

**BERRIEN COUNTY INTERMEDIATE
SCHOOL DISTRICT
PROCEDURE HANDBOOK**

COGNITIVE IMPAIRMENT

**GUIDELINES FOR IDENTIFICATION OF
ELIGIBLE INDIVIDUALS**

10/20/2007

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ENDORSEMENT PAGES

The undersigned certify:

That representative(s) from my school district have been involved in and/or apprised of the **Cognitive Impairment Guidelines**, which were developed and/or modified to assist in the evaluation and eligibility determination of students with cognitive impairment within the Berrien County Intermediate School District. My signature certifies that my district will use and implement the **Cognitive Impairment Guidelines**.

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INTRODUCTION TO COGNITIVE IMPAIRMENT (CI)

The purpose of this policy handbook is to provide users with information relative to the identification of individuals with cognitive impairments. While it will not address every situation it should provide guidance in most situations.

What is Cognitive Impairment?

The terms “cognitive impairment” and “mental retardation” are synonymous as they appear in this guide. There have been several emerging definitions of the terms since 1908 (Tregold). The current definition advanced by the American Association on Intellectual and Developmental Disabilities (AAIDD) reads: “Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.” Generally speaking, the disability is characterized by well below average intellectual functioning due to low IQ scores that result in (or are associated with) deficits in adaptive behavior. These deficits may exist in any of the following areas:

During Infancy and Early Childhood:

- Sensory-motor skills
- Communication skills (including speech and language)
- Self-help skills
- Socialization (development of ability to interact with others)

During Childhood and Early Adolescence:

- Basic academic skills
- Appropriate reasoning and judgment
- Social skills (participation in group activities; interpersonal relationships)

During Late Adolescence and Adult Life:

- Vocational responsibilities
- Social responsibilities

Federal definition of “COGNITIVE IMPAIRMENT”

CFR § 300.8(c)(6) Child with a disability.

“*Mental retardation* means significantly sub average general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, (defined as “children ages 3 through 9”), that adversely affects a child’s educational performance.

Common Characteristics of Cognitive Impairment

Cognitive:

Perhaps the most obvious characteristic of individuals having a cognitive impairment is their below average intellectual functioning. Sometimes referred to as delayed intellectual development, a person with CI has a lower IQ score than chronological age mates, demonstrates intellectual performance more like that of a younger individual, and is developing intellectually at a slower rate. CI persons will

not learn as much as their age mates and the learning difference between them and their age mates will increase over time.

The CI student that is developing intellectually at a rate of about two-thirds that of normal peers would be two years behind in mental development at age six, four years behind at age 12, and so forth. In many regards, the CI student will be intellectually and conceptually similar to chronologically younger students. However, the CI student with delayed mental development is not identical to the younger child. Life experiences and maturational development will be more similar to that of chronological age mates.

Typically, individuals with a cognitive impairment have **delayed intellectual development, inefficiency in learning, failure expectancy, and social competency deficiencies.** *

*Special Education Program Outcomes Guide: Educable Mental Impairment, 1992. Copyright by Disability Research Systems, Inc. & Michigan Department of Education.

Academic:

- 1) Are inefficient learners in formal learning situations, such as those found in schools, and may be even more inefficient in acquiring information in naturally occurring situations.
- 2) Have difficulty mastering higher-order types of learning, including discrimination learning, concept learning, rule learning, and problem solving.
- 3) Have reduced capability for processing sensory information.
- 4) Lack strategies sufficient for information processing (fewer processing approaches).
- 5) Have difficulties in the initial stage of attending to a task (e.g. getting started).
- 6) Are unable to discriminate relevant stimuli (or screen out irrelevant stimuli).
- 7) Have lower capabilities for “chunking” information and manipulate information at slow speeds.
- 8) Have restricted access to long-term memory, and have less information to pass on to working memory.
- 9) Have deficits in social roles (adaptive behavior).

Adaptive Behavior:

R340.1701a Definitions;

(a) “Adaptive behavior” means a student’s ability to perform the social roles appropriate for a person of his or her age and gender in a manner that meets the expectations of home, culture, school, neighborhood, and other relevant groups in which he or she participates.

Children with cognitive impairment tend to have substantial deficits in adaptive behavior. These limitations can take many forms and tend to occur across domains of functioning. Limitations in self-care skills and social relationships, as well as behavioral excesses are common characteristics of individuals with cognitive impairment. Individuals with cognitive impairment who require extensive supports are often taught basic self care skills such as dressing, eating, and hygiene. Direct instruction and environmental supports, such as added prompts and simplified routines are necessary to ensure that deficits in these adaptive areas do not come to seriously limit one’s quality of life.

Most children with milder forms of cognitive impairment learn how to take care of their basic needs, but they often require training in self- management skills to achieve the levels of

performance necessary for eventual independent living. Making and sustaining friendships and personal relationships present significant challenges for many persons with cognitive impairment. Limited cognitive processing skills, poor language development, and unusual or inappropriate behaviors can seriously impede interacting with others. Students with cognitive impairment more often exhibit behavior problems than children without disabilities. Some of the behaviors observed by students with cognitive impairment are difficulties accepting criticism, limited self control, and bizarre and inappropriate behaviors.

Behavioral:

There are no social or emotional characteristics specific to persons having cognitive impairments since the behavioral effect is individualized in each. However, CI individuals typically exhibit socially inappropriate behaviors, which may also be due to emotional immaturity. Others may shy away from those with CI if inappropriate/antisocial behaviors or odd mannerisms are manifested. Behavioral issues are often a consideration when dealing with cognitively impaired persons.

What are the known causes of cognitive impairment?

- 1) Heredity factors (inborn errors of metabolism, genetic abnormalities, chromosomal abnormalities; Down syndrome, for example).
- 2) Alterations of embryonic development due to maternal ingestion of toxins (alcohol, drugs, etc.), infections (maternal rubella), cerebral malformation, or other as yet unknown causes.
- 3) Pregnancy and prenatal problems (prematurity, fetal malnutrition, anoxia).
- 4) Physical disorders acquired through childhood (lead poisoning, infections, brain disease).
- 5) Environmental influences (psychological deprivation, sensory deprivation, severe neglect, malnutrition, complications of severe mental disorders).

*The following charts are more comprehensive in scope:
Behavioral Phenotypes of Selected Genetic Disorders, *Appendix C*
Risk Factors for Mental Retardation, *Appendix D*

Michigan's Definition of Cognitive Impairment

R 340.1705 Cognitive Impairment; determination.

Rule 5. (1) Cognitive impairment shall be manifested during the developmental period and be determined through the demonstration of all of the following behavioral characteristics:

- (a) Development at a rate at or below approximately 2 standard deviations below the mean as determined through intellectual assessment.
- (b) Scores approximately within the lowest 6 percentiles on a standardized test in reading and arithmetic. This requirement will not apply if the student is not of an age, grade, or mental age appropriate for formal or standardized achievement tests.
- (c) Lack of development primarily in the cognitive domain.
- (d) Impairment of adaptive behavior
- (e) Adversely affects a student's educational performance.

(2) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a psychologist.

ADDRESSING CONCERNS RELATED TO POSSIBLE CI

Students both within and outside of the special education system may come to staff members' attention as possibly exhibiting characteristics of a Cognitive Impairment. When this occurs, there is a process that must be followed to determine whether or not an evaluation is necessary and, if so, how that evaluation will be conducted and the impact it will have on the student's educational program.

Pre-Referral Process

The Berrien County Intermediate School District recommends a pre-referral process to be implemented as an integral part of the referral procedures for any suspected disability. The purposes of this process are to:

- Identify a problem,
- Identify a student's strengths and needs,
- Identify potential diagnostic/prescriptive interventions, and
- Implement those interventions with the anticipated outcome of resolving a student's academic and/or behavioral challenges in the general education setting.

Following this process helps ensure that students are being educated in the least restrictive environment as required by Act 451 of 1976 and the Individuals with Disabilities Education Act of 2004 (IDEA 2004), and reduces the frequency of inappropriate referrals to special education. It is important that appropriate comprehensive educational interventions be implemented and documented for a minimum of 45 school days prior to referring a student for special education services.

The pre-referral process is most effectively conducted by an instructional support team composed of general and special education teachers and related services personnel operating at the local building level. Depending on the district, students will be referred to a team with various names but a similar function. Regardless of the name, the committee has an important function of gathering information that becomes a source of information for the IEP Team to use in determining if special education services are necessary for an individual student. It is appropriate for all teachers working with the student to be involved in the documentation of the student's classroom performance and the educational alternatives utilized to increase his/her ability to function in general education.

Pre-Referral Strategies

These strategies are meant to address the communication, behavioral, social and learning differences that students may exhibit in the school environment. Many of these strategies and techniques are elements of good teaching that will be beneficial for all students in general and special education settings. It is critical to recognize that the strategies listed here are beneficial for students with a variety of needs and impairments. Staff may find that these strategies work for a particular student; however, that does not necessarily mean the student is cognitively impaired. The following strategies are starting suggestions and do not constitute an exhaustive list.

Transition Problems

Students transition from one activity to another better when they understand what and when things will happen.

1. Provide a visual schedule to prepare the student for the day's activities. Allow the student to cross out/remove activities as they are completed. Use photos, drawings, symbols, or words depending on developmental level and reading ability of the student. The schedule can be provided on the board for the entire class, or at the student's desk for personal use.
2. Use a timer to signal the beginning and end of activities. Visual timers are available that do not make any noise.
3. Provide advance warning for transitions. For example, "Work time will be done in 5 minutes."
4. Provide advance warning for schedule changes. For example, "The assembly is cancelled for this afternoon so we will be playing board games instead." Use the visual schedule to make changes.

Recess Problems

Students participate better when they have some structure regarding peers and activities that are available.

1. Consider restructuring recess, rather than taking it away as a consequence for having problems during that time. Many students need the active recess time to help keep them regulated.
2. Provide a peer or small group of peers to play with the student at recess.
3. Have the student choose the activity he/she will participate in prior to going outside. Help the student by providing a visual or written list of activities that are available if needed.
4. Collaborate with staff supervising recess.

Issues with Frustration/Emotional Self-Regulation

Students feel more secure knowing there is a way they can calm themselves and regain control.

1. Analyze the times, places, and situations where the student is having difficulty. Make accommodations as necessary during those times.
2. Provide a quiet space or "safe spot" for the student to go when he/she needs a break. Make sure the student understands what the space is to be used for and how to access that space. Use a timer to transition the student back into classroom activities if needed.
3. Change the student's environment; run an errand to the office, get a drink from the fountain, and so on.
4. Provide the student with a set number of passes or break cards to use when he/she is becoming agitated. These passes can be used to access a quiet space, take a walk in the hall, or do something similar.
5. Allow the student to use a stress ball or other sensory tool to assist with calming.

Difficulty Following Directions/Routines

Students follow directions and complete routines better when they do not have to rely solely on their auditory processing skills.

1. Break the instructions into smaller pieces and explain the process step-by-step as the activity proceeds.
2. Write the directions on the board or on a piece of paper for the student to have at his/her

desk.

3. For classroom routines, provide the student with a checklist or set of pictures of things he/she needs to do, as with writing a routine for starting the morning.

Difficulties with Organization

Students are more likely to stay organized when the teacher provides visual cues and when organizational skills are directly taught and practiced.

1. Provide labeled containers such as boxes and binders to help the student know where material and papers belong.
2. Label areas of the student's locker or cubby to help him/her know where to put his/her belongings.
3. Set aside a weekly cleaning/organization time when an adult (or a peer for older students) can assist the student with sorting through papers and organizing materials.
4. Teach the student to use a planner for keeping track of assignments and other responsibilities.

Difficulties with Written Expression

Students can process information and organize their responses better when they do not have to focus on the motor task of writing.

1. Note taking
 - a. Allow the student access to copies of another student's notes. Carbon notebooks could be used.
 - b. Provide a copy of the overhead notes for the student to follow along and highlight throughout the lecture.
 - c. Provide a scribe to take notes.
 - d. Provide a "fill-in-the-blank" format for students to take notes.
2. Allow the student to use a computer or other keyboard device during writing activities.
3. Provide other ways for students to show what they know. Allow them to take tests verbally, draw pictures or diagrams, etc.

Multidisciplinary Evaluation Team (MET) Process

Special Education Rules Related to the MET Process

Rule 340.7121a (1) Evaluation procedure. Each student suspected of having a disability shall be evaluated by a multidisciplinary team.

Rule 340.1701b(b) Multidisciplinary Evaluation Team means a minimum of two persons who are responsible for evaluating a student suspected of having a disability. The team shall include at least one special education teacher or other specialist who has knowledge of the suspected disability.

Rule 34 CFR§300.303 Reevaluations. A public agency must ensure that a reevaluation of each child with a disability is conducted in accordance with §§ 300.304 through 300.311-

- (1) If the public agency determines needs warrant an evaluation; or
- (2) If the child's parent or teacher requests a reevaluation.

Rule 340.1705(2) Cognitive impairment; determination. A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a psychologist.

Definition/Purpose of MET

The Multidisciplinary Evaluation Team (MET) is a group of persons who have responsibility for evaluating or reevaluating a student with a suspected disability. This team conducts a comprehensive assessment, which varies depending on the student's age, physical condition, and nature of the presenting problem. The purpose of an evaluation conducted by school personnel is to determine the presence of an educational disability and the need for special education services. Information gathering during the evaluation process must provide data that supports the presence or absence of Cognitive Impairment and the resulting adverse effect on educational performance in cognitive, academics/achievement, and adaptive behavior areas. Once a student is determined eligible the selection of programs and services is determined by the student's individual needs. These needs are documented in the present level of academic achievement and functional performance statement.

ASSESSMENT PROCESS FOR COGNITIVE IMPAIRMENT

The evaluation of Cognitive Impairment (CI) is a process that requires a team of professionals. Time must be taken to ensure that information regarding all aspects of a student's development and needs are gathered. The goal of a school-based evaluation for Cognitive Impairment is not to provide a clinical diagnosis for students, but to determine eligibility as well as the need for special education services based upon the characteristics manifested. Because the determination of Cognitive Impairment is a subjective process given numerous exclusionary clause considerations, it is essential that at least one member of the evaluation team have a broad experience with individuals with cognitive impairment to avoid under- or over-identification based on exposure to a limited number of students.

As discussed in earlier chapters, there is a triad of impairments that defines Cognitive Impairment. The significance of impairments affecting all three areas – cognitive, academic achievement, and adaptive behavior – is critical in distinguishing Cognitive Impairment. In completing a comprehension evaluation, however, there are additional areas that need to be assessed to acquire a complete picture of a specific student's strengths and needs. Additionally, as schools become increasingly diverse, the evaluation process must seek to understand cultural and socioeconomic differences relative to the influence this provides as the student interacts with his or her environment.

Developmental History

Because symptoms of Cognitive Impairments are typically present prior to age three, it is critical to acquire a thorough developmental history of any student suspected of having this disability. Plotts and Webber (2001-02) stated their view that "parents are the most important resource available to professionals attempting to diagnose and intervene with" Cognitive Impairments. Developmental history information is also beneficial when addressing issues of differential diagnosis and looking at other potential impairment categories. The following information is necessary for any initial evaluation for Cognitive Impairment and should be updated as needed during subsequent evaluation:

- Parents' perception of concern and child's age when concerns began
- Health and medical history
- Prenatal and birth history
- Educational history
- Developmental milestones
- Language acquisition
- Social development/play patterns
- Evidence of skill regression in any area
- Family history of developmental conditions

Educationally Relevant Medical Information

Medical conditions and interventions, such as medications, may affect a child's behavior or development. A thorough review of the student's medical history is critical. Consider if potential behavioral side effects of various medications are affecting the student.

Cognitive

Measures of cognitive development must be determined through psychological testing, while measures of both reading and mathematics development must be determined through achievement testing (when standardized results are attainable).

Psychological tests measure cognition with intelligence quotients (IQs), usually given in standard scores and percentiles. Intelligence is defined as “general mental ability which includes reasoning, planning, problem solving, abstract thinking, comprehending complex ideas, rapid learning, and learning from experience.”*

The IQ for CI eligibility typically extends through **70 (second percentile)**. The American Association on Intellectual and Developmental Disabilities believes that the upper limit IQ could be extended to 75 or more when it is clinically judged that impaired behavior is the result of deficits in reasoning and judgment.

*Special Education Program Outcomes Guide: Educable Mental Impairment, 1992. Copyright by Disability Research Systems, Inc. & Michigan Department of Education.

**See *Appendix A*.

Cognitive factors to evaluate include:

- Processing
- Memory
- Reasoning and concept formation
- Attending
- A profile of strengths and deficits and whether there are splinter skills
- Evaluating patterns of response – Does the child persevere?
- Whether the skill levels represent delayed or deviant patterns of cognitive functioning

Academic/Achievement

Achievement test results are also measured in standard scores and percentiles. Reading and mathematics achievement scores must both be around the **sixth percentile or lower**.

Adaptive Behavior

Adaptive behavior is defined as the development and application of abilities required for the attainment of personal independence and social sufficiency (Stone et al., 1999). Adaptive behaviors are strong predictors of outcome, since they require the student to use whatever capacities she/he possesses to function within the everyday environment. These skills are particularly important in individuals with Cognitive Impairments because it is these, rather than cognitive level, that contributes most to the individual's ability to function successfully and independently in the world (Paul et al., 2004). Adaptive behavior scores obtained on very young children may also prove more stable than cognitive scores throughout childhood, and are better able to predict language acquisition in nonverbal children than performance IQ scores (Stone, Ousley et al., 1999).

Adaptive behavior tends to be impaired commensurate to cognitive abilities in individuals with Cognitive Impairments. Individuals with Cognitive Impairments typically show an even pattern of skill development across adaptive behavior domains.

Discrepancies between mental age and adaptive behavior scores would indicate that other issues such as environment, socio-cultural issue or a lack of educational exposure are to be considered more carefully. Adaptive behavior scores in Cognitive Impairments show significant deficits in adaptive behaviors (Carter et al., 1998).

Adaptive behavior assessment also assists with development of goals and programming, and can serve to monitor a student's development over time and across settings. The following areas of adaptive behavior require assessment:

- Communication skills
- Social skills, including play skills
- Daily living/self-help skills – dressing, eating, job skills, money management
- Motor skills (if motor concerns are present)

Adaptive behavior can be measured using **either** of the following options:

1. *When assessing adaptive behavior using the model currently advanced by the AAIDD*, significant limitations should be established through the use of standardized measures normed on the general population, including people with and without disabilities. Significant limitation is defined as “performance that is at least two standard deviations below the mean of **either**:
(a) one or more of the following three types of adaptive behavior: **communication, social, or daily living/self-help skills**, or
(b) an overall score on a standardized measure on **communication, social, and daily living/self-help skills**.”
2. *When assessing adaptive behavior using “functional life limitations”*, both quantitative and qualitative standardized measures of functional life skills should be considered to determine “substantial limitation.” A substantial limitation is at least one and one-half (1 ½) standard deviation below the mean.

Persons with cognitive impairments have substantial, functional life limitations in adaptive behavior, which, for diagnostic purposes, must be manifested in a **majority** of the following ten (10) skill areas: Communication, Community Use, Functional Academics, Home Living, Health & Safety, Leisure, Self-Care, Self-Direction, Social, Work

Additional considerations:

Adaptive behavior is considered to be conceptually different from maladaptive or “problem behavior.” Therefore, inappropriate behaviors which interfere with an individual's daily activities (or with the activities of others around him or her) should be considered problem behavior rather than adaptive behavior. There is general agreement that the presence of clinically significant levels of problem behavior found on adaptive behavior scales *does not* meet the criterion of significant limitations in adaptive functioning (Greenspan, 1999a; Jacobson & Mulick, 1996).

A vexing problem is the lack of agreement among raters. When reported, interrater agreement is often poor for adaptive behavior scales. The interpretation of such findings can proceed along two lines. First, poor agreement can suggest lack of reliability. This would suggest three potential problems: (1) The specific items are difficult to understand or interpret; (2) the criteria used to rate the behavior are subjective; or (3) one or both of the rater are insufficiently familiar with the student.

Lack of inter-rater agreement can also suggest lack of validity. Thus two potential problems: (1) One of

the raters may have distorted perceptions or may not be entirely truthful; or (2) the student's behavior may vary in different contexts. In practice, examiners have few options for dealing with rater disagreement. Assessors should select as the respondent the person who is most familiar with the student, who has seen the student in most contexts, and who will provide the most truthful and objective responses. Examiners should also guard against conveying their own expectations to the respondent. Finally, when behavior clearly varies across contexts, examiners should consider elements in those contexts that may set the occasion for behavior because such elements may have importance in educational interventions.

**See Appendix B*

ISSUES OF ELIGIBILITY

Exclusionary Considerations

In addition to considering the eligibility for special education criteria within the state and federal definitions of cognitive impairment, there is a need to consider (1) adverse educational impact and (2) need for special education. Eligibility must result from the condition and its effects on performance, but not from lack of instruction or limited English proficiency. Courts and hearing officers frequently refer back to three basic elements in the determination of special education eligibility: (a) criteria within an eligibility category, (b) adverse educational impact, and (c) need for special education programs and services. Important considerations include the following:

1. If a student has a clinical diagnosis of mental retardation or a related disorder, she/he may not automatically qualify for special education.
2. Even though Cognitive Impairment is considered a lifelong disability, a student with CI may or may not **need** special education services at a given point in time.
3. The IEP Team should address the need for a special education program and/or services based on the student's current functioning, not his/her projected needs.
4. If a student with cognitive impairment needs accommodations only, consider providing those through a Section 504 plan.

See appendix F for an example of an exclusionary factors worksheet to assist in exclusionary considerations.

Adverse Impact

Both Michigan's current definition of Cognitive Impairment and the IDEA definition of Cognitive Impairment specify that adverse impact on education must be determined. The *Revised Administrative Rules for Special Education* state:

R 340.1705 Cognitive Impairment; determination.

Rule 5. (1) Cognitive impairment shall be manifested during the developmental period and be determined through the demonstration of all of the following behavioral characteristics:

- (a) Development at a rate at or below approximately 2 standard deviations below the mean as determined through intellectual assessment.
 - (b) Scores approximately within the lowest 6 percentiles on a standardized test in reading and arithmetic. This requirement will not apply if the student is not of an age, grade, or mental age appropriate for formal or standardized achievement tests.
 - (c) Lack of development primarily in the cognitive domain.
 - (d) Impairment of adaptive behavior
 - (e) Adversely affects a student's educational performance.
- (2) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a psychologist.

The IDEA regulations state the following:

CFR § 300.8 Child with a disability

- (a) General. (1) Child with a disability means a child evaluated in accordance with §§ 300.304 through 300.311 as having mental retardation and who, by reason thereof, needs special education and related services.

Courts and hearing officers have addressed adverse impact in special education cases involving a number of diagnoses. Case law has determined that even when specific conditions exist that could be the basis for special education eligibility under various eligibility categories, the conditions themselves do not automatically trigger eligibility. Rather, the impact of the disorders is not determinative when the diagnosed conditions do not meet the additional criteria of adverse effect on the student's educational performance.

While one facet of adverse impact may be reflected in a student's grades, this is not the only factor that must be considered. Although case law is not definitive on this point, determinations of adverse impact or need for special education have been based on such evidence as progress in the general education curriculum. Academic achievement and progress is a fundamental consideration in addressing this issue and should be carefully reviewed. Social and other behavioral factors should also be considered as they relate to overall educational performance and progress in the general education curriculum. For example, if a student diagnosed with Cognitive Impairment is receiving passing grades but is having chronic difficulties in other aspects of his/her school environment, then social/behavioral concerns should be considered when determining the need for special education or accommodations.

Need for Special Education

Michigan addresses the need for special education in the following rule:

Rule 340.1702 (2): Student with a disability means a person who is determined by an individualized education program team or hearing officer to have 1 or more of the impairments specified in this part that necessitates special education or related services, or both . . .

IDEA has similar language regarding need for special education as follows:

Rule 300.8(a) General . . . the term child with a disability means . . . who, by reason thereof, needs special education and related services.

In addition to consideration of adverse impact, a determination must be made of the child's need for special education. The issue of adverse impact is certainly a critical question to consider in determining need for special education, but it may be found that the adverse impact can be addressed with general education accommodations and without special education. It is important for educational teams to review the amount of support that is necessary for the student to be successful. The extent and type of modifications needed will, therefore, be an important consideration to address.

Courts and hearing officers have addressed the need for special education in considering numerous disorders. A student may meet the criteria for one of the eligibility categories and have a disability that also adversely affects educational performance; but if the student does not need special education in order to benefit from his school program, then she/he is not eligible for special education. Also, in *Letter to Gallagher* (1996), OSEP noted that the need for special education is an essential requirement separate from other criteria in determining eligibility.

Lack of Instruction or Limited English Proficiency

An additional component of eligibility determination for all categories is the exclusion from eligibility due to a lack of instruction in math, the essential components of reading instruction, or limited English proficiency. Although these exclusionary factors may not be applicable in all Cognitive Impairment referrals, these factors still need to be considered. While this is not addressed in Michigan's rules, it is specified in IDEA and so must be addressed. The IDEA 2004 language is as follows:

§614 (b) (5) In making a determination of eligibility . . . a child shall not be determined to be a child with a disability if the determinant factor for such determination is (A) lack of instruction in reading, including in the essential components of reading instruction (as defined in section 1208 (3) of the Elementary and Secondary Education Act of 1966); (B) lack of instruction in math; or (C) limited English proficiency.

The issue of attendance needs to be addressed under this section of consideration. It is suggested that no later than the student's 12th day of absence instructional intervention be provided to return the student to instructional expectations. Upon reaching 20 or more days of missed instruction it is difficult to determine if deficits are the result of a student-based disability or a lack of instruction. When numerous days of instruction are missed it is crucial to document instructional interventions to establish the provision of appropriate learning opportunities. Without documented interventions and the student's response to those interventions this element of the exclusionary clause can not be addressed.

Social and Cultural Background

A vitally important consideration in the evaluation process is the consideration of cultural differences and socioeconomic influences. As the variance of scores within the data increases careful consideration must be given to the possible impact of social and cultural issues.

The consideration of the following questions is helpful:

1. Was the family of the student involved in the data collection and decision-making process relative to pre-referral interventions and evaluation data collection? This acknowledges the unique contribution that individuals from diverse backgrounds can bring to the process.
2. Was student progress and instructional strategies reviewed in a manner which reflected culturally responsive learning environments?
3. Was test data interpreted in light of the influence social and cultural issues?
4. Were a variety of assessment strategies utilized?
5. To the extent available were culturally sensitive assessment practices utilized?

§300.306 (c)(1)(i)(ii) In interpreting evaluation data for the purpose of determining if a child is a child with a disability under §300.8, and the educational needs of the child, each public agency must- (i) Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, and teacher recommendations, as well as information about the child's physical condition, social or cultural background, and adaptive behavior; and (ii) Ensure that information obtained from all these sources is documented and carefully considered.

REFERENCES

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Appendix A

COMPREHENSIVE SKILL AREAS ASSESSED IN DIAGNOSING CI*

AREA	CHARACTERISTICS	POTENTIAL PROBLEMS
COGNITIVE	Limited memory. Limited general knowledge and information. Concrete rather than abstract thinking. Slower learning rate.	Inattention. Inefficient learning style. Difficulty communicating. Prone to failure. Standard teaching practices can be ineffective.
ACADEMIC	Difficulty learning most academic content. Limited performance in most content areas. Limited problem-solving ability. Limited content mastery.	Limited attention, organizational skills, questioning behaviors, direction following, monitoring of time and other school coping skills.
PHYSICAL	Discrepancies between physical and mental abilities.	Performance often less than expected, based on physical appearance.
BEHAVIORAL	Limited social and personal competence. Limited coping skills. Limited personal life skills and competence.	Tardiness, complaints of illness, classroom disruptiveness, social isolation and inappropriate activity.
COMMUNICATION	Lower levels of language development. Limited listening and speaking vocabularies.	Difficulty following directions. Trouble making requests, interacting, or communicating.

*Ysseldyke, J.R. and Algozzine, B. (1995), Special Education: A Practical Approach for Teachers, Houghton Mifflin Company; Boston, MA.

Appendix B

ADAPTIVE SKILL AREAS ASSESSED IN DIAGNOSING CI*

COMMUNICATION	Includes the ability to comprehend and express information through spoken words, written words, graphic symbols, sign language, and manually coded English or non-symbolic behaviors such as facial expressions, body movements, and gestures.
COMMUNITY USE	Refers to appropriate use of resources in the community, including transportation, shopping, obtaining services, worship, and using public facilities.
FUNCTIONAL ACADEMICS	Includes cognitive abilities and skills related to learning in school (for example, practical reading, writing, math, science, geography, and social studies).
HOME LIVING	Refers to daily functioning related to areas such as housekeeping, clothing care, property maintenance, food preparation, planning and budgeting for shopping, and home safety.
HEALTH & SAFETY	Refers to maintaining one's well-being, including having an appropriate diet, identifying, treating, and preventing illness, knowing basic first aid, and following rules and laws.
LEISURE	Refers to recreational interests and skills related to them, such as choosing and initiating activities, taking turns, and engaging in home and community activities alone and with others.
SELF-CARE	Involves skills such as eating, dressing, grooming, toileting, and personal hygiene.
SELF-DIRECTION	Refers to making choices related to learning and following a schedule, initiating appropriate activities consistent with personal interests, completing tasks, seeking assistance when needed, and resolving problems productively.
SOCIAL SKILLS	Includes appropriate (for example, making friends, showing appreciation, smiling) and inappropriate (for example, tantrums, jealousy, public sexual behavior) social behaviors.
WORK	Relates to holding a job (part or full time) or participating in volunteer activities.

*Ysseldyke, J.R. and Algozzine, B. (1995), Special Education: A Practical Approach for Teachers, Houghton Mifflin Company; Boston, MA.

Appendix C

BEHAVIORAL PHENOTYPES OF SELECTED GENETIC DISORDERS*

Down Syndrome	<ol style="list-style-type: none"> 1. Better performance on visual-spatial tasks than on verbal or auditory tasks. 2. Adaptive behavior strength relative to intelligence. 3. Pleasant and sociable personality. 4. Depression common in adulthood.
Williams Syndrome	<ol style="list-style-type: none"> 1. Strengths in language, auditory memory, and facial recognition. 2. Limitations in visual-spatial functioning, perceptual-motor planning, and fine motor skills. 3. Strength in theory of mind (interpersonal intelligence). 4. Friendliness with impaired social intelligence. 5. Anxiety disorders common at all ages.
Fragile X Syndrome	<ol style="list-style-type: none"> 1. Verbal skills better than visual-spatial skills. 2. Relative strengths in daily living and self-care skills. 3. Frequent association with inattention, hyperactivity, and autistic-like behaviors. 4. Anxiety disorders common at all ages.
Prader-Willi Syndrome	<ol style="list-style-type: none"> 1. Impaired satiety, food-seeking behavior, and obesity. 2. Strength in visual processing and solving jigsaw puzzles. 3. Obsessive-compulsive disorders and impulse control disorders at all ages. 4. Occasional psychosis in adults.
Velocardiofacial Syndrome	<ol style="list-style-type: none"> 1. Verbal skills better than nonverbal skills. 2. Inattention and hyperactivity common in children. 3. Schizophrenia and mood disorders more common in adults and older adolescents.
Rubinstein-Taybi Syndrome	<ol style="list-style-type: none"> 1. Inattention and impulsivity common in children. 2. Friendliness. 3. Occasional association with mood disorders, tics, and obsessive-compulsive disorders. 4. Interests in music.
Smith-Magenis Syndrome	<ol style="list-style-type: none"> 1. Delayed speech acquisition. 2. Relative weakness in sequential processing. 3. Sleep disorders common. 4. Frequent stereotyped and self-injurious behaviors. 5. Impulse control disorders common in children.
Angelman Syndrome	<ol style="list-style-type: none"> 1. Bouts of inappropriate laughter characteristic in younger individuals. 2. Generally happy disposition at all ages. 3. Hyperactivity and sleep disorders in younger individuals.

*American Association on Mental Retardation, 2002.

Appendix D

RISK FACTORS FOR MENTAL RETARDATION*

TIMING	BIOMEDICAL	SOCIAL	BEHAVIORAL	EDUCATIONAL
PRENATAL	<ol style="list-style-type: none"> 1. Chromosomal disorders. 2. Single-gene disorders. 3. Syndromes. 4. Metabolic disorders. 5. Cerebral dysgenesis. 6. Maternal illness. 7. Parental age. 	<ol style="list-style-type: none"> 1. Poverty. 2. Maternal malnutrition. 3. Domestic violence. 4. Lack of access to parental care. 	<ol style="list-style-type: none"> 1. Parental Drug use. 2. Parental alcohol use. 3. Parental smoking. 4. Parental immaturity. 	<ol style="list-style-type: none"> 1. Parental cognitive disability without supports. 2. Lack of preparation for parenthood.
PERINATAL	<ol style="list-style-type: none"> 1. Prematurity. 2. Birth Injury. 3. Neonatal disorders. 	<ol style="list-style-type: none"> 1. Lack of access to birth care. 	<ol style="list-style-type: none"> 1. Parental rejection of caretaking. 2. Parental abandonment. 	<ol style="list-style-type: none"> 1. Lack of medical referral for intervention services at discharge.
POSTNATAL	<ol style="list-style-type: none"> 1. Traumatic brain injury. 2. Malnutrition. 3. Meningoencephalitis. 4. Seizure disorders. 5. Degenerative disorders. 	<ol style="list-style-type: none"> 1. Impaired child-caregiver. 2. Lack of adequate stimulation. 3. Family poverty. 4. Chronic illness in the family. 5. Institutionalization. 	<ol style="list-style-type: none"> 1. Child abuse and neglect. 2. Domestic violence. 3. Inadequate safety measures. 4. Social deprivation. 5. Difficult child behaviors. 	<ol style="list-style-type: none"> 1. Impaired parenting. 2. Delayed diagnosis. 3. Inadequate early intervention services. 4. Inadequate special education services. 5. Inadequate family support.

*American Association on Mental Retardation, 2002

APPENDIX E

Vineland Adaptive Behavior Scales (VABS), 1984

Authors: Sara S. Sparrow, David A. Balla, Domenic V. Cicchetti

Publisher Information: American Guidance Service, Inc.
4201 Woodland Road
Circle Pines, MN 55014-1796

Age Range: Interview Editions: Birth through 18-11 and low-functioning adults
Classroom Edition: 3 through 12-11

Administrative Time

- *Interview Edition Survey Form* 20-60 minutes
- *Interview Edition Expanded Form* 60-90 minutes
- *Classroom Edition* 20 minutes

Areas Assessed

- Communication (expressive, receptive, written)
- Daily living skills (personal, domestic, community)
- Socialization (interpersonal relationships, play and leisure time, coping skills)
- Motor skills (gross and fine)
- Maladaptive behavior (included in *Interview Editions*; optional domain)

Description of Instrument

- Semi-structured interview and classroom questionnaire formats gather multiple measures/perspectives of an individual's skills in areas necessary for everyday living
- *Interview Editions* are completed with parent/caregiver while *Classroom Edition* is a questionnaire completed by teacher(s)
- *Survey Form* – 297 items to gather general information on adaptive behavior
- *Expanded Form* – 577 items provide comprehensive assessment of adaptive behavior

Strengths

- Proven to be an accurate resource for predicting autism and Asperger syndrome
- Supplementary norm groups available for early childhood and coming soon for ASD
- Computer *ASSIST* scoring programs available

Potential Concerns

- Lengthy administration time for Expanded Form
- Some of the items assess skills that are not as prevalent today as when test was first published

Recommended Use

- Comprehensive assessment of adaptive behavior
- Part of a comprehensive assessment of communication, social interaction, and behaviors associated with ASD
- Useful for differential diagnosis as well as educational program planning and monitoring of progress (Expanded Form most beneficial for these areas)

Cost: \$199.00 for Starter Kit including *Survey, Expanded, and Classroom Editions*

Other Considerations: Video training and materials available from publisher

AAMR Adaptive Behavior Scale – School 2 (ABS-S2)

Authors: Nadine Lambert, Henry Leland, and Kazuo Nihira

Publisher Information: PRO-ED
8700 Shoal Creek Boulevard
Austin, TX 78758
800-897-3202
www.proedinc.com

Age Range: 3-0 through 18-11

Administration Time: 15-30 minutes

Areas Assessed: Part 1

- Independent & responsible functioning
- Physical development
- Language development
- Socialization

Part 2

- Adaptation
- Maladaptive behaviors

Description of Instrument

- The ABS-S2 is an individually administered, norm-referenced scale designed for use with individuals between 3 and 18 years of age.

Strengths

- Reliable, especially with CI populations
- Factor scores more reliable than subject scores

Potential Concerns

- Age scores can be less than reliable
- Concern over stability of scores
- Not reliable at the extremes

Recommended Use

- Assessment used in conjunction with other scores can assist in functional skills assessment.

Cost: \$150.00 for Starter Kit including Examiner's Manual, 25 Examination Booklets, and 25 Profile/Summary Forms, all in a sturdy storage box

Adaptive Behavior Inventory (ABI)

Authors: Linda Brown and James E. Leigh

Publisher Information: PRO-ED
8700 Shoal Creek Boulevard
Austin, TX 78758
800-897-3202
www.proedinc.com

Age Range: 6-0 through 18-11

Administration Time: Under 30 minutes

Areas Assessed

- Self-care skills – 30 items
- Communication Skills – 30 items
- Social Skills – 32 items
- Academic Skills – 30 items
- Occupational Skills – 28 items

Description of Instrument

- The ABI is intended to be used to provide information about adaptive behavior during the diagnosis of CI, to compare various components of adaptive behavior exhibited by one individual, and to evaluate instructional programs. The preferred respondent for the ABI is the classroom teacher or other professional who has relevant contact with the student being assessed.

Strengths

- Adequate norms
- Adequate reliability and validity
- ABI users are urged to postpone administration of the device if a rater cannot be found who has had sufficient contact with the student to provide complete and reliable information

Potential Concerns

- Norms are poorly described so caution is needed for scores on the extremes
- Does not measure functional skills

Recommended Use

- Reliable assessment of adaptive behavior from the academic perspective

Cost: \$92.00 for Starter Kit including 25 Profile and Response Sheets, 25 Short Form Response Sheets, and Examiner's Manual, all in a sturdy storage box

Responsibility and Independence Scale for Adolescents (RISA)

Authors: John Salvia, John T. Neisworth, Mary W. Schmidt

Publisher Information: The Riverside Publishing Company
8700 Shoal Creek Boulevard
Austin, TX 78758
800-897-3202
www.proedinc.com

Age Range: 12 through 19-11

Administration Time: 30-45 minutes

Areas Assessed

- Domestic Skills
- Money Management
- Citizenship
- Personal Planning
- Transportation Skills
- Career Development
- Self-Management
- Social Maturity
- Social Communication

Description of Instrument

- An individually administered, norm-referenced device intended to assess the adaptive behavior of adolescents in a question format (yes or no).

Strengths

- Although no specialized training is required the authors provide practice exercises for individuals who are not experienced in the use of this type of instrument.
- Good representative sampling in test norming
- Reliable instrument

Potential Concerns

- Limited scope of use
- Does not assess a wide range of skills

Recommended Use

- Helpful, particularly when used in conjunction with transition planning

Cost: \$219.00 for Starter Kit including Test Book, Examiner's Manual and package of 25 Response Forms

EXCLUSIONARY FACTORS WORKSHEET
Cognitive Impairment

Each factor must be ruled out as the PRIMARY FACTOR for the student's inability to progress in the general education curriculum, and for obtained cognitive and adaptive scores.	Yes	No
1. Lack of instruction in essential components of reading and math		
Does information obtained during assessment indicate lack of instruction in reading and math is not the determinant factor in this student's inability to progress in the general education curriculum?		
2. Limited English Proficiency		
Answer the following questions		
• Is there a language other than English spoken by this student?		
• Is there a language other than English spoken by the student's home?		
• Are there any specific dialect or cultural influences that would affect the student's ability to speak or understand English?		
<i>If questions in Section 2 are NO, limited English proficiency is not a determinant factor. If any of the questions in Section 2 are YES, please document the reason(s) that English proficiency is not the primary reason for the student's deficit cognitive and/or adaptive scores.</i>		
3. Cultural Background Differences		
<i>Document all information gathered in assessment that would exclude environmental or cultural disadvantage as the determinant factor for this student's inability to access general education curriculum or perform significantly below normal on measures of Cognition, Achievement, and Adaptive Behavior</i>		
• Is there compelling evidence from data gathered and information generated to indicate this student is unable to learn or perform on assessments due to cultural or background difference?		
4. Medical Conditions That Impact School Performance		
<i>Document all information gathered through assessment that would exclude medical or health reasons for this student's deficient performance on both assessments of cognition and adaptive behavior.</i>		
• Does the student have a medical history and/or school history of medical or health-related difficulties?		
• If yes, would the student's health-related difficulties cause the student to have difficulty accessing general education curriculum?		
• Are there school records of illness or health-related conditions that would impact negatively on this student's ability to progress in the general education curriculum?		
5. Socioeconomic Status, or Communication, Sensory or Motor Impairments		
<i>Document all information gathered through assessment that would exclude sensory or motor impairments as a factor for this student's deficient performance on assessment of cognition, achievement, and adaptive functioning.</i>		
• Are the student's measured skills on the cognitive assessment consistently in the significantly deficient range across the assessment battery (language and visual/motor skills are equally deficient)?		
• Are the student's measured skills of home adaptive behavior consistently in the significantly deficient range across the adaptive area domains (communication, functional daily life skills, and motor skills are in the deficient or near-deficient range)?		
• Are the student's observed behaviors in the classroom and school setting consistent with significantly deficient cognitive, academic, and adaptive functioning?		
• Does the assessment data indicate that lack of opportunity to learn due to socioeconomic circumstances is not the cause or primary reason for the student's deficient scores obtained on cognitive, achievement, and adaptive skills measured?		
<i>If the questions in Section 5 are YES, socioeconomic, communication, sensory or motor skills are not the reason for the student's inability to progress in the general education classroom.</i>		