Handbook on *Assessment and Evaluation* in Early Childhood Special Education Programs

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Ordering Information

Copies of this publication are available for $13.50 each, plus shipping and handling charges. California residents are charged sales tax. Orders may be sent to CDE Press, Sales Office, P.O. Box 271, Sacramento, CA 95812-0271; FAX (916) 323-0823. Prices on all publications are subject to change.

A partial list of educational resources available from the Department appears on page 69. In addition, an illustrated *Educational Resources Catalog* describing publications, videos, and other instructional media available from the Department can be obtained without charge by writing to the address given above or by calling the Sales Office at (916) 445-1260.

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The California Department of Education gratefully acknowledges Michael Salcedo of the SEEDS project for the use of the photos in this document.

Notice

The guidance in *Handbook on Assessment and Evaluation in Early Childhood Special Education Programs* is not binding on local educational agencies or other entities. Except for the statutes, regulations, and court decisions that are referenced herein, the document is exemplary, and compliance with it is not mandatory. (See *Education Code* Section 33308.5.)

Prepared for publication
by CSEA members.

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Preface

The early years are the foundation for a child's healthy development and readiness for lifelong learning. For young children with disabilities, development and learning in the early years depend on the quality of early intervention services. This handbook provides information on the development and maintenance of quality programs, the statutory and regulatory requirements, and the resources available to local educational agencies to support those programs.

Background

Infant and toddler and preschool special education programs and services have changed substantially in recent years. The implementation of Senate Bill 1085 in 1993 established the Early Start interagency program in collaboration with the California Department of Developmental Services (DDS). This program provides early intervention services that are individually designed for infants and toddlers from birth through two years of age and their families. Funding is provided under Part C of the Individuals with Disabilities Education Act (20 USC Section 1471 et seq.) to develop innovative ways of providing family-focused, coordinated services that are built on existing systems.

Preschool special education programs received a boost from the federal government with the increased funds and expansion of eligibility categories for children with disabilities between the ages of three and five years under Title II of the Education of the Handicapped Act Amendments of 1986, Public Law 99-457 (20 USC sections 1411, 1412, 1413, and 1419).

California state law, Chapter 311 (AB 2666, Hannigan, Statutes of 1987), established program standards for all preschoolers with exceptional needs in California. Prior to enactment of this law, public schools in California were mandated to serve only preschool children requiring intensive special education and services.

Principles of Early Childhood Special Education Service Delivery

The handbooks in the Early Childhood Special Education series are based on the following principles:

- Early childhood special education programs must be child-centered.
- Programs should be family-focused.

- Programs should be culturally sensitive.
- Collaborative interagency coordination is the most efficient and effective way to provide services to families.
- Programs should provide transdisciplinary approaches to the assessment of children and delivery of services.
- Programs should provide opportunities for staff development.
- Program evaluation is a necessary component of special education programs and services.

Purpose of the Handbook

The Early Education Unit of the Special Education Division, California Department of Education, is providing staff in the field with a resource that presents quality criteria for best practices in program development, ideas, and concepts in the context of the statutory requirements for early childhood special education programs. New federal and state statutes and changed regulations and funding mechanisms have affected the provision of services for young children with disabilities. Such changes make it necessary to update and expand the *Preschool Special Education Program Handbook* (published in 1988) to include information on the infant and toddler early intervention programs.

Each handbook in the Early Childhood Special Education series describes core concepts and best practices that are based on an in-depth review of current literature, statutes, and regulations. These handbooks may be accessed on the Department's Web site.

We thank the parents and educators who contributed the ideas in this handbook to make it a valuable resource for administrators, teachers, and family members.

HENRY DER
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Introduction

The process of screening and assessment goes beyond scores, standard deviations, and levels of functioning. It is often a family's first introduction to the human service or educational system and it is potentially a short-term therapeutic experience in itself. For examiners, tests and other procedures may be used to organize observations about a child and family rather than merely as a way to control eligibility for services. Assessment, in particular, should be approached as an ongoing, dynamic process with multiple components, including case management, family support, transitional programs, and the development of the IFSP/IEP.

—Samuel Meisels and Sally Provence, *Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families*

This handbook provides information that reflects the preferred practices in the field of evaluation and assessment of children ages birth through five years. It presents guidelines with references to give service providers direction in how to accurately evaluate and assess this age group. The requirements of the individualized family service plan (IFSP) under the Individuals with Disabilities Education Act (IDEA), Part C, and those for the individualized education program (IEP) under IDEA, Part B, are included. Appendix A contains the statutory and regulatory requirements regarding the evaluation and assessment of young children.

Evaluation may be defined as the act of determining a child's eligibility for special education. *Assessment* is a process through which one determines the child's abilities and need for services. Evaluations and assessments of infants, toddlers, and preschoolers are conducted differently from those of older children. During development a young child will act differently from one situation to another and even from one time of day to another. Changes in the environment, the child's physical state, and the interactions that a

child has with significant people in his or her life may have a critical impact on how a young child will react to evaluation settings and procedures.

To address the differences between young children and older children, programs may use a multidisciplinary, interdisciplinary, or transdisciplinary team approach. A child may not respond to traditional evaluation and assessment methods; consequently, alternative procedures may be the only way in which to obtain accurate information. Tools may include standardized assessment measures and alternative approaches, including play-based assessments and clinical observations of the child in a variety of settings. (See the glossary for definitions of terms that are used regarding evaluation and assessment.)

The following concepts represent the preferred practices in early childhood evaluation and assessment:[1]

- A collaborative evaluation/assessment process includes families as providers of information and as team members.
- A transdisciplinary team knowledgeable in all areas of child development, including typical and atypical development and family systems, conducts the assessments. As part of the assessment team, families are given the opportunity to learn about the procedures, observations of the professionals, and interpretations of the data. The result of the assessment is a coordinated intervention plan.
- The evaluation/assessment team looks at the child in the context of the family, culture, and community, interpreting information about the child in the child's environment. According to the *California Code of Regulations, Title 17,* Section 52084(e), evaluations and assessments must be conducted in natural environments whenever possible. An ecological model of assessment allows the interaction between a child and the environment to be judged in the context of his or her daily activities and routines and to be enhanced by environmental support. The assessor must focus ongoing assessment on the child's developmental skills, challenges, and individual differences and on the child's responses alone and in social interactions in different experiences and settings and with different people throughout the day.
- The assessment team focuses on the concerns of the family, referral sources, service providers, and specific requirements regarding the child's eligibility for programs.
- The assessment team considers the reliability and validity of the various procedures for the child and the family when choosing observation strategies and assessment measures.
- The evaluation or assessment team designs procedures to obtain appropriate information for determining a child's eligibility for programs and his or her progress and for planning intervention strategies.
- The team provides a written report that communicates the results and recommendations in lay terms without jargon to parents and program providers.

Personnel who assess children ages birth to five years should adopt a philosophy about assessment practices. The publication *Guidelines and Recommended Practices for the Individualized Family Service Plan* identifies the following

[1] Adapted from Linda Brekken, "Key Points in Assessing Preschoolers and Their Families," in *Preschool Special Education Program Handbook*. Sacramento: California Department of Education, 1988.

principles regarding the evaluation and assessment of young children:[2]

- Informed consent must be obtained from a family for all initial evaluation and assessment activities.
- Assessment must be nondiscriminatory. Children should be assessed for their strengths and needs, with the assessment team showing sensitivity to the impact of the disability on the child.
- The evaluation/assessment process should be conducted in the language preferred by the family whenever possible. (See the *Code of Federal Regulations*, Section 300.532 [a] [1] [ii], in Appendix A.)
- The child's assessment should be shaped by the family's priorities and need for information as well as by the child's characteristics and by diagnostic concerns.
- The evaluation/assessment process must reflect a respect for family values and different styles of decision making.
- In a team assessment process, all information is shared freely among the team members.
- Family members are an integral part of any team and have the opportunity to attend evaluation/assessment sessions and participate in all discussions.

[2] *Guidelines and Recommended Practices for the Individualized Family Service Plan* (Second edition). Edited by Mary McGonigel and others. Bethesda, Md.: National Early Childhood Technical Assistance System (NECTAS) and Association for the Care of Children's Health (ACCH), 1991, p. 40.

Team Assessment of Preschool-Age Children

Many early childhood programs use some form of collaboration to assess and plan an appropriate program for young children. In a study of preschool assessment practices in California, researchers found variations in team composition; namely, multidisciplinary, interdisciplinary, and transdisciplinary. Many programs that were being studied were changing, reflecting an increase in team-based assessment practices.[3]

Types of Assessment Teams

Team approaches differ in the amount of direct contact and interaction that team members have with one another during the assessment process. In the *multidisciplinary team* approach, there is very little contact between professionals. Children are assessed, and decisions and recommendations are made by professionals independently.

The *interdisciplinary team* approach is one in which professionals maintain their role in a specific discipline but work

[3] Maureen Ballard-Rosa and others, *Preschool Assessment Practices in California: Characteristics and Issues of Alternative Approaches.* Sacramento: California Department of Education, 1996.

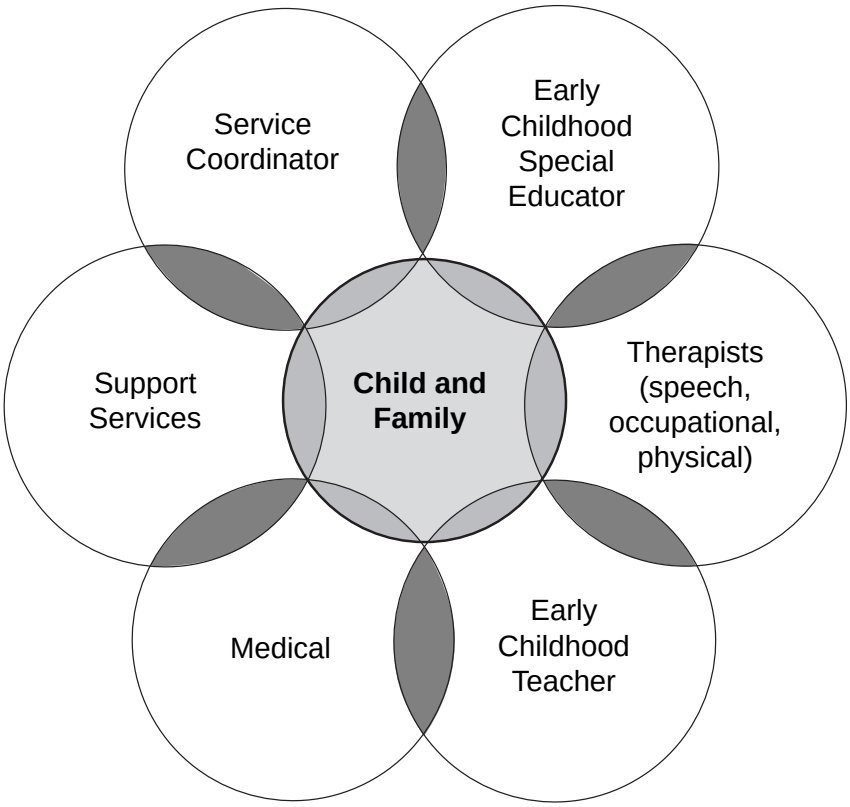
together with the child and family. The team makes decisions and recommendations as a group, but each professional on the team has a role in implementing the program once it is determined.

The *transdisciplinary team* is described as follows:

> A group of professionals and family members who work together to assess, plan, and provide early education services to an infant (or preschooler) and his or her family. Transdisciplinary team members train each other in individual areas of expertise and share the responsibility for assessment and implementation of an educational program. Each professional is committed to incorporating the perspectives and techniques of other disciplines into one's own area of expertise. Team members increase each other's knowledge by training each team member in their own respective discipline. In the transdisciplinary approach, team members become aware of each other's disciplines, yet areas of expertise remain in the discipline of training.[4]

[4] Patrick Campbell, "Clarification of Transdisciplinary Team." Memorandum from the Director of Special Education. Sacramento: California Department of Education, 1987.

Transdisciplinary Team



Transdisciplinary Early Childhood Assessment Teams

The early childhood special education assessment team is a well-established component of quality early intervention programs. Implementing a transdisciplinary team assessment model requires additional staff training, reallocation of staff time, and revision of schedules to conduct team assessments. These initial investments in staff training and time yield many benefits to the children and families served. The reasons for implementing a transdisciplinary team assessment model in early childhood special education and infant and preschool programs are as follows:

- The various areas of development overlap in the young child and are less differentiated than in the older child. Therefore, behaviors are more difficult to separate into discipline-specific realms. A single behavior may involve aspects of cognitive, motor, language, and emotional development. When a team observes the same behavior, each member can provide a unique perspective and interpretation based on expertise in a particular discipline. Thus, a total picture of the child emerges.
- The whole [assessment result] is greater than the sum of its parts. The team process provides a more valid and complete synthesis of assessment results than individual reports put together.
- Teaming is an efficient process that saves time for both staff and families by reducing the duplication of assessment services.
- The quality of the observations, assessments, and reports is improved. Teaming improves the accuracy of the observations, assists in the recall of specific behaviors, allows synthesis of the information, and provides validation of the observations and recommendations regarding the child's functioning.
- Observations and recommendations are consistent, and the family does not receive conflicting information. The team process allows one of the team members to work with the family to explain the process and clarify assessment activities, providing an educational experience for the family during the assessment. The development of a parent–professional partnership at the initial contact establishes the family's trust in the system and allows for immediate verification and validation of the assessment results.
- Team members receive the benefit of learning from one another so that they are all enriched in their knowledge of child development.
- Team assessment provides an integrated picture of the whole child within the family system and community. The synthesis of information provides a much broader and more accurate view of the child and family.

The composition of the transdisciplinary early childhood special education assessment team is dependent on the program's resources, the skills of the staff, and the family's and child's needs. The assessment team should develop a philosophy and service delivery model that reflects and responds to these variables.

Examples of the composition and functions of a transdisciplinary assessment team model are as follows:

- Two to three team members assess all children. Consultants in special areas are added to the team as needed.
- The team composition is developed individually for each child and family to meet individual needs.
- An interagency team (i.e., consisting of Head Start and local educational agency staff) assesses all children.
- The entire team assesses all children.

These models are not inclusive. Each program should develop a transdisciplinary early childhood special education assessment model that meets the particular needs of the program, family, and community.

Adapted from Linda Brekken and Gina Guarneri, "Rationale for Transdisciplinary Early Childhood Assessment Teams," in *Preschool Special Education Program Handbook.* Sacramento: California Department of Education, 1988.

It is important for the staff to examine the current practices of its program by asking the following questions:

- What approach is being used (e.g., individual professional or a multidisciplinary, interdisciplinary, transdisciplinary, or transitional team) for assessment?
- Does the current approach match the philosophy of the program?
- Does administrative support exist for a team model?
- What is the goal of the program?
- What changes need to be made to develop a stronger team?
- What barriers hinder implementation of the new approach?
- What staff development should occur for the program to be successful?
- What is the timeline for implementing the change?

Radford and Wolfe identified some common concerns in the development of successful teams.[5] Although most effective in developing transdisciplinary teams, these concerns apply to interdisciplinary teams as well:

- Develop an assessment philosophy.
- Establish team goals.
- Clarify team priorities.
- Identify the specific steps and actions to be included in assessments.
- Allocate sufficient time to share observations, results, and recommendations.
- Define the skills needed by the team.
- Define roles and responsibilities of team members.
- Create a system of team support.
- Define the process for team decision making.
- Establish linkages with other programs and services.
- Plan for ongoing team development.

Even in programs that operate transdisciplinary teams, teaming issues should be revisited on a regular basis to

[5] Adapted from Linda Radford and Sheila Wolfe, "Development of an Early Childhood Assessment Team," in *Preschool Special Education Program Handbook.* Sacramento: California Department of Education, 1988.

maintain continuity. Some factors that may affect a team include the following:

- Changes in personnel
- Changes in laws and regulations that may require altering established procedures
- Allocation of adequate time for the team process
- Changes in workload or assignments of individual team members
- Changes in the assessment approach

Composition of the Team

Administrators should consider who will participate and how the team will function. The following guidelines should be kept in mind:

- The core infant and preschool assessment personnel are qualified and are interested, experienced, and trained in the assessment of infants and preschool-age children.
- To maintain continuity of the transdisciplinary team, administrators should make a commitment to stable staffing when assigning core assessment personnel.
- The assessment team *must* include the parent or guardian and may consist of the following members:
  - —General education teacher or child care provider
  - —Early childhood special education teacher
  - —School nurse
  - —School psychologist
  - —Speech, language, and hearing therapist
- If a child is suspected of having a low-incidence disability, an assessor who is certified in the specific low-incidence disability is required to participate as part of the team (pursuant to *Education Code* Section 56320[g]).
- Qualified school personnel who should be involved in the assessment of a child with a low-incidence disability (depending on the disability) are as follows:
  - —Interpreter/translator
  - —Adaptive physical education teacher
  - —Occupational or physical therapist
  - —Teacher of children who are visually impaired
  - —Orientation-and-mobility specialist
  - —Teacher of children who are deaf or hard of hearing
  - —Teacher of children who are orthopedically impaired
  - —Program specialist
  - —Assistive technology specialist
- The size and makeup of the team may vary, depending on the age and needs of the child, family preferences, and location of the evaluation.
- Sufficient clerical support is necessary to coordinate referrals, set up IEP/IFSP meetings, and prepare necessary reports and documents.
- Others who may be involved in assessment, when appropriate, include the following:
  - —Community service providers
  - —Medical specialists
  - —Personnel from such agencies as the regional center, a public health department, or a mental health center; Women, Infants, and Children (WIC) Nutrition Program; and California Children Services (CCS)
- The child's teacher or child care provider may be a valuable source of information.

The roles among preschool assessment personnel may be considerably blurred, depending on the skills of the assessment personnel, the amount of time available, and established staff agreements. The selection of participants in the assessment process is determined in part by the type

of assessment required and the suspected disability. However, the assessment team *always* includes the parents and other persons requested by the parents for their knowledge of the child and family. Team members are selected on the basis of their special expertise, the preference of the family, and language skills.

Parents or guardians: The child's parents or guardians are central to the assessment of young children. IDEA '97 requires the parents to be a part of the team that determines their child's eligibility for special education services. The parents participate in the development of the assessment plan to ensure that family concerns are addressed; to determine the amount of assessment that will take place in the home; to determine the family's level of participation; to provide assessment information; and to help link assessment to their concerns, resources, and priorities for their child. Parents who accept a specific responsibility, such as engaging the child in a play activity, become more directly involved in the assessment process.

Early childhood general education teacher or care provider: In a preschool, child care center, or family child care home, the general education teacher's or care provider's responsibility may include screening the child, providing a referral, consulting with team members, and acting as a liaison between the parent and the school and between the parent and assessment personnel. The classroom or group situation is often the setting of the child's initial school experience. The teacher or care provider is frequently the first trained observer of a child's growth and development. His or her informal assessments provide valuable documentation of a child's skills, talents, abilities, and needs that lead to referral for further assessment when appropriate. After receiving a parent's signed consent, the general education teacher or care provider includes the developmental information when making the referral to the assessment team. He or she can facilitate the flow of information to parents, helping to increase the family's understanding of and involvement in the assessment process.

Early childhood special education teacher: The teacher's responsibility may include assisting in identifying and addressing the individual needs of a child. The teacher may provide observations of the child in a variety of settings and activities and participate with the assessment team in assessing the child. The teacher assists in writing realistic goals and objectives or outcomes for each child and monitors the progress of the child within the placement setting.

Nurse: The nurse's responsibility may include obtaining a relevant health and developmental history from the child's parents, the medical community, and other community agencies. A nurse will typically evaluate the child's current health and nutritional status (including dental health), vision, hearing, immunizations, and sleep patterns and, when relevant, screen the child's self-help skills, fine and large motor skills, and social–emotional development, including parent–child interactions. Evaluating the specialized health care needs of a child and the impact of those needs on educational placement and learning is of critical importance. Because health issues may have a significant impact on a young child's development, all infants and toddlers referred are required to receive at the minimum an assessment for hearing and vision as part of the health status determination. Nurses should also communicate with primary care physicians and specialists to obtain the most current information on medications, equipment, technology, and special services needed by the child.

Psychologist: The school psychologist's responsibility involves both formal and informal assessment of a child's overall functional level. The psychologist assesses a child's coping skills, social–emotional skills, parent–child interaction, school readiness skills, cognitive development, and general adaptive behavior. He or she may assist in integrating evaluations from other persons participating in the assessment and take the major responsibility for preparing the psychoeducational team report. The psychologist also assists in identifying the child's preferred learning style.

Speech, language, and hearing therapist: The speech, language, and hearing therapist's responsibility is to assess the child's speech, language, and other communication development and determine what interventions, if any, are necessary to correct identified problems. A speech and language evaluation needs to be considered for nearly all children in this age range because speech and language development is a critical developmental area for young children. The speech and language developmental level ascertained by the therapist represents essential information in determining a child's overall developmental and educational needs. In many cases the decision to seek additional assessment information is based on the results of the speech and language evaluation.

Interpreter/translator: The responsibility of the interpreter/translator is to assist the assessment personnel in gathering information from the family, explaining the assessment process, administering the evaluation, and translating written information between the program personnel and the family. An interpreter primarily exchanges the information between the family and staff orally, and the translator provides the required information in written form. A sign language interpreter provides visual interpretation of the information that was presented orally. The interpreter/translator may be an invaluable resource in identifying cultural issues and values and in training personnel to recognize them and their potential impact on the assessment process for the child and family. See Appendixes B and C for additional information about using interpreters.

Auxiliary personnel: Auxiliary personnel in assessment may include the adaptive physical education teacher; occupational or physical therapist; audiologist; and specialists in the areas of visual, orthopedic, and hearing impairments. Depending on the nature of the referral, the suspected disability of the child, and the makeup of the assessment team, those individuals may participate in the assessment. Their primary responsibility in assessment is to provide evaluation and expertise related to their specific discipline; assist the team in determining the child's and family's eligibility and making recommendations about placement and services; and develop goals, objectives, and outcomes suited to the child and family.

Administrator or service coordinator: The administrator or service coordinator is responsible for overseeing the assessment process and for ensuring that the team has adequate training, materials, and time for the appropriate assessment of young children. Although some administrative responsibilities may be delegated, the program administrator or service coordinator must ensure accountability in, and coordination of, the assessment process.

Eligibility of Infants and Toddlers

The law states that an infant or toddler must have a disability to be eligible for special education and related services and need intensive special education and services because of that disability (*Education Code*, Part 30, Section 56026). *California Code of Regulations (CCR), Title 5*, Section 3030, is more specific about the definition of a disability, and Section 3031 details which children are considered in need of intensive special education and services.

Disabling Conditions

An infant or toddler is qualified to receive special education and related services if he or she has one or more of the following conditions (*5 CCR* 3030):

a. Hearing impairment
b. Hearing and visual impairment
c. Language or speech disorder
d. Visual impairment
e. Severe orthopedic impairment
f. Other health impairment
g. Autisticlike behaviors
h. Mental retardation
i. Emotional disturbance
j. Specific learning disability

These categories are somewhat different from those used to report the number of children served in CASEMIS (California Special Education Management Information System). The reportable conditions of children served correspond to federal requirements for children who are three to twenty-two years of age. CASEMIS contains data on the following categories of disabilities: autism, deaf-blindness, deafness, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, emotional disturbance, specific learning disability, speech or language impairment, traumatic brain injury, and visual impairment. The eligibility of children under three years of age does not fall under the federal requirements of Part B of IDEA and is determined by using the categories in *5 CCR* 3030. However, program administrators should also be prepared to disaggregate data on those children who are deaf or who have a traumatic brain injury, a hearing impairment, or multiple disabilities (for the purposes of reporting pupil counts).

Need for Intensive Special Education and Services

An infant or toddler is considered in need of intensive special education and services if he or she also meets the requirements set forth in *5 CCR* 3031 in combination with *5 CCR* 3030. There are three ways in which a child may meet those requirements:

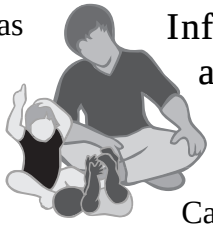
- The child is functioning at or below 50 percent in any one skill area for the child's chronological age. The skill areas are gross and fine motor development, receptive and expressive language, social and emotional development, cognitive development, and visual development.
- The child is functioning between 51 percent and 75 percent of his or her chronological age in any two (or more) of the skill areas (listed above).
- The child has a disabling medical condition, such as a visual impairment, deaf-blindness, a hearing impairment, a severe orthopedic impairment, or a congenital syndrome that the individualized family service plan (IFSP) team determines has a high predictability of requiring intensive special education and services.

If an infant or toddler is eligible for special education services, she or he is also eligible for services under state and federal Early Start requirements. In 1993 California enacted the California Early Intervention Services Act, implementing Part H (now Part C) of IDEA. This program is known as Early Start in California. The requirements for Early Start may be found in the *Government Code*, Part 14, Section 95000, and in the *California Code of Regulations, Title 17*, Section 52000. Under state and federal requirements, the three categories of eligibility for Early Start are as follows:

1. *Developmental delay*. An infant or toddler is considered to have a developmental delay when there is a significant difference between the expected level of development and the current level of functioning in one or more of the following developmental areas: cognitive development, physical and motor development (including vision and hearing), communication development, social or emotional development, or adaptive development. Most children found eligible for special education have a disability and a significant developmental delay. Therefore, they meet the eligibility requirements for Early Start.
2. *Established risk conditions*. An established risk condition is a condition that

has a known origin (etiology) and has a high probability of resulting in a developmental delay even though the delay is not evident at the time of diagnosis. Children who have a disability and have a disabling medical condition or syndrome that the IFSP team determines has a high predictability of requiring intensive special education and services qualify for Early Start under this category. Low-incidence disabilities are established risk conditions.

3. *At risk of a developmental disability (regional centers only).* An infant or toddler is considered at risk of a developmental disability when a multidisciplinary team determines that a child has a combination of two or more risk factors that require early intervention services. The risk factors are listed in Early Start regulations (17 *CCR* 52022 [c]). Children identified as at risk of a developmental disability are not considered eligible for special education unless they also meet the requirements contained in the *Education Code* and *5 CCR.* Being found at risk is not considered a disabling medical condition or a congenital syndrome requiring intensive special education and related services under *5 CCR* 3031. Children meeting the definition of being at risk of a developmental disability are considered eligible for services from the regional center.



Infants and Toddlers with a Solely Low-Incidence Disability

With the enactment of the California Early Intervention Services Act in 1993, LEAs became responsible for serving all infants and toddlers who have a solely low-incidence disability. Under state law and regulations for Early Start, a solely low-incidence disability means one disability or a combination (vision, hearing, orthopedic impairment) that is the primary disability and has a significant impact on the child's learning and development. The determination of a solely low-incidence disability is made by the IFSP team of the LEA. The infant or toddler who has a solely low-incidence disability is not eligible for services from a regional center.

To be considered to have a solely low-incidence disability, a child must meet the appropriate eligibility criteria under *5 CCR* 3030 and 3031. All children who meet criteria under Section 3030 for one or more of the low-incidence disabilities (and for whom the low-incidence disability is considered the primary disability) are considered eligible for special education and related services as well as Early Start because, under state Early Start regulations (17 *CCR* 52022[b][2], the existence of a low-incidence condition constitutes an established risk condition.

Assessment of the Developmental Domains of Infants and Toddlers

Assessment serves several purposes: It helps to determine the child's eligibility for programs and services, ascertains the strengths and concerns of the child and family, establishes the child's present levels of functioning, directs the development of a plan for intervention, and notes the child's progress. All areas of development and health status of children ages birth to three years must be assessed. Additional *Education Code* requirements state that all children assessed must have a hearing and vision assessment before the first IFSP and IEP are developed unless parental consent is denied.

The following sections describe each developmental domain and include suggestions for assessment strategies. In all domains the results will be most accurate when the assessment is completed in a variety of contexts, including the home, and when each domain is viewed in relation to others.

Cognitive Domain

The cognitive domain encompasses a child's ability to learn from past and novel experiences. Infants' skills include early object use, interaction with the environment, object permanence, and understanding of cause and effect. The

skills of older toddlers and preschoolers include verbal and nonverbal problem solving, symbolic play, memory, attention, discrimination, classification, sequencing, numeric reasoning, visual perception, and visual motor integration. A profile of a child's cognitive development should be obtained by incorporating information collected from various sources, including information from parents and caregiver, formal and informal observations in a variety of settings, play-based and standardized assessment, when appropriate, and a review of developmental concerns.

Physical Development Domain

The physical development domain encompasses both large and fine motor abilities. Large motor skills include rolling; creeping; crawling; and balance and mobility in standing, walking, running, and hopping. Other aspects assessed as part of this domain are the child's range of motion and quality and integration of movement and muscle tone. Fine motor skills include oral motor movement for feeding and speech; manual grasp and release; and the ability to reach and to use small muscles for self-help and drawing. Assessment takes into account the young child's regulatory and sensory system by determining patterns of consistency in sleeping and eating and the ability to comfort himself or herself. Information is obtained through formal and informal observations or a report of a child's skills and abilities in those areas.

Health Domain

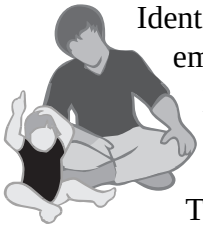
The health domain includes the child's birth and developmental history, current health information, current diagnoses, medications and possible effects, required medical procedures, current medical supplies and technological devices, primary and specialty care providers, neurological status, nutrition, feeding and oral health, immunizations, hearing, and vision. Qualified assessment team members evaluate the impact of the child's health problems on his or her development and assess prenatal, perinatal, and general health conditions that may increase the child's vulnerability and risk. Information on physical development and health is obtained from parents, health care providers, medical records, and other sources as well as by direct assessment and observation of the child. Because accurate screening of young children's hearing and vision may be difficult, specific procedures have been developed for this age group. The recommended procedures are outlined in the publications *Ear-Resistible: Hearing Test Procedures for Infants, Toddlers, and Preschoolers, Birth Through Five Years of Age (*1998) and *First Look: Vision Evaluation and Assessment for Infants, Toddlers, and Preschoolers, Birth Through Five Years of Age (*1998).

Communication Domain

The communication domain covers both verbal and nonverbal modes. It encompasses preintentional and intentional communication, speech development, receptive and expressive language development, gestures, body movement, and posture. Areas of language and speech development encompass articulation (sound development), semantics (word meaning), morphology (grammar), syntax (word order), pragmatics (how language is used in relation to others), voice, and fluency. Communication and language should be assessed in an interactive, meaningful context in which the child is encouraged to initiate communication. Differences in communication between home and school or other less familiar surroundings should be noted. The assessment should be based on information provided by parents, other caregivers, and a variety of sources, including structured

and unstructured conversations, play-based assessment, and standardized assessment, when appropriate.

Social–Emotional Domain



Identifying infants and toddlers with emotional disturbance requires the participation of professionals with expertise in mental health and behavioral interventions. The Infant Mental Health Work Group has made recommendations regarding screening, assessment, and interventions for children from birth to three years. It urges team members, in the family-centered assessment, to discuss the following areas with parents:[6]

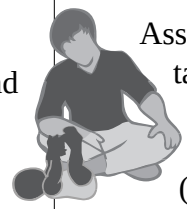
- Emotional and social vulnerabilities of infants/toddlers who are at risk or who have developmental disabilities, and the role they may play
- Infant/toddler cues and special developmental needs that affect social and emotional well-being
- Characteristics of the caregiving environment
- Family strengths, concerns, needs, and resources
- Social support networks
- Significant life stressors

The comprehensive assessment includes information on the presenting behavior, the infant's temperament, parent-child interaction patterns, and the full-scale developmental assessment components for young children.

Social–emotional development means the acquisition of capacities for human relationships, emotional expression, communication, and learning. Social–emotional development is based on the motivation to engage in positive interaction and to sustain personal relationships and precedes the development of effective coping skills, self-esteem, and the ability to take advantage of opportunities for learning. Differences in temperament, self-regulation, range and intensity of affect, and modulation of one's response to the environment are additional factors influencing social–emotional development.

An assessment of a child's social–emotional development includes observations of the attachment of the child to the parents or guardians; relationships and interaction with other adults and peers; and the child's temperament, awareness of social roles and conventions, initiation of reciprocity, and motivation. Social–emotional skills are assessed by observing or reporting a child's ability to gain attention appropriately from and respond to others, express affection and protest, ask for help when a task is too difficult, and engage in interactions with adults and then with peers.

Adaptive Domain



Assessment of the adaptive domain takes into consideration the various abilities of a child to adapt and function within the environment (for example, self-help skills; interaction with toys, other objects, and family members and peers; activity level; attention span; and motivation). Use of a standardized form or informal interview/questionnaire with one or more parents or family members may be an effective way in which to acquire information about the child's functioning in the home environment. The information should reflect the values and culture of the family. When a child is in child care or a school program, information may also be obtained by consulting an adult who has knowledge of the child in that setting.

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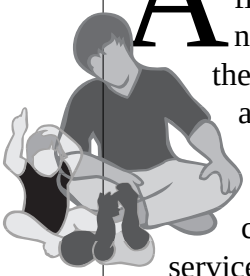
[6] Adapted from *The California Infant Mental Health Work Group Report.* Sacramento: California Department of Developmental Services, 1996, p. 17.

Family Assessments



A **family** assessment, which identifies the family's strengths and needs, is a required component of the assessment process for children ages birth to three years. This information is required under IDEA, Part C, as part of the child's individualized family service plan (IFSP). The family assessment is a *voluntary process* that has been established, not to rate or evaluate a family, but rather to assist the team in understanding the outcomes that families want for themselves and their children and the ways in which the team can assist them in achieving those outcomes. The categories that have been defined for the family assessment are family concerns, family priorities, and family resources.

Family concerns are the issues or problems that the family wishes to address as a part of the IFSP. Priorities are defined as the family's determination of what is the most important to them—how services and outcomes noted on the IFSP fit into the family's daily life. Resources are those items that the family identifies as providing support related to the child and the family's concerns. It is important to give families multiple opportunities to

identify their concerns, priorities, and resources during the assessment process. The following principles should be considered when team members help the family to identify concerns, priorities, and resources:[7]

- The inclusion of family information in the IFSP is voluntary on the part of families.
- The family identifies its concerns, priorities, and resources in accordance with the aspects of family life that are relevant to the child's development.
- A family need or concern exists only if the family perceives that the need or concern exists.
- Families have a broad array of formal and informal options in determining how they will identify their concerns, priorities, and resources.
- Assessment personnel respect family confidences and refrain from casually discussing information shared by the family with other staff members.

The methods that professionals use with families to gather this information can make a difference in the relationship that is established between program staff and the family. It is important to view the assessment process as collaborative and nonintrusive and to allow the family to take the lead in sharing information and expressing its opinions about important issues and resources. Respecting the family's ability to identify its own strengths, concerns, and needs, as well as being sensitive to the family's cultural and child-rearing values, fosters a strong reciprocal relationship between the professionals and the family. Although many areas of need may be identified, they should always be limited to those that the family decides are important to the development of the child. The following principles should be considered:

- Establish open, two-way communication.
- Allow ample time to discuss the issues that the family member introduces.
- Be an active listener.
- Be willing to meet with the family as often as necessary throughout the process.

Identifying concerns, priorities, and resources may be difficult for a family, particularly if this is the family's first encounter with the IFSP process. The use of a self-assessment checklist or survey may be helpful in bringing up and clarifying issues that a family might not have thought about before. The checklist or survey may be completed privately or with the help of a team member. It should not be used as the sole method of collecting this information and should *never* be considered a written evaluation of the family.

Sometimes, families are initially unable to disclose much information in the assessment process. A service coordinator may assist by focusing on the family's strengths and supports, which include human and financial resources. An example of a question asked to identify human supports is, "If your child took his first steps, whom would you call?"

One objective of this process is for family members to leave with the knowledge that they have control over decisions regarding their child and the identified systems of support. Families need to know that it is acceptable to ask for help and for the names of individuals who can provide assistance. Appendix D contains suggestions for teachers and administrators gathering information from families.

[7] Adapted from Roxane Kaufmann and Mary McGonigel, "Identifying Family Concerns, Priorities, and Resources," Chapter 6 in *Guidelines and Recommended Practices for the Individualized Family Service Plan* (Second edition). Edited by Mary McGonigel and others. Bethesda, Md.: National Early Childhood Technical Assistance System (NECTAS) and Association for the Care of Children's Health (ACCH), 1991, pp. 48–51.

Eligibility of Preschool-Age Children

Criteria regarding the eligibility of children ages three through five years of age are established in *Education Code* Section 56441.11. Under this section a child is eligible for special education and related services if he or she meets criteria for the following conditions:

- Autism
- Deaf-blindness
- Deafness
- Hearing impairment
- Mental retardation
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Emotional disturbance
- Specific learning disability
- Speech or language impairment in one or more areas of voice, fluency, language, or articulation
- Traumatic brain injury
- Vision impairment
- Established medical disability

Established medical disability is defined under *Education Code* Section 56441.11 as a disabling medical condition

or congenital syndrome that the IEP team determines has a high probability of requiring special education and related services. A child who has been diagnosed as such but is not currently exhibiting a delay may be found eligible under this category. In an effort to make this category consistent with federal law, the California Department of Education is reconsidering this category; state statutory changes may be made.

The IEP team must also determine that the child needs specially designed instruction or services; that the needs cannot be met with modification of a regular environment at home or in school; and that he or she meets the eligibility requirement under *5 CCR* 3030. Although the current language in *5 CCR* 3031 defines the eligibility requirements for children up to the age of four years, nine months, *Education Code* Section 56441.11 supersedes that section. Therefore, children over the age of three years do *not* have to meet the requirement for intensive special education under *5 CCR* 3031.

Assessment of All Areas of the Suspected Disability of Preschool-Age Children

The assessment process for preschoolers is similar to the one for infants and toddlers. One key similarity is the need to use multiple measures when determining a child's eligibility and planning the services needed. The statute (IDEA Section 614[b]) requires that a variety of assessment tools and strategies be used to gather relevant functional and developmental information, including information from the parent. Preschoolers, however, do not have to be assessed in all areas of development; only areas of the suspected disability are assessed.

A key difference between the assessment process for preschoolers and the process for infants/toddlers is that preacademic performance is assessed. IDEA, Part B, Section 300.532(g), requires children to be assessed in all areas of the suspected disability, including (if appropriate) health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. IDEA Section 614(b) requires the assessment of preschoolers to include information related to enabling the child to be involved and progress in appropriate activities for preschool children. State requirements regarding the eligibility

of young children for special education include all the disability categories contained in IDEA, Part B.

Assessment for Autism

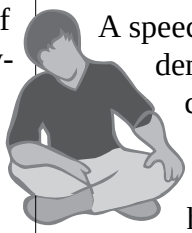
Autistic spectrum disorders is a category of disorders that includes autistic disorder, Asperger disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), Rett's disorder, and childhood disintegrative disorder. These disorders are all characterized by impairments in social interaction and communication and by a limited range of interests and activities. The assessment should emphasize the areas of communication, social interaction, behavior, play, attention and activity, cognition, and sensorimotor functioning. The publications *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* and *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (see Selected References) may provide guidelines for diagnosis. In school districts a team may determine a child is eligible for special education under the provision for autisticlike behaviors specified in *5 CCR* 3030(g).

A child suspected of having autism or a pervasive developmental disorder similar to autism will exhibit severe difficulties in relating and communicating with others and in regulating his or her physiological, sensory, attentional, motor, cognitive, somatic, and affective processes.

Methods of assessment are tailored according to a child's age, developmental level, diagnosis, and areas of need. The methods may include the use of standardized assessment tools, developmental assessment approaches, a developmental history, a medical history, a family interview, a review of records, natural and structured observations in multiple settings, a functional analysis of behavior, documentation of symptomatology, and a family assessment. Several instruments are available to assess the characteristics of autism, although few standardized instruments for children under the age of five exist.

For more information, review the publication *Best Practices for Designing and Delivering Effective Programs for Individuals with Autistic Spectrum Disorders* (1997).

Assessment for Speech and Language Disorders



A speech or language disorder is demonstrated by a child's difficulty in understanding or using spoken language to such an extent that it adversely affects his or her educational performance and cannot be corrected without special education and related services. The assessment team includes a speech, language, and hearing specialist who determines that the difficulty results from any of the following disorders: articulation; abnormal voice; fluency; inappropriate or inadequate acquisition, comprehension, or expression of spoken language; or hearing loss (*Education Code* Section 56333). A speech, language, and hearing specialist often uses a language sample in assessing verbal expression in young children.

For more information, refer to the publication *Program Guidelines for Language, Speech, and Hearing Specialists Providing Designated Instruction and Services* (1989).

Assessment for a Specific Learning Disability

A preschool child with a specific learning disability may be eligible for special education and related services when the assessment results indicate

that there is a significant developmental lag between the child and children of the same age. The IEP team determines what is significant. Federal law does not require a minimum threshold (i.e., percentage of developmental delay) for preschoolers as it does for infants. Preschoolers may demonstrate differences or lags in development that represent extremes within the normal range. Many educators believe that it is inappropriate to call such variations disabilities and that it is inaccurate to diagnose a preschool child as learning disabled because of those variations.

Many assessors feel uncomfortable labeling a preschool child with a specific learning disability because they are unable to establish a severe discrepancy between the child's intellectual ability and achievements in academic areas.

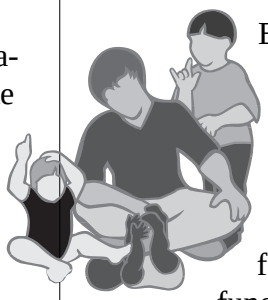
Although IDEA permits the option of identifying young children with disabilities under the category of *developmental delay*, the California Department of Education has not adopted developmental delay as a criterion of preschoolers' eligibility for special education (*Education Code* Section 56337).

Informed observation (based on knowledge of typical and atypical child development) and clinical opinion are the primary assessment tools to be used for children under five years suspected of having a learning disability. Standardized tests for young children of this age are often not valid or reliable.

Attention deficit and hyperactivity disorders may adversely affect a preschool child's development or educational performance or both. Children diagnosed with attention deficit or attention deficit hyperactivity disorder can meet eligibility criteria under the following categories: specific learning disability, serious emotional disturbance, or other health impairment (*Education Code* Section 56339).

For more information, refer to *Mainstreaming Preschoolers: Children with Learning Disabilities* and *I Can Learn: A Handbook for Parents, Teachers, and Students* (see Selected References).

Assessment for Visual Impairments



Every child is required to have a vision and hearing assessment prior to the first IEP (*Education Code* Section 56320). The term *visually impaired* includes, for educational purposes, functionally blind students (who because of the severity of their visual impairment rely basically on senses other than vision as their major channels for learning) and low-vision students (who use vision as a major channel for learning). A visual impairment does not include visual perceptual or visual motor dysfunction resulting solely from a learning disability.

Assessments for children with a suspected visual impairment typically begin with an eye report from an ophthalmologist or optometrist. This report describes the child's near and distant visual acuity with and without best possible correction; field of vision; the etiology of and prognosis for the visual impairment; and the eye specialist's recommendations for school personnel and parents.

A teacher of the visually impaired, the orientation-and-mobility specialist, and the child's family conduct a functional vision assessment. The functional vision assessment determines what the student sees functionally in a variety of educational situations and settings; is used to evaluate how or when the vision impairment might adversely affect the student educationally; is used to evaluate the student's ability to move efficiently, safely,

and independently in multiple environments; provides one criterion for the determination of the appropriate reading and learning media; and is used to identify vision-related needs.

For further information, refer to the Department publication *Program Guidelines for Students Who Are Visually Impaired* (1997).

Assessment for Hearing Impairments

The preferred practice for conducting hearing evaluations and assessments of preschoolers with a suspected hearing loss includes reviewing the child's medical or case history; making informal observations of the child's behavior; listening to parental concerns; reviewing reports; and beginning hearing test procedures appropriate for the age, development, and unique needs of the child. Hearing test procedures may include electrophysiological testing, otoacoustic emission response measures, and behavioral assessment measures. Optional procedures include tympanometry in conjunction with electrophysiological, acoustic emittance, or behavioral assessments, and a visual inspection of the external ears.

For further information, refer to the Department publication *Ear-Resistible: Hearing Test Procedures for Infants, Toddlers, and Preschoolers, Birth Through Five Years of Age* (1998).

Assessment for Orthopedic Impairments

The term *orthopedic impairment* includes those impairments caused by congenital anomalies, diseases, and other conditions. Conditions resulting in severe orthopedic impairments include, but are not limited to, cerebral palsy, muscular dystrophy, spina bifida, spinal cord injuries, head traumas, juvenile rheumatoid arthritis, and tumors. A severe orthopedic impairment is persistent and significantly restricts an individual's physical development, movement, and activities of daily living. As a result, this impairment may affect the pupil's educational performance. Accompanying sensory, intellectual, behavioral, learning, and medical problems often occur that may also affect the pupil's school performance.

The assessment team must include a teacher of individuals who are orthopedically impaired and other persons who are knowledgeable about the implications of the orthopedic condition on the pupil's ability to learn. Assessment data are gathered from the family physician and professionals representing other public and private service agencies, such as regional centers, the California Children Services branch of the Department of Health Services, hospitals, and rehabilitation centers. When preparing the assessment plan, the assessors must consider whether the child:

- Has sensory impairments, limited physical movements, or severe speech impairments
- Needs speech aids or an augmentative mode of communication
- Has a primary language other than English
- Needs assistive technological devices or specialized services
- Needs specialized physical health care services

Assessment team members may include a vision specialist, an occupational therapist or physical therapist, and a specialist in assistive technology.

For more information, refer to the Department publication *Program Guidelines for Individuals Who Are Severely Orthopedically Impaired* (1992).

Assessment for Emotional Disturbance

In an assessment for a suspected emotional disturbance, the team must determine whether the child has one or more of the conditions named in IDEA and assess the nature of the child's social maladjustment. The IEP team member who conducts the mental health portion of the emotional disturbance assessment must have training and experience in assessing emotional function and use a variety of instruments and procedures.

The psychoeducational assessment of the child should include assessment in the following areas:

- Health background (developmental history, emotional history, medications, major illnesses and hospitalizations, and current health status)
- Functioning in the home and community (socioeconomic background; language; cultural and educational background; family experiences, including losses and stresses)
- Functioning in school (attendance, achievement, adjustment, behavior in academic and nonacademic situations)
- Behavior (assessment of the student's behavior in the context in which it occurs, exact description and definition of the problem, function of the behavior, analysis of what happens before and after the behavior occurs)
- Social–emotional status (includes specific tests and techniques validated to determine the extent of conditions such as depression)
- Previous evaluations (record review, parent report, and information from other agencies)
- Interviews and self-reports (interview or structured self-report instrument completed by the parent, teacher, or student and observation of the student in a different setting)
- Pervasive nature of the condition (the presence of the condition and its pervasiveness in the student's environment as cross-validated by observation and interviews with parents, teachers, and staff personnel)
- Educational performance (assessment of the child's ability to function in the learning environment to determine whether the condition adversely affects the preschool child's educational performance)
- Cultural differences (a determination that the child's conduct is not due to cultural, ethnic, or language differences)

For more information on assessment, refer to the publication *California Programs and Services for Students with Serious Emotional Disturbances.* [8]

[8] *California Programs and Services for Students with Serious Emotional Disturbances.* Sacramento: Resources in Special Education, California State University, Sacramento, 1991, pp. 35–36.

Preparation for the Assessment

Awareness of one's own culture is a first step in recognizing the cultural diversity of others.

—Barbara Lowenthal, "Training Early Interventionists to Work with Culturally Diverse Families," *Infant–Toddler Intervention*

Planning is necessary for a successful assessment of a young child. Many assessment teams conduct planning meetings, either regularly or on a case-by-case basis. Setting aside time regularly for planning assessments is recommended to maintain continuity and to build the working relationship of those conducting the assessments. If conflicting schedules make this option impossible, a conference call for discussion, at a minimum, is imperative to conduct an accurate assessment. A team of professionals can provide transdisciplinary expertise and interagency coordination for children served by multiple agencies. After the first communication with the parent, the team meets to discuss an assessment plan based on the needs of the child and family. This meeting includes a comparison of test protocols and identification of common items to ensure nonduplication by professionals and the comfort of the family.

For each child referred, the assessment team answers the following questions:

- What are the concerns of the family and the referral source?
- What information exists regarding this child? What additional information is needed?

- Who will be involved in the assessment?
- Where will the assessment be conducted (at home, in the family child care home, preschool center, assessment center, or a combination)?
- What needs to be in place to ensure accurate information on the child's abilities and needs?
- What tools and procedures will be used to gather information?
- What role does the child's health or physical disability play?
- Are other agencies currently involved with the child and family?
- Who will be the primary contact with the parent?

Once those questions have been answered, the designated case manager or service coordinator contacts the parent to begin the assessment process. It is the manager's or coordinator's responsibility to explain the process and the rights of the parent and child regarding assessment, to gather the information that has been identified during planning, and to help put the family at ease. This initial communication with the family ensures that the family is comfortable with the assessment, that the process proceeds smoothly, and that it is completed within a time frame that meets legal requirements and the family's needs. Planning with the parent is critical to the success of an assessment. Successful preparation takes time; the family may need help to understand the assessment content and procedures and feel comfortable with the assessment process.

At the planning meeting with the parent or guardian, make sure that the following tasks are accomplished:

- Determine whether an interpreter is needed and provide one if necessary.
- Acquire written parental consent to conduct the assessment.
- Provide information about the purpose, steps, and time frame of the assessment.
- Explain the parent's and child's rights related to the assessment and answer any questions the parent may have.
- Discuss the parent's role in the assessment process and encourage parental participation in the process to the extent that the parent is comfortable and is willing to participate.
- Obtain the consent of the parent for the release of needed medical, therapy, and developmental records.
- Agree on the best time, location, methods, and sequence for the assessment that are suited to the child's feeding and sleeping patterns and temperament.
- Agree on adaptations that may be necessary in the assessment environment.
- Gather information regarding legal custody, if necessary.
- Gather background information that may be useful, such as other agency involvement, prior assessments, and cultural issues.

In addition, take into account the following information to establish the assessment setting:

- Ask questions and solicit the concerns of other persons knowledgeable about the child (e.g., clinic, preschool, or child care personnel).
- Determine the parent's preference for places in which the child should be observed (e.g., home, preschool, child care setting, hospital).
- Determine the time of day that is best for the parents and when the child is most alert.
- Identify toys or activities that will help the child to be focused, motivated, and comfortable.
- Determine the role that the parent wishes to take during the assessment.

Establishing rapport with the child is critical to the success of the assessment

process. The California Association of School Psychologists has identified the following ways to build rapport:[9]

- Take cues from the child during the assessment process.
- Use the child's favorite toys or interests to engage him or her.
- Know and use the parent's vocabulary with the child.
- Involve the parents in the assessment if they agree to do so.
- Sit down at the child's level rather than have the child sit at an adult-sized table.
- Allow the child to play and explore the environment.
- Make transitions quickly and smoothly between materials and activities.

Information from Parents or Guardians

Typically, the information that accompanies the initial referral is only a small portion of what is needed in a comprehensive developmental history. More information may be obtained through written questionnaires sent or given to the family. One of the best methods of gathering information about a child age birth to five years is through a conversation with the parent. The kind of questions asked and the method used for gathering this information are important in determining the depth of information to be obtained. In most interviews about a child's developmental history, specific questions are asked, such as, "When did your baby first roll over?" or "Does your baby have differentiated cries for different needs?" These questions may be difficult for a parent to answer and, at best, will provide only limited specific information. The use of conversation and open-ended questions will be more likely to set a parent at ease and elicit in-depth information. See Appendix D for further information on questions to ask parents in interviews.

Information from Other Sources

To accurately assess the developmental levels of a young child, gather information from as many different sources as possible. Ask parents about the following sources:

- Birth records and any other hospitalizations
- Names and locations of the primary health provider and all physicians, including specialists
- Child development, Head Start, or child care program staff

[9] *Best Practices in Early Childhood Assessment Manual.* Edited by Diane Ashton. Millbrae, Calif.: California Association of School Psychologists, 1990, p. 13.

- Past and current regional center records
- California Children Services (CCS)
- Clinics or service providers, such as Shriner's Hospitals for Children or the Easter Seal Society
- County public health department records
- Women, Infants, and Children (WIC) nutrition program
- Audiologist(s)
- Private service providers, such as a speech therapist or occupational or physical therapist
- Social services agencies
- Mental health providers
- Former school district programs

Find out whether any of the current or previous providers already have copies of the records mentioned above that may be sent directly to the assessment team. For example, if a child is a current or past client of the regional center, the medical records may be sent at the request of the parent. Contacting the regional center rather than all the physicians and hospitals individually may save considerable time and effort.

Once information sources have been identified, the parent or guardian must provide written consent to release the records to the assessment team. In some instances there may be reports that the parent does not wish to have included. In other instances it may be the first opportunity the parent has had to review written records from other agencies. To make the assessment process easier and more timely for all involved, many school districts and agencies in communities have developed an interagency authorization form for the exchange of confidential information. See Appendix E for a sample form for an interagency exchange of information.

Information about a child's medical diagnosis and health status is a central element in the assessment process and in the development of the IEP/IFSP. It is important to note the influence of health conditions on the child's development and to determine whether any health conditions place restrictions on the child or require specialized health care services. Berman and Shaw describe the importance of two-way communication between the health care community and other professionals working with young children. "Information from a health evaluation can enable staff to design more appropriate programming for a child and may uncover a physical basis for learning difficulties or lack of progress."[10] Similarly, the sharing of developmental information may help the health care provider plan appropriate medical care for the child.

The following strategies enhance regular communication between health care providers, early intervention specialists, and preschool program staff:[11]

- Provide written information free of jargon.
- Incorporate health status information in the IFSP and the IEP.
- Encourage health care providers' participation in the assessment and IFSP process.
- Pursue mechanisms to reimburse medical and health personnel for their participation in these processes.
- Plan to implement and integrate health interventions within the educational setting

When background information is not readily available, the team should so note that omission in the written assessment records.

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[10] Carol Berman and Evelyn Shaw, "Family-Directed Child Evaluation and Assessment under the Individuals with Disabilities Education Act (IDEA)," in *New Visions for the Developmental Assessment of Infants and Young Children*. Edited by Samuel Meisels and Emily Fenichel. Washington, D.C.: Zero to Three, 1996, p. 373.

[11] Ibid, pp. 373–374.

Cultural Diversity in Assessment

The more the assessment team understands the cultural values of the family, the more successful the interactions and assessment will be. Each assessment team member brings his or her own set of beliefs, customs, and values to any situation. It is important to recognize one's own values and assumptions first before one can begin to understand the cultural differences of another family. Lowenthal cites important issues for staff to recognize in working with families of diverse cultures: differences in family structures, diverse child-rearing practices and styles of communication, different perspectives about the cause of the disabilities and the value of interventions, and socioeconomic difficulties. [12]

It is also important to recognize that a family may or may not hold the general viewpoints that are attributed to its ethnic culture. Each family's cultural practices will vary.

When working with families from diverse cultures, keep in mind the following guidelines:

- Recognize the language, ethnicity, culture, structure, and preferences of the family.
- Conduct the assessment in the family's language of choice (use an interpreter/translator if necessary).
- Consider whether the normative samples included members of the family's cultural group before using a particular instrument.
- Recognize differences in child-rearing practices that may affect a child's performance in a particular area.

[12] Barbara Lowenthal, "Training Early Interventionists to Work with Culturally Diverse Families," *Infant–Toddler Intervention*, Vol. 6, No. 2 (1996), p. 146.

Assessment Methods

Assessment practices with young children encompass a variety of general methods, perspectives, and tools. As mandated by law, no single test measurement may be used in the assessment process. A brief description of types of assessment tools follows. For additional information on specific assessment tools, contact the Early Start Resources office at (916) 492-9990 or (800) 869-4337 or CalSTAT (California Services for Technical Assistance and Training) at (707) 664-3160.

Screening Tools

Screening tools are used primarily to identify a suspected area of concern related to a child's development that may warrant further evaluation. These tools are *not* appropriate to use for the determination of eligibility for special education programs and related services. Screening measures take a sampling of a few skills that may indicate a need for a diagnostic assessment. The measures are generally more reliable when used with children ages three to five years than with infants and toddlers.[13] Because of the small sample of behaviors that they mea-

[13] Samuel Meisels and Sally Provence, *Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families.* Washington, D.C.: Zero to Three, 1992.

sure, screening tools may not identify all children in need of referral. Screening tools should not be the only method for such identification, or child find; rather, the use of ongoing observation, parent interview, and information from other care providers along with a screening measure increases the accuracy of the identification procedure.

Traditional Methods

Traditional assessment methods include standardized tests and systematic observations. Assessment tools may be norm-referenced or criterion-referenced and may measure one or more developmental domains. The purpose of an early childhood assessment is to gather information about a child's performance in order to plan an educational and developmental program that meets a child's specific needs.

Norm-ReferencedAssessment Tools

These tools are used to evaluate various developmental areas while the child is engaged in specific activities. Test items must be administered in a prescribed way to be valid. A child's responses are compared with those of a normative sample of same-age peers. The child's raw score is converted to a standard score within a range or a percentile rank. The validity of the measurement should be judged, in part, by comparing the makeup of the children in the normative sample with the characteristics of the child being tested. The California Association of School Psychologists has determined that:

> Traditional instruments are inappropriate for assessing certain groups of children with disabilities or who are from culturally or linguistically diverse backgrounds. School psychologists who assess young children often make adaptations to the standardized instruments and interpret their findings based on item analysis. This use of item analysis must be described in the assessment report. Reliability and validity of these traditional tools with the preschool population are, at best, generally low. Under non-standardized conditions of administration, results need confirmation by use of a multimeasure approach, using other assessment tools, as well as observational and interview data.[14]

Criterion-ReferencedAssessment Tool

These tools are used to evaluate a child's performance against a specific criterion. Skills are typically assessed according to a scale on the assumption that skill acquisition follows a sequential pattern. These tests are used to determine a child's level of functioning within a developmental domain. Test results are typically reported within an age range, and a list is presented of the specific tasks a child is or is not able to perform.

Curriculum-BasedAssessment Tools

These tools are criterion-referenced but use the child's natural environment and ongoing activities and materials in the home, classroom, or child care setting as the source of information collected. Rather than measure a child's achievement against external norm-referenced data, these tools rate skills against previous performance along a developmental continuum of instructional objectives. These tools are best used for planning the child's instructional program or intervention. This type of assessment generally uses a single set of observations at specified times for data collection rather than the information gathered during ongoing observations. The assessment can be used to determine a child's rate of learning, ability to make generalizations, and learning style.

[14] *Best Practices in Early Childhood Assessment Manual.* Edited by Diane Ashton. Millbrae, Calif.: California Association of School Psychologists, 1990, p. 16.

Alternative Methods

Alternative assessment approaches are highly recommended for children ages birth through five years. Such approaches are a more realistic way to obtain valid information about a child's knowledge, skills, and abilities. Greenspan and Meisels identified several issues regarding assessment design:[15]

> Assessment approaches that rely on structured tasks or questions in early childhood are marked by recurrent practical problems, which contribute to error in determining early childhood capacities:
>
> - Young children have a restricted ability to comprehend assessment cues.
> - Young children's verbal and perceptual-motor response capabilities are limited.
> - Some types of questions require complex information-processing skills that young children do not possess.
> - Young children may have difficulty understanding what is being asked of them in an assessment situation, and they may not be able to control their behavior to meet these demands.

In addition, children who have disabilities may not develop according to the usual sequential pattern. Alternative assessment approaches are described below.

Play-Based Assessment

This method is a highly recommended form of alternative assessment. All developmental areas can be assessed, and there is a greater likelihood that the child will demonstrate his or her true abilities in this setting. Play-based assessments yield information to develop a plan for intervention, to make recommendations for goals or outcomes for the child and family, and to evaluate progress. The assessment may be conducted in any play setting, depending on the needs of the child, family, and assessment team. Play is a process for intervention as well as for assessment.

The observation of play provides an understanding of the child's development in various areas. Play is generally associated with social–emotional development and the development of relationships between the child and his or her peers and adults. Although there are developmental trends in play, not all children acquire the play skills in the same order or experience them with the same intensity.

Psychologist Diane Ashton describes the following categories of play:[16]

- *Solitary play (all ages):* The child plays alone. This type of play is not necessarily an indicator of immaturity. High-level play may occur.
- *Onlooker play (all ages):* The child watches other people play. This type of play appears to be a passive process whereby the child observes the play levels of other children. The examiner should use caution in interpreting this type of play.
- *Parallel play (one to three years):* Two children pursue similar activities but do not always engage in eye contact or social behavior. Children play alongside each other.
- *Associative play (two to three years):* Children engage in the same or similar activity and may exchange toys or make occasional comments to each other. This type of play lacks organization and organized reciprocity.
- *Cooperative play (four to five plus years):* This type of play is organized

[15] Stanley Greenspan and Samuel Meisels, "Toward a New Vision for the Developmental Assessment of Infants and Young Children," *Zero to Three*, Vol. 14, No. 6 (June/July 1994).

[16] *Best Practices in Early Childhood Assessment Manual.* Edited by Diane Ashton. Millbrae, Calif.: California Association of School Psychologists, 1990, p. 22.

reciprocal play with rules, roles, and individual functions well defined. Give and take is evident. Themes are readily observable.

In addition to social play with peers, as noted, a child develops through other types of play: social play with adults, exploration and functional play with objects, and symbolic and social pretend play. Wolfberg and Schuler characterize the following forms of play: [17]

- *Social play with adults:* Consists of give and take, attachment, and shared attention
- *Exploration and functional play with objects:* Involves simple exploration and shifts to increased organization in the use of toys and other objects
- *Symbolic pretend play:* A highly imaginative play form that moves from simple reenactment of events to the creation of new roles and the use of objects in new ways
- *Social pretend play:* Includes make-believe play that is interactive, with a complex language, social scripts, and rules

Play may be evaluated through direct observation in natural settings or in a formal, established assessment environment. Information may also be obtained from the observations of others and reported to the team. Assessment of play may be a useful way to gather information in various play settings.

Portfolio-Based Authentic Assessment

This method embeds assessment in the child's curriculum and involves gathering information from events throughout the child's school day. Because this method of assessment is not used in an artificial setting, the data collected present a truer picture of the child's skills and abilities. The "Program Advisory on Appropriate Assessment Practices of Young Children," developed by the California Department of Education's Child Development Division, outlines the following ways of documenting children's strengths, developmental needs, and evolving understanding of the world: [18]

- *Informal and formal observation:* Observations may be focused on a specific concept or learning domain (e.g., observing whether the child is able to pedal a tricycle) or on a general record of actions that were observed throughout the course of the day (e.g., the types of interactions that took place with other children over a three-hour class period). Records that are made at regular intervals throughout the year focus on changes and outstanding highlights. For example, observations may focus on play with peers, highlighting the increase in positive interactions with other children in the program. Structured team observations of play in developmentally appropriate settings are valuable to include along with informal observations.
- *Developmental profile:* All publicly funded child development programs require a developmental profile to be maintained on each child enrolled. The profile must record the child's growth in emotional, social, physical, and cognitive domains. It should also include anecdotal records. Data should be gathered during the course of the curriculum rather than through an artificial testing situation.
- *Portfolio:* This is a collection of materials organized to document a child's

[17] Pamela Wolfberg and Adriana Schuler, *Integrated Play Groups.* San Francisco: San Francisco State University, Department of Special Education, 1992, pp. 37–40.

[18] Bill B. Honig, "Program Advisory on Appropriate Assessment Practices of Young Children: Implementing the Recommendations" of *Here They Come: Ready or Not! Report of the School Readiness Task Force* and *It's Elementary! Elementary Grades Task Force Report.* Sacramento: California Department of Education, 1992.

growth in all developmental domains. It may contain the following:

- Developmental profiles
- Examples of the child's developing fine motor skills (drawings, paintings, cutting)
- Photographs and audio or videotape recordings documenting activities in all domains
- Materials showing developing number skills
- Material showing an interest in language and literacy
- Notes of personal and social development
- Parent/teacher conference notes
- Children's observations about themselves
- Teachers' observations of uniqueness

Performance Assessment

This method is similar to the portfolio-based method. Meisels describes it as a way of depicting a child's performance in a developmental area by recording within daily contexts the child's knowledge, skills, changes in temperament, and achievements in relation to specific developmental goals. The child's family and service providers may set goals or outcomes based on developmental expectations for the child's age. Performance assessments are different from other types of assessments because assessment and intervention are combined into one set of procedures.[19]

[19] Samuel Meisels, "Charting the Continuum of Assessment and Interventions," in *New Visions for the Developmental Assessment of Infants and Young Children.* Edited by Samuel Meisels and Emily Fenichel. Washington, D.C.: Zero to Three, 1996, pp. 38–39.

Assessment of Children with Low-Incidence Disabilities

The principles of assessment discussed in this handbook reflect the preferred practices for the evaluation and assessment of *all* children. For some disabilities, however, the assessor requires additional knowledge and skills to accurately evaluate the child's current developmental levels and to determine the appropriate program for the child's educational needs. The team must include individuals with training and expertise in the specific area of disability. This section outlines the characteristics of various low-incidence disabilities and the needs that the assessment team must address. The California Department of Education has published guidelines that contain in-depth information and list the resources pertaining to each disability (see Selected References).

Hearing Impairment

The Department of Education publication *Program Guidelines for Hearing Impaired Individuals* (1986) outlines the characteristics of assessments for this population. The assessment of a child who is deaf or hard of hearing must take into account the conditions that may affect the child's needs. These conditions include the

amount of residual hearing, cause of the hearing loss and age of onset, communication skills, first language, other disabilities, and cultural and linguistic background. Any standardized test measurement will need to be administered in a nonstandardized mode for the hearing-impaired child unless the measurement has been standardized for the deaf population. Specialized assessment instruments and techniques have been developed specifically for the very young hearing-impaired child. These are described in the California Department of Education publication *Ear-Resistible* (1998).

The assessment team must include an audiologist—a person with knowledge and expertise in assessing and intervening with infants, toddlers, and preschool-age children who are deaf or have hearing loss (*Education Code* Section 56320[g]). Some causes of hearing loss, including meningitis, rubella, and neurologically based deafness, may impair the vestibular system. This impairment may result in an adverse effect on equilibrium, body awareness, and visual/motor functioning.

Audiological assessments determine a person's functional hearing level and appropriate amplification needs. It is recommended that children ages birth through three years have their hearing examined by an audiologist every six months and more often if speech or language problems are identified or if they have frequent ear infections. Children over three years of age need an audiogram once a year.

The *Program Guidelines for Hearing Impaired Individuals* also identifies considerations regarding the family's role in the assessment and program planning process and notes: "Parental involvement during the assessment process is crucial in obtaining both the quantity and quality of information required to make the best educational and communication decisions for the hearing impaired child."[20] Information on how parents currently communicate with their child to meet basic needs and socialize and interact with them should be elicited.

Visual Impairment

Determining the vision of young children may begin with a brief vision assessment by the school nurse. The California Department of Education's publication *First Look* (1998) provides in-depth information on vision assessments for children ages birth through five years. When a visual impairment is suspected, the child should be referred to an eye specialist, preferably a pediatric ophthalmologist. Additional information should be obtained from the pediatrician and other medical personnel. State guidelines recommend a functional vision assessment for children ages birth to three years who fail the initial vision assessment given by the nurse. This assessment is also beneficial for children with multiple impairments or for those who are unable to respond to traditional assessment procedures.

The assessment team must include a person with knowledge and expertise in assessing and intervening with infants, toddlers, and preschool-age children who are blind or have low vision (*Education Code* Section 56320[g]). This staff member is responsible for conducting the functional vision assessment to determine the way the child is using his or her sight, the child's vision-related needs, and the interventions and compensations that are required for the child to function as independently as possible. The publication *Program Guidelines for Students Who Are*

[20] *Program Guidelines for Hearing Impaired Individuals.* Sacramento: California Department of Education, 1986, p. 6.

Visually Impaired (1997) recommends this practice.

The guidelines also state that assessment should include the areas of concept development, sensorimotor development, adaptive development, communication skills, and social–emotional development for assessment of children ages birth through five years.

Severe Orthopedic Impairment

A child with a severe orthopedic impairment may have been referred or identified by another agency, such as the regional center or California Children Services (CCS). A physician may refer a child to CCS if the cause of the impairment is a musculoskeletal or neuromuscular condition that may require occupational or physical therapy. The occupational therapist, the physical therapist, or both, assess the child's areas of orthopedic function and fine and gross motor functional skills. When the child is referred to the school program, the school staff should work with other agencies on the additional assessment, sharing of current information, and program planning for the child and family. The assessment team must include a person who is knowledgeable about orthopedic impairments and trained to provide intervention for such disabilities (*Education Code* Section 56320[g]). Consult *Program Guidelines for Individuals Who Are Severely Orthopedically Impaired* (1992) for more information.

Of particular importance during assessment is the recognition that a child with an orthopedic impairment may not have typical motor responses. In that case extra time, positioning, and technological devices should be considered. The use of alternative assessment methods will not invalidate the results for a child who cannot produce a motor, speech, or movement response that is required in most traditional evaluation measurements.

Deaf-Blind

"The assessment of students who are deaf-blind must be a transdisciplinary effort conducted by persons who are knowledgeable in this area. This approach requires that assessment personnel share and exchange information and skills across traditional disciplinary lines."[21] Assessment takes into consideration the age of onset, degree of hearing and visual impairment, other disabling conditions, and environmental situations and expectations. Specialized health needs should also be determined. Few formal assessment instruments have been standardized for the deaf-blind population. The child's developmental levels and educational needs should be informally assessed in the child's natural environment with accurate information provided by the parent or guardian. Deaf-blindness is a low-incidence disability and requires a specialized assessment to obtain meaningful data (*Education Code* Section 56320[g]).

[21] *Program Guidelines for Individuals Who Are Deaf-Blind.* Sacramento, California Department of Education, 1990, p. 4.

Report of the Findings

Although a written report is not specifically required for the Early Start program, sharing the information with the family is an important element in the assessment process:

> Traditionally, assessments of the child were conducted by professionals according to their professional disciplines and were followed by a time during which staff synthesized results to share with family members at a later meeting. Best practice in recent years, however, has shifted toward sharing information and results with families as soon as they are gathered. The process of gathering information about the child should be intermingled with the reciprocal process of sharing it.[22]

Delivering assessment results throughout the process and at the end of the testing sessions gives the parent time to assimilate the information and helps alleviate worry and stress during the traditional waiting period before the IEP or

[22] Ann Turnbull, "Identifying Children's Strengths and Needs," in *Guidelines and Recommended Practices for the Individualized Family Service Plan* (Second edition). Edited by Mary McGonigel and others. Bethesda, Md.: NECTAS and ACCH, 1991, p. 45.

IFSP meeting. The parent may ask questions and receive clarification about the assessment process immediately. If possible, provide a short, written summary of findings along with the oral report. Immediate feedback also gives the family the opportunity to observe and note any changes that may occur between the assessment and the IEP/IFSP meeting. An oral report does not replace a written summary of the assessment findings; however, it is the first step in ensuring that accurate information is shared with the family.

The assessment information is gleaned from parents' reports, direct observation, and a review of records. It is then compiled into a framework that integrates the data and is discussed with the parents. The process of reporting the information becomes a parent education intervention itself that will lead to formal services when appropriate. The way in which this information is reported and shared with parents is a part of the foundation for the relationship between parents and program staff. The report may also set the stage for future home-school relationships. If the report is not presented in a way that is understandable and respects the parents' values, perspectives, language, and culture, it may become a barrier. Technical terms should be accompanied by a written explanation.

Section 56327 of the *Education Code* requires that the following items, at a minimum, be included in the report about a preschool child:

- Background information
- A comprehensive developmental history
- Family concerns and priorities
- Recommendation for eligibility
- Assessment finding
- A statement about the validity and reliability of the methods and procedures
- Recommendations to address the child's areas of need

Test results should be accompanied by explanations so that scores may be interpreted correctly. The Department publication *Program Guidelines for Individuals Who Are Severely Orthopedically Impaired* (1992) recommends that the following factors be included when reporting assessment and background information: the time of day and length of contact with the child, the type of environment in which the child was assessed, the presence or absence of family members, the child's familiarity with the evaluator, and observations of the child's behavior. The report must account for any variance or factors that may have contributed to the results obtained. These factors include, but are not limited to, the use of an interpreter/translator, standardized tests given outside the required protocol, the familiarity of the child with the situation, the physical state of the child during the evaluation, and cultural customs of the family.

Only the information that is necessary and relevant to the evaluation of the child and to the services and placement decisions for the child should be reported. According to the *Best Practices in Early Childhood Assessment Manual*, "The dignity and privacy of the parents should be respected, and information which they may have shared with you in confidence (e.g., history of substance abuse, incarcerations) should be omitted *if not pertinent* to relevant educational decisions." [23]

Traditionally, assessment reports were written separately by each team member and reflected individual areas of professional expertise. As teams move

[23] *Best Practices in Early Childhood Assessment Manual.* Edited by Diane Ashton. Millbrae, Calif.: California Association of School Psychologists, 1990, p. 23.

from the traditional model to a transdisciplinary model, there is a shift toward compiling a single assessment report that includes the evaluation results and recommendations of all team members. Changing to this model requires time and ongoing communication among the team members. One person should be designated to compile all the information provided by the team members and to ensure that the final report is clear and concise. The transdisciplinary model has several advantages:

- There is less duplication of pertinent information, such as background, observations of behavior, and so forth, by all writers.
- A single report simplifies the data and reduces the amount of reading material for the family and others.
- Teaming is enhanced through the process.

Communication of Results

Even when caring and skilled professionals have conducted the assessment and teamed well with the young child's parents, sharing the assessment results is often a difficult experience. Parents understandably may approach the assessment with conflicting feelings. Often, the family members not only are in the midst of coping with the emotional dynamics of having a child with a disability but also are struggling with the anxiety of not knowing how disabled their child may be. To see in writing what they may or may not know to be fact or to hear out loud for the first time the extent to which their child's disability has affected his or her development may cause parents extreme stress and sometimes unexpected shock. Professional sensitivity around the impact of the assessment and the means of conveying the assessment results to the family are vitally important in helping the young child.

Presenting information to parents about their young child's special needs is the most difficult task professionals involved with the early childhood assessment will be required to perform. Rarely are individuals in early education prepared to work with parents in this manner. And rarely are professionals prepared for the personal impact these experiences may have on their own feelings. There is no easy way in which to convey this sensitive information to another individual; consequently, the team may feel varying degrees of inadequacy and discomfort in this role. Parents, however, need to receive concise, accurate information about their child's development and be told with sensitivity and support.

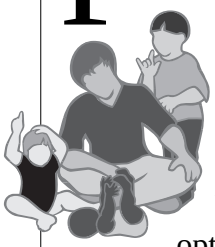
By being empathic and nonjudgmental and allowing the parents to openly share their feelings, professionals help facilitate the growth of the families with whom they are working.

Remember:

- Provide concise, accurate, and honest information with care and sensitivity.
- Ask questions frequently and be a good listener.
- Offer families time to express grief and support them in that experience.

Source: Adapted from Linda Cranor, "Foundations for a Family Approach to Early Childhood Assessment," in *Preschool Special Education Program Handbook*. Sacramento: California Department of Education, 1988.

Program Planning



From the beginning of the assessment process, parents usually want to know what services are available and appropriate for their child. Keeping parents informed and involved throughout the assessment, helping them to identify the options, and focusing on those appropriate for their child are important parts of program planning after the assessment is completed. Parents who provide important observations of a child's needs contribute much to the assessment. Charting observations of a child's skill level and behavior will help parents develop goals and objectives for their child.

Program planning is based on a thorough assessment. For example, a curriculum-based assessment would identify many developmental skills of children ages three through five years. Such an assessment helps to focus on children's strengths as well as their needs. The setting, procedures, and equipment are adapted for each skill; and expectations are delineated for all the developmental domains. This type of learning program may be an extension of the infant/toddler program in the developmental sequence for specific skills.

Assessors participate in the planning of comprehensive services. Special educators, therapists, classroom teachers, and psychologists work together to promote an integrated program that focuses on the whole child. Assessment procedures and instructional activities may be adapted to a classroom or other setting. The IFSP/IEP team helps families to consider both the most appropriate services to meet the child's needs and the variety of settings in which services are delivered.

To make the best choice for their child, parents may want to visit the various programs. A member of the assessment team should be available to assist parents. Educational placement decisions need to take into account the priorities of the family and its vision for the child. Parents need to see the types of special education classrooms and understand the regular early childhood education alternatives. Parents have a legal right to be informed of all program options for their child so that they can make meaningful, informed decisions during the IFSP or IEP team meetings.

Program planning includes making the decision to place the infant or toddler in a setting that is a natural environment for him or her or, for preschoolers, in the least restrictive environment. Natural environments, according to federal law (34 CFR 303.18), means settings that are natural or normal for the child's peers who are the same age and who have no disabilities. Part C regulations of IDEA (34 CFR 303.12[b]) require that early intervention services be provided to the maximum extent appropriate to meet the needs of the child in natural environments, including the home and community settings in which children without disabilities participate.

Program planning for preschoolers requires consideration of education in the least restrictive environment. The term *least restrictive environment* (LRE) under IDEA, Part B, means:

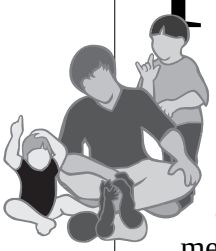
> Children with disabilities, to the maximum extent appropriate, including children in public or private institutions or other care facilities, are educated with children who are not disabled. Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (34 CFR 300.550)

The regulation about LRE also requires a continuum of placement options for all children three to twenty-one years old. The options include regular class placement, a resource specialist program, designated instruction and services, special classes and centers, nonpublic nonsectarian school services, state special schools, settings other than the classroom where specially designed instruction may occur, and home or hospital instruction.

Placement decisions must always take into account the relationship of the services to the outcomes, goals, and objectives agreed on in the IEP for the child. The assessment team should consider the child's needs when determining the frequency and duration of services and consider the family's needs when determining the location of a program and the hours of program operation. Lack of transportation is frequently an issue for parents.

Several service delivery options may be available to meet a child's needs. The family is an integral part of the post-assessment process for determining the child's educational placement and the services needed. Parents must be provided with all facts to be informed decision makers for their child. The goal is to meet the child's specific needs by developing a service plan that fits the child, the family, and the local educational agency.

Staff Development for Assessors



The administration must ensure that the staff has knowledge of effective assessment practices for young children and the expertise to conduct an accurate evaluation or assessment. The needs identified by the teams determine specific areas for training and support. Staff members may wish to consider individual or team needs in the following areas:

- Transdisciplinary or multidisciplinary teaming
- Means of incorporating the family in the evaluation and assessment process
- Methods of assessing play skills
- Play-based assessments
- Developmentally appropriate practices related to the evaluation and assessment of young children
- Typical and atypical development
- Informal observations and recording data
- Disability-specific assessment, evaluation, and services
  - —Hearing impairment
  - —Vision impairment
  - —Severe orthopedic impairment
  - —Autistic spectrum disorders
  - —Mental retardation

—Language and speech disorder
—Specific learning disability
—Traumatic brain injury
—Deaf-blind
—Emotional disturbance
—Other health impairment

- Nutrition and feeding assessments
- Specialized health care needs and procedures
- Occupational and physical therapy assessments

The following activities are low cost and may be incorporated into the program to address staff development needs on an ongoing basis:

- Establish time for staff to plan together and discuss assessments.
- Share observations.
- Videotape the assessment and review it with the entire team.
- Observe other team assessment processes.
- Network with other assessment teams, if possible.

The following statewide organizations and agencies regularly provide training in the assessment of young children:

Infant Development Association

California Association for the Education of Young Children

Supporting Early Education Delivery Systems (SEEDS) Project

Colleges and universities

California Early Intervention Technical Assistance Network (CEITAN)

Information on forthcoming training may be provided to programs directly or through the SELPA, the school district's director of special education, or the district staff development committee. The staff should establish a link with other departments in the school district or other regionalized school district training programs to ensure that information on training reaches the program in a timely way. Early in the program year, staff should identify professional development needs and set aside funds for those activities. See Appendix F for statewide resources for technical assistance and staff development related to assessment.

The administration can support professional training in the following ways:

- Make a commitment to send teams to assessment training. The interaction within the team increases the learning and the likelihood that new information will be incorporated and leads to peer support.
- Provide on-site follow-up to any training.
- Set aside time at staff meetings for team members who attend training to share information with others.
- Provide opportunities for cross-training among staff members.

Conclusion

Assessment and evaluation during early childhood are critical to a child's development. This handbook seeks to assist professionals in early childhood special education who are challenged by recent changes in state and federal law to examine the way in which they conduct assessments and evaluations.

Making a commitment to incorporate and maintain the best practices in assessment and evaluation requires professionals to stay current in research and trends in the field. Such a commitment leads to more accurate assessments and evaluations of children and better planning for intervention. In addition, positive relationships are established between families and professionals that set the framework for future collaboration between the home and the school.

Professionals in early childhood special education should review the assessment/evaluation protocol in their school district or county early childhood special education program. The indicators of a viable, child-focused, and family-friendly assessment/evaluation process are as follows:

- Assessment and evaluation are viewed as a part of the intervention process and

not just as a means of determining eligibility and services.

- Flexible procedures are designed to facilitate collaboration with parents or other caregivers. Parents are no longer limited to the role of informant; instead, they are active participants in the assessment/evaluation process.
- The assessment/evaluation report is readable and free of jargon and reflects the child's functional abilities rather than mere test scores. Assessment participants are identified in the report. Oral reports are followed by a written report. Reports are shared with the parents. Confidentiality of reports is a consideration when sharing information with other agencies; parents determine who may be permitted to receive a copy of a report.
- Family involvement and informed consent are recognized as an important part of the evaluation and assessment process.
- The evaluation and assessment process uses multiple measures, such as assigning the child familiar tasks, in a setting that is comfortable for the child and the child's family. Using multiple measures will increase the likelihood that the results will be valid.
- The measures are reviewed on several occasions in various settings.
- Developmental assessments are ongoing. It is important to reassess on several occasions after services have been initiated rather than rely on a one-time-only evaluation.
- The evaluation/assessment team consists of qualified individuals.
- The staff training program is effective, and administrators are supportive of the need for both regular evaluation of training and technical assistance.

The family assessment process is another new challenge for professionals in the early intervention (Early Start) program. It is hoped that local educational agencies develop additional measures of family functioning.

Appendix A
Pertinent Legal Citations

The following sections of the *Code of Federal Regulations* pertain to this handbook:

Section 300.532 Evaluation procedures.

Each public agency shall ensure, at a minimum, that the following requirements are met:

(a)(1) Tests and other evaluation materials used to assess a child under Part B of the Act—

(i) Are selected and administered so as not to be discriminatory on a racial or cultural basis; and

(ii) Are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so; and

(2) Materials and procedures used to assess a child with limited English proficiency are selected and administered to ensure that they measure the extent to which the child has a disability and needs special education, rather than measuring the child's English language skills.

(b) A variety of assessment tools and strategies are used to gather relevant functional and developmental information about the child, including information provided by the parent, and information related to enabling the child to be involved in and progress in the general curriculum (or for a preschool child, to participate in appropriate activities), that may assist in determining—

(1) Whether the child is a child with a disability under Section 300.7; and

(2) The content of the child's IEP.

(c)(1) Any standardized tests that are given to a child—

(i) Have been validated for the specific purpose for which they are used; and

(ii) Are administered by trained and knowledgeable personnel in accordance with any instructions provided by the producer of the tests.

(2) If an assessment is not conducted under standard conditions, a description of the extent to which it varied from standard conditions (e.g., the qualifications of the person administering the test, or the method of test administration) must be included in the evaluation report.

(d) Tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient.

(e) Tests are selected and administered so as best to ensure that if a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (unless those skills are the factors that the test purports to measure).

(f) No single procedure is used as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate educational program for the child.

(g) The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.

(h) In evaluating each child with a disability under Sections 300.531-300.536, the evaluation is sufficiently comprehensive to identify all of the child's special education and related

services needs, whether or not commonly linked to the disability category in which the child has been classified.

(i) The public agency uses technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.

(j) The public agency uses assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child.

(Authority: 20 U.S.C. 1412(a)(6)(B), 1414(b)(2) and (3))

Section 303.322 Evaluation and assessment.

(a) General. (1) Each system must include the performance of a timely, comprehensive, multidisciplinary evaluation of each child, birth through age two, referred for evaluation, including assessment activities related to the child and the child's family.

(2) The lead agency shall be responsible for ensuring that the requirements of this section are implemented by all affected public agencies and service providers in the State.

(b) Definitions of evaluation and assessment. As used in this part—

(1) Evaluation means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of "infants and toddlers with disabilities" in Section 303.16, including determining the status of the child in each of the developmental areas in paragraph (c)(3)(ii) of this section.

(2) Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify—

(i) The child's unique strengths and needs and the services appropriate to meet those needs; and

(ii) The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

(c) Evaluation and assessment of the child. The evaluation and assessment of each child must—

(1) Be conducted by personnel trained to utilize appropriate methods and procedures;

(2) Be based on informed clinical opinion; and

(3) Include the following:

(i) A review of pertinent records related to the child's current health status and medical history.

(ii) An evaluation of the child's level of functioning in each of the following developmental areas:

(A) Cognitive development.

(B) Physical development, including vision and hearing.

(C) Communication development.

(D) Social or emotional development.

(E) Adaptive development.

(iii) An assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c)(3)(ii) of this section, including the identification of services appropriate to meet those needs.

(d) Family assessment. (1) Family assessments under this part must be family-directed and designed to determine the resources, priorities, and concerns of the family related to enhancing the development of the child.

(2) Any assessment that is conducted must be voluntary on the part of the family.

(3) If an assessment of the family is carried out, the assessment must—

(i) Be conducted by personnel trained to utilize appropriate methods and procedures;

(ii) Be based on information provided by the family through a personal interview; and

(iii) Incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development.

(e) Timelines. (1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within

the 45-day time period required in Section 303.321(e).

(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will—

(i) Document those circumstances; and

(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with Section 303.345 (b)(1) and (b)(2).

(Approved by the Office of Management and Budget under control number 1820-0550)

(Authority: 20 U.S.C. 1476(b)(3); 1477 (a)(1), (a)(2), (d)(1), and (d)(2))

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

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

Section 303.323 Nondiscriminatory procedures.

Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that—

(a) Tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so;

(b) Any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory;

(c) No single procedure is used as the sole criterion for determining a child's eligibility under this part; and

(d) Evaluations and assessments are conducted by qualified personnel.

(Approved by the Office of Management and Budget under control number 1820-0550)

(Authority: 20 U.S.C. 1476(b)(3); 1477(a)(1), (d)(2), and Individualized Family Service Plans (IFSPs))

Appendix B

Qualifications of Interpreters

An interpreter working to facilitate communication between a family and a professional should possess the following qualifications:

- High degree of oral proficiency in both the language of the family and that of the professional
  - Has frequent exposure to both languages to maintain proficiency in each
- Ability to translate from one language to the other
  - Avoids word-for-word interpreting but is cognizant of possible omissions, additions, substitutions, and transformations that may distort or inaccurately represent the speaker's intended meaning
  - Is sensitive to the subtleties and nuances of the language; may need to reword/rephrase interpretations for both parties (certain words/phrases may have different meanings for different subgroups that may be offensive or inappropriate)
  - Avoids use of unnecessary words and excessive professional jargon
- Sensitivity to the speaker's style
  - Watches tone, inflection, body movements (Sometimes the intonation of the words can totally change their meaning.)
- Ability to adjust to linguistic variations in different communities
  - Understands the varying grammar and syntax (including slang and dialects) of subgroups
- Respect for and familiarity with the family's national origin, indigenous community, and culture
  - Knows family's nationality and corresponding ethnic group history (including migration experience and local community history and characteristics)
  - Knows specific cultural orientations and traditional views (e.g., toward disabilities, child rearing, health and healing)
- Familiarity with the culture and language of the professional and the field
  - Knows the procedures and practices of the field, relevant policies, current terminology, and subject matter
- Understanding of the role and function of the interpreter on the team
  - Accepts and is comfortable with the role of communicator of information
  - Provides accurate interpretations and maintains neutrality (Does not offer subjective interpretations, personal opinions, or evaluations of situations unless asked to do so)
  - May assist professional or team members in identifying possible cultural bias or inappropriateness in various statements, questions, or interventions that are presented as part of the interaction
- Significant experience (and training) as an interpreter with corresponding professional and personal attributes
  - Is able to remain objective and nonjudgmental and maintain confidentiality
  - Demonstrates good listening skills; is respectful, patient, flexible, and appropriately empathetic but does not get emotionally overinvolved

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Source: Adapted from D. E. Randall, *Strategies for Working with Culturally Diverse Communities and Clients.* Washington, D.C.: Association for the Care of Children's Health, 1989.

Appendix C

Guidelines for Working with Interpreters

The following guidelines are offered to help make the interview more productive and comfortable for all concerned:

1. Learn proper protocols and forms of address (including a few greetings and social phrases) in the family's primary language and the names family members wish to be called and the correct pronunciation.
2. Introduce yourself and the interpreter, describe your representative roles, and clarify mutual expectations and the purpose of the encounter. Assure the family member(s) of confidentiality and be sensitive to the family's needs and requests for privacy.
3. Learn basic words and sentences in the family's language and become familiar with special terminology family members may use so you can selectively attend to them during interpreter-family member interchanges.
4. Address remarks and questions directly to the family member during the interaction; look at and listen to the family member as he or she speaks. Observe the person's nonverbal communication and be alert to indications of anxiety, confusion, or difficulty in understanding.
5. Avoid body language or gestures that may be offensive or misunderstood as well as side conversations, whispering, or writing while the interpreter is interpreting.
6. Use a positive tone of voice and facial expressions that sincerely convey respect and interest in the family member(s). Address the family member(s) in a calm, unhurried manner.
7. Speak clearly and somewhat more slowly (but *not* loudly); allow adequate time for the interpreter to interpret and listen carefully to the family member's response.
8. Limit your remarks and questions to a few sentences between interpretations and avoid giving too much information of long, complex discussions of several topics in a single session.
9. Avoid technical jargon, colloquialisms, idioms, slang, and abstractions.
10. Keep words and phrases as simple as possible, but avoid oversimplifying and condensing important explanations.
11. Give information in a clear, logical sequence; emphasize important words or points; and repeat vital information. Clarify and rephrase information when necessary.
12. Check periodically on the family member's understanding and the accuracy of the translation by asking him or her to repeat instructions, or whatever has been communicated, in his or her own words with the interpreter facilitat-

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Source: Adapted from D. E. Randall, *Strategies for Working with Culturally Diverse Communities and Clients.* Washington, D.C.: Association for the Care of Children's Health, 1989.

ing; however, avoid literally asking, “Do you understand?” (In many cultural groups, a “no” response would make all parties lose face and is thus unlikely to be admitted.)

13. Offer explanations for specific recommendations and summarize the outcome of the meeting, session, or visit.

14. Reinforce verbal information, when possible, with materials written in the family’s language and with visual aids or behavioral modeling, if appropriate. Before introducing written materials, tactfully determine the family member’s literacy level through the interpreter.

15. Be patient and be prepared for the additional time inevitably required for careful interpretations.

Appendix D
Parent Interview Strategies

Much information may be gathered from parents by engaging them in a conversation about their child. Ask open-ended questions that elicit information about the child's habits and ways of relating. The following are suggested conversation starters that will elicit information about parent and child interactions, the child's temperament, and his or her strengths and needs.

If possible, begin by trying to engage the child so that the parent can observe the relationship you are building with the child. Make positive comments about what the child is doing or how he or she interacts with the parent. For example, watch for the nuances of body language or tone of voice that provides clues about the child-parent relationship. Observe the engagement because it establishes a link with the baby and a link with the parents, then share the observation during the conversation. Let them know you value what they say about their child, that they have credibility.

Examples of open-ended questions are as follows:

1. If you wanted to do the dishes and Susie were 10 feet away, what would you give her to amuse herself? Would she play happily? For how long?

2. If you are on the phone and Jamie is awake, what happens?

3. What helps soothe your child?

4. How do you know when your child is hungry or thirsty?

5. What are the things that make your child happy/sad/angry? How does he or she let you know that?

6. Can you tell me some of the ways that Sam lets you know that he is enjoying something? Whether he is really hungry? When he wants to play? When he wants to stop?

7. What is the favorite thing your child likes to play with?

8. If there were one thing that you could do during the day that you know would make your child smile or laugh, what would it be? Could you show me how you do that?

9. Can you remember something that happened yesterday that makes your heart warm?

10. Give the parents an opportunity to teach you about their child by asking them:

    —What can I do to make your child smile the way that you do?

    —Show me how I can do that same thing.

11. How do you know what makes your child sad?

    Always follow this question with a conversation that explores the reasons the child is sad. For example, ask, "Do you think that sometimes she is trying to tell you something and you're not getting it?"

Appendix E

Sample Cover Letter and Interagency Consent to Share Information

Sample Form

A school district may permit access to pupil records to any person to whom a parent of the pupil has given written consent specifying the records to be released and identifying the party or class of parties to whom the records may be released. The recipient must be notified that the transmission of the information to others without the written consent of the parent is prohibited. The consent notice shall be permanently kept with the record file. **California *Education Code* Section 49075**

Date Requested: _____

TO: _____

_____

_____

____ Enclosed is the following confidential information on the infant or toddler named below.

____ We would appreciate receiving the following confidential information on the infant or toddler named below:

____ Psychological

____ Medical (Medical Record #: _____)

____ Health and Developmental

____ Educational

____ Hearing/Audiological

____ Vision

____ Speech and Language

____ Other: _____

Child Name: _____ Date of Birth: _____

Residence Address: _____

Number Street City ZIP Code

Current Program Site: _____

The confidential information identified above has been requested or is being sent by:

Signature:_____

Name:_____ Title:_____

Program Site:_____ Phone No.: _____

Address: _____

Number Street City ZIP Code

A copy of the Interagency Consent to Share Information form has been appropriately signed by the parent(s), guardian, or surrogate parent and is attached.

_____ _____

Signature *Date*

Sample Form
Interagency Consent to Share Information

Child's Name: _____ Date of Birth: _____

Residence Address: _____
Number Street City ZIP Code

Residence Phone: _____ Message Phone: _____

I give permission until my child is age 3, by way of my signature, to the agencies or individuals listed below, to share important medical, education, social, and psychological information regarding my child. I understand that the information obtained will be used to coordinate and plan services for my child. Confidentiality will be maintained. I may write to the agencies listed below and withdraw my permission at any time. A photocopy of this consent form is considered valid.

Signature:

_____ _____
Parent/Legal Guardian/Surrogate Parent *Date*

Agencies authorized to exchange information (initial only):

____ California Children Services (CCS)
____ Family Resource Center
____ Regional Center
____ Early Start Program
____ County Office of Education
____ School District of Residence
____ County Social Service Agency
____ Private Social Service Agency(ies)
____ County Mental Health Agency
____ County Alcohol and Drug Abuse Services
____ County Department of Public Health

Please indicate any individual or agency specific to your child:

Hospital: _____ Medical Record No.:_____
Address: _____ City:_____ ZIP: _____

Primary Care Physician: _____ Phone No.: ( ) _____
Address:_____ City:_____ ZIP: _____

Other Physician: _____ Phone No.: ( ) _____
Address:_____ City:_____ ZIP: _____

Other Physician: _____ Phone No.: ( ) _____
Address: _____ City:_____ ZIP: _____

Program or Therapist: _____ Phone No.: ( ) _____
Address: _____ City:_____ ZIP: _____

Other: _____ Phone No.: ( ) _____
Address:_____ City:_____ ZIP: _____

Other: _____ Phone No.: ( ) _____
Address:_____ City:_____ ZIP: _____

Appendix F
Resources for Technical Assistance

Excellent resources are available to assist staff in improving the quality of assessments and evaluations. Many of these are projects funded through California state departments. Others, in the form of professional organizations and research journals, provide a rich source of written materials or consultant services to assist programs. Some are identified below; however, the list is not exhaustive. The descriptions are taken from information provided by each respective project or organization.

California Early Intervention Technical Assistance Network

The California Early Intervention Technical Assistance Network (CEITAN) is contracted through the California Department of Developmental Services (DDS) to ensure a comprehensive system of personnel development. Each year DDS hosts Early Start statewide institutes entitled "Building Blocks for Early Start: Supporting the Professional Development of Persons Who Serve Infants and Toddlers with Special Needs and Their Families." Flyers regarding these training opportunities are widely disseminated to each SELPA.

In addition, CEITAN provides scholarships and training grants to early intervention direct service providers for personnel development activities. There are attendance scholarships (conferences or other training), college course work scholarships, grants for local training events, and start-up grants to establish local Early Start personnel development programs or innovative systems change. For information regarding CEITAN activities, call (916) 492-9999.

CalSTAT

CalSTAT is a program of the California Institute on Human Services at Sonoma State University and a special project of the Special Education Division, California Department of Education. In addition to the regularly scheduled trainings, CalSTAT also provides professionals and families with customized technical assistance, leadership and system change support, and Internet resources. Contact CalSTAT by calling (707) 664-3062 or visit the Web site <*http://www.sonoma.edu/cihs/calstat/calstat.html*>.

CONNECTIONS: Learning Communities for All Children

This program is an 18-month to two-year in-service training model designed to provide an innovative and individualized approach to early childhood and early childhood special education programs. In responding to current and emerging needs of professionals, children, and families, CONNECTIONS combines both research and information on quality practices from the fields of early childhood education

and early childhood special education. The approach to supporting administrators, educators, and family members incorporates a model of interagency and cross-discipline training combined with on-site follow-up and technical assistance. For information, contact the California Institute on Human Services (CIHS), Sonoma State University at (707) 664-4230.

Diagnostic Centers

Diagnostic Centers of the California Department of Education provide high-quality, individualized services to special education students, their families, and school districts. The telephone numbers of the centers, which are located in southern, central, and northern California, are as follows:

- Los Angeles: (323) 222-8090
- Fresno: (209) 445-5982
- Fremont: (510) 794-2500

Expert interdisciplinary teams of diagnostic professionals, including education specialists, speech/language specialists, transition specialists, school psychologists, clinical psychologists, pediatricians, and motor skill specialists, address the unique needs of children enrolled in special education programs. Referrals for an assessment of an eligible student must be made by the child's local school district or county office of education.

Local district special education administrators, SELPA directors, and county office special education administrators may request technical assistance and professional staff development services. Diagnostic services are provided at no charge.

Early Start Information Line

The toll-free information line puts parents and professionals working with infants and toddlers with disabilities in touch with local Early Start resources in California. Information may be obtained by contacting the DDS Early Intervention office at (800) 515-BABY.

NECTAS

NECTAS stands for the National Early Childhood Technical Assistance System in Chapel Hill, North Carolina. Documents on assessment and evaluation issues may be viewed on the NECTAS Web site <*www.nectas.unc.edu/*>. To order these documents, call (919) 962-2001.

Project EXCEPTIONAL

The primary focus of this project is to develop a replicable statewide model to train the child care staff on ways to include young children with disabilities (from birth to five years) in community child care settings. In addition, training materials have been developed for community college instructors. Along with California, five states in the Outer Pacific have participated in EXCEPTIONAL outreach trainings. For information on training and the purchase of materials, call the California Institute on Human Services at Sonoma State University at (707) 664-2051.

Region IX, Quality Improvement for Disabilities Services, Head Start

Located at the California Institute of Human Services, at Sonoma State University, this project supports Head Start programs throughout Region IX by providing quality services to children with disabilities and their families. Consultants provide technical assistance in developing state and local interagency agreements, developing and implementing disabilities service plans, and visiting Head Start grantees on site upon request. In addition,

the project provides training on requested topics and develops and disseminates resource materials. The office may be reached at CIHS, Sonoma State University, 1801 E. Cotati Avenue, Rohnert Park, CA 94928; telephone (707) 664-4230; or through the Internet <*http://www.sonoma.edu/CIHS*>.

Special Education Early Childhood Administrators Project

The Special Education Early Childhood Administrators Project (SEECAP) is a project of the California Department of Education, Special Education Division, and the HOPE Infant and Family Support Program, San Diego County Office of Education. The project sponsors symposia annually for experienced and emerging leaders and administrators in the field of early childhood special education. Sessions are held in the northern and southern areas of the state. The symposia cover a wide range of topics, including forums on current issues in the field, funding, updates on laws and regulations, and exemplary program models. Attendees receive a variety of written material and resources that support each session. Additional information may be obtained by calling (619) 292-3800.

Supporting Early Education Delivery Systems Project

The Supporting Early Education Delivery Systems (SEEDS) project is funded through the California Department of Education, Special Education Division, and is coordinated by the Sacramento County Office of Education. Its mission is to help provide technical assistance to early childhood special education programs by using a network of consultants and visitation sites. The SEEDS project is designed for administrators, staff, and families involved in early childhood special education programs in local educational agencies. The priorities for technical assistance have been established in cooperation with the California Department of Education.

Support activities include individual consultation on site or by telephone, small- and large-group training, program assessment and recommendations, referral to other resources or programs, help in arranging trips to visitation sites, identification of print or audiovisual materials, or help in providing or arranging for speakers as a part of a conference or workshop. Technical assistance includes but is not limited to assessment and evaluation; collaboration with families; curriculum, IFSP, and IEP development and implementation; interagency collaboration; development of educational programs pertinent to specific disabilities; referral and intake; and information on service delivery models, staffing models, systems change, and transitions to other programs. For more information or to request technical assistance, call (916) 228-2379.

Glossary

achievement test. A test that measures the extent to which an individual has acquired certain information or mastered certain skills.

advocate. One who pleads the cause of another or takes action on someone's behalf.

affective. Pertaining to the domain of feelings or emotions.

amino acid(s). One of the chief components of proteins; they are obtained from the individual's diet or are manufactured by living cells.

amniocentesis. A medical procedure in which a hollow needle is inserted into the uterus to obtain amniotic fluid for detecting any genetic abnormalities of the fetus.

anemia. A reduced number of red blood cells usually resulting from inadequate nutrition. The patient is often characterized by listlessness and lack of color.

aphasia. The inability to express oneself or to comprehend spoken or written language, usually due to damage or disease in the language area of the cortex.

aptitude. A combination of characteristics, whether genetic or acquired, known or believed to be indicative of a child's ability to learn in some particular area.

assessment. "Ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify (i) the child's unique needs; (ii) the family's strengths and needs related to development of the child; and (iii) the nature and extent of early intervention services that are needed by the child and the child's family" (PL 99-457 Regulations, Section 300.322).

attachment. The process of building positive and trusting bonds between individuals, usually infant and parents or major caregiver; closeness and affectionate interacting.

attention deficits (or attention deficit disorder). A learning disability characterized by a child's short attention span, distractibility, and heightened level of movement and physical activity.

atypical development. Any aspect of a child's physical or psychological makeup that is different from what is generally accepted as normal in early childhood.

audiologist. A certified professional who conducts testing of hearing and is skilled in detecting hearing impairments.

auditory. Pertaining to the sense of hearing.

autism. A developmental disability that significantly affects a child's verbal and nonverbal communication and social interaction and is generally evident before age three; it adversely affects educational performance (*Code of Federal Regulations*, Section 1308.15).

autonomy. Self-directing and acting and reacting independently; the ability and willingness to make choices and decisions.

behavior modification. A system by which particular environmental events are intentionally arranged to produce specified behavioral changes.

cerebral palsy. A condition caused by injury to certain parts of the brain; usually results in paralysis and uncontrollable muscle movement in particular parts of the body.

child find. A series of public awareness efforts designed to alert the community at large about the availability of and rationale for early childhood intervention programs and services.

chromosomal disorder. A vast number of developmental problems that come about at the moment of conception when the genetic information from each parent is merged and mapped out.

cochlea. A bony, snail-shaped structure in the inner ear that allows hearing to occur.

cochlear implant. A device, surgically placed by opening the mastoid structure of the skull, that allows electrical impulses (sound) to be carried directly to the brain.

conductive hearing loss. Refers to problems in the mechanical transmission of sounds through the outer or middle inner ear.

cognition, cognitive skills. Thinking skills, sometimes referred to as preacademic or problem-solving skills in young children.

congenital anomaly. A developmental difference that is present at birth and is not necessarily genetic in origin.

cumulative deficits. An adding on or layering on of developmental problems as in an undiagnosed hearing loss, which can result in an accumulation of additional problems (e.g., as in language, cognitive, and social).

criterion-referenced test. A test that measures a specific level of performance or a specific degree of mastery.

developmental assessment. Standardized tests that are intended to document the emergence of a sequence of behaviors, skills, or abilities over a period of time.

developmental continuum. The range of skills or behaviors among children in any one area of development; for example, from no ball-throwing skill to spinning out a hard ball overhand. The child who can play catch is somewhere in the middle on that continuum. *Developmental delay* is a term that describes children who are not able to perform the skills that other children of the same age are able to perform.

diagnostic evaluation. An examination used to ascertain conclusively whether a child has special needs, determine the nature of the child's problems, and suggest the cause of the problems and possible remediation strategies.

disequilibrium. Out of balance or out of harmony; a way of describing a child who seems to be experiencing temporary developmental irregularities.

dyad. A pair of individuals whose relationship has social significance, such as a husband and wife or mother and child.

dysfluency. Hesitations, repetitions, and omitted or extra sounds in speech patterns.

dyslexia. An impaired ability to read; may also refer to an inability to understand what is read.

earmold. That part of an amplification device (hearing aid) that is fitted to the individual's ear.

echolalic. Describes an individual whose language is characterized by meaningless repetition of words and sentences used intelligently by others; a condition often associated with autism and schizophrenia.

egocentric. In reference to young children, it implies a restricted view of the world from one perspective only: the child's own.

etiology. The cause or origin of a handicapping condition.

evaluation. "Procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for services" (PL 99-457 Regulations, Section 300.322).

failure-to-thrive. Refers to undersized infants whose bodies, for various reasons (organic, genetic, or environmental), either do not receive or cannot utilize the nurturance necessary for proper growth and development.

fine motor skills. Those skills involving hand use or the use of small-muscle groups.

functional. When referring to children's learning, *functional* refers to the child acquiring skills that are useful in everyday living.

generalization. The spread of a learned response from the training situation to an everyday, real-life situation.

generalize. To apply what has been learned in one situation to a variety of other related situations.

gross motor skills. Those skills involving the use of large-muscle groups.

hydrocephalus. A medical condition in which undrained spinal fluids leads to an enlarged head and ultimate deterioration of the brain**.** The condition is often relieved by the insertion of a shunt.

immune system. That aspect of body functioning responsible for warding off diseases.

incidence. The frequency of occurrence of a problem at a particular point in time.

incremental step. A step added to a series in a regular order; often a very small increase.

individualized education program (IEP): A written document prepared by the IEP team, which includes the parents and the local educational agency staff, that indicates the current level of the child's educational performance (at age three and older), annual goals, short-term objectives, and appropriate services needed to meet the goals.

individualized family service plan (IFSP). A written document that states the family's strengths and needs related to enhancing the development of the child (birth to three years), including specific statements about outcomes, criteria, and timelines regarding progress; specific services; provisions for case management; and dates for initiation, duration, and reevaluation of service.

individual program plan (IPP). A written plan prepared by regional center staff and parents for persons with developmental disabilities to describe the provision of services and supports to meet the written goals and objectives for the child.

interdisciplinary team. A group of professionals who substitute for one another; they determine their roles in relation to the characteristics of each child and family. They rely on each other to build on the range of strengths found among different types of child development experts.

interpreter. An individual who translates spoken language into sign language for those who are deaf.

in utero. Unborn; literally, in the uterus.

irreversible developmental damage. A condition that results in damage from which there is no recovery, such as a missing arm or a child with Down syndrome; the irreversibility of the problem does not mean the individual cannot find ways of living life more normally.

jargon. Refers to the specialized language of a particular profession that is not easily understood by the ordinary person. URI, for example, refers to the common cold (upper respiratory infection).

juvenile rheumatoid arthritis. Inflammation of the joints with stiffness, swelling, and limited motion; may be accompanied by inflammation of the eyes, which can have serious consequences.

learning theory. Emphasizes the dominant role of environment and reinforcing experiences in all learning. Social learning theory adds other dimensions: that learning also occurs through observing and imitating and that individuals can generate their own satisfaction (intrinsic reinforcement).

meningocele. Hernial protrusion of the meninges through a defect in the skull; usually causes little or no neurological impairment.

metabolize. The chemical process in living cells by which energy is manufactured so that the body can carry out its many functions.

multidisciplinary assessment. An evaluation of a child's strengths and weaknesses from a variety of professional viewpoints using a number of different sources of information and involving the child's parents. Typically, the child's present level of physical, neurological, cognitive, speech and language, psychosocial development, and self-help skills is assessed.

multidisciplinary team. A group of professionals who work independently of each other in a kind of *parallel play* format; each discipline is viewed as important, but the profes-

sional takes responsibility only for his or her own area of clinical expertise.

muscle tone. The interaction between the central nervous system and motor activity. It does not mean the same thing as muscle strength. Without muscle tone there is no voluntary movement.

mutual gaze. The steady looking at each other's face that goes on between intact neonates and their mother or primary caregiver.

myelomeningocele. A congenital protrusion of the spinal cord through the vertebrae, often resulting in paralysis of the lower trunk and legs.

neonatal. Pertaining to the first four weeks following birth.

neural. Pertaining to a nerve or the nerves.

neurological. Pertaining to the nervous system in general.

nonambulatory. The inability to move oneself about; usually the inability to walk.

normalization. The act of making normal. The care and education of the handicapped should be as culturally normal as possible with services provided in regular community facilities rather than in segregated institutions.

norms. Statistics that describe the test performance of specified groups, such as children of various ages or handicapping conditions in the standardization sample of a test.

occlusion. An obstruction; something used to prevent vision. ***Occluder*** would be the object that the examiner used to prevent the child from seeing (usually one eye at a time is tested).

oral muscular dysfunction. Weak or faulty movement or muscle tone of the mouth and tongue.

organic. A condition in the individual's own body or neurological system.

orientation-and-mobility specialist. A therapist who teaches vision-impaired individuals awareness of their position in the environment and of significant objects in the environment (orientation) as well as how to move about safely and efficiently (mobility) by utilizing their remaining senses (including any useful vision).

orthopedic. Pertaining to the branch of medicine concerned with the bones and joints; osteogenesis imperfecta (brittle bones) is an orthopedic problem.

paraprofessional. A trained person who assists a certified professional as a teacher's aide.

pediatric ophthalmologist. A physician who is an expert on eye diseases and malfunctioning of the eyes in children.

peripheral vision. That degree of vision available at the outer edges of the eyes.

pervasive developmental disorder. A severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills or the presence of stereotyped behavior, interests, and activities. This category includes *atypical autism.*

physical prompt. Providing physical assistance to help a child perform a task. For example, positioning the teacher's hand around the learner's hand and actually putting the learner through the motions is a physical prompt.

pincer grasp. The ability to pick up a small object by using the forefinger and thumb (a developmental skill that does not emerge until the latter part of the infant's first year).

play-based assessment. A form of assessment that involves observation of a child at play and provides understanding of a child's development.

prerequisite skills. Skills that must be acquired before a next higher level skill can be attempted. For example, children must be able to stand before they can walk and be able to walk before they can run.

prevalence. The number or proportion of individuals in a community or population with a given condition or problem.

primitive reflexes. Involuntary responses of a newborn infant, such as grasping, rooting, and sucking. When the infant is around four months of age, the responses are replaced by

similar but voluntary behaviors as in the sucking response.

psychometric test. Quantitative assessments of an individual's psychological and other developmental traits or abilities.

readiness test. A test that measures the extent to which a child has acquired certain skills or information for successfully undertaking some new learning activity.

reflexive. An involuntary body reaction to specific kinds of stimulation (e.g., a tap on the knee precedes the knee jerk). Infants are born with reflexes that decrease as the nervous system matures.

reinforcement. A general term for a consequence, an event, or procedure that rewards or maintains the behavior it follows; for example, paychecks are reinforcement for working.

reinforcers. A consequence, event, or procedure that increases the behaviors it follows; however, reinforcers differ according to individuals. For example, candy is a reinforcer for many children, but for some it is not.

reliability. The extent to which a test yields the same results on repeated trials.

reliable and valid tests. *Reliable* relates to consistency: how accurate, dependable, and predictable a test is. *Valid* refers to tests that measure what they say they are measuring. For example, a low score on a verbal IQ test for a child with an undiagnosed hearing impairment is not likely to be valid. The test is not measuring the child's intelligence, although it purports to be doing so; instead, it is a measure of how well the child's faulty hearing allows for interpretation of the questions.

repertoire. The sum total and range of an individual's social skills.

residual hearing. The remaining degree of hearing in a person who is deaf or hearing impaired.

residual vision. The remaining vision after disease or damage to a person's visual system.

respiratory distress syndrome (RDS). A problem commonly found among premature infants because of the immature development of their lungs; may also occur in about one percent of full-term infants during the first days of life.

respite care. Temporary caregiving so that regular caregivers (usually the mother) get some relief and time away from the sick or disabled individual.

rote memorization. Memorizing things without understanding them; the ability to recite something from memory without having learned the meaning.

screening. A brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment. Screening is designed to help children who are at risk of health and developmental problems, handicapping conditions, or school failure so that they may receive ameliorative intervention services as early as possible.

sensorimotor. Piaget's term for the first major stage of cognitive development, from birth to about eighteen months, when the infant moves from reflexive to voluntary behavior.

sensorineural hearing loss. A malfunctioning of the cochlea or auditory nerve.

sensory system. Any one of several ways in which individuals receive information from their environment; the most familiar sensory systems are vision, hearing, tasting, smelling, and touch or feeling.

separation protest. The fussing or displeasure that an infant displays between eight and twelve months (approximately) when the mother or principal caregiver tries to leave.

shunting. A process for implanting a tube (shunt) into the brain to allow proper circulation and drainage of fluids within the skull.

signing. Nonoral communication systems, such as finger spelling, SEE (signing exact English), or ASL (American sign language, in which fingers, hands, arms, and upper torso are used to communicate ideas).

speech pathologist. A certified professional expert in speech-related problems.

sphincter muscles. Those muscles that determine bowel and bladder control (the retention and release of urine and fecal material).

standardized IQ test. A test for which the norms or averages for intellectual performance have been established by the testing of large numbers of individuals of the same age (ideally, of the same socioeconomic background too). Generally, it is not reliable or useful for young children.

standardized norms. Norms based on a large number of averaged scores of similar-aged children on the same test items. For example, the average seventeen-month-old can build a tower of three cubes.

standardized test. A systematic sample of performance obtained under prescribed conditions, scored according to definite rules, and capable of evaluation by reference to normative information.

stigmata (stigma). An identifying mark, characteristic, or sign of a disease or disability.

surrogate parent. A person appointed to act in the place of a parent in exercising educational rights during the IEP process.

symptom. A sign or indication of a problem. (Sneezing and a runny nose often are symptoms of an allergy problem.)

tactile. What is learned or perceived through touch.

tangible reinforcers. Material things that an individual likes and that can be used to reinforce a particular behavior; in children, reinforcers may be favorite foods and drinks, toys, stickers, and so on (older children usually like money).

temperament. An individual's psychological makeup or personality traits.

therapeutic. Treatment of a disease or disability.

threshold. The physical or psychological point at which an individual begins to respond to certain kinds of stimulation.

transdisciplinary team. A group of professionals who cross discipline borders, acquire knowledge from the other professionals on the team, and incorporate skills from the other disciplines into their own practice (similar in ways to the interdisciplinary model).

validity. The overall degree of justification for interpreting and using a test's findings. It concerns a test's accuracy. Different kinds of validity evidence are appropriate for different kinds of tests.

visual acuity. How well an individual is able to see; keenness of vision.

voluntary motor responses. Those responses that an individual controls, such as when the involuntary or primitive sucking reflex gives way to an infant deciding when and whether she or he will suck.

wedges, bolsters, and prone boards. Therapeutic positioning devices used by physical (developmental) therapists in treating individuals with impaired motor skills.

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