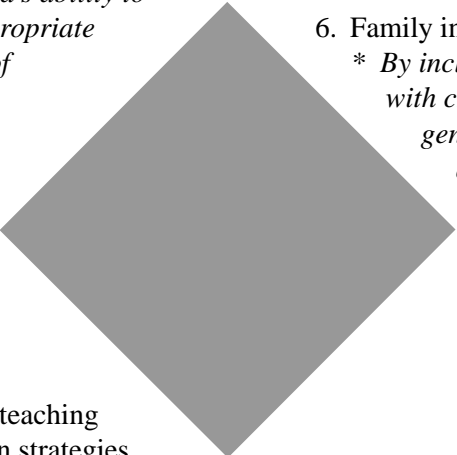
1. No known cause
2. Not caused by psychological factors
3. Hypotheses refer to chemical imbalance, genetic factors, environmental conditions, physical abnormality affecting parts of the brain that process language and sensory information, and/or a combination of causes

What are the characteristics of Asperger's Syndrome?

1. Onset usually later than classic autism, and outcome more positive
2. Verbal IQ is usually higher than performance IQ
3. Socially awkward and clumsy in relations with peers and adults
4. Naïve and gullible

What are the Common Elements of Successful Early Intervention Programs?

In the widely cited article, "Early Intervention in Autism"(1996), Geraldine Dawson and Julie Osterling examine eight different early intervention programs and define six elements common to all of them. According to the authors, these common elements are the ones that the program directors agree are essential, although their methods for addressing each element may vary. The six elements common to all successful early intervention programs, as determined by Dawson and Osterling are listed on the next page.

1. The curriculum content of successful programs includes:
 - a. ability to attend to elements of the environment
 - * *In order to begin learning, children with autism must be taught to pay attention to other people.*
 - b. ability to imitate others
 - * *All programs emphasize both verbal and motor imitation of others.*
 - c. ability to comprehend and use language
 - * *Most programs try to tempt the child to communicate by providing immediate and rewarding responses after each communication.*
 - d. ability to play appropriately with toys
 - * *Successful early intervention programs focus on increasing the child's ability to use toys in functionally appropriate ways and promote the use of symbolic play.*
 - e. ability to interact socially with peers
 - * *Most programs focus on teaching fundamental skills like turn taking and sharing.*
 2. The need for highly supportive teaching environments and generalization strategies
 - * *All of the programs have a very low staff-to-child ratio in the early stages.*
 3. The need for predictability and routine
 - * *Most programs call for a highly structured environment.*
 4. A functional approach to problem behaviors
 - * *After a behavioral assessment, one or more intervention methods is used to redirect the child's behavior while addressing the root motive.*
 5. Transition plan from the preschool classroom (and between other environments and staff) is clearly defined
 - * *Preschool children are prepared for transition to kindergarten by being taught "survival skills" for the classroom that include complying with adult requests, taking turns, sitting quietly during activities, volunteering, raising one's hand, and communicating basic needs.*
 6. Family involvement strongly encouraged
 - * *By including parents in the interventions with children, greater maintenance and generalization of skills can also be achieved.*
- 

Due Process Errors to Avoid

1. Procedural errors
 - a. delays in evaluating for ASD
 - b. failure to evaluate individual needs
 - c. delay in conducting the IEP
 - d. failure to involve parents in the process of developing an IEP and determining placement
 - e. making decisions based on program availability / design rather than individual needs
 - f. failure to review all relevant information, including independent evaluation, before making IEP and placement decisions
 - g. failure to provide promised programs
 - h. failure to collect objective data to demonstrate students are making measureable and adequate gains
2. Programming errors
 - a. program judged to be insufficient in meeting the extensive needs of the child
 - b. refusing to consider a specific methodology
 - c. not utilizing methodologies / teaching strategies supported by empirical evidence

Promising Practices for School Districts

1. Identify and train key staff members to act as ASD resources for the district.
2. Train staff to conduct thorough evaluations for both eligibility and program planning.
3. Clearly written IEP that takes into account each student's unique educational needs and is developed before making placement decisions.
4. Give credence and respect to independent evaluations sought by parents as well as district evaluators that are well-qualified to adequately address the child's needs.
5. Provide programs that incorporate research-based practices and are based on the unique needs of the child.
6. Offer parents a range of placement options.
7. Provide options for intense intervention at the preschool level including an "applied behavioral analysis" component.
8. Provide training on characteristics and programming for all special education staff.
9. Provide training to general education teachers / staff.
10. Collect and review objective data on IEP goals to evaluate the effectiveness of the programming.
11. All available evaluative information, school records, and other relevant information should be shared by parents and school districts.



Material from the following resource was included in the last two sections on due process and promising practices:

Mandalawitz, Esq., Myrna R.; The "Dos and Don'ts" of Avoiding Litigation: School Districts & Services for Young Children with Autism, Young Children with Autism: Navigating the Legal System, pp.81-109, August 1998.

Using the New
Autism Spectrum
Disorders Criteria:
Determination of Eligibility
for Special Education

Minnesota Eligibility Criteria for Special Education

Minnesota Rules, Chapter 3525 – Adopted June 12, 2000
3525.1325 Autism Spectrum Disorders (ASD)

Subpart 1. Definition. “Autism spectrum disorders (ASD)” means a range of pervasive developmental disorders that adversely affect a pupil’s functioning and result in the need for special education instruction and related services. ASD is a disability category characterized by an uneven developmental profile and a pattern of qualitative impairments in several areas of development: social interaction, communication, or restricted repetitive and stereotyped patterns of behavior, interests, and activities, with onset in childhood. Characteristics can present themselves in a wide variety of combinations from mild to severe, as well as in the number of symptoms present, for example Autistic Disorder, Childhood Autism, Atypical Autism, Pervasive Developmental Disorder: Not Otherwise Specified, Asperger’s Disorder, or other related pervasive developmental disorders.

Subpart 2. (See repealer.)

Subpart 3. Criteria. The multidisciplinary team shall determine that a pupil is eligible and in need of special education instruction and related services if the pupil demonstrates patterns of behavior consistent with those in item A and fulfills the requirements in item B.

A. An educational evaluation must address all three core features in subitems (1) to (3). For eligibility purposes, there must be documented evidence the student demonstrates the specific patterns of behavior described in at least two of these subitems, one of which must be subitem (1). The eligibility determination must be supported by information collected from multiple settings and sources.

Behavioral indicators of these core features must be atypical for the pupil’s developmental level. Documentation of behavioral indicators must include the use of at least two of these methods: structured interviews with parents, autism checklists, communication and developmental rating scales, functional behavior assessments, application of diagnostic criteria from the current Diagnostic and Statistical Manual (DSM), informal and standardized evaluation instruments, or intellectual testing.

(1) Qualitative impairment in social interaction, as documented by two or more behavioral indicators, such as: limited joint attention and limited use of facial expressions directed toward others; does not show or bring things to others to indicate an interest in the activity; demonstrates difficulties in relating to people, objects, and events; a gross impairment in ability to make and keep friends; significant vulnerability and safety issues due to social naivete; may appear to prefer isolated or solitary activities; misinterprets others’ behaviors and social cues.

(2) Qualitative impairment in communication, as documented by one or more behavioral indicators, such as: not using finger to point or request; using others’ hand or body as a tool; showing lack of spontaneous imitation or lack of varied imaginative play; absence or delay of spoken language; limited understanding and use of nonverbal communication skills such as gestures, facial expressions, or voice tone; odd production of speech including intonation, volume, rhythm, or rate; repetitive or idiosyncratic language or inability to initiate or maintain a conversation when speech is present.

(3) Restricted, repetitive, or stereotyped patterns of behavior, interest, and activities, as documented by one or more behavioral indicators, such as: insistence on following routines or rituals; demonstrating distress or resistance to changes in activity; repetitive hand or finger mannerism; lack of true imaginative play versus reenactment; overreaction or under-reaction to sensory stimuli; rigid or rule-bound thinking; an intense, focused preoccupation with a limited range of play, interests, or conversation topics.

B. The team shall verify that an ASD adversely affects a pupil's present level of performance and that the pupil is in need of special education instruction and related services. This verification is completed through the multidisciplinary team evaluation and summarized in the pupil's evaluation report. Documentation must be supported by data from each of the following components:

- (1) The evaluation must identify the pupil's present level of performance and educational needs in each of the core features identified by the team in item A. In addition, the evaluation process must give consideration to all other areas of educational concern consistent with the IEP process.
- (2) The pupil's need for instruction and services must be documented and supported by evaluation and observations in two different settings, on two different days.
- (3) A developmental history which summarizes developmental information and behavior patterns.

Subpart 4. Team membership. At least one professional with experience and expertise in the area of ASD must be included on the team determining eligibility and educational programming, due to the complexity of this disability and the specialized intervention methods. The team must include a school professional knowledgeable of the range of possible special education eligibility criteria.

Subpart 5. Implementation. Pupils with various educational profiles and related clinical diagnoses may be included as eligible if they meet the criteria of ASD. However, a clinical or medical diagnosis is not required to be eligible for special education services. Due to the wide variation in characteristics and needs, pupils with different educational profiles or a specific clinical diagnosis must also be determined as eligible following the criteria in subpart 3. Following this eligibility determination process is essential to identify and document individual strengths and weaknesses and the pupil's unique educational needs so that an effective individual educational program may be planned and implemented.

How do we Utilize the Eligibility Criteria?

This checklist is an aid to guide teams through the process of determining eligibility. In order for a student to be eligible for special education and related services under the category Autism Spectrum Disorders (ASD), the following steps and conditions must be met.

Subpart 3A

- _____ At least two methods of documenting behavioral indicators have been used.
- _____ Criteria for Core Feature 1 (Qualitative impairment in social interaction) are met.
- _____ Criteria for Core Feature 2 (Qualitative impairment in communication) *and/or* Core Feature 3 (Restricted, repetitive, or stereotyped patterns of behavior, interest, and activities) are met.

Subpart 3B(1)

- _____ The student's present level of performance and current educational needs in Core Feature 1 have been identified.
- _____ The student's present level of performance and current educational need in Core Feature 2 have been identified *if Core Feature 2 criteria were met.*
- _____ The student's present level of performance and current educational need in Core Feature 3 have been identified *if Core Feature 3 criteria were met.*
- _____ Consideration has been given to all other areas of educational concern consistent with the IEP process.

Subpart 3B(2)

- _____ The student's need for instruction and services is documented and supported by evaluation and observations in two different settings, on two different days.

Subpart 3B(3)

- _____ A developmental history summarizing developmental information and behavior patterns has been completed.

Subpart 4

- _____ At least one professional with experience and expertise in the area of ASD is on the team.
- _____ The team includes a school professional knowledgeable of the range of possible special education eligibility criteria.

An outline for using the new ASD eligibility criteria is on pages 34 through 38. It was developed as a guide to school personnel to ensure that all components of the process are well documented. It is not a required form, but was designed as a promising practice to assist teams. A version of the Evaluation Report utilizing ASD Criteria using a fictitious sample student appears in Appendix a, pages 47 through 53.

Patterns of Qualitative Impairment/Possible Behavioral Indicators

Subpart 3, Section A of the new rule describes the three core features that must be considered in an educational evaluation for Autism Spectrum Disorders. Note that the rule specifies that a student should demonstrate *patterns of behavior* in the core features identified. The Rule, in Subpart 3, A(1, 2, 3), provides descriptions of each core feature and list some behaviors that may help discriminate between Autism Spectrum Disorders and other categories. As teams review the criteria, the following expanded list of behavioral indicators may be helpful.

These examples have been summarized from the following diagnostic and assessment tools: **DSM-IV, Autism Diagnostic Observation Schedule, Autism Diagnostic Interview-Revised, Gilliam Autism Rating Scale, and Childhood Autism Rating Scale.**

These examples *should not* be used as discrete items in a check-off list, but as possible behavioral indicators that must be viewed as patterns or clusters of behaviors.

Core Feature 1: Qualitative impairment in social interaction

In addition to those behavioral indicators listed as examples in the rule, consider the following.

- lack of emotional or social reciprocity
- limited insight into social relationships
- limited empathy/comments on others' emotions
- unusual eye contact; limited shared enjoyment in interaction
- reduced quality of social overtures and responses
- lack of social smiling; impairment in group play with peers
- reduced imitative social play
- lack of interest in or response to other children
- doesn't give affectionate responses (e.g., hugs and kisses)
- looks through people (i.e., shows no recognition that a person is present)

Core Feature 2: Qualitative impairment in communication

In addition to those behavioral indicators listed as examples in the rule, consider the following.

- reduced amount of social communication
- limited frequency of vocalization directed to others
- echolalia
- inappropriate questions or statements
- pronominal reversal
- repeats words or phrases over and over
- looks away or avoids looking at speaker when name is called
- avoids asking for things he or she wants
- fails to initiate conversations with peers or adults
- repeats unintelligible sounds (babbling) over and over

Core Feature 3: Restricted, repetitive, or stereotyped patterns of behavior

In addition to those behavioral indicators listed as examples in the rule, consider the following.

- persistent preoccupation with parts of objects
- excessive interest in highly specific topics or objects
- compulsions/rituals
- licks, smells or sniffs inedible objects (e.g., person's hand, toys, books)
- spins objects not designed for spinning (e.g., saucers, cups, glasses)
- rocks back and forth while seated or standing
- makes rapid lunging, darting movement when moving from place to place
- flaps hands or fingers in front of face or at sides
- responds negatively or with temper tantrums when given commands, requests, or directions
- lines up objects in precise, orderly fashion and becomes upset when the order is disturbed

Examples of Documentation Methods

Subpart 3, section A of the Minnesota Eligibility Criteria states:

“Behavioral indicators of these core features must be atypical for the pupil’s developmental level. Documentation of behavioral indicators must include the use of at least two of these methods: structured interviews with parents, autism checklists, communication and developmental rating scales, functional behavior assessments, application of diagnostic criteria from the current Diagnostic and Statistical Manual (DSM), informal and standardized evaluation instruments, or intellectual testing.”

The following information is not intended to be a comprehensive list, nor does it infer that all instruments are equally valuable or appropriate for every student. Rather, the list is intended to be used as a resource when planning assessments. Keep in mind that instruments without “autism” in the title may not have been normed on students with ASD.

Structured interviews with parents

This may include reviewing the three core features of the criteria with the parents to document what behaviors they observe. It also may include a structured interview with the parents regarding the pupil’s developmental history, including general milestones and characteristics on the autism spectrum. An instrument designed specifically for this purpose is the Autism Diagnostic Interview—Revised (ADI-R).

Communication and developmental rating scales

Examples include:

- Test of Language Development (TOLD)
- Clinical Evaluation of Language Fundamentals (CELF)
- Preschool Language Scale (PLS)
- Psycho Educational Profile-Revised (PEP-R)

Autism checklists/Rating Scales

Examples include:

- Gilliam Autism Rating Scale (GARS)
- Autism Screening Inventory for Educational Planning (ASIEP)
- Autism Behavior Checklist (ABC) from the ASIEP
- Childhood Autism Rating Scale (CARS)
- Autism Diagnostic Observation Schedule (ADOS-G)

Functional behavior assessments

A functional behavior assessment is composed of structured observations and interviews to determine the function or purpose the behaviors serve. This is accomplished by analyzing the antecedents and consequences of specific behaviors. This form of assessment can be helpful in developing interventions for those behaviors of concern.

Application of diagnostic criteria from the current Diagnostic and Statistical Manual (DSM)

Appropriately trained and licensed staff should be involved in this consideration. Information from the DSM that comes from an outside agency may be reviewed by the school team and used to help document educational criteria.

Informal and Standardized evaluation instruments

Informal evaluation procedures are not standardized and therefore do not report standard scores, percentiles, standard deviations, etc. These methods will document a child's individual level of performance, skill attainment, etc. It is not a comparison to the performance of other pupils the same age. Examples of informal assessment may include summarizing the pupil's strengths and weaknesses after interviewing staff and parents, observing the pupil, or documenting the pupil's skill levels (e.g., "can point to 16 of 26 lower case letters when asked," "can rote count to 15," "can count to 5 with one-to-one correspondence").

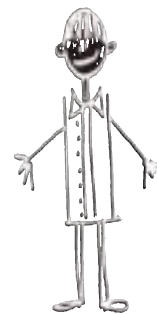
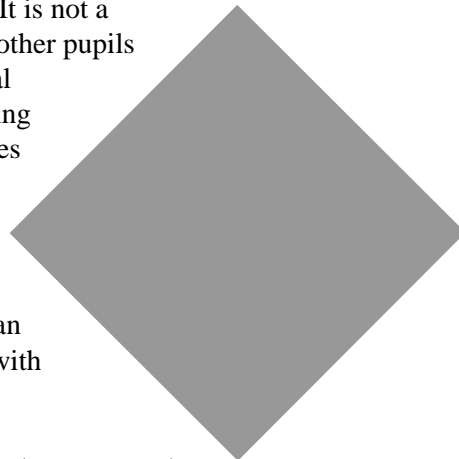
Standardized evaluation instruments may report a standard score, percentile, standard deviation, an algorithm with cutoff scores, etc. that compares the pupil's current level of performance to same-aged peers. Standardized instruments may be used to assess intellectual ability, academic achievement, communication, fine and gross motor skills, emotional / social development & behavior skills, functional skills, and vocational skills. Examples include:

- Autism Diagnostic Observation Schedule—Generic (ADOS—G),
- Vineland Adaptive Behavior Scales,
- Scales of Independent Behavior-Revised; &
- Play-Based Assessment.

Intellectual testing

Examples include:

- The Wechsler scales: (Wechsler Preschool Primary Scale of Intelligence-Revised (WPPSI-R), Wechsler Intelligence Scale for Children-Third Edition (WISC-III), and Wechsler Adult Intelligence Scale-Third Edition (WAIS-III))
- Stanford-Binet Intelligence Scale-Fourth Edition (SB-IV)
- Differential Ability Scales (DAS)
- Leiter Intelligence Performance Scale (LIPS)
- Kaufman Assessment Battery for Children (K-ABC)
- Mullen Scales of Early Learning



Examples of ASD Rating Scales

The following methods of assessment for children with ASD were reviewed in *School Psychology Review*, 1999, Vol. 28, No. 4, pages 538-558. Information about other methods and instruments for assessing children with ASD appear in Appendix of this manual, beginning on page 57.

Method	Test Name	Description	Validity	Reliability	Utility
Observation	Autism Screening Instrument for Educational Planning (ASIEP)	5 subtests Vocal behavior, interaction, rate of learning, & 2 other subtests using other methods	No validity data reported in the manual for these 3 subtests	Internal, test-retest, inter-rater reliabilities reported in manual but not for all subtests; acceptable levels	Verification
Observation	Childhood Autism Rating Scale (CARS)	15 4-point scales based on TEACCH Program in NC; uses DSMIII-R criteria	Criterion related validity reported in manual acceptable	Data reported in manual from 1980 data; internal, test-retest, inter-rater reliabilities acceptable	Verification
Observation Direct interaction	Autism Diagnostic Observation Schedule-Generic (ADOS-G)	Children from walking age to adult ages; based on ICD-10 and DSM-IV criteria	Discriminative validity data based on four groups of 20 children	Inter-rater, test-retest reliability reported and adequate	Verification
Verbal Report	Autism Diagnostic Interview-Revised (ADI-R)	Semi-structured interview for caregiver; based on ICD-10 and DSM-IV criteria	Discriminant validity reported is acceptable	Inter-rater & internal reliability reported is acceptable; test-retest data is acceptable but based on sample of six mothers	Verification

Method	Test Name	Description	Validity	Reliability	Utility
Verbal Report	Gilliam Autism Rating Scale (GARS)	Behavior Rating form completed by parent or teacher	Content, criterion-related, and construct validity evidence reported in manual	Internal, test-retest and inter-rater reliabilities reported in manual and acceptable	Verification
Verbal Report	Autism Behavior Checklist (ASIEP)	Fourth subtest of the ASIEP Behavior form completed by parent or teacher	Content, concurrent, criterion-related validity evidence reported in manual	Inter-rater reliability reported in the manual and acceptable	Verification
Direct Interaction	Educational Assessment (ASIEP)	Fifth subtest of the ASIEP Criterion-referenced assessment in 5 areas	Content and convergent validity evidence reported in the manual	Test-retest and inter-rater reliability data reported in the manual and acceptable, but based on only 11 and 9 subjects respectively	Programming
Direct Interaction	Psycho Educational Profile-Revised (PEP-R)	Provides information on developmental functioning. Ages 6 mo.-7 years or under 12 years if DD	Content validity evidence based on CARS and clinical use	Inter-rater reliability reported in manual, but based on 5 raters' evaluations of one child	Programming

Outline for Evaluation Report Using ASD Criteria



EVALUATION REPORT (Page 1 of ___)

<input type="checkbox"/> Initial Evaluation	Student Name: _____	D.O.B.: _____
<input type="checkbox"/> Reevaluation	School: _____	Grade: _____
Date of this report: _____		

This evaluation report must include:

- information reported by parents
- evaluation results
- interpretation of evaluation results and determination of eligibility by addressing criteria components verifying the child is a child with a disability and is in need of (or continues to need) special education and related services
- SLD written report components (for SLD evaluations)
- the educational needs of the child

Purpose of Evaluation and Record Review

Includes purpose of evaluation and a review of student's file.

Educational Evaluation Methods

Documentation of Behavioral Indicators for the Identification of Autism Spectrum Disorders must include the use of at least 2 of the following. Results and interpretation from these instruments should be briefly described in Interpretation section.

- ___ structured interviews with parents
- ___ communication and developmental rating scales
- ___ functional behavior assessments
- ___ informal and standardized evaluation instruments
- ___ intellectual testing
- ___ autism checklists
- ___ application of diagnostic criteria from the current Diagnostic & Statistical Manual

Parent Information

- Structured interview
- Developmental history
- Medical information
- Strengths of the student
- Main concerns of the parents

Evaluation Results

Informal and standardized evaluation instruments and intellectual testing results can be elaborated here.

Interpretation of Evaluation Results and Determination of Eligibility

Application of Criteria for ASD

The multidisciplinary team shall determine that a pupil is eligible and in need of special education instruction and related services if the student demonstrates patterns of behavior consistent with those in item A and fulfills the requirements in item B. In order to qualify for services, student must fulfill requirements in *both* items A and B.

- A.** An educational evaluation must address all three core features listed below. For eligibility purposes, a student must meet criteria in Core Feature 1 AND *either* Core Feature 2 **or** 3. They may meet criteria in all three Core Features.

Core Feature 1: Qualitative impairment in social interaction, as documented by *two or more behavioral indicators*, such as:

- limited joint attention and limited use of facial expressions directed toward others
- does not show or bring things to others to indicate an interest in the activity
- demonstrates difficulties in relating to people, objects, and events
- a gross impairment in ability to make and keep friends
- significant vulnerability and safety issues due to social naivete
- may appear to prefer isolated or solitary activities
- misinterprets others' behaviors and social cues
- other _____

Core Feature 2: Qualitative impairment in communication, as documented by *one or more behavioral indicators*, such as:

- not using finger to point or request
- using others' hand or body as a tool
- showing lack of spontaneous imitation or lack of varied imaginative play
- absence or delay of spoken language
- limited understanding and use of nonverbal communication skills such as gestures, facial expressions, or voice tone
- odd production of speech, including intonation, volume, rhythm or rate
- repetitive or idiosyncratic language or inability to initiate or maintain a conversation when speech is present
- other _____

Core Feature 3: Restricted, repetitive, or stereotyped patterns of behavior, interest, and activities, as documented by *one or more behavioral indicators*, such as:

- insistence on following routines or rituals
- demonstrating distress or resistance to changes in activity
- repetitive hand or finger mannerism
- lack of true imaginative play versus reenactment
- overreaction or under-reaction to sensory stimuli
- rigid or rule-bound thinking
- an intense, focused preoccupation with a limited range of play, interests, or conversation topics
- other _____

B. The team shall verify that an Autism Spectrum Disorder adversely affects a student's present educational level of performance and identifies the student's needs. Documentation must be supported by data from components 1, 2 and 3, described below.

1. Identify the student's present levels of performance and educational needs in each core feature identified by the team in item A above. Core Feature 1 must be included if eligibility is to be met. In addition, the evaluation process must give consideration to all other areas of educational concern consistent with the IEP process.

CORE FEATURE 1 (Social Interaction) (required):

Present levels of performance:

CURRENT EDUCATIONAL NEEDS:

CORE FEATURE 2 (Communication) (if identified in Part A):

Present levels of performance:

CURRENT EDUCATIONAL NEEDS:

CORE FEATURE 3 (Behavior, interest, & activities) (if identified in Part A):

Present levels of performance:

CURRENT EDUCATIONAL NEEDS:

OTHER AREAS OF EDUCATIONAL CONCERN (academics, motor, sensory, etc.):

Present levels of performance:

CURRENT EDUCATIONAL NEEDS:

and

- The student's need for instruction and services must be documented and supported by evaluation and observations in two different settings, on two different days.

Observation Summary:***and***

- A developmental history is included which summarizes developmental information and behavior patterns. See Parent Information and Developmental History on the first page of this report for a summary.

Conclusions

According to the MN criteria for the identification of Autism Spectrum Disorders, a student is eligible when he meets at least two of the three Core Features presented above (one of which must be Feature 1) *and* demonstrates educational need in those Core Features identified. Results for this student are indicated with an "X" in the chart below.

	Behavioral Indicators Present	Educational Need Identified
Core Feature 1 (Social)	_____	_____
Core Feature 2 (Communication)	_____	_____
Core Feature 3 (Restricted Behavior)	_____	_____

Page of Evaluation Report Student Name: _____

Based on the information included in this report, the student:

A. does not meet eligibility criteria for special education for the following reason(s):

- does not have a disability.
- does not demonstrate need for special education service at this time.
- learning difficulty is primarily due to lack of instruction in reading or math or to limited English proficiency.
- no longer qualifies for special education services.
- is no longer eligible under developmental delay criteria and does not meet other eligibility criteria.

B. does meet eligibility criteria for special education for the following reason(s):

- meets entrance criteria for the disability(ies) indicated below (initial evaluation).
- continues to have a disability and demonstrate a need for special education service (reevaluation).
- qualifies through a team override decision in accordance with 3525.1354 for the following disability(ies).

(P) indicates primary disability and (S) indicates secondary disability(ies):

- | | | |
|--|---|---|
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Mild to Moderate Mentally Impaired | <input type="checkbox"/> Specific Learning Disability (SLD) |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Moderate to Severe Mentally Impaired | <input type="checkbox"/> Speech/Language Impairment |
| <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Emotional/Behavior Disorder | <input type="checkbox"/> Severely Multiply Impaired | |

If a team member disagrees with the decision in A. or B., a statement as to the reason must be attached.

Team signatures and indication of agreement with conclusions are required only for SLD evaluations and for an override of any criteria.		AGREEMENT WITH CONCLUSIONS	
SIGNATURE	TITLE	YES	NO
_____	Parent	<input type="checkbox"/>	<input type="checkbox"/>
_____	Regular Education Teacher (K-12)	<input type="checkbox"/>	<input type="checkbox"/>
_____	Special Education Teacher	<input type="checkbox"/>	<input type="checkbox"/>
_____	District Representative	<input type="checkbox"/>	<input type="checkbox"/>
_____	Student (by grade nine or age 14)	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>

This form is available in several languages, Braille, or other formats. Contact the IEP manager for an alternate format.

3.4.1 AUTISM SPECTRUM DISORDERS (ASD)

Evaluation ___ Reevaluation ___ Date of Evaluation Report _____

Name _____

Federal Setting _____ DOB _____

ELIGIBLE : YES NO*A student is considered **eligible** for Special Education when the student meets criteria items A and B.*

A. Documentation in evaluation report of at least two of these subitems; one must be subitem 1. The evaluation must address all three subitems collected from multiple settings:

1. Qualitative impairment of reciprocal social interactions: (two or more indicators) **Yes No**

- | | |
|---|--|
| <input type="checkbox"/> limited use of facial expressions towards others | <input type="checkbox"/> limited joint attention |
| <input type="checkbox"/> gross impairment in ability to make friends | <input type="checkbox"/> difficulty relating to people |
| <input type="checkbox"/> appears to prefer isolated or solitary activities | <input type="checkbox"/> <u>other</u> _____ |
| <input type="checkbox"/> misinterprets others' behaviors and social cues | |
| <input type="checkbox"/> significant vulnerability and safety issues due to social naivete | |
| <input type="checkbox"/> does not show or bring things to others to indicate interest in activity | |

2. Qualitative impairment in communication: (one or more indicator) **Yes No**

- | | |
|--|---|
| <input type="checkbox"/> not using finger to point or request | <input type="checkbox"/> using others' hand or body as a tool |
| <input type="checkbox"/> absence or delay of spoken language | <input type="checkbox"/> repetitive, idiosyncratic language |
| <input type="checkbox"/> inability to initiate or maintain conversation | <input type="checkbox"/> <u>other</u> _____ |
| <input type="checkbox"/> odd production of speech (intonation, rhythm, rate) | |
| <input type="checkbox"/> showing lack of spontaneous imitations of lack of varied imaginative play | |
| <input type="checkbox"/> limited understanding of nonverbal communication skills (gestures, facial expressions, tone of voice) | |

3. Restricted, repetitive or stereotyped patterns of behavior, interests, activities: (one or more indicator) **Yes No**

- | | |
|---|--|
| <input type="checkbox"/> repetitive hand or finger mannerisms | <input type="checkbox"/> rigid, rule-bound thinking |
| <input type="checkbox"/> lack of true imaginative play vs. reenactment | <input type="checkbox"/> insistence on following routines or rituals |
| <input type="checkbox"/> demonstrating distress or resistance to change | <input type="checkbox"/> <u>other</u> _____ |
| <input type="checkbox"/> over-reaction or under-reaction to sensory stimuli | |
| <input type="checkbox"/> intense, focused preoccupation with a limited range, interests, or conversation topics | |

Behavioral indicators in item A must include the use of at least two of the methods below:

- | | |
|--|---------------|
| <input type="checkbox"/> structured interview with parents | Yes No |
| <input type="checkbox"/> autism rating scales or checklist(s) | |
| <input type="checkbox"/> communication and developmental scales | |
| <input type="checkbox"/> functional behavior evaluation | |
| <input type="checkbox"/> application of DSM-IV diagnostic criteria | |
| <input type="checkbox"/> informal and standardized evaluation instruments: | |
| <input type="checkbox"/> intellectual testing: | |

AND

B. Verification that ASD adversely affects the pupil's present level of performance; data from each of these:

- | | |
|--|---------------|
| 1. Education needs in each core feature identified in A | Yes No |
| and | |
| 2. Observation in two different settings on two different days | Yes No |
| and | |
| 3. Historical summary of developmental information and behavior patterns | Yes No |

For complete information regarding eligibility requirements, refer to Minnesota Rule 3525.1325

How do you Initiate the Discussion of ASD with Families?

As educators, we did not choose this profession to give difficult news to parents. We chose this profession to help children and families. The key to remember is that we can be HELPFUL by giving difficult news in a thoughtful, considerate and professional manner. Here are some DOs and DON'Ts to assist in that process.

“DO”

DO bring up the possibility of ASD when both parents are present whenever possible.

DO use lead-in phrases such as: *“Has anyone brought up the possibility of Autism Spectrum Disorders for your child?”* or *“When we see difficulties in social interaction, communication and a limited range of interests, we need to discuss the possibility of Autism Spectrum Disorders.”*

DO limit the initial discussion to as few team members as possible in order to address sensitive issues with some privacy. Be ready to answer general ASD questions.

DO give specific behavioral indicators and symptoms that lead you to suspect the possibility of ASD for the child.

DO propose an evaluation and discuss specifics about how it will go and how parents will be involved.

DO evaluate for ASD as early as possible. Obtain training on assessment instruments if your team is hesitant about early identification.

DO discuss with your educational team the issues regarding identification and enhance competencies, when needed. Coach one another to develop the balance of sensitivities and technical knowledge needed.

DO present results as soon as possible following the evaluation. Again, limit the number of team members when appropriate to the emotional content of the information. Allow plenty of time for questions. Be prepared with factual information.

DO allow parents to reject the identification of ASD and, instead, qualify for services under DD (ECSE) or another category.

Base the educational plan on the needs of the child, not the willingness of the family to participate in identification. Note that the parents have refused the identification process. Continue to have appropriate educational strategies available.

DO ask questions about emotional support systems available to parents and/or make referrals when necessary.

DO know your professional boundaries.

DO become a professional that parents can trust because you are able to handle not just the easy tasks (“he’s making progress...”) but the tough situations (“he has an Autism Spectrum Disorder...”).

“DON’T”

DON’T mention ASD to everyone else on the child’s team without plans to discuss this with parents.

DON’T say that you do not know much about ASD and have no one as a resource to join the team.

DON’T dismiss parental concerns about ASD. You as a professional may not have enough experiences to recognize the various types of the spectrum. Seek resources.

DON’T give prognosis statements before an evaluation is completed. When prognosis statements are made, they should be cautious in nature.

DON’T allow speculation/rationalizations such as *“It must be the result of all his ear infections.”* or *“He’s just a slow talker like his father.”*

DON’T give outdated information. The state of this disability has changed dramatically and so have the outcomes for young children.

DON’T allow your educational team to decide that parents are “not ready.” Objective information about behavioral symptoms and possible disabilities NEED to be shared with parents. It would be arrogant and unethical for a doctor to withhold information from a patient regarding his/her full care. The same principles apply here.

DON’T assume that this identification process is someone else’s responsibility.

DON’T tell parents to get a medical diagnosis because your staff does not do the identification.

DON’T wait many weeks to get back to parents with results.

DON’T use a large meeting to provide information regarding first identification of ASD.

DON’T back off from parents who are rejecting or hostile regarding ASD information you provide. Instead, continue to revisit these behavioral indicators and the disability issues each time the team meets with the parents.

DON’T let a bad experience prevent you from developing skills in this area. Be professional and give professional advice.

DON’T assume that a parent who reaches out to you emotionally has another place to go. When asked, give help.

DON’T make assumptions about the grieving process that the parents may be going through. Remember that the parents have emotional lives that are their own and their acceptance process is private unless they choose to share it.

DON’T ignore your own emotional needs following an identification of ASD. There is an impact to you as a compassionate human being.

Common Questions about the Evaluation Process

Q: How do you differentiate Autism Spectrum Disorders from other Special Education categories?

The new educational criteria for Autism Spectrum Disorders allows individuals with disabilities and needs related to ASD such as Asperger's Disorder to receive special education services. Due to the overlap in behaviors, it may be difficult to differentiate an ASD from mental impairment (MMMI or MSMI), developmental delay (DD, formerly ECSE), or emotional/behavioral disability (EBD). For example, it is not unusual for individuals with a moderate or severe/profound mental impairment to demonstrate behaviors similar to ASD, even when an Autism Spectrum Disorder is not present.

Given that intensive early intervention has been shown to be effective for individuals with ASD, early and accurate identification is essential.

Therefore, ASD can and should be differentially determined via comprehensive evaluation by a special education team including a professional knowledgeable about Autism Spectrum Disorders. The evaluation should specifically probe behaviors uniquely characteristic of ASD using a variety of evaluation procedures including structured parent interview, direct observations, and interactions with the student. Merely having a parent or teacher complete an autism rating scale is not sufficient to differentiate behaviors related to ASD versus Mental Impairment, Developmental Delay, or Emotional/Behavioral Disorders. A psychologist or professional knowledgeable about all special education categories must be an integral part of determining the appropriate disability category. Also, be aware that, according to Dr. Catherine Lord, lead researcher on the ADOS, the differentiation between learner with MSMI and learners with ASD is very difficult in the toddler years.

While developmental disability and mental impairment are delineated by deficits across developmental domains, emotional/behavioral domains are marked by specific behavioral patterns and deficits. Therefore, careful evaluation of specific deficits and behavioral excesses is necessary for an accurate evaluation of Autism Spectrum Disorders. Specifically, a scattered developmental profile with some skills near or even above age level often is seen in individuals with an Autism Spectrum Disorder. Whereas individuals with other developmental delays, such as Mental Impairment, typically have skills that are similarly delayed across domains. In the case of Emotional/Behavioral Disorders, the specific behavioral indicators or patterns differ from the qualitative social, communication, and behavioral impairments evident in ASD.

Q: How can the team determine the student's primary disability category if he or she qualifies in more than one area?

The team will need to discuss which disability area best describes the pupil's educational needs and learning style. Questions you may want to discuss include: Which area gives the best overall "snapshot" of the needs of the pupil? Which area describes the best "snapshot" of the kinds of interventions or strategies that will be needed? Which area tells the most about how the pupil learns and what kind of support they will need?

Reevaluation

According to IDEA 97, reevaluations continue to be required every three years but comprehensive assessments utilizing formal or standardized tests/procedures may not need to be conducted. Instead, teams may review existing and current data to determine whether additional information is needed to establish whether they continue to have a disability, the pupil's present level of performance, and educational needs whether they continue to need special education and related services as they relate to ASD and whether any additions or modifications are needed to meet goals and to participate in general curriculum. This determination may be based on professional judgment utilizing student performance-based data on IEP goals, classroom-based assessments, observations by teachers and related service providers, review of student's school records and include input from parents. If the IEP team identifies the need for additional data, the reevaluation is customized to answer the specific area of concern.

Q: In a three year reevaluation, what if a pupil doesn't meet all of the eligibility criteria as they did in their initial evaluation? Are they still eligible for service?

As a pupil receives specialized intervention over time, you would expect to see gains made. These gains may be reflected in the pupil displaying less significant or fewer behaviors that are part of the eligibility criteria. It is not required that a pupil demonstrate the same level of severity upon reevaluation, however the report must document what behaviors are present that are associated with the disability area (ASD). This can be accomplished by including the eligibility criteria for ASD in the reevaluation report and documenting which behavioral indicators (characteristics of an Autism Spectrum Disorder) currently are observed. The report also should document the ongoing educational needs for the student, based upon those behaviors that are still present. If it is determined that the ongoing educational needs cannot be met in the general education setting with general educational services/modifications, the team can then document and establish a continuing need for special education services.

Q: What are the components for reevaluation in the area of Autism Spectrum Disorder?

While it is not required that a pupil demonstrate the same level of severity upon reevaluation to remain eligible for special education, it is important to address the pupil's present levels of performance and educational needs in each of the core features associated with ASD. The team should consider using existing and current data to meet evaluation requirements and criteria components for ASD.

Further, while an initial evaluation for ASD requires a developmental history and recommends the use of an autism rating scale, it may not be necessary to re-collect the information if this information is well documented in a previous evaluation in the area of ASD. For the current reevaluation, the team may choose to briefly update, highlight or summarize the developmental information from the initial or previous evaluations, noting that further details may be found in the previous evaluation.

Regardless of whether additional data are deemed necessary, a written Evaluation Report is required that includes all of the same components required for an initial evaluation report.

Planning Tool for Reevaluation of Autism Spectrum Disorders

<u>Reevaluation Component</u>	<u>Existing & Current Data Summary</u>	<u>Additional Information Needed</u>
Was initial eligibility for ASD met?	Review past evaluations and if eligibility is well documented, summarize findings in current report. If eligibility is not documented, the current evaluation team must determine the most appropriate eligibility category.	
Core Feature 1—Social Interaction (see behavioral indicators) 1. Review behavioral indicators demonstrated by pupil 2. Identify Present Level of Performance related to IEP Goals 3. Document continuing educational need related to behavioral indicators		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Core Feature 2—Communication (see behavioral indicators) 1. Review behavioral indicators demonstrated by pupil 2. Identify Present Level of Performance related to IEP Goals 3. Document continuing educational need related to behavioral indicators		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Core Feature 3—Restricted interests & stereotyped behaviors (see behavioral indicators) 1. Review behavioral indicators demonstrated by pupil 2. Identify Present Level of Performance related to IEP Goals 3. Document continuing educational need related to behavioral indicators		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Review of all other areas of educational concern: •Academic •Functional/Adaptive •Social Emotional/Behavioral •Intellectual/Cognitive •Communication •Motor •Physical status •Sensory •Transition/Vocational		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Student's need for instruction and services is documented and supported by evaluations and observations in 2 different settings, on 2 different days.		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Two methods of documenting behavioral indicators have been used.		___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
Developmental history summarizing development and behavior patterns.	Review past assessments. If previous developmental history is well documented, a new developmental history is not needed. Summarize previous results in the current report and refer to the initial/previous evaluation. Update as appropriate.	___NO; identify team member responsible for written summary in report ___YES; identify reevaluation plan and document on <i>Notice of Educational Evaluation/Reevaluation form</i>
		*If <u>No</u> additional data is needed is needed complete <i>Notice of Educational Evaluation/Reevaluation form</i>
Professional with ASD experience on the reevaluation team.		
Professional knowledgeable in the range of special education criteria on the reevaluation team.		

This chart is a "planning tool for reevaluation" developed by the Minneapolis-Citywide Autism Program. It is not a required form but may be a valuable promising practice tool in guiding teams through the reevaluation process.

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Evaluation Report: A Sample Student

Outline for Evaluation Report Using ASD Criteria
(Sample student)



**EVALUATION
REPORT**
(Page 1 of ___)

Initial Evaluation Student Name: Michael Wattson D.O.B.: 7-15-88
 Reevaluation School: Mudd Lake Middle School Grade: 6
Date of this report: 5-25-00

This evaluation report must include:

- information reported by parents
- evaluation results
- interpretation of evaluation results and determination of eligibility by addressing criteria components verifying the child is a child with a disability and is in need of (or continues to need) special education and related services
- SLD written report components (for SLD evaluations)
- the educational needs of the child

Purpose of Evaluation and Record Review

A review of this student's file indicated that an initial referral for assessment occurred in October 1989 at the age of three due to concerns in language development and unusual behaviors as reported by parents and Michael's daycare provider. Michael was referred for a full educational evaluation following early childhood screening. He qualified and received special education services under the Early Childhood Special Education Criteria during his preschool years. At the age of 6, he was placed under the EB/D criteria as primary and Speech / Language as secondary disability, with several notations referring to unusual or odd types of behaviors. He has received speech therapy and social skills training, along with assistance in reading and math during the elementary years. A three-year re-evaluation is being completed as part of current Special Education due process standards, and for the purpose of remaining current in planning an appropriate educational program. Continued concerns in social interaction, unusual or odd behavior patterns, and a history of sensory concerns have led the educational team to consider the criteria for autism spectrum disorders at this three-year evaluation. Additional evaluation information is available in Michael's educational file.

Educational Evaluation Methods

Documentation of Behavioral Indicators for the Identification of Autism Spectrum Disorders must include the use of at least 2 of the following:

- structured interviews with parents
- communication and developmental rating scales
- functional behavior assessments
- informal and standardized evaluation instruments
- intellectual testing
- autism checklists
- application of diagnostic criteria from the current Diagnostic & Statistical Manual

Parent Information

A structured interview was completed with Michael's parents on 5-15-00. Michael is the younger of two children in a two-parent household. He was born following an uncomplicated pregnancy, labor, and delivery. A developmental history indicated that Michael reached his motor milestones at appropriate ages, but did not use single words to communicate until age two, and sentences at age four. His parents indicate that as a preschooler, Michael used some words, usually in echo to their questions, but his primary mode of communication was to take their hand and lead them to a desired item, and if not understood, he screamed. He spent many hours lining up his toy cars and trucks, and often lined up food items before eating them. His mother reports that Michael was a "picky eater" and still is selective about the foods he eats. He frequently seeks out the swing in the back yard or nearby playground, and can be found twirling around and around on the swing for indefinite periods of time if allowed. He does not like to change from summer to winter clothing or winter to summer, but would probably choose to wear long sleeved sweatshirts and sweatpants all year. Relevant medical information includes a history of ear infections from the age of 18 months to 4 years of age. Michael had PE tubes inserted in both ears at age 3 ½, and the file indicates that Michael's language skills seemed to improve after this. Michael was an early reader, and is still very interested in reading factual books, especially on the topics of car racing and monster truck building. His parents report that Michael does not have many friends, he prefers to be with adults or by himself with books or building model cars. Their main concerns at this time are to help Michael gain more social skills to get him through middle school and high school without being teased or picked on by peers.

Evaluation Results

Wechsler Intelligence Scale for Children – Third Edition (WISC – III)

Previous scoring results on the WISC – III show a verbal scale of 95, performance scale of 95, and a full scale score of 94 completed in 1994, and a verbal scale of 95, performance scale of 90, and a full scale of 92 completed in 1997. These scores consistently place Michael in the average range of intelligence. The educational team felt there was not a need to re-administer an intelligence scale at this point.

Woodcock Johnson Test of Achievement-Revised

Michael was administered the Woodcock-Johnson Achievement Test in a private room on 5-18-00. He was cooperative and worked hard during the entire test, but did need a short bathroom break in the middle of the session. His combined standard scores include Broad Reading at 87, Broad Math at 95, Broad Written Language at 78.

Autism Diagnostic Observation Schedule - Generic (ADOS-G)

Michael participated in the (ADOS-G), a standardized, semi-structured assessment of social interaction, communication and play or imaginative use of materials for individuals suspected of having Autism or ASD. The ADOS-G consists of standard activities that allow the examiner to observe the occurrence or nonoccurrence of behavior that have been identified as important to the identification of Autism Spectrum Disorders across developmental and chronological ages. Planned social occasions are created in which a behavior of a particular type is likely to occur. The ratings taken during the administration of the assessment are used to determine a classification or to formulate a diagnosis through the use of an algorithm. The overall ratings are organized according to five main groupings: Language and Communication; Reciprocal Social Interaction; Play; Stereotyped Behaviors and Restricted Interests; Other Abnormal Behavior.

In the area of communication, Michael met the cutoff score for Autism Spectrum with difficulties in conversation and the use of idiosyncratic words and phrases. In the area of impairment in social interaction, Michael has limited use of facial expressions and the overall quality and quantity of his social responses are restricted. Rapport with Michael is sometimes comfortable, but not sustained. He met cutoff score for Autism Spectrum in the area of social interactions. Michael displays unusual hand mannerisms and has some restricted range of play interests. See attached algorithm for complete scoring.

Michael is displaying the symptoms of Autism Spectrum Disorder. He meets educational criteria for Autism Spectrum Disorders by demonstrating symptoms and education needs in the areas of social interaction, communication and a restricted range of activities/interests.

Autism Checklists (such as GARS or CARS):

The Childhood Autism Rating Scale (CARS) is a rating scale concerning behaviors which are typically manifested by children with Autism Spectrum Disorders. The CARS consists of 15 subscales which include: Relating to People, Imitation, Emotional Response, Body Use, Object Use, Adaptation to Change, Visual response, Listening Response, Taste / Smell / Touch Response and Use, Fear or Nervousness, Verbal Communication, Nonverbal Communication, Activity Level, Level and Consistency of Intellectual Response, and General Impressions. These subscales are combined to obtain an overall score indicating whether a student is demonstrating behaviors associated with autism spectrum disorders. The CARS was completed on 5-15-00 and 5-16-00 as part of the overall evaluation process. Results of this scale show that Michael falls in the mild-to-moderate range of autism, with an overall rating of 34.

Communication and Developmental Rating Scales:

The Checklist of Behaviors that May Be Personal Challenges for a Student with an Autism Spectrum Disorder is used to identify clusters of behaviors that may indicate a concern in the categories of Interests and Activities, Communication, Learning Characteristics, Environmental Challenges, Sensory Challenges, Social Skills, and Motivational Factors. A score is not given on this particular checklist, but the number of items marked in a particular category gives information that substantiates the formalized checklists, and assists with program planning. Behavior clusters of concern for Michael were in the areas of social interaction, communication skills, and sensory concerns.

Interpretation of Evaluation Results and Determination of Eligibility

Application of Criteria for ASD

The multidisciplinary team shall determine that a pupil is eligible and in need of special education instruction and related services if the student demonstrates patterns of behavior consistent with those in item A and fulfills the requirements in item B. In order to qualify for services, student must fulfill requirements in **both** items A and B.

- A.** An educational evaluation must address all three core features listed below. For eligibility purposes, a student must meet criteria in Core Feature 1 AND *either* Core Feature 2 or 3. They may meet criteria in all three Core Features.

Core Feature 1: Qualitative impairment in social interaction, as documented by *two or more behavioral indicators*, such as:

- limited joint attention and limited use of facial expressions directed toward others
- does not show or bring things to others to indicate an interest in the activity
- demonstrates difficulties in relating to people, objects, and events
- a gross impairment in ability to make and keep friends
- significant vulnerability and safety issues due to social naivete
- may appear to prefer isolated or solitary activities
- misinterprets others' behaviors and social cues
- other _____

Core Feature 2: Qualitative impairment in communication, as documented by *one or more behavioral indicators*, such as:

- not using finger to point or request
- using others' hand or body as a tool
- showing lack of spontaneous imitation or lack of varied imaginative play
- absence or delay of spoken language
- limited understanding and use of nonverbal communication skills such as gestures, facial expressions, or voice tone
- odd production of speech, including intonation, volume, rhythm or rate
- repetitive or idiosyncratic language or inability to initiate or maintain a conversation when speech is present
- other _____

Core Feature 3: Restricted, repetitive, or stereotyped patterns of behavior, interest, and activities, as documented by *one or more behavioral indicators*, such as:

- insistence on following routines or rituals
- demonstrating distress or resistance to changes in activity
- repetitive hand or finger mannerism
- lack of true imaginative play versus reenactment
- overreaction or under-reaction to sensory stimuli
- rigid or rule-bound thinking
- an intense, focused preoccupation with a limited range of play, interests, or conversation topics
- other _____

B. The team shall verify that Autism Spectrum Disorders adversely affect a student's present educational level of performance and identifies the student's needs. Documentation must be supported by data from components 1, 2 and 3, described below.

1. Identify the student's present levels of performance and educational needs in each core feature identified by the team in item A above. Core Feature 1 must be included if eligibility is to be met. In addition, the evaluation process must give consideration to all other areas of educational concern consistent with the IEP process.

CORE FEATURE 1 (Social Interaction) (required):

Present levels of performance:

Michael is able to participate in school activities, will do his share of structured small group

class work that is clearly defined, and relates well to adults in his environment. His ability to make eye contact with others is somewhat minimal, but enough that he doesn't stand out as not ever making eye contact with others. He is not able to make or keep friends easily, often misinterprets the behavior or social cues of people around him, and prefers to isolate himself in the lunchroom, gym, or other unstructured times of the day.

CURRENT EDUCATIONAL NEEDS:

Michael needs to learn to appropriately interact with classmates in order to make and keep friends. Michael needs to learn how to interpret the behavior and social cues of others in order to better read his environment and react appropriately.

CORE FEATURE 2 (Communication) (if identified in Part A):

Present levels of performance:

Michael is able to initiate and answer short concrete questions, carry on a conversation on a preferred topic for 2-3 conversation turns, and will share information with classmates in a structured lesson format. He shows difficulty in maintaining conversations on someone else's topic, and uses limited nonverbal facial and body gestures in communication.

CURRENT EDUCATIONAL NEEDS:

Michael needs to learn specific skills of initiating and continuing a conversation so that he can interact with people in his environment. He also needs to learn to read gestures and body language of those around him in order to allow for increased understanding of his environment.

CORE FEATURE 3 (Behavior, interest, & activities) (if identified in Part A):

Present levels of performance:

Michael is able to adapt to changes in his environment and daily routine without undue stress. He shows interest in various activities such as watching TV, playing nintendo games, reading books, building model cars from kits or with legos, and plays the trumpet in the Middle School band. He sometimes gets preoccupied with model cars and monster trucks, and during these periods he is not able to show interest in any other topics. These periods often last two or three weeks.

CURRENT EDUCATIONAL NEEDS:

Michael needs to learn to adapt to these periods of preoccupation by allowing a variety of suggestions from peers and adults, and by seeking out various activities on his own.

OTHER AREAS OF EDUCATIONAL CONCERN (academics, motor, sensory, etc.):

Present levels of performance:

CURRENT EDUCATIONAL NEEDS:

and

- The student’s need for instruction and services must be documented and supported by evaluation and observations in two different settings, on different days.

Observation Summary:

Michael was observed on 5-10-00 in his math classroom and on 5-18-00 in the lunchroom. The observations were completed on separate days from the formal evaluations and in a different setting. During these observations, Michael was noted to follow the classroom routine during the structured lesson in math. He raised his hand to answer a question when called on, completed the assignment during the class time, and turned it in to the “work basket” at the front of the room. In the lunchroom, Michael was observed to sit off to the side by himself. When asked by a lunchroom assistant if he wanted to move over to another table to join his classmates, Michael turned away from the adult and said “I’m not going over there”. Observations of behavior in the natural setting support the information found in the formal evaluation process, and indicate that Michael has difficulty in peer interactions, and in using appropriate social skills in generalized settings throughout his day.

and

- A developmental history is included which summarizes developmental information and behavior patterns. (See Parent Information for developmental history on the first page of this report for a summary.)

Conclusions

According to the MN criteria for the identification of Autism Spectrum Disorders, a student is eligible when he meets at least two of the three Core Features presented above *and* demonstrates educational need in those Core Features identified. Results for this student are indicated with an “X” in the chart below.

	Behavioral Indicators Present	Educational Need Identified
Core Feature 1 (Social)	__X__	__X__
Core Feature 2 (Communication)	__X__	__X__
Core Feature 3 (Restricted Behavior)	__X__	__X__

Page of

Evaluation Report

Student Name: Michael Wattson

Based on the information included in this report, the student:

A. does not meet eligibility criteria for special education for the following reason(s):

- does not have a disability.
- does not demonstrate need for special education service at this time.
- learning difficulty is primarily due to lack of instruction in reading or math or to limited English proficiency.
- no longer qualifies for special education services.
- is no longer eligible under developmental delay criteria and does not meet other eligibility criteria.

B. does meet eligibility criteria for special education for the following reason(s):

- meets entrance criteria for the disability(ies) indicated below (initial evaluation).
- continues to have a disability and demonstrate a need for special education service (reevaluation).
- qualifies through a team override decision in accordance with 3525.1354 for the following disability(ies).

(P) indicates primary disability and **(S)** indicates secondary disability(ies):

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Mild to Moderate Mentally Impaired | <input type="checkbox"/> Specific Learning Disability (SLD) |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Moderate to Severe Mentally Impaired | <input type="checkbox"/> Speech/Language Impairment |
| <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Emotional/Behavior Disorder | <input type="checkbox"/> Severely Multiply Impaired | |

If a team member disagrees with the decision in A. or B., a statement as to the reason must be attached.

Team signatures and indication of agreement with conclusions are required only for SLD evaluations and for an override of any criteria.		AGREEMENT WITH CONCLUSIONS	
SIGNATURE	TITLE	YES	NO
<u><i>Gene Doe Wattson</i></u>	Parent	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Chris Rebl</i></u>	Regular Education Teacher (K-12)	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Pat Olson (Autism Specialist)</i></u>	Special Education Teacher	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Mary Swanson</i></u>	District Representative	<input type="checkbox"/>	<input type="checkbox"/>
<u>Student (by grade nine or age 14)</u>	Student (by grade nine or age 14)	<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Bosh Smith - school psychologist</i></u>		<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Bill Jooney - speech + language</i></u>		<input type="checkbox"/>	<input type="checkbox"/>
<u><i>Lisa Mikkelsen - EBD</i></u>		<input type="checkbox"/>	<input type="checkbox"/>

This form is available in several languages, Braille, or other formats. Contact the IEP manager for an alternate format.

Possible Co-Existing Medical Conditions

Possible Co-existing Medical Conditions

There are a number of diseases that can cause children to display some of the symptoms of ASD. Also, on occasion, brain injury has caused people to display some of the symptoms of autism. Below are some of the conditions teams should consider when evaluating these children. If teams suspect one of these conditions, they should work collaboratively with the child's parents and medical professionals.

Heller's Disease. Normal development to age 3 or 4, then abrupt onset of fretfulness, negativism and anxiety. Regression of mental development and gradual loss of speech.

LKS or Landau-Kleffner Syndrome. Also called *Acquired Childhood Epileptic Aphasia*. Very rare disorder. Typical profile: normal development and age appropriate language for the first 3 to 7 years; loss of receptive language while retaining some expressive language; "telegraphic" speech (few verbs); suspicion of deafness; child frustrated, puzzled by change in himself; autistic-like behaviors; normal or above normal non-verbal IQ score; abnormal EEG with or without seizures. Some practitioners suspect that some cases of Childhood Disintegrative Disorder or "late onset" autism may be Landau-Kleffner Syndrome.

Tourette's Syndrome. A condition thought to be genetic that causes uncontrollable motor and/or vocal tics.

Obsessive-Compulsive Disorder. Obsessions are thoughts or images that are involuntary, intrusive and anxiety-provoking. Compulsions are impulses to perform a variety of stereotyped behaviors or rituals. OCD is a neurological disorder of uncertain cause. However, it often is confused with obsessions and compulsions caused by mental illness or simple neurosis, in much the way that the term "autism" has been used to refer to any person who is severely

withdrawn. Clinical OCD has easily categorized symptomology that tend to occur at certain stages of life. Counting and sorting and "evening out" usually start during childhood. "Grooming" compulsions usually start at puberty and "ruminating" (obsessions) usually begin during adulthood.

Fragile-X Syndrome. The most common cause of inherited mental retardation, with an incidence of about 1 in 1500 males and 1 in 2500 females. The inheritance pattern of the disease is unlike other X-linked disorders because it shows significant numbers of apparently unaffected male carriers and some clinically affected females. The disease derives its name from the presence of a fragile site on the X chromosome of affected individuals.

Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD). A persistent pattern of inattention and/or hyperactivity-impulsivity that is more severe than is typical for developmental level and causes significant impairment. Thought to be caused by a chemical imbalance in the brain, which results in a biological deficiency in a child's ability to concentrate. Diagnosis of ADHD is a gray area. There are 18 criteria involved in identifying ADHD including such traits as difficulty sustaining attention on tasks or play activities, poor organizational skills, and excessive motor movement. It has been proposed that there may be a continuum from ADHD to autism.

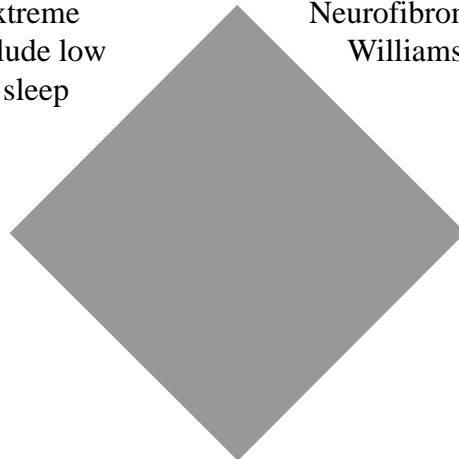
Hyperlexia. A disorder in which a child exhibits superior word recognition skills, disordered language acquisition and social and behavioral deficits. It is a matter of discussion whether to consider it a type of ASD.

Angelman Syndrome. Resembles autism only superficially since Angelman kids are profoundly retarded and may not exhibit the lack of empathy, eye contact, etc. typical of autism. It is caused by a particular defect in chromosome 15, which can be diagnosed accurately by chromosome testing. The other name for it is the Happy Puppet because the children's limbs usually are held out from the body stiffly and the children always have a smiling countenance. Besides extreme retardation, other symptoms include low muscle tone, recurring seizures, sleep disorders, gastrointestinal problems, and slow development.

Smith-Magenis Syndrome. This is caused by a particular defect in chromosome 17. These children exhibit many characteristics typical of ASD.

Klinefelter Syndrome. Caused by having an XXY chromosome makeup. It is easily testable through genetic testing and occurs in about 1 in 1000 births Often includes developmental and language impairment and has been correlated with some kinds of withdrawn behavior.

Other conditions to consider: Anxiety disorders; Intermittent Explosive Disorder; Oppositional Defiant Disorder; Neurofibromatosis, Tuberous Sclerosis, and Williams Syndrome.



Assessment Packet
for
Autism Spectrum Disorders

Introduction to Assessment Packet for Autism Spectrum Disorder (ASD)

This packet has been designed to assist Autism Resource Specialists and other educators and may be used as a guide in developing evaluation plans. It includes a list of various assessments by IEP areas with brief descriptions.

This packet is not intended to be a comprehensive list nor to imply that all instruments are equally valuable for every student. Rather it is intended to be used as a resource when planning evaluations. We are suggesting that teams carefully consider the function of the evaluation desired before selecting instruments or proceeding with the evaluation process. Is the purpose to establish or initial eligibility, assist in program planning or document student progress? The purpose of the evaluation will then guide the planning and selection of tools. These decisions will be driven by the needs of the specific student.

The instruments reviewed in this document can provide specific information on the functioning of persons with ASD. Since individuals with autism exhibit considerable variability in their skills across different ages and functioning levels, it is important to gather a broad range of information from parents and professionals. This information should include informal and formal measures across a number of settings and consider all areas including intellectual, academic, communication, motor, sensory, health and physical, social/emotional and behavior, functional, transition areas, and the person's developmental history. Keep in mind that unless specified, most of these tests were not normed on the autistic population and these limitations should be considered when interpreting results.

Compiled by Metro SPLISE Autism Resource Specialists. Fall, 1996.
Prepared by Ann M. Fox, Minneapolis Autism Specialist
Updated Through Fall 2000

Intellectual Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?*	DESCRIPTION
Bayley Scales of Infant Development (1969) The Psychological Corporation, 5555 Academic Court San Antonio, TX 78204-0952	Individual	2months to 2- _ years	Psychologist	Carefully developed measure of infant development. Contains two scales: a mental scale , a motor scale. Infant Behavior Record provides a systematic way of assessing and recording observations of child's behavior in 11 areas: visual orientation, cooperativeness, fearfulness, attention span, endurance, activity and reactivity.
Columbia Mental Maturity Scale (CMMS), Third Edition (Burgemeister, Blum, & Lorge, 1972	Individual	3-6 to 9-11 years of age	Psychologist	Useful in evaluating children who have sensory or motor defects or who have difficulty in speaking and, to some extent, in reading. The child is required to make perceptual discriminations involving color, shape, size, use, number, missing parts, and symbolic material.
Differential Ability Scales (DAS) (Elliott,1990)	Individual	2-6 to 17-11 years of age	Psychologist	The DAS measures overall cognitive ability and specific abilities in children and adolescents. It is better suited for intellectually higher functioning children with autism. The 17 cognitive and 3 achievement subtests yield an overall cognitive ability score and achievement scores. The 3 achievement subtests are Basic Number Skills, Spelling, and Word Reading. The Preschool Level measures reasoning as well as verbal, perceptual, and memory abilities and is suitable for ages 2.6 to 6.
French Pictorial Test of Intelligence (1964) The Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631	Individual	3-8 years of age	Psychologist	Assesses general intellectual level of children with and without handicaps. Subtests include verbal comprehension; form discrimination; information and comprehension; similarities; size and number; and immediate recall.
Infant Mullen Scales of Early Learning (Mullen, 1989)	Individual	birth to 36 months	Psychologist	Comprehensive scale of mental and motor abilities. It evaluates visual and language abilities at both receptive and expressive levels and provides a framework in which to examine infant development and interactional patterns. The test identifies uneven learning patterns and children who need support for weaknesses in reception and memory, and indicates when input would be reduced due to sensory overload.
Kaufman Assessment Battery for Children (K-ABC) 1983, American Guidance Service , Circle Pines, MN 55014	Individual	2-5 to 12-5 years of age	Psychologist	Assesses learning potential, preferred learning style and academic achievement.

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Letter International Performance Scale (LIPS) , 1948	Individual	3 years and older	Psychologist	Measures intelligence independent of language ability. The LIPS provides activities which foster attention and allow you to observe a student's approach to problem solving, as well as his emotional reactions. The LIPS scale has 4 tests at each age level. The scale has a number of limitations. The most serious are the out dated norms, inadequate standardization, and lack of information about the reliability of the scale for various age levels. It does merit consideration as an aid in clinical diagnosis rather than as a measure of intelligence.
McCarthy Scales of Children's Abilities (MSCA) 1972, The Psychological Corp. , San Antonio, TX	Individual	2-6 to 8-6 years of age	Psychologist	Evaluates general intellectual level of young children as well as strength and weaknesses in several ability areas.
Merrill-Palmer Scale of Mental Tests (Stutsman, 1948, 1931) (MPSMT)	Individual	1-6 to 6 years of age	Psychologist	Is widely used as a nonverbal test instrument for assessing visual-spatial skills and can be used for young autistic children at the beginning of intervention, at 12 months, and 24 months into the intervention.
Stanford-Binet Intelligence Scale-4th Edition (1986) (Thorndike, Hagen, & Sattler)The Riverside Publishing Co. 8420 Brynmawr Ave. Chicago, IL 60631	Individual	2 years to adults	Psychologist	The Stanford-Binet Fourth Edition has a new format and scoring system, mostly new items, and a new national standardization. It provide scores in four areas: Verbal Reasoning, Abstract/Visual Reasoning, Quantitative Reasoning, and Short-Term Memory, plus a Composite Score that is equivalent to the Wechsler Scales Full Scale IQ.
Test of Nonverbal Intelligence-2 (TONI-2), Linda Brown, Rita j. Sherbenou, and Susan K. Johnson	Individual	age 5 and older	Psychologist	TONI is a language-free measure of intelligence, aptitude, and reasoning. The TONI-2 contains 55 problem-solving tasks that progressively increase in complexity and difficulty.
Wechsler Intelligence Scale for Children-Third Edition(WISC-III)	Individual	6-16 years of age	Psychologist	While retaining the basic structure and content of the Revised edition, the WISC-III has updated normative data, improved items and design, and an optional subtest. It is valuable for psychoeducational assessment, diagnosis, placement and planning.

Intellectual Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI), Wechsler, 1989) The Psychological Corp. 555Academic Court, San Antonio, TX 78204	Individual	3-7years of age	Psychologist	Contains the original WPPSI subtests, plus an additional performance subtest, Object Assembly, which consists of colorful appealing puzzles. Animal Pegs and Sentences are now optional subtests. A design-recognition task was added to the Geometric Design subtest so that it now has two parts: Visual Recognition/Discrimination for younger children and Drawing of Geometric Figures for older children.

Intellectual Assessments

Academic Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?*	DESCRIPTION
Brigance Diagnostic Inventories of Basic Skills-1978, Curriculum Associates, North Billerica, MA				Listed below as Numbers 1, 2, and 3
1. Diagnostic Inventory of Early Development	Individual	developmental age 7 or less	Special Educator	Tests early developmental skills in the basic areas.
2. Diagnostic Inventory of Basic Skills	Individual	K-6 grades	Special Educator	Tests basic skills in reading, math, language.
3. Diagnostic Inventory of Essential Skills	Individual	7-12grades	Special Educator	Tests basic skills in reading, math, writing, spelling, and applied skills.
Kaufman Test Os Educational Achievement (KTEA-1985), American Guidance Service, Circle Pines, MN 55014	Individual	1-12 grades	Special Educator	Tests skills in reading, math and spelling.
Key Math Revised-A Diagnostic Inventory of Essential Mathematics-1988, Connolly, A.J. American Guidance Service, Circle Pines, MN 55014	Individual	K-9 grades	Special Educator	Measures understanding and application of important mathematics concepts and skills. Areas include : Concepts and knowledge, Computational processes, and Applications.
Peabody Individual Achievement Test-Revised (PIAT-R) American Guidance Services Circle Pines, MN 55014-1796, F. Markwardt	Individual	K-12 grades	Special Educator	A wide-range screening of broad areas of achievement to help select diagnostic procedures, Includes general information, reading recognition, reading comprehension, math, spelling, and written expression.
Slosson Oral Reading Test (SORT) 1963 Richard Slosson Slosson Educational Publications, Inc. P.O. Box 280, East Aurora, N.Y. 1052	Individual	1-12 grades	Special Educator	Designed to test student ability to pronounce English words at different levels of ability from standard readers.
Test of Written Language (TOWL) 1983, D. Hammil and S. Larsen Pro-ED 5341 Industrial Oaks Blvd. Austin, Texas 78735	Individual	3-12 grades	Special Educator	Assesses students in six areas of written language: Vocabulary, Thematic Maturity, Spelling, Word Usage, Style and Handwriting.
Wide Range Achievement Test-Revised (WRAT-R), Jastak Assessment Systems 1526 Gilpin Av. Wilmington DE 19806 Jastak and Wilkinson	Individual	K-12 grades	Special Educator	A screening measure that involves two levels, elementary and secondary and three areas of skill--decoding letters and words, spelling from dictation, and math computation.
Woodcock-Johnson Achievement Battery-Revised 1989 DLM 1 DLM Park Allen, TX 75002	Individual	K through adult	Special Educator	The standard battery includes letter-word identification, passage comprehension, math calculation, applied math, spelling, writing samples, science, social studies, and humanities, knowledge. Also contains a supplemental battery which includes word attack, reading vocabulary, quantitative concepts, proofing, writing fluency, punctuation, grammar, and handwriting.
Woodcock Reading Mastery Test, Revised (WRMT-T) American Guidance 1987	Individual	K through adult	Special Educator	A norm-referenced comprehensive battery of reading tests which includes formal and informal error analysis to diagnose reading problems.

Communication Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTRATORS?	DESCRIPTION
Assessment of Discourse Strategies—Verbal and Nonverbal, Lapidus, Adler, Modugno, 1984	Individual	all	Speech/Language	Assesses communicative behavior, conversation, topic maintenance.
Autism Diagnostic Interview-Revised (ADI-R)	Individual Interview	2 yrs and up	Trained psychologists, special educators, professional clinicians	Extensive, semi-structured interview for evaluator to use with parent or primary caregiver. Administration requires approx. 1-2 hours, special training, and utilizes a standardized scoring algorithm to verify that an individual is functioning within the Autism Spectrum. Based upon DSM-IV and ICD-10 diagnostic criteria.
Autism Diagnostic Observation Schedule-Generic (ADOS-G). Lord, C., Risi, S., et al., University of Chicago, Western Psychological Corporation, 2000	Inter-active/ Individual	1 yr—adult	Trained psychologists, special educators, professional clinicians and others with specialized training	A semi-structured, standardized assessment of social interaction, communication and play or imaginative use of materials for individuals who have been referred for evaluation because of possible autism or other pervasive developmental disorders. The play-based activities provide an interesting, yet standardized, reliable and valid measure to use in the evaluation process. It utilizes a standardized scoring algorithm to verify that an individual is functioning within the Autism Spectrum. Based upon DSM-IV and ICD-10 diagnostic criteria.
Checklist for Autism in Toddlers (CHAT). Simon Baron-Cohen, University of Cambridge, Cambridge, UK, 1994	Individual interview/ observation/ checklist	18—36 months	Educational, health and child development professionals	A brief, 14-item checklist, yet effective instrument used as a screening test to identify very young children with possible autism. It has adequate sensitivity and specificity for detecting young children at risk for being diagnosed with autism. Primarily used to identify early behavioral indicators and direct further evaluation.
Checklists of Communicative Functions	Individual	Any	Speech/Language	Identifies verbal and nonverbal communicative functions by regulation, interaction, and joint attention.
Communication and Symbolic Behavior Scales. Wetherby, A. & Prizant, B. The Riverside Publishing Co., 1993.	Individual	9 mo – 6 yrs	Speech/Language, ECSE teachers	CSBS is a standardized method of examining communicative and symbolic behaviors of children.
Communicative Gestures, Bates, 1979	Individual	Pre-verbal	Speech/Language	Breakdown of non-verbal communication.
Conversation Analysis, INREAL, 1987	Individual	all	Speech/Language Spec Ed Teachers	Identifies by checklist/rating components of conversation skills.
Expressive One-Word Picture Vocabulary Test-Revised (EOWPVT), Gardner, M. And Expressive One-Word Picture Vocabulary Test-Upper Extension (EOWPVT-UE), Brownell, R., 1983	Individual	2-11 12-15 (Upper)	Speech/Language Spec Ed Teachers	Measures verbal expression of language based on a child's ability to associate words with pictures.
Functional Communicative Profile				
Language Samples	Individual	Any	Speech/Language	Identifies the spontaneous and elicited language from student across environments.

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Peabody Picture Vocabulary Test, Revised III (PPVT - R) American Guidance Service, Circle Pines, MN. 55014., 1981.	Individual	2 _ - 40	Speech/Language, Spec Ed Teachers	Is a measure of listening comprehension for spoken words in standard English and a screening test of verbal ability.
Picture Exchange Communication System (PECS) by Lori A. Frost and Andrew S. Bondy Mayer-Johnson (619-550-0084)	Individual	any age	Speech Pathologist and Special Educator	Training system designed for use with children with autism and related developmental disabilities. Children are taught to approach and give a picture of a desired item to a communication partner in exchange for that items.
Receptive One-Word Picture Vocabulary Test,(ROWPVT), Gardner, M. And Receptive One-Word Picture Vocabulary Test-Upper Extension, 1985, 1987	I ndividual	2-11 12-15 (Upper)	Speech/Language Spec Ed Teachers	Designed to assess the level of receptive vocabulary development of children. It can be used as a companion to the Expressive One-Word Picture Vocabulary Test.
Rossetti Infant-Toddler Language Scale, Lingui Systems Inc., 1990	Individual	0-3 years	Speech/Language	Assesses interaction, communication, and language.
Sequenced Inventory of Communication Development-Revised (SICD-R) Western Psychological Services , 123031 Wilshire Boulevard, Los Angeles CA 90025, 1984	Individual	4-48 months	Speech/Language Spec Ed Teachers	Comprised of two major sections: Receptive (sound and speech discrimination, awareness, understanding) and Expressive (imitating, initiating, responding, verbal output, and articulation).
Test of Adolescent Language (TOAL-3) Hammill, D., Brown, V., Larsen, S., & Wiederholt, J., The Riverside Publishing Co., 1993	Individual	12-24	Speech/Language Spec Ed Teachers	Provides a comprehensive language evaluation.
Test of Auditory Comprehension of Language-Revised (TACL-R),Carrow-Woolfolk, E.,The Riverside Publishing Co.,1985	Individual	3-10	Speech/Language Spec Ed Teachers	Receptively measures auditory comprehension.
Test of Language Development (TOLD-2),Newcomer, P.& Hammill, D. The Riverside Publishing Co, 1988.	Individual	Primary: 4-8- Intermediate 8-12	Speech /Language Spec Ed Teachers	A global assessment to identify children with language disorders and to isolate areas of deficit in language development.
Test of Problem Solving-Adolescent (TOPS)	Individual	12 years and older	Speech/Language Pathologist, Psychologist, Special Educational Consultant	Is a diagnostic test of problem solving and critical thinking for secondary students. Designed for assessing student's language-based critical thinking skills. Test addresses the school curricular and the social arena faced by today's adolescents. Skills include clarifying, analyzing, generating, solutions, evaluating and affective thinking.
The Listening Test Lingui Systems, Inc.	Individual	ages 6-12	Speech/Language Pathologist	Assesses student's abilities to listen and attend to a wide variety of classroom language. Also can find out how students process and respond to what they hear.
The Token Test for Children 1978, Teaching Resources Corp, 100 Boylston St. Boston, MA 02116	Individual	3-12 years	Speech/Language Spec Ed Teachers	Measured ability to carry out spoken commands of increasing complexity.

Communication Assessments

Motor Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Brigance Inventory of Early Development, Curriculum Associates North Billerica, MA	Individual	2-7 years	Spec Ed Teacher	Assesses gross motor development.
Bruininks-Oseretsky Test of Motor Proficiency 1978, American Guidance Service, Circle Pines, MN 55014	Individual	4-14	Adapted Phy Ed Teacher	Assesses serious motor dysfunctions and developmental delays.
Developmental Test of Visual-Motor Integration (VMI) 1982, Beery, K.E. Modern Curriculum Press, Cleveland, OH	Individual or group	2-15 years	Occupational Therapist Spec Ed Teacher	Assesses visual-motor functions.
Minnesota Physical Fitness and Object Control Computer Test				
Test of Gross Motor Development. Proed. 5341 Industrial Oak Boulevard. Austin, TX 78735	Individual	3 - 10 years	Adaptive Phy Ed Teacher	Assesses early childhood gross motor development. Good for screening for adaptive phy ed.

Sensory Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Sensory Integration Inventory for Individuals with Developmental Disabilities (Revised) Riseman, J., Hanschu, B., 1992, PDP Press, Inc. Hugo, MN	Individual	Any age	Occupational Therapist	An inventory that addresses the sensory areas including tactile, vestibular, and proprioception.
Sensory Integration and Praxis Tests(SIPT) (Revision of Southern California Sensory Integration Tests, 1972) A. Jean Ayres, Ph.D. Western Psychological Services Los Angeles, CA	Individual	4–8 years	Occupational Therapist	Assesses integration of the sensory motor functions.
Symptom List G.A. DeGangi, Ph D., OTR	Individual	0–3 years	Occupational Therapist Spec Ed Teacher	Identifies possible symptoms in 9 different areas including: Self Regulation, Attention, Sleep, Eating or Feeding, Dressing, Bathing, Touch, Movement, Listening, Language, and Sound, Looking and Sight, Attachment/Emotional Functioning..

Health/Physical Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Developmental History (no one specific)	Individual	Any Age	Any member of Educational Team	Any developmental history form can be used to gather information regarding the individual's early development from 0-3 years of age.
Parent Interview taken from Syracuse Curriculum, Alison Ford, Roberta Schnorr, Luanna Meyer, (1989), Paul Brookes Publishing Co., P.O. Box 10624 Baltimore, Maryland, 21205-0624	Individual	Any Age	Any member of Educational Team	Designed to elicit information from parents regarding the child's home routine, likes and dislikes, leisure activities in the home, and specific needs of the child based on parent's priorities that can be used in IEP planning.
Quick Neurological Screening Test (QNST) Margaret Mutti, M.A., Harold M. Sterling, M.D., and Norma V. Spaulding, Ed.D. 1978, Academic Therapy Publications, 20 Commercial Blvd., Novato, California 94947	Individual	K-12 grades	Classroom teachers and Special Educators	Assesses 15 areas of neurological integration in approximately 20 minutes. A series of motor tasks are required. The tasks sample in an organized and orderly way, maturity of motor development, skill in controlling large and small muscles, motor planning and sequencing, sense of rate and rhythm, spatial organization, visual and auditory perceptual skills, balance and cerebellar-vestibular function, and disorders of attention.

Social/Emotional/Behavior Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
AAMD Adaptive Behavior Scale for Children and Adults (AAMD-ABS) 1975 American Association on Mental Deficiency Nihira, K., R., Shellhaas, M., & Leland, H. Washington, DC.	Individual	3-69 in 11 age groups	Spec Educator	Provides information about the way the person maintains personal independence and meets social situations.
AAMD Adaptive Behavior Scale, School Edition (ABS-SE)1981 (adaptation fo AAMD ABS scale above for use in schools.	Individual (third person interview)	School ages	Spec Educator School Psychologist	Provides information about personal independence and social skills and reveals areas of functioning where special program planning is indicated.
Autism Diagnostic Interview-Revised (ADI-R)	Individual Interview	2 yrs and up	Trained psychologists, special educators, professional clinicians	Extensive, semi-structured interview for evaluator to use with parent or primary caregiver. Administration requires approx. 1-2 hours, special training, and utilizes a standardized scoring algorithm to verify that an individual is functioning within the Autism Spectrum. Based upon DSM-IV and ICD-10 diagnostic criteria.
Autism Diagnostic Observation Schedule-Generic (ADOS-G). Lord, C., Risi, S., et al., University of Chicago, Western Psychological Corporation, 2000	Inter-active/ Individual	1 yr—adult	Trained psychologists, special educators, professional clinicians and others with specialized training	A semi-structured, standardized assessment of social interaction, communication and play or imaginative use of materials for individuals who have been referred for evaluation because of possible autism or other pervasive developmental disorders. The play-based activities provide an interesting, yet standardized, reliable and valid measure to use in the evaluation process. It utilizes a standardized scoring algorithm to verify that an individual is functioning within the Autism Spectrum. Based upon DSM-IV and ICD-10 diagnostic criteria.
Autism Screening Instrument for Educational Planning-2 (ASIEP) Western Psychological Services 12031 Wilshire Blvd. Los Angeles CA 90025	Individual	Preschool and school age	Spec Educator	Contains five subtests: autism checklist, sample of vocal behavior interaction assessment, educational assessment of functional skills, prognosis of learning rate. Items are weighted according to how predictive they are of autism.
Checklist for Autism in Toddlers (CHAT). Simon Baron-Cohen, University of Cambridge, Cambridge, UK, 1994	Individual interview/ observation/ checklist	18—36 months	Educational, health and child development professionals	A brief, 14-item checklist, yet effective instrument used as a screening test to identify very young children with possible autism. It has adequate sensitivity and specificity for detecting young children at risk for being diagnosed with autism. Primarily used to identify early behavioral indicators and direct further evaluation.

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Childhood Autism Rating Scale (CARS), Irvington Publisher's, Inc, 740 Broadway, New York, NY 10003, 1986	Individual	Preschool and early elementary	Educational Team	Purpose of this scale is to rate a child's behavior characteristics without judging whether the behavior may be explained by brain damage, mental retardation, or some other impairment. The child's behaviors are scored on a scale of 1 to 4 ranging from normal to severely abnormal, considering his or her age.
Functional Analysis of Behavior, Durand	Individual	all	Spec Educator	Assesses the communicative functions of maladaptive behavior, (Attention, Escape, Tangible, Sensory).
Gilliam Autism Rating Scale (GARS), Pro-ed 8700 Shoal Creek Boulevard Austin, Texas 78757	Individual	ages 3-22	Educational Team	Purpose is to assess for autism and provides for IEP goal and objectives planning.
Groden Stress Survey	Individual	all	Spec Educator	Interview style assessment to determine stressful situations and assist in proactive planning.
Mainstream Survival Skills Checklist., Minneapolis Public Schools, 1988	Individual	Elementary & Secondary	Spec Educator	Assesses students survival skills in the areas of Functional Academics, Classroom and Personal Responsibility, and Socialization as compared to typical peers.
Minnesota State Criteria for the Identification of Autism	Individual	all	Spec Educator School Psychologist Educational Team	Identifies students who meet the educational label for autism.
Problem Behavior Checklist (Revised) 1983 Quay, H., Applied Social Sciences University of Miami P.O. Box 248074 Coral Gables FL 33124	Individual /checklist	5-15 years	Spec Ed Teacher	Checklist covers a total of 89 items grouped into six scales: Conduct Disorder, Socialized Aggression, Attention Problems-Immaturity, Anxiety-Withdrawal, Psychotic Behavior, and Motor Excess. Uses a 3 point scale to rate problem behavior traits.
Scale of Independent Behavior (SIB), Teaching Resources Corp./DLM, One DLM Park Allen TX 75002	Individual	all	Spec Ed Teacher School Psychologist	Assesses the individual's adaptive behavior in four areas: gross and fine motor; social interaction and communication; personal living; and community living. Also contains a maladaptive behavior index.
Social Skills for Daily Living, American Guidance Service, Inc. 1988.	Individual or Group	8 years and up	Special Educator	Assesses specific social skills including Body Basics. Skills are recorded on a student Profiles and the sequence of the skills that are to be taught is identified.
Social Skills Rating System, Gresham, F. & Elliott, S., 1990, American Guidance Service, Inc., Publisher's Building, Circles Pines, MN 55014	Individual	Grades K-12	Spec Ed Teacher School Psychologist	Questionnaire is designed to measure how often a student exhibits certain social skills and how important those skills are for success in your classroom.
Symbolic Play Scale Checklist, (Carol Westby)	Individual	0-5 years	Spec Ed Teacher	Side by side assessment of language and play skills.
Vineland Adaptive Behavior Scale (VABS) 1984,'85 Sparrow, S., Balla, D., Cicchetti, D. American Guidance Service Circle Pines, MN 55014	Individual	infant to 18	Special Ed Teacher School Psychologist	Assesses social competence.

Social/Emotional/Behavior Assessments

Functional Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
COACH (See Other Developmental Assessments for decription)	Individual	Children and adults	Special Educator	Assesses critical living and working skills in persons with moderate to severe and multiple handicapping conditions. A domain-referenced behavioral checklist, its 343 items cover a wide range of functional levels. They are divided into 8 content area scales: Basic Skills and Concepts, Communication, Personal Care, Homemaking, Work Skills and Concepts, Community Living, Social Awareness, and Problem Behaviors. FSSI scores may be based on direct observation in natural settings or on reports of behavior by persons familiar with the individual. Accompanying profile sheets provide graphic representations of the student's/client's performance of each scale.
Inventory for Client and Agency Planning (ICAP) DLM , 1 DLM Park, Allen, TX 75002, Bruininks, Hill, Weatherman, Woodcock 1986	Individual	birth to adult	Special Educator	Serves as a rating scale and information record; a condensed form of the Scales of Independent Behavior. Designed to assess the status, adaptive functioning, and service needs of agency clients through self-administered rating scale and questionnaire. The adaptive behavior section includes 77 of the SIB items in motor, social-communication, personal living, and community living skills.
Scale of Independent Behavior-R (See Social and Behavior)				
Vineland Adaptive Behavior Scales-Classroom Edition, American Guidance Service , 1985 Sara Sparrow, David Balla, Domenic Cicchetti	Individual	Pre K-6 grade	Special Educator	Assesses adaptive behavior in the classroom and the domain areas of: Communication, Daily Living, Socialization, and Motor.
Vineland Adaptive Behavior Scales-Interview Edition American Guidance, 1984	Individual	Birth to 19 years or low functioning adults	Special Educator	A general assessment of adaptive behavior to determine strengths and weaknesses, obtain normative, information for comparison with nOnhandicapped and handicapped populations; for evaluation and diagnosis of mental retardation; for program planning, placement, and progress monitoring. Domains include communication, daily living, motor, socialization, and maladaptive behavior.

Transition Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?	DESCRIPTION
Ender:e-Severson Transition Ratin Scale (ESTR SCALE) Practical Press P.O. Box 455 Moorhead, MN 56561-0455	Individual	14 to 22 years of age	Special Educator or Vocational Teacher	Is an informal criterion-referenced assessment device used to provide the statement of transition needs. The categories reflect the traditional domains addressed in life skills curricula: recreation/leisure, vocational, community and domestic and the post-secondary element supported by PL 101-476. These elements are reflected in the subscales of the ESTR Scale: Jobs and Job Training, Recreation and Leisure, Home Living, Community Participation, and Post-Secondary Training and Learning Opportunities.
ICAP (See Functional Assessments for description)				
McGill Action Planning System (MAPS) Forest and Lusthaus, 1987	Individual	any age	Special Ed Team	Is an affirming planning process that begins with a committed group of adults and peers coming together to think creatively about the future individual specific student. It is based on the assumption of inclusion in the community, individualization, central involvement of friends and family, collaboration and flexibility.
Nonverbal Vocational Interest Inventory				
Pictorial Inventory of Careers (PIC) Talent Assessment, Inc. P.O. Box 5087 Jacksonville, FL. 32247	Individ or group	14 years and up	Special Educator and Vocational Teacher	Assessment of interests related to 17 occupational clusters, and 11 categories of work environments, No reading skills required.
Reading-free Vocational Interest Inventory Elbern Publications P.O. Box 09497 Columbus, OH 43209 1989 R.L.Becker	Individual	13 years to adult	Special Educator and Vocational Teacher	Pictorial vocational interest inventory for students with learning disabilities and mild mental impairments. Eleven areas include: automotive, building trades, housekeeping, personal service, laundry service, materials handling, food service, patient care, horticulture, animal care.
Syracuse Ecological Assessment Transition Rating Scale Alison Ford, Roberta Schnorr, Luanna Meyer (1989) Paul Brooks Publishing Co. P.O. Box 10624 Baltimore, Maryland 21205-0624	Individual	ages 14-22	Special Educator	Informal checklists with specific skills in the areas of self-management/home living, recreation/leisure and general community functioning domains.

Other Developmental Assessments

NAME _ AUTHOR _ PUBLISHER	FORMAT	AGE	WHO ADMINISTERS?*	DESCRIPTION
Addressing Unique Educational Needs of Children with Disabilities (AVEN)	Individual	6–21 years	Spec Ed Teacher	Addresses educational needs of individuals with autism through expected outcomes presented as patterns of behavior
Adolescent and Adult Psychoeducational Profile	Individual	14 – adult	Spec Ed Teacher Vocational Teacher	Direct observation scale looking at the areas of Vocational Skills, Independent Functioning, Leisure Skills, Vocational Behavior, Functional Communication, and Interpersonal Behavior.
Autism Screening Inventory for Educational Planning	Individual	Preschool and school age	Spec Ed Teacher ECSE Teacher	Contains five subtests: autism checklist, sample of vocal behavior interaction assessment, educational assessment of functional skills, prognosis of learning rate.
Cayuga-Onondaga Assessment for Children with Handicaps (COACH), National Clearing House of Rehabilitation Training Materials, Oklahoma State Univ. 816 West 6th Street Stillwater, OK 74078	Individual	3–21 years	Spec Ed Teacher	Assesses socialization, communication, recreation/leisure, self help, applied academics, and sensory skills across different environments.
Developmental Profile II (DPII) 1972/1986, Alpern–Boll–Shearer, Western Psychological Service 12031 Wilshire Blvd. Los Angeles, CA 90025	Individual	0–9 years	Spec Ed Teacher	186 items, assessing 5 key areas: physical, self–help, social, academic and communication. Provide age norms in each area.
Developmental Activities Screening Inventory, Teaching Resources/DLM, One DLM Park Allen TX 75002	Individual	6mos–5years	Early Childhood Spec Ed	A non–verbal design which assesses fine–motor, cause–effect & means–end relationships, association, number concept, size discrimination and seriation.
Parent, Professional, Preschool Performance Profile (5 P’s) Bloch, J., Variety Pre–Schooler’s Workshop 47 Humphrey Drive, Syosset, N.Y. 11791	Individual	6–60 months	Spec Ed Teacher	Assesses development in the areas of: Language, Social, Motor and Cognitive, Classroom Adjustment, and Self Help Skills.
Psychoeducational Profile, University Park Press, 1979	Individual	2–7 years	Spec Ed Teacher	Assesses functioning in seven areas: Imitation, Perception, Fine Motor, Gross Motor, Eye–Hand Integration Cognitive Performance, Cognitive Verbal. Also has a Pathology section.
The Teaching Research Curriculum For Handicapped Adolescents and Adults–Assessment Procedures, Fredericks, B., & Bunse C.	Individual	12–adults	Spec Ed Staff	Assesses skills in the areas of: Communication, Social, Sexual Awareness, Personal Hygiene, Dressing, Clothing Care, Eating, Meal Planning & Shopping, Food Preparation, Home & Yard Maintenance, Health and Safety, Community Mobility, Personal Information, Money Management, Leisure Skills, Associated Work Skills.