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Special Education Advocacy

Unit 5

Psychological and Educational Tests for Special Education Students

Young children **are difficult subjects to assess** accurately because of their activity level and distractibility, shorter attention span, wariness of strangers, and inconsistent performance in unfamiliar environments. Other factors that may affect a child's performance include cultural differences and language barriers, parents not having books to read to their child and a child's lack of interaction with other children. Consequently, assessment of infants, toddlers, and young children requires sensitivity to the child's background, and knowledge of testing limitations and procedures with young children.

Assessment, differentiated from test administration and interpretation, is usually a comprehensive process of gathering information about a child across developmental areas. Current trends in preschool assessment include a **move away from a "single assessor" model** to an environmental model which is designed for the individual child. Through a team approach, children are evaluated with family members present, and factors of the home and social environment are taken into consideration. Because of the increased situation-specificity of developmental tests, which can be administered by professionals other than practicing psychologists, their use is increasing.

Educational Testing should be used for the following purposes.

- 1) To confirm or assist in making a diagnosis.**
- 2) To confirm eligibility for special education or section 504 services.**
- 3) To set a definitive benchmark or baseline for determining the success or failure of the IEP. This is called the PLOP or Present Level of Performance.**
- 4) To determine goals and objectives.**
- 5) As a follow up measure of success and failure.**
- 6) To ascertain skills and deficits**
- 7) To determine preferred learning and teaching methods.**

The Assessment Plan

The school district is required to assess your child upon your request, or the request of any teacher. The assessment commences with an assessment plan which under California law must meet the following timelines:

California Education Code 56043. The primary timelines affecting special education programs are as follows:

(a) **A proposed assessment plan shall be developed within 15 calendar days of referral for assessment**, not counting calendar days between the pupil's regular school sessions or terms or calendar days of school vacation in excess of five schooldays from the date of receipt of the referral, unless the parent agrees, in writing, to an extension, pursuant to subdivision (a) of Section 56321.

(b) **A parent shall have at least 15 calendar days from the receipt of the proposed assessment plan to arrive at a decision**, pursuant to subdivision (c) of Section 56321.

Typically the assessment plan in California will look like the form attached as exhibit A. You will note that this form gives very little information about the specific tests to be used to assess your child. It is believed that there could be challenges to the use of this form in California with a claim that this form does not give you an "informed consent" as required by federal regulations, specifically 34 C.F.R. 300.505 of the federal regulations require that the parents provide an "**informed**" consent to an assessment proposed by the school.

Sec. 300.505 Parental consent.

(a) General.

(1) Subject to paragraphs (a)(3), (b) and (c) of this section, **informed parent consent must be obtained** before—

(i) **Conducting an initial evaluation or reevaluation**; and

(ii) Initial **provision of special education and related services** to a child with a disability.

(2) Consent for initial evaluation may not be construed as consent for initial placement described in paragraph (a)(1)(ii) of this section.

(3) Parental consent is not required before—

(i) Reviewing existing data as part of an evaluation or a reevaluation; or

(ii) Administering a test or other evaluation that is administered to all children unless, before administration of that test or evaluation, consent is required of parents of all children.

(b) Refusal. **If the parents** of a child with a disability **refuse consent** for initial evaluation or a reevaluation, the agency **may continue to pursue those evaluations by using the due process** procedures under Secs. 300.507-300.509, or the mediation procedures under Sec. 300.506 if appropriate, except to the extent inconsistent with State law relating to parental consent.

(c) Failure to respond to request for reevaluation.

(1) Informed parental consent need not be obtained for reevaluation if the public agency can demonstrate that it has taken reasonable measures to obtain that consent, and the child's parent has failed to respond.

(2) To meet the reasonable measures requirement in paragraph (c)(1) of this section, the public agency must use procedures consistent with those in Sec. 300.345(d).

(d) Additional State consent requirements. In addition to the parental consent requirements described in paragraph (a) of this section, a State may require parental consent for other services and activities under this

part if it ensures that each public agency in the State establishes and implements effective procedures to ensure that a parent's refusal to consent does not result in a failure to provide the child with FAPE.

(e) Limitation. A public agency may not use a parent's refusal to consent to one service or activity under paragraphs (a) and (d) of this section to deny the parent or child any other service, benefit, or activity of the public agency, except as required by this part. (Authority: 20 U.S.C. 1415(b)(3); 1414(a)(1)(C) and (c)(3))

The terms “informed consent” has substantial legal significance in the medical and professional communities, including legal definitions emanating from the medical and psychological malpractice literature. Failure of a professional under these authorities to obtain a consent that is sufficient to constitute and “informed consent” is evidence to support a monetary recovery in tort to a plaintiff for battery and or negligence against the professional practitioner who failed to obtain “informed” consent.. The form shown in Exhibit A may not meet the minimal standards of “informed” consent due to the open ended and non specific nature of the “one size fits all” document. To this extent the parents are deprived of their substantive rights under 34 C.F.R. 300.505 to an “informed consent” if they are forced to agree to this form without any other data being provided.

Notwithstanding the requirements that the consent sought by Exhibit A be capable of rising to the level of an “informed” consent consistent with 34 C.F.R. 300.505, it does not meet the federal procedural safeguards provided to parents for any consent. The term “consent” (as opposed to the conjunctive phrase informed consent) is defined as a mandated procedural safeguard by 34 .C.F.R. 300.500 as follows:

Sec. 300.500 General responsibility of public agencies; definitions.

(a) Responsibility of SEA and other public agencies. Each SEA shall ensure that each public agency establishes, maintains, and implements procedural safeguards that meet the requirements of Secs. 300.500-300.529.

(b) Definitions of “consent,” “evaluation,” and “personally identifiable.” As used in this part -

(1) Consent means that –

(i) The parent has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language, or other mode of communication;

The definition of the consent required of parents under this federal law uses two words requiring maximum information to the parents. They must be “fully” informed as opposed to partially informed” and be given “all” relevant data, rather than just some relevant data. “Fully” and “all” would suggest that limitations of the information provided by Exhibit A falls far short of the federal mark of “fully” and “all”. The document attached as Exhibit A does not provide this parent, nor any parent “all information relevant to the activity” since it does not even name the specific tests and provides irrelevant and meaningless information to the parent at best. This document deprives the parents of their rights under 34 .C.F.R. 300.500.

It is hoped that using these arguments, perhaps you can have some say in the design of the assessment plan, and perhaps some control in the selection of the measures that are used.

Independent Educational Evaluation

A parent may obtain an independent educational evaluation (IEE) performed by a qualified specialist at any time, and may obtain one at public expense if (1) the parent disagrees with an evaluation obtained by the educational agency and (2) **the educational agency is unable to show at a due process hearing that its evaluation was appropriate.** 34 C.F.R. §§ 300.502(b); Cal. Educ. Code §§ 56329(b). In this context, "independent educational evaluation" means an evaluation conducted by a qualified examiner who is not employed by the public agency responsible for the education of the child in question. 34 C.F.R. §§ 300.502(a)(3)(i). The phrase "at public expense" means that the public agency either pays for the full cost of the evaluation or ensures that the evaluation is otherwise provided at no cost to the parent. 34 C.F.R. §§ 300.502(a)(3)(ii).

Sec. 300.502 Independent educational evaluation.

(a) General.

(1) The parents of a child with a disability **have the right under this part to obtain an independent educational evaluation of the child**, subject to paragraphs (b) through (e) of this section.

(2) Each public agency shall provide to parents, upon request for an independent educational evaluation, information about where an independent educational evaluation may be obtained, and the agency criteria applicable for independent educational evaluations as set forth in paragraph (e) of this section.

(3) For the purposes of this part—

(i) Independent educational evaluation means an evaluation conducted by a qualified examiner who is not employed by the public agency responsible for the education of the child in question; and

(ii) Public expense means that the public agency either pays for the full cost of the evaluation or ensures that the evaluation is otherwise provided at no cost to the parent, consistent with Sec. 300.301.

(b) Parent right to evaluation at public expense.

(1) A parent has the right to an independent educational evaluation at public expense if the parent disagrees with an evaluation obtained by the public agency.

(2) **If a parent requests an independent educational evaluation at public expense, the public agency must, without unnecessary delay, either—**

(i) Initiate a hearing under Sec. 300.507 to show that its evaluation is appropriate; or

(ii) Ensure that an independent educational evaluation is provided at public expense, unless the agency demonstrates in a hearing under Sec. 300.507 that the evaluation obtained by the parent did not meet agency criteria.

(3) If the public agency initiates a hearing **and the final decision is that the agency's evaluation is appropriate, the parent still has the right to an independent educational evaluation, but not at public expense.**

(4) If a parent requests an independent educational evaluation, the public agency may ask for the parent's reason why he or she objects to the public evaluation. However, the explanation by the parent may not be required and the public agency may not unreasonably delay either providing the independent educational evaluation at public expense or initiating a due process hearing to defend the public evaluation.

(c) Parent-initiated evaluations. **If the parent obtains an independent educational evaluation at private expense, the results of the evaluation-**

(1) Must be considered by the public agency, if it meets agency criteria, in any decision made with respect to the provision of FAPE to the child; and

(2) May be presented as evidence at a hearing under this subpart regarding that child.

(d) Requests for evaluations by hearing officers. If a hearing officer requests an independent educational evaluation as part of a hearing, the cost of the evaluation must be at public expense.

(e) Agency criteria.

(1) If an independent educational evaluation is at public expense, the criteria under which the evaluation is obtained, including the location of the evaluation and the qualifications of the examiner, must be the same as the criteria that the public agency uses when it initiates an evaluation, to the extent those criteria are consistent with the parent's right to an independent educational evaluation.

(2) Except for the criteria described in paragraph (e)(1) of this section, a public agency may not impose conditions or timelines related to obtaining an independent educational evaluation at public expense.

(Authority: 20 U.S.C. 1415(b)(1))

Here is an illustrative case found in the archives of the California Special Education Hearing Office database (http://www2.otan.dni.us/seho_search/sehosearch.taf) **Student v Moorpark Unified School District** California Special Education Hearing Office case 98-1021. Remarkably, this case went to hearing on the issue of reimbursement for the costs of an IEE of about \$1,100. At the conclusion of the case, the Moorpark School District was required to pay this bill, and then appealed the decision, the end result of which was payment of more than \$50,000 in attorney fees to the parent attorney who was the “prevailing party” at due process.

This matter was heard before Van T. Vu, Hearing Officer of the California Special Education Hearing Office (Hearing Office), University of the Pacific, McGeorge School of Law, in Moorpark, California, on April 29 and 30, and June 24 and 25, 1999. Moorpark Unified School District (District or Moorpark USD) was represented at hearing by attorney Andrew Arczynski. Also present on the District's behalf was Dolores Allen, special education administrator for Moorpark Unified School District. STUDENT was represented at the hearing by attorney Tom Beltran. STUDENT's parents, PARENTS, were also present on STUDENT's behalf. Kings Canyon Joint Unified School District (Kings Canyon) was represented at hearing by attorney Raymond Dunn. Dr. Lowell Boldt, lead psychologist for Kings Canyon, was also present on Kings Canyon's behalf. Moorpark Unified School District called the following witnesses to testify at the hearing: Jan Mecagni, social worker with Behavioral Health; Richard Jenkins, program specialist for Moorpark USD; Dr. Lowell Boldt, lead psychologist for Kings Canyon; and Jan Van Atta, school psychologist at Moorpark USD. STUDENT called the following witnesses to testify at the hearing: Lisa Melchior, STUDENT's mother; Dr. James Kehr, clinical psychologist; and Dr. John Lutzker, chairman of the Department of Psychology at the University of Judaism. Oral and documentary evidence was received and the record was left open for the submission of closing arguments. Closing arguments were received on August 2, 1999. The record was closed and the matter was submitted for decision.

(portions omitted)**

On the last day of hearing, **STUDENT, through his parents and attorney, withdrew all of his issues except those related to the issue of whether he is entitled to reimbursement for Dr. Kehr's assessment.** The withdrawal of the issues was done on the record. Accordingly, the **parties requested that the decision address the sole issue of whether the PARENTS are entitled to reimbursement for Dr. Kehr's assessment of STUDENT.**

(portions omitted)**

ISSUES I. Was the District required to conduct a functional analysis assessment (FAA) following the June 9, 1997 incident in when STUDENT kicked a hole in the wall of his residential unit? **II. If so, are the PARENTS entitled to reimbursement for the independent assessment conducted by Dr. James Kehr on September 22, 1997?**

POSITIONS OF THE PARTIES STUDENT identified **two primary reasons why he should be reimbursed for the independent assessment by Dr. Kehr. First, he argued that his behavior and act of kicking a hole in the wall necessitated that the District conduct an FAA, but that no FAA was performed by the District. Second, STUDENT asserted that the District did not conduct an FAA when one was requested by his parents on August 12, 1997. Thus, because the District failed to**

perform the FAA timely when one was required and after one was requested by his parents, STUDENT argued he was entitled to seek an independent evaluation at the District's expense to address his behavioral needs. Accordingly, Respondent requested reimbursement for the independent assessment conducted by Dr. Kehr on September 22, 1997. **The District, on the other hand, made three arguments as to why STUDENT was not entitled to reimbursement for the independent assessment conducted by Dr. Kehr. First,** the District argued that STUDENT's behaviors did not constitute "serious behavior problems," which are a requirement for an FAA. Therefore, the District was not required to conduct an FAA and there was no need for STUDENT to procure the independent assessment from Dr. Kehr. **Second,** the District asserted that, even if an FAA were warranted, Dr. Kehr's independent evaluation fell short of the requirements for an FAA and, thus, is not reimburseable as such. **Third,** the District argued that it fully and thoroughly assessed STUDENT in his triennial assessment during the fall of 1997. The District also asserted that Respondent procured Dr. Kehr's assessment prior to the District's completing the assessments listed on the assessment plan and that, therefore, no assessments existed with which Respondents could have disagreed. Thus, according to the District, if there were no assessments with which Respondents disagreed, it was premature for Respondent to seek an independent evaluation. Based on the above, the District contended that it is not required to pay for Dr. Kehr's assessment.

BACKGROUND FACTS STUDENT is a sixteen-year-old tenth-grader who has been qualified for special education since 1994 as a student with a **serious emotional disturbance** (ED). STUDENT and his parents are residents of the Moorpark Unified School District within Ventura County. At all the dates relevant to the issue of this case, STUDENT was attending Kings View Center, a residential facility in Tulare County. No information was provided at hearing regarding where, or whether, STUDENT currently attends school. **Because of behavior including aggression, violence (which includes an attack of his father with a knife), verbal abuse toward others, refusal to attend school, and destruction of property, STUDENT was hospitalized at Vista Del Mar psychiatric hospital** from January to April 1997. On February 11, 1997, STUDENT's IEP team (which included Ventura County Mental Health) convened and agreed to place him in a special day class at a residential facility. The IEP team also agreed to continue his IEP goals and objectives from his prior November 11, 1996 IEP. Such goals included social and emotional development to promote positive interactions with peers in the school and community setting, as well as work on his arithmetic and written expression. Although STUDENT's placement at a residential facility was agreed to by the IEP team, the specific residential facility placement was to be determined at a later date. Pursuant to a mediated IEP, STUDENT was placed at Kings View Center (Kings View) residential facility on April 1, 1997. While STUDENT was at Kings View, he attended Rio Canyon School, a public school located on the grounds of the Kings View residential facility within the Kings Canyon Unified School District. His psychotherapist at Kings View was Lynn Kliewer. Between April and June 1997 (during STUDENT's first quarter at Kings View), **STUDENT's behavior included "defiance, pushing limits, kicking the walls when angry, leaving the facility without permission or escort, refusing to go to school, threatening others and suicidal ideation."** According to his mother, **he was also engaged in "picking" behavior, picking at his skin and eyelashes to the point of bleeding.** Additionally, STUDENT missed 11 out of 52 days of school during his first quarter at Kings View. On June 9, 1997, while on the residential portion of the Kings View placement, STUDENT became upset after being denied television privileges and kicked a hole in the wall. Kings View staff, apparently following standard policy for all property damage at the facility, reported the incident to the local sheriff's department. Four days after the kicking incident, STUDENT's therapist, Lynn Kliewer, informed STUDENT's parents about his behavior and the property damage. STUDENT was eventually charged with a misdemeanor, but the charges were subsequently dropped after his parents appeared at the juvenile court proceeding. On August 12, 1997, the PARENTS sent Richard Jenkins, program specialist for Moorpark USD, a letter in which they requested that an independent "psychological and educational" assessment be conducted by Dr. James Kehr. Mr. Jenkins responded to the PARENTS by letter on August 25, 1997, which stated that the District intended to complete a full triennial assessment of STUDENT and, thus, an independent assessment would be unnecessary. **Mr. Jenkins attached an assessment plan to his letter which called for assessments in the areas of academic achievement, health, cognitive functioning, speech and language, psycho-motor**

development, self-help/adaptive behavior, social emotional functioning, and vocation. The PARENTS responded to Mr. Jenkins by a letter stating that the assessment plan did not include the "psychological assessment" they had requested on August 12. The PARENTS consented to the assessment plan on September 19, 1997, but attached a letter from their attorney which clarified that they intended to pursue the independent assessment with Dr. Kehr since no FAA had been conducted by the District. Dr. Kehr met with and assessed STUDENT on September 22, 1997. The District performed its various assessments of STUDENT beginning October 20, 1997. According to a report by STUDENT's therapist, Lynn Kleiwer, STUDENT's behavior improved significantly from July 1997 until April 1998. However, by May 1998, STUDENT's behavior had "deteriorated significantly." STUDENT relapsed into refusing to attend school and had increasing difficulties in the residential unit. In mid-May, STUDENT again damaged property when he punched a hole in a wall through to another room. Fearing that STUDENT would harm himself or others, Mental Health was called and STUDENT was hospitalized at a psychiatric facility. After discharge, he was not allowed to return to Kings View Center. In his discharge summary, Lynn Kleiwer recommended that STUDENT be placed in a more restrictive environment than the Kings View residential facility could offer. No information was provided at hearing regarding where STUDENT currently attends school.

On June 19, 1998, **the District filed a request for a special education due process hearing with the Hearing Office to resolve the issue of whether its assessment of STUDENT was appropriate.** The District submitted required supporting information on June 25, 1998. On October 5, 1998, STUDENT, through his parents and attorney, cross-filed a request for hearing. STUDENT's case was consolidated into the District's case on January 12, 1999. On the last day of hearing, Respondent STUDENT withdrew all his issues unrelated to issue of whether the District was required to reimburse the PARENTS for Dr. Kehr's independent assessment.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Was the District required to conduct a functional analysis assessment (FAA) following the June 9, 1997, incident when STUDENT kicked a hole in the wall of his residential unit? STUDENT's position is that the District failed to conduct a functional analysis assessment, as is required under the Hughes Bill, after he kicked a hole in the wall of his residential unit at Kings View on June 9, 1997. Thus, **Respondent argued that the District's failure to assess him necessitated that he procure an independent evaluation from Dr. Kehr, for which he should be reimbursed. Because the District never conducted an FAA with regard to STUDENT's behaviors leading up to the June 9 incident, the issue of whether Respondent should be reimbursed for Dr. Kehr's assessment hinges on whether the District's decision not to conduct such assessment was appropriate.** In 1990, California passed Education Code Section 56520 et seq., which is commonly known as the "Hughes Bill." Regulations implementing the Hughes Bill are contained in Title 5, California Code of Regulations 3001 and 3052. According to the Hughes Bill, a functional analysis assessment (FAA) forms the basis of a behavior intervention plan. C.C.R. 3052 (a)(3). Subsection (h) of 3001 states that the "behavior intervention plan" is a written document which is developed when the individual exhibits a serious behavior problem that significantly interferes with the implementation of the goals and objectives of the individual's IEP." The regulations define serious behavior problems as "behaviors which are self-injurious, assaultive, or cause serious property damage and other severe behavior problems that are pervasive and maladaptive for which instructional/behavioral approaches specified in the student's IEP are found to be ineffective." 5 C.C.R. 3001(ah). When members of an IEP team find that the instructional/behavioral approaches specified in the student's IEP are found to be ineffective, an FAA must be conducted. 5 C.C.R. 3052 (a)(6)(b). 1. Serious behavior problem The evidence established that STUDENT's behavior from April 1 to June 9, 1997, was self-injurious, assaultive, and caused serious property damage. According to STUDENT's Treatment Plan dated April 24, 1997, STUDENT made suicidal and homicidal threats, had angry and destructive outbursts, and threw things when he was angry. (Dist. Exh. 15.) According to the Serious Incident Logs from the residential staff at Kings View, STUDENT made suicidal threats and would cut scratches into his arm and pick at his skin and

scabs until they bled. (Student's Exh. Z.) STUDENT also made racial, sexual, abusive, and homicidal threats and comments to the staff, his parents, and his peers. The logs also noted that STUDENT banged on walls, tipped over his dresser, destroyed peers' belongings, and scratched his name on the wall. Moreover, the logs indicated that STUDENT kicked a "big hole" in the wall on April 29, 1997, and then kicked another hole in the wall on June 9, 1997. Based on the above, the Hearing Officer finds that STUDENT's behavior during his first quarter at Kings View was self-injurious, assaultive, and caused serious property damage. 2. Significantly interferes with the implementation of the goals and objectives of the IEP For STUDENT's behaviors to trigger an FAA, they must have significantly interfered with the implementation of the goals and objectives in his IEP. As was noted above, STUDENT's February IEP indicated goals to work on his ability to do arithmetic computations, his ability to write legibly, and his social and emotional development to promote peer interaction. (footnote 4) The IEP team also indicated that STUDENT's behavioral needs were extensive, that he participated minimally in his educational program, and that his attendance had been inconsistent. While at his residential placement at Kings View, STUDENT's behavioral needs were addressed by treatment plans developed by an interdisciplinary team of staff at Kings View. The evidence established that STUDENT's behavioral problems interfered with the implementation of his IEP goals and objectives. In his discharge summary, Lynn Kliewer wrote that, during STUDENT's first quarter at Kings View, he missed 11 of 52 days of class, missed half of his individual therapy sessions, and occasionally missed his group therapy sessions. Mr. Kliewer also noted that STUDENT only met a few of his short-term behavior treatment plan goals during this time. (Student's Exh. I.) STUDENT's short-term treatment plan goals included reducing his destruction of property or throwing things when angry to no more than one or two times a week, intruding on other's space or speech to no more than two times most days, and responding to calls from parents, consequences, or limit setting with destructive or defiant outbursts to no more than one or two times a week. In his Serious Incident Logs, STUDENT was noted for being defiant and for leaving the residential facility without consent or escort on numerous occasions and for varying lengths of time. (Student's Exhs. A and Z.) On one such occasion, STUDENT ran away from the residential facility and wandered into a nearby town, where he was recognized by the residential facility staff and returned to Kings View. STUDENT's behaviors and actions resulted in his missing a significant amount of class and therapy time and being away from the residential facility where he was supervised and his behaviors monitored by the residential staff. As such, his behaviors interfered with the implementation of his academic goals because of his significant absences from class. Additionally, his absence from individual therapy and from the supervision of residential staff substantially interfered with his behavior treatment as provided by Kings View. Although STUDENT was placed at the residential facility because of his extensive behavioral needs, his behaviors were relatively uncontrolled during this time, and his social and behavioral development goal on his IEP was rendered virtually ineffective. Based on the foregoing, the evidence established that STUDENT's behaviors significantly interfered with the implementation of his IEP goals and objectives during this time. Although the District asserted that STUDENT's behaviors reflected his adjustment to the facility and not a serious behavior problem, his behaviors during his first quarter at Kings View (from April to July 1997) were similar to behaviors exhibited prior to his psychiatric hospitalization in January 1997. In January, STUDENT was hospitalized because he was aggressive, violent and verbally abusive, he refused to attend school, and he threw things and destroyed property. Such behaviors persisted despite STUDENT's being placed in a more restrictive residential placement where various treatment plans were implemented to address his behaviors. **In summary, STUDENT met the criteria for an FAA. His behaviors were assaultive, self-injurious, caused property damage, and significantly interfered with the implementation of the goals and objectives of his IEP. Therefore, STUDENT's behaviors were "serious behavior problems" which would have triggered the need for an FAA and a behavior intervention plan.**

B. Are the PARENTS entitled to reimbursement for the independent assessment conducted by Dr. James Kehr on September 22, 1997? California Education Code 56329(b) provides that a parent may obtain an independent educational evaluation from a qualified specialist at public expense if the

parent disagrees with the assessment conducted by the educational agency. However, if the educational agency establishes at a due process hearing that its assessment is appropriate, it is not required to pay for the independent evaluation. Id. Based on this code section, **the District has the burden at hearing to prove the appropriateness of its actions.** In this case, the Respondent procured an independent evaluation because no FAA was conducted by the District. Because no FAA was planned for or conducted by the District when Respondent asserted one should have been conducted, the District must prove at hearing that its decision not to plan for or conduct such assessment was appropriate. As discussed above, the District failed to do so. **Because the District did not plan for or conduct an FAA when one was warranted, Respondent is entitled to reimbursement for the independent assessment procured from Dr. Kehr.** (footnote 5) Although the District asserted that it is not required to reimburse Respondents for Dr. Kehr's assessment because such assessment did not meet the formal requirements of an FAA, it provided no authority to support its contention. The Hearing Officer notes that, although it is not a formal FAA, Dr. Kehr's assessment outlined and identified STUDENT's behaviors which were antecedent to his behavioral outbursts. Additionally, Dr. Kehr and Dr. Lutzker testified that Dr. Kehr's assessment contained key components of an FAA. Both doctors are psychologists with extensive experience working with school Districts in conducting FAAs and developing behavior intervention plans. Such information reasonably could have been considered by an IEP team in developing a behavior intervention plan for STUDENT. **The parents' decision to have STUDENT assessed by Dr. Kehr was a reasonable response to the District's failure to conduct any assessment that effectively addressed STUDENT's severe behavioral problems. Because the PARENTS procured an assessment of STUDENT's behavioral problems when the District failed to do so, they are entitled to reimbursement for such assessment. Thus, based on the foregoing, the District is required to reimburse Respondent for the cost of Dr. Kehr's independent evaluation.**

ORDER Moorpark USD shall reimburse PARENTS for the cost of the independent assessment conducted by Dr. James Kehr within one month of the date of this decision.

PREVAILING PARTY ON EACH ISSUE Pursuant to Education Code 56507(d), the hearing decision must indicate the extent to which each party has prevailed on each issue heard and decided. The following findings are made in accordance with this statute: Respondent **STUDENT prevailed on the issue decided.**

RIGHT TO APPEAL THIS DECISION The parties to this case have the right to appeal this decision to a court of competent jurisdiction. If an appeal is made, it must be made within ninety (90) days of receipt of this decision. Education Code 56505(i).

DATED: September 8, 1999 _____ Van T. Vu, Hearing Officer
California Special Education Hearing Office

Thus you can see that either at the time of the school assessment plan, or afterward when you pursue your rights to an I.E.E. either at school expense or at your own, your knowledge of the domains of assessment devices will be of use to you.

Survey of Test Instruments

It is virtually **impossible for anyone to know all of the hundreds if not thousands of assessment devices in use.** It is possible to know something about the major ones and to look up the rest. The professionals who need to know all the measures that are currently published would

consult a three volume work prepared by the Buros Institute known as Tests in Print (Edited by Linda L. Murphy, James C. Impara, and Barbara S. Plake. 1999. Hardbound, 1710 pp., 2 volumes, 7 1/2 x 10 1/4 in., ISBN 0-910674-51-5. \$325.00) and then the The Fourteenth Mental Measurements Yearbook (2001), available from the University of Nebraska Press 233 N. 8th Street, P.O. Box 880255 Lincoln, NE 68588-0255. (Edited by Barbara S. Plake and James C. Impara, 2001. Hardbound, 1530 pp., 7 1/4 x 10 in., LC 39-3422, ISBN 910674-55-8. \$195.00) Tests In Print can be utilized to determine a test's availability; then the appropriate MMY volume referenced for a critical, candid review of its merits. TIP contains a reference list of professional literature providing information about specific tests as well. (TIP) which serves as a comprehensive bibliography to all known commercially available tests which are currently in print. It also functions as an index for the entire MMY series by directing readers to the appropriate volume(s) for reviews of specific tests. For over 60 years the Buros Institute of Mental Measurements has worked to serve the public interest and advance the field of measurement. Founded in 1939 by Oscar K. Buros, the Institute is dedicated to monitoring the quality of commercially published tests. Typical MMY test entries include descriptive information, one or two professional reviews, and an extensive list of references to pertinent literature. To be reviewed in the MMY a test must be commercially available, be published in the English language, and be new, revised, or widely used since it last appeared in the MMY series. There is now an index of the MMY on the internet at this URL, which can be used without purchasing either product

<http://www.unl.edu/buros/00testscomplete.html>

Assuming this index provided information about a listed test, you can then obtain a review of that one measure for \$15.00 online at this URL.

<http://frontier-s.unl.edu/BUROS/trolpage1a.html>

Consulting either MMY or TIP would be somewhat ambitious for non-professionals, and for that reason, I would suggest instead that you purchase and use the following.

Special Educator's Complete Guide to 109 Diagnostic Tests

Roger Pierangelo, George A. Giuliani \$23.96 at www.bn.com

A good guide for professionals in addition to the above is:

- (1) Assessing Special Students 4th Edition by Jaes A. McLoughlin and Rena B. Lewis
- (2) Assessment of Exceptional Students 4th Edition by Ronald L Taylor.

Measurement of Ability - IQ Tests

For most children the first question is usually to determine the basic intelligence of the child. From this you can determine if the performance of the child is within the expected range.

IQ is usually very stable over time **and for this reason it should not need to be re-measured frequently.**

The Wechsler Scales The Psychological Corporation (<http://www.psychcorp.com>)

A) The Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI-R) is a battery of tests for **3-7 year olds** that assesses intellectual functioning. The WPPSI-R has two parts, the Verbal Scale and the Performance Scale. Each of these scales has several subtests.

The Verbal Scale measures language expression, comprehension, listening, and the ability to apply these skills to solving problems. The examiner gives the questions orally, and the child gives a spoken response. The Performance Scale assesses nonverbal problem solving, perceptual organisation, speed, and visual-motor proficiency. Included are tasks like puzzles, analysis of pictures, imitating designs with blocks, and copying.

B) Wechsler Intelligence Scale for Children, Third Edition, (WISC-III) Wechsler, David (Age 6-16). This intelligence test is the universal standard which School Psychologists use most often. This version of the Wechsler is standardized for children from **age 6 to 16.**

The test, itself, is divided into **two main sections.** The **Verbal** Scale measures how well children are able to express themselves verbally and how well they are able to understand what is being said to them. The **Performance Scale** measures the nonverbal areas of being able to perceive spatial relationships; such as in putting puzzles together, and being able to transfer visual information rapidly. Using test interpretation, the three I.Q. scores and the specific pattern of strengths and weaknesses indicate how well the child is able to learn and whether there are any specific learning disabilities. This information is then used to predict at what academic level the child should be functioning. In this way, diagnoses of learning impairments are possible.

Within the Verbal Scale are the following subtests and what they measure:

- Information (measures a child's range of factual information)
- Similarities (measures a child's ability to categorize)
- Arithmetic (measures the ability to solve computational math problems)
- Vocabulary (measures the ability to define words)
- Comprehension (measures the ability to answer common sense questions)
- Digit Span (short-term auditory memory)

Within the Performance Scale are the following subtests and what they measure:

- Picture Completion (telling what's missing in various pictures)
- Coding (copying marks from a code; visual rote learning)
- Picture Arrangement (arranging pictures to tell a story)
- Block Design (arranging multi-colored blocks to match printed design)
- Object Assembly (putting puzzles together - measures nonverbal fluid reasoning)

Here is a sample scoring. The Full Scale IQ is reported as a standard score with 100 being average, and 15 points is a standard deviation. Subscales 10 is average and 3 points is one standard deviation.

<u>Verbal</u>		<u>Performance</u>	
Information	8	Picture Completion	19
Similarities	14	Coding	6
Arithmetic	10	Picture Arrangement	10
Vocabulary	9	Block Design	14
Comprehension	16	Object Assembly	10
Digit Span	6		
Verbal IQ		108	
Performance IQ		112	
Full Scale IQ		111	

Be careful to note **differences between verbal and performance IQ that is more than ten points, and to note substantial subscale scatter between subscales.**

If your child suffers from **attention disorder the freedom from distractability score** of the WISC-III should show a decrement. This score is made up of the arithmetic, digit span, and coding sub tests which are vulnerable to attention disorder.

C) Wechsler Adult Intelligence Scale - III, (WAIS-III) Wechsler, David (Age 16-74)

One of the most frequently used tests of adult intelligence, it was derived from the earlier Wechsler Bellevue Scale and is based upon a series of subtests with two general categories of items, verbal and performance. Verbal items deal with general information, vocabulary, arithmetic tests, comprehension, similarities, analogies, etc.; performance items deal with picture arrangement and completion, block designs, spatial relations, and the like.

Wechsler **Strengths** - Reliable and Valid Score correlate highly with academic achievement **Weaknesses** - does not allow FSIQ distinctions below 40, so not useful in distinguishing levels of retardation. May be culturally biased.

If culture, motor skills and language impair the ability to administer a WISC-III, you may consider a culture free test such as the CTONI.

The Comprehensive Test of Nonverbal Intelligence (CTONI) is an unbiased test that measures nonverbal reasoning abilities of individuals for whom most other mental ability tests are either inappropriate or biased. The CTONI measures analogical reasoning, categorical classifications, and sequential reasoning in two different contexts: pictures of familiar objects (e.g., people, toys, and animals) and geometric designs (e.g., unfamiliar sketches and drawings).

Results of the CTONI are most *useful for estimating the intelligence of individuals who experience undue difficulty in language or fine motor skills, including individuals who are bilingual, who speak a language other than English, or who are socioeconomically disadvantaged, deaf, language disordered, motor disabled, or neurologically impaired.* No oral responses, reading, writing, or object manipulation are required to take the test.

Other tests of intelligence you may encounter.

Stanford Binet Intelligence Scale, Fourth Edition, (Riverside Publishing, <http://www.riverpub.com/>)

Purpose: Assesses intelligence and cognitive abilities. Ages: **2 - Adult**

Administration Time: Varies depending on number of subtests administered

Scores: SS; SAS; AE; PR

Standardized: on a carefully stratified national sample of more than 5,000 subjects ages 2 through adult

Kaufman Assessment Battery for Children Mental Processing Scales K-ABC
(Psychological Assessment Resources Inc.- <http://www.parinc.com>)

The K-ABC defines intelligence as a child's ability to solve problems using simultaneous and sequential mental processes. The K-ABC measures intelligence separately from achievement. The battery consists of three scales with a total of 16 subtests. The Sequential Processing Scale contains 3 subtests: Hand Movement, Number Recall, and Word Order. The child solves tasks by arranging stimuli in sequential or serial order. The Simultaneous Processing Scale consists of 7 subtests that measure acquired knowledge: Magic Window, Face Recognition, Gestalt Closure, Triangles, Matrix Analogies, Spatial Memory, and Photo Series. The child solves tasks by simultaneously integrating and synthesizing information. The Achievement Scale contains 6 subtests: Expressive Vocabulary, Faces & Places, Arithmetic, Riddles, Reading/Decoding, and Reading/Understanding. In conjunction with the two processing scales, this scale is useful for evaluating the child's ability to apply processing skills to various learning situations.

Kaufman Brief Intelligence Test -KBIT
(American Guidance Service <http://www.agsnet.com>)

A brief, individually administered screener of verbal and nonverbal intelligence. Ages: 4-90
Administration Time: 15-30 minutes Scores/Interpretation: Vocabulary (verbal, crystallized), Matrices (nonverbal, fluid), IQ composite: Standard Scores (M=100, SD=15) and percentile ranks by age. A well-respected, popular measure of verbal and nonverbal intelligence

Other tests of intelligence that you may encounter:

Columbia Mental Maturity Scale (CMMS)

McCarthy Scales of Children's Abilities (MSCA)
Slosson Intelligence Test - Revised (SIT-R)
Test of Nonverbal Intelligence- Third Edition (TONI-3)
Assessment in Infancy: Psychological Development
Bayley Infant Development Scale
Bracken Basic Cognitive Scale (BBCS)
Cattell Infant Intelligence Scale
Columbia Mental Maturity Scale
Developmental Pinpoints
Differential Abilities Scales (DAS)
Griffiths Mental Developmental Scale
Kaufman Adolescent and Adult Intelligence (KAIT)
Kaufman Infant Preschool Scale
Leiter International Performance Scales
McCarthy Scales of Children's Abilities

Alternate/Developmental Instruments of Intellectual Functioning

Alpern-Boll Developmental Profile
Assessment in Infancy: Ordinal Scales of Psychological Development (Uzgiris-Hunt)
Bayley Infant Development Scale
Cattell Infant Intelligence Scale
Denver Developmental Screening Test - Revised (DDST-R)
Developmental Activities Screening Inventory
Reynell - Zinken Scales: Developmental Scales for Young Visually Handicapped
Children Part 1 - Mental Development
Nonverbal Scales of Intellectual Functioning
Columbia Mental Maturity Scale (CMMS)
Developmental Checklist: Stage O (Hearing Impaired)
Goodenough-Harris Drawing Test (Draw-A-Man)
Hiskey-Nebraska Test of Learning Aptitude (H-NTLA)
Matrix Analogies Test (MAT)
Merrill-Palmer Scale of Mental Abilities
Nonverbal Test of Cognitive Skills
Pictorial Test of Intelligence (PTI)
Raven's Progressive Matrix
Test of Nonverbal Intelligence - 2 (TONI)

Note that there are substantial disputes about intelligence testing. The biggest dispute pertains to cultural problems with the African-American community. In 1979 massive litigation occurred generally known as the **Larry P. v Riles** cases that went on for more than a decade, one chief citation is 495 F. Supp. 926, and then other rulings issued from this the net effect was that the 9th Circuit **issued an injunction against California schools prohibiting them from using about 20 tests on African American children** as it was determined that all of these measures

improperly categorized these children as being in the mentally retarded range when they were not.

The WISC-III is sensitive to attention disorder, verbal deficits and motor deficits and many handicapped children have deficits in all three. Hence, an IQ report may not be a reflection of the true IQ. **Schools sometimes hide behind a low IQ score** by contending that the child is not capable of doing any better.

Comprehensive Measurement of Achievement

Once a child's basic ability is measured, the next question is to determine if his/her performance in academic areas is above, at or below expected levels. This is usually done with Achievement Measures. Here are some of the commonly administered achievement tests.

Wide Range Achievement Test Revision 3 (WRAT3)., Wilkinson, Gary S

The new 1993 edition of the Wide Range Achievement Test expands on this effective and popular tool to further enhance the study of the development of reading, spelling, and arithmetic codes. The WRAT 3 features a new national stratified sample, all new grade ratings, scaling and item analysis by the Rasch Method and all new test forms. New absolute scales are provided to precisely measure each code across its full range of development. Two equivalent alternate test forms are provided. Each **can be used for persons 5 through 75 years of age**. These alternate forms can be used for pre- and post-testing or combined for more comprehensive test results. The WRAT 3 is normed by age not grade level for greater accuracy. Its standard scores and percentiles compare an individual's performance with others of the same age. Its grade levels are rough clues to instructional levels, not determinations of specific instructional needs. Each form of the WRAT 3 has three subtests focusing on the coding skills of:

READING recognizing and naming letters, pronouncing printed words

SPELLING writing name, writing letters and words from dictation

ARITHMETIC counting, reading number symbols, oral and written computation.

Total test time is 15 to 30 minutes, depending upon age. Scoring by hand takes less than 5 minutes. A valuable instrument to assist in diagnosing levels of academic achievement, learning disabilities, and checking progress in academic remedial programs.

Peabody Individual Achievement Test-Revised (PIAT-R)

(<http://www.agsnet.com>)

With PIAT-R, only those items within the student's range of difficulty are administered. The subtests measure:

General Information—100 verbal items assess general knowledge.

Reading Recognition—100 items measure recognition of printed letters and the ability to read words aloud.

Reading Comprehension—82 items measure reading comprehension. The student chooses one of four pictures that best illustrates a sentence.

Written Expression—assesses written language skills for two levels. Level I, for K-1, tests pre-writing skills. Level II, Grades 2-12, requires the student to write a story about a picture.

Mathematics—100 multiple choice items test knowledge and application of math concepts and facts.

Spelling—100 multiple choice items measure recognition of correct word spelling.

PIAT-R also provides a Written Language Composite, obtained by combining scores on the Spelling and Written Expression subtests, and a Total Reading score, a combination of scores from the Reading Recognition and Reading Comprehension subtests for overall indexes for written expression and reading achievement

Wechsler Individual Achievement Test (WIAT),

This achievement test measures all of the standard achievement areas: **reading recognition, reading comprehension, spelling, written language, math calculation and math reasoning.** Generally, this test is a measure of academic skills, independent of speed. (The only subtest which imposes a time limit is written language.)

There is one distinct advantage using the WIAT over other achievement tests. When making comparisons between ability and achievement (as required for certification as Learning Disabled, **the validity of the discrepancy calculation is increased when both the I.Q. test and the achievement test have been standardized together,** as is the case with the WISC-III and the WIAT. In addition, there are software programs available for this I.Q./achievement combination which will do all the calculations automatically.

Woodcock Johnson Psychoeducational Battery-III (WJ-III)

The Woodcock-Johnson Psychoeducational Battery is **one of the primary diagnostic tools used by evaluators** to determine whether a student has learning disabilities. Parents and teachers who refer a student to a school study team for assessment need to request that both the cognitive and achievement portions of the Woodcock-Johnson test be administered. Often only the achievement portion is given which points out the student's academic weaknesses. The cognitive test needs to be given to provide a more complete picture of the student's academic functioning and strengths. The combination of both the cognitive and achievement test results gives valuable information concerning the strengths and weaknesses of the student, the student's learning style, the possible presence of visual perceptual difficulties, and the student's aptitude in academic areas.

Here is a sample of a Woodcock-Johnson -R given on two occasions.

Attribute	4/7/95 SS	10/12/00 SS
Letter Word Identification	61	61
Passage Comprehension	54	77
Calculation	69	54
Dictation	69	47
Writing Samples	40	42
Science	97	NA
Social Studies	91	NA
Broad Reading	.1	64
Broad Written Language	.1	46
Broad Math	NA	63

Broad Knowledge	NA	NA
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More General Batteries

- Basic Achievement Skills Academic Screener (BASIS)
- Basic School Skills (Diagnostic Version)
- Boehm Test of Basic Concepts - Preschool Version (BTBC-PV).
- Boehm Test of Basic Concepts - Revised (BTBC-R)
- Bracken Basic Concept Scale
- Brigance Diagnostic Inventory of Basic Skills
- Brigance Diagnostic Inventory of Early Development
- Brigance Diagnostic Inventory of Essential Skills
- Diagnostic Achievement Battery (DAB)
- Kaufman Test of Educational Achievement (K-TEA)
- Learning Accomplishment Profile (LAP)
- Psychoeducational Profile (PEP) (for students with severe disabilities)

How to compute a learning disability using Ability and Achievement Scores

Learning disability criteria.

Assuming the achievement test data shown below, and assume the student has an IQ of 89, does he/she meet the following definition of “severe discrepancy” to qualify as learning disabled?

(A) When standardized tests are considered to be valid for a specific pupil, a **severe discrepancy is demonstrated by: first, converting into common standard scores, using a mean of 100 and standard deviation of 15, the achievement test score and the ability test score to be compared; second, computing the difference between these common standard scores; and third, comparing this computed difference to the standard criterion which is the product of 1.5 multiplied by the standard deviation of the distribution of computed differences of students taking these achievement and ability tests.** A computed difference which equals or exceeds this standard criterion, adjusted by one standard error of measurement, the adjustment not to exceed 4 common standard score points, indicates a severe discrepancy when such discrepancy is corroborated by other assessment data which may include other tests, scales, instruments, observations and work samples, as appropriate.

	11/12/99- WAIT Standard Score	1/13/98 - WAIT Standard Score	11/03/94 K/TEA Standard Score	10/17/91 K/TEA Standard Score
Reading	98	91	81	80
Math	62	67	92	80
Writing	79	72	83 (Woodcock)	

Stand Alone Measures

There are many stand alone tests of various academic areas which test each domain separately. Here is list of common stand alone tests.

Reading Assessments

The general batteries of achievement tests do not go into the detail of the reading process itself, and thus it is possible with specialty instruments to actually “diagnose” the precise step in the reading process that is at issue. Reading generally follows this process. Starting on the right side of the brain, the student must visually see the graphic elements of what is a letter, and identify and assemble each letter together until it constitutes a word. The graphic depiction of a word is then transferred to the left side of the brain that is responsible for language (Wernicke’s area). On the left side of the brain, the graphical representation is then decoded to constitute a word in the vocabulary of the student. This decoded word is then transferred back to the right side of the brain where the word is then comprehended as to meaning. If there is a breakdown in any of these processes, then the student has a problem with reading. Facilities such as Lindamood-Bell (<http://www.lbpl.com>) focus extensively on the reading process when they perform their assessment. The following are examples of specialty assessments in reading.

- Gates-MacGinitie Reading Tests
- Gray Oral Reading Test
- Stanford Diagnostic Reading Test
- Test of Early Reading Ability (TERA)
- Test of Reading Comprehension (TORC)
- Woodcock Reading Mastery Tests - Revised

Mathematics Assessments

Similarly, there are specialty assessments in Math. Difficulty on a measure of math skills may reflect limits in understanding of numerical concepts, remembering math facts, understanding the language of mathematics, remembering which operations to apply when, visualizing concepts, sequencing (e.g., performing the right steps in the right order), and/or attending to visual details (e.g., operational sign, place, columns of numbers). The assessment is structured to investigate aspects or subcomponents of the child’s performance that will clarify the nature of their detected weakness within a specific area. The following are some examples.

- Enright Diagnostic Math Inventory
- Key Math Diagnostic Arithmetic Test
- Key Math Revised
- Kramer Preschool Math
- Stanford Diagnostic Math Test
- Test of Early Mathematical Ability (TEMA)
- Test of Mathematical Abilities

Psychological Processes

- Bender Visual Motor Gestalt Test
- Bruininks-Oseretsky Test of Motor Proficiency
- Carrow Auditory-Visual Abilities Test (CAVAT)
- Detroit Test of Learning Aptitude (DTLA - 3, DTLA - P2)
- Developmental Test of Visual-Motor Integration
- GFW Auditory Skills Test Battery

Illinois Test of Psycholinguistic Abilities
Visual Aural Digit Span Test (VADS)
Wepman's Auditory-Discrimination Test 2nd Edition
Woodcock Johnson Test of Cognitive Ability - Revised

Adaptive Behavior

Adaptive behaviors are everyday living skills such as walking, talking, getting dressed, going to school, going to work, preparing a meal, cleaning the house, etc. They are skills that a person learns in the process of adapting to his/her surroundings. Since adaptive behaviors are for the most part developmental, it is possible to describe a person's adaptive behavior as an age-equivalent score. An average five-year-old, for example, would be expected to have adaptive behavior similar to that of other five-year-olds.

AAMR Adaptive Behavior Scale, 2nd Edition
Adaptive Behavior Inventory
Behavior Evaluation Scales
Behavior Rating Instrument for Autistic and Other Atypical Children (BRIAAC)
Child Behavior Checklist
Conners Parent Rating Scale
Conners Teacher Rating Scale
Caine-Levine Social Competency Scale
Comprehensive Test of Adaptive Behavior (CTAB)
Developmental Task Analysis
Normative Adaptive Behavior Checklist
Rimland's Diagnostic Checklist for Behavior Disordered
The Childhood Autism Rating Scale
The Ritvo-Freeman Real Life Rating Scale
The Scales of Independent Behavior
The TARC Assessment System

Vineland Adaptive Behavior Scales Classroom edition: Teacher (most familiar with child) fills out 224-item questionnaire on classroom behaviors of the child; the questionnaire responses are interpreted by "a trained professional who has a graduate degree in assessment and test interpretation." Interview edition: Filled out by parent, caregiver or someone who knows individual well. 297 items (survey form), or 577 items (expanded form-- more detail on behaviors), given by trained administrator. Rating scale: 0=never performs activity, 1=sometimes or with partial success, 2=usually or habitually.

Depression/Anxiety and Personality and Attitude Assessment

Depression in children and adolescents is very difficult to diagnose. A depression can cause an effect in a child that can look like just about anything, a personality change, moodiness, aggression anger and acting out, hyperactivity, physical complaints, and so forth. Most children

cannot report their inner life, so they have a difficult time reporting to you that they are depressed. A number of tools can be used to determine if there is a depression. NOTE: that there is now a problem with misdiagnosis of ADHD and bipolar disorder that requires an assessment of depression in order to distinguish between the two. Here are some measures that are commonly used.

- Rorschach - Exner Scored has children norms, good for depression and thought disorder.
- Children's Apperception Test
- Children's Depression Inventory
- Human-Figure-Drawing (House-Tree-Person Draw-a-person)
- Millon Adolescent Personality Inventory
- Minnesota Multiphasic Personality Inventory-2
- Personality Inventory for Children - R
- Robert's Apperception Test
- Reynolds Children or Adolescent Depression Scale
- Thematic Apperception Test

Behavior Rating Scales

- Burks' Behavior Rating Scale - Revised (BBRS-R)
- Behavior Assessment System for Children (BASC)
- Behavior Rating Profile - 2 (BRP)
- Child Behavior Checklist
- Child Behavior Rating Scale (BRS)
- Devereux Behavior Rating Scale School Form
- Devereux Child Behavior Rating Scale
- Devereux Elementary School Behavior Rating Scale
- Ottawa School Behavior Checklist (OSBCL)
- Peterson's and Quay's Revised Behavior Problem Checklist
- Preschool Attainment Record
- Social Skills Rating System(AGS)
- Walker Problem Behavior Identification Checklist
- Revised Behavior Problem Checklist

Hearing Impaired Developmental Skills or Academic Achievement

- Test of Early Reading Ability - Deaf or Hard-of-Hearing
- Woodcock Reading Mastery Test - Revised
- SKI-HI Language Development Scale
- Birth-to-Three Developmental Scale
- Stanford Achievement Test - Hearing Impaired Edition
- Receptive-Expressive Emerging Language Scale

Physically Impaired Screenings or Evaluations in Gross and Fine Motor Functioning

Bender Visual Motor Gestalt Test
Developmental Test of Visual Motor Integration
Bayley Scales of Infant Development - Motor Scales
Bruininks-Oseretsky Test of Motor Proficiency - Selected Subtests
Body Skills Motor Development Curriculum - Selected Portions
Contextual Assessments (e.g., observations in physical therapy and activities necessary to the educational environment)

Sensory Integration

The **Sensory Integration and Praxis Test (SIPT)** is a nationally standardized test battery which assesses children **four to ten years of age** for sensory integration dysfunction. Within occupational therapy it is our most sophisticated tool and like other standardized tests must be administered in a standardized manner. Because of both its complexity and its sophistication, a certification process has been established through Sensory Integration International. The process involves three courses that run from three to five days each (see page 12), an observation of administration proficiency and certification examination. This process is similar to the process required for other tests such as intelligence tests. It is a process designed and endorsed by Dr. Ayres and her colleagues as important to ensure competency in administration of this complex assessment.

Daily Living Skills

Brigance Diagnostic Inventory of Early Development
Oregon Project for Visually Impaired and Blind Preschool Children
Assessing Basic Competencies: Visually Impaired, APH
Determining Mode of Reading for Visually Impaired Learners (FY 1991-2)
Functional Vision: Criterion-Referenced Checklists
Functional Vision Report for Visually Handicapped Students Reading Print Included as part of the
Functional Vision Observation Low Vision Observation Checklist
Program to Develop Efficiency in Visual Functioning: Diagnostic Assessment Procedure (DAP)
Project IVEY: Increasing Visual Efficiency Observation Report

Speech and Language

The five components of language, and common tests for each component is as follows..

Phonology

The smallest significant units of sound are phonemes. Phonemes are then combined into words. The word "goes" has three phonemes (g) (oh) (zzz).

Some measures of Phonology are the following.

The Goldman-Fristoe Test of Articulation (Goldman & Fristoe, 1986) A systematic measure of articulation of consonant sounds for children and young adults. Authors: Ronald Goldman & Macalayne Fristoe Ages: 2–21 Administration Time: 5–15 minutes for Sounds-in-Words Section, varied for other two sections. Scores/Interpretation: Age-based standard scores, percentile ranks, and test-age equivalents for Sounds-in-Words, with separate norms for females and males.

Arizona Articulation Proficiency Scale (2nd ed) (Fudala & Reynolds, 1986)

Photo Articulation Test (Pendergast, Dickey, Selmar, & Soder, 1984)

Templin-Darley Tests of Articulation (2nd ed.) (Templin & Darley, 1969)

The Auditory Discrimination Test (Wepman & Reynolds, 1986)

The Goldman-Fristoe-Woodcock Test of Auditory Discrimination (Goldman, Fristoe, & Woodcock, 1970)

Morphology

Morphology studies how phonemes are put together to make meaning. The word "displacement" has three morphemes (dis) (place) (ment).

Morphology and Syntax are commonly tested together with one exception.

Test for Examining Expressive Morphology (Shipley, Stone, & Sue, 1983)

Syntax

Syntax involves the relational meaning of language, or how words are put together to make acceptable phrases, clauses and sentences. Measures of both Morphology and Syntax are the following.

Carrow Elicited Language Inventory (Carrow- Woolfolk, 1974)

Developmental Sentence Analysis (Lee, 1974)

Language Sampling, Analysis and Training (rev. ed.) (Tyack & Gottsleben, 1977)

Northwestern Syntax Screening test (Lee, 1971)

Test for Auditory Comprehension of Language-Revised (Carrow-Woolfolk, 1985)

Semantics

Semantics refers to the meaning of individual words and of word relationships in messages. In a rough sense, semantics is a measure of vocabulary or an estimate of the number of words known by the student both expressive and receptive.

1 The Expressive Vocabulary Test (EVT) is an individually administered norm-referenced assessment of expressive vocabulary and word retrieval for children and adults. The EVT measures expressive vocabulary knowledge with two types of items,

labeling and synonym. Ages: 2-6 to 90+ Administration Time: 15 minutes
Scores/Interpretation: Age-based standard scores (M = 100, SD = 15), percentiles, NCEs, stanines, and test-a

2 The Peabody Picture Vocabulary Test - Third Edition (PPVT-III), which was conormed with the EVT, is an individually administered norm-referenced assessment. The PPVT-III is an achievement test of receptive vocabulary that measures listening comprehension of spoken words for children and adults. Word retrieval is evaluated by comparing expressive and receptive vocabulary skills using standard score differences between EVT and PPVT-III.

3 Assessment of children's Language Comprehension (Foster, Giddan, & Stark, 1972)

4 Boehm Test of Basic Concepts- Preschool Edition (Boehm, 1986a)

5 Boehm Test of Basic Concepts-Revised (Boehm 1986b)

6 Environmental Language Inventory (MacDonald, 1978)

Pragmatics

Pragmatics refers to the use of language within the communicative context. It is possible to have all the necessary skills in phonology, morphology, syntax and semantics and yet still have difficulty communicating with others.

Let's Talk Inventory for Children (Bray & Wiig, 1987)

Test of Pragmatic language (Phelps-Terasaki & Phelps-Gunn, 1992)

Test of Pragmatic Skills (rev. ed.) (Shulman, 1986)

Comprehensive General Survey Measures of Oral Language

These measures assess a wide range of language skills.

Bankson Language Test (2nd ed.) Bankson, 1990)

BRIGANCE Diagnostic Inventory of early Development-Revised (Brigance 1991)

Clinical Evaluation of Language Fundamentals-Revised (Semel, Wiig and Secord, 1987)

Illinois Test of Psycholinguistic Abilities (Kirk, McCarthy, & Kirk, 1968)

Test of Adolescent Language -2 (Hammill, Brown, Larsen, & Wiederholt, 1987)

Test of Early Language Development (3rd ed.) (Hresko, Reid, & Hammill, 1991)

Test of language Development-2 Intermediate (Hammill & Newcomer, 1988)

Utah Test of language Development (3rd. ed.) (Mecham, 1989)

Woodcock language Proficiency Battery Revised (Woodcock, 1991)

ADD/ADHD ASSESSMENT

CPT Assessment of Attention

The Test of Variables of Attention (T.O.V.A.® www.tovatest.com), a 21.6 minute computerized continuous performance test used by professionals in the diagnosis and monitoring of treatment of attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD)

in children and adults. The standardized test is well normed and extremely helpful in predicting responsiveness to treatment modality. Ages: 4-80+ Test Duration : 21.6 minutes with a 3 minute Practice Test Scores/Interpretation: Raw Scores, Standard Scores, Standard Deviations.

Conners CPT II Continuous Performance Test for Windows administers the protocol directly to the subject, using the computer screen, keyboard or mouse. An optional tutorial prepares the patient for the task. The subject is instructed to press the spacebar (or mouse button) immediately following the presentation of specific letters on screen. A proprietary standard mode of presentation, developed by Dr. Conners, is administered. The standard mode controls for the number of trials, target letters presented, varied inter-stimulus intervals between letters, and more. It normally takes 14 minutes to administer. The User Manual presents data on nearly 2000 new cases and the clinical sample consists of more than 600 cases of varying diagnoses and includes new ADHD normative data. The data is broken down into groups by age levels for comparison purposes.

Popular rating scales used in the assessment of ADD

- Conners Teacher Rating Scale (CTRS) and the Conners Parent Rating Scale (CPRS),
- ADD-H Comprehensive Teacher's Rating Scale, Second Edition.
- ADHD Rating Scale,
- Child Attention Profile,
- Child Behavior Checklist (CBCL),
- Home Situations Questionnaire,
- School Situations Questionnaire

Assessment of Autism

A number of tools have been developed to assess autism. One of the more popular is the CARS: Childhood Autism Rating Scale. The following items are a sample of the questions found on the Childhood Autism Rating Scale (Eric Schopler, Robert Reichler, MD, and Barbara Rothen Renner, Western Psychological Services, Los Angeles: 1993) This instrument is often used to evaluate young children who may have autistic spectrum disorders.

Evaluators using the CARS rate the child on a scale from one to four in each of fifteen areas. Children with a probable diagnosis of PDD-NOS or Atypical PDD generally (but not always) fall between 30 and 37 on the complete CARS scale, which indicates a mild or moderate degree of autistic behavior.

Relating to People

1	No evidence of difficulty or abnormality in relating to people. The child's behavior is appropriate for his or her age. Some shyness, fussiness, or annoyance at being told what to do may be observed, but not to an atypical degree.
1.5	(if between these points)
2	Mildly abnormal relationships. The child may avoid looking the adult in the eye, avoid the adult or become fussy if interaction is forced, be excessively shy, not be as responsive to the adult as is typical, or cling to parents somewhat more than most children of the same age.

2.5	(if between these points)
3	Moderately abnormal relationships. The child shows aloofness (seems unaware of adult) at times. Persistent and forceful attempts are necessary to get the child's attention at times. Minimal contact is initiated by the child.
3.5	(if between these points)
4	Severely abnormal relationships. The child is consistently aloof or unaware of what the adult is doing. He or she almost never responds or initiates contact with the adult. Only the most persistent attempts to get the child's attention have any effect.

Body Use

1	Age appropriate body use. The child moves with the same ease, agility, and coordination of a normal child of the same age.
1.5	(if between these points)
2	Mildly abnormal body use. Some minor peculiarities may be present, such as clumsiness, repetitive movements, poor coordination, or the rare appearance of more unusual movements.
2.5	(if between these points)
3	Moderately abnormal body use. Behaviors that are clearly strange or unusual for a child of this age may include strange finger movements, peculiar finger or body posturing, staring or picking at the body, self-directed aggression, rocking, spinning, finger-wiggling, or toe-walking.
3.5	(if between these points)
4	Severely abnormal body use. Intense or frequent movements of the type listed above are signs of severely abnormal body use. These behaviors may persist despite attempts to discourage them or involve the child in other activities.

Adaptation to Change

1	Age appropriate response to change. While the child may notice or comment on changes in routine, he or she accepts these changes without undue distress.
1.5	(if between these points)
2	Mildly abnormal adaptation to change. When an adult tries to change tasks the child may continue the same activity or use the same materials.
2.5	(if between these points)
3	Moderately abnormal adaptation to change. The child actively resists changes in routine, tries to continue the old activity, and is difficult to distract. He or she may become angry and unhappy when an established routine is altered.
3.5	(if between these points)
4	Severely abnormal adaptation to change. The child shows severe reactions to change. If a change is forced, he or she may become extremely angry or uncooperative and respond with tantrums.

Listening Response

1	Age appropriate listening response. The child's listening behavior is normal and appropriate for age. Listening is used together with other senses.
1.5	(if between these points)
2	Mildly abnormal listening response. There may be some lack of response, or mild overreaction to certain sounds. Responses to sounds may be delayed, and sounds may need repetition to catch the child's attention. The child may be distracted by extraneous sounds.
2.5	(if between these points)
3	Moderately abnormal listening response. The child's responses to sounds vary; often ignores a sound the first few times it is made; may be startled or cover ears when hearing some everyday sounds.
3.5	(if between these points)
4	Severely abnormal listening response. The child overreacts and/or under reacts to sounds to an extremely marked degree, regardless of the type of sound.

Verbal Communication

1	Normal verbal communication, age and situation appropriate.
1.5	(if between these points)
2	Mildly abnormal verbal communication. Speech shows overall retardation. Most speech is meaningful; however, some echolalia or pronoun reversal may occur. Some peculiar words or jargon may be used occasionally.
2.5	(if between these points)
3	Moderately abnormal verbal communication. Speech may be absent. When present, verbal communication may be a mixture of some meaningful speech and some peculiar speech such as jargon, echolalia, or pronoun reversal. Peculiarities in meaningful speech include excessive questioning or preoccupation with particular topics.
3.5	(if between these points)
4	Severely abnormal verbal communication. Meaningful speech is not used. The child may make infantile squeals, weird or animal-like sounds, complex noises approximating speech, or may show persistent, bizarre use of some recognizable words or phrases.

In addition, specific instruments have been developed to assess subtypes of autism such as Asperger's Disorder. For example, the Asperger Syndrome Diagnostic Scale (ASDS) by Brenda Myles, Stacey Bock, and Richard Simpson was designed to identify Asperger Syndrome in children ages 5 through 18. Anyone who knows the child or youth well can complete this scale. Parents, teachers, siblings, paraeducators, speech & language pathologists, psychologists, psychiatrists, and other professionals can answer the 50 yes/no items in 10 to 15 minutes. Designed to identify Asperger Syndrome in children ages 5 through 18, this instrument provides an AS Quotient that tells the likelihood that an individual has Asperger Syndrome.

Neuropsychological Assessment

There are times when a full neuropsychological battery is warranted. Neuropsychology is the study of how the functions of your brain and nervous system affect the way you think and

behave. For some time now, neuropsychology has helped hospital clinicians assess patients who have experienced head injuries to determine how neurological damage affects their patients' thinking skills and behavior. Clinical psychologists have also benefitted from neuropsychology because it helps them more accurately assess the causes of some patients' behaviors. **A neuropsychological assessment is typically provided by a licensed psychologist who has had specialized training and experience in neuropsychology. A neuropsychological assessment is more sensitive to a neurological evaluation by an M.D. and can detect dysfunction not yet apparent on imaging schemes such as MRI or CAT scans.**

In the traditional definition, the discipline of child neuropsychology is concerned with understanding brain-behavior relationships in the developing individual. Historically, the field evolved from a **lesion localization model** (e.g., trauma to a particular part of the brain leads to a particular kind of deficit) and from studies of the effects of neurological disease, primarily in adults, on cognitive functioning. **At present, behaviors are further defined and linked to brain processes through the use of new technologies** (e.g., neuroimaging or brain scans). The study of these processes in children and the effects of neurodevelopmental disorders is a growing field of research. In clinical settings, the neuropsychologist typically has a role in determining the functional impact of neurological diseases or damage to the brain (e.g., acquired in a car accident). **More broadly, the neuropsychologist endeavors to assess different domains of functioning** (e.g., attention, memory, problem solving) in order to generate a profile of strengths and weaknesses that can inform treatment planning and adaptation in daily life.

Recently, education experts have begun to use neuropsychology to explain why some children have trouble acquiring language skills, learning to read, developing arithmetic reasoning skills, and so on. Using neuropsychology in schools can help teachers serve children with learning disabilities more effectively because a child who has neurologically related disabilities does not benefit from the same teaching techniques (such as repetition) that a student who learns at a slower rate benefits from.

Neurological assessment is a tool for evaluating how much a child's performance may be influenced by unusual functions of the brain and nervous system. It helps school psychologists systematically measure a child's skills and determine the best learning environment for the child.

The two most common tests are:

- 1) The Halstead-Reitan Neuropsychological Test Battery (which includes the revised Wechsler Intelligence Scale for Children) and
- 2) The Luria-Nebraska Neuropsychological Battery.

Neither of these is especially suited for children, and none of them specifically address educational implications.

A third method known as the Murial Lezak, or the UCLA method, or the hypothesis testing method would be better suited.

A neuropsychological assessment typically evaluates multiple areas of functioning. The following represents a set of cognitive functions that is likely to be assessed:

Attention

Sensory perceptual and motor functions

Memory

Auditory and visual processing
Language
Concept formation and problem solving
Planning and organization
Speed of Processing
Intelligence
Academic skills
Behavior, emotions, and personality

Various tests can be used to assess the domains listed above. In this regard, the tests that are used by individual neuropsychologists are not fixed but may be selected according to: the referral questions, age of the child, clinician's preference, soundness of the measures, and issues pertinent to a particular child. One common assessment approach is to make use of a core battery of tests and then supplement with tests of specific skills in view of the results from the standard battery. Other considerations in this process include the child's developmental history, the clinical interview, observations of test behavior (e.g., during more or less structured situations), naturalistic observations (e.g., adjustment in the classroom), behavioral and emotional presentation, and interviews with selected individuals in the child's everyday environment (e.g., teachers, therapists). Exploring why the child is encountering difficulties involves examining converging lines of evidence from different tests, parent and teacher report, observations of behavior, and clinical judgment.

The **testing situation is also typically set up to obtain the best possible performance** from the child, under optimal conditions. An implicit question underlying many referrals is whether the behaviors that the child is displaying at home and school or with peers are due to, for example, compliance, motivation, or emotional factors, or because they are lacking some of the component skills necessary for success in these realms. As we isolate the child's individual strengths and weaknesses, we achieve a better understanding of where breakdowns may be occurring and what compensatory strategies are being used.

Byron P. Rourke Ph.D, Professor of Psychology and a University Professor at The University of Windsor, and a member of the faculty of the School of Medicine, Yale University is probably the most notable neuropsychologist who has written extensively on the application of neuropsychological principles to learning disabilities.