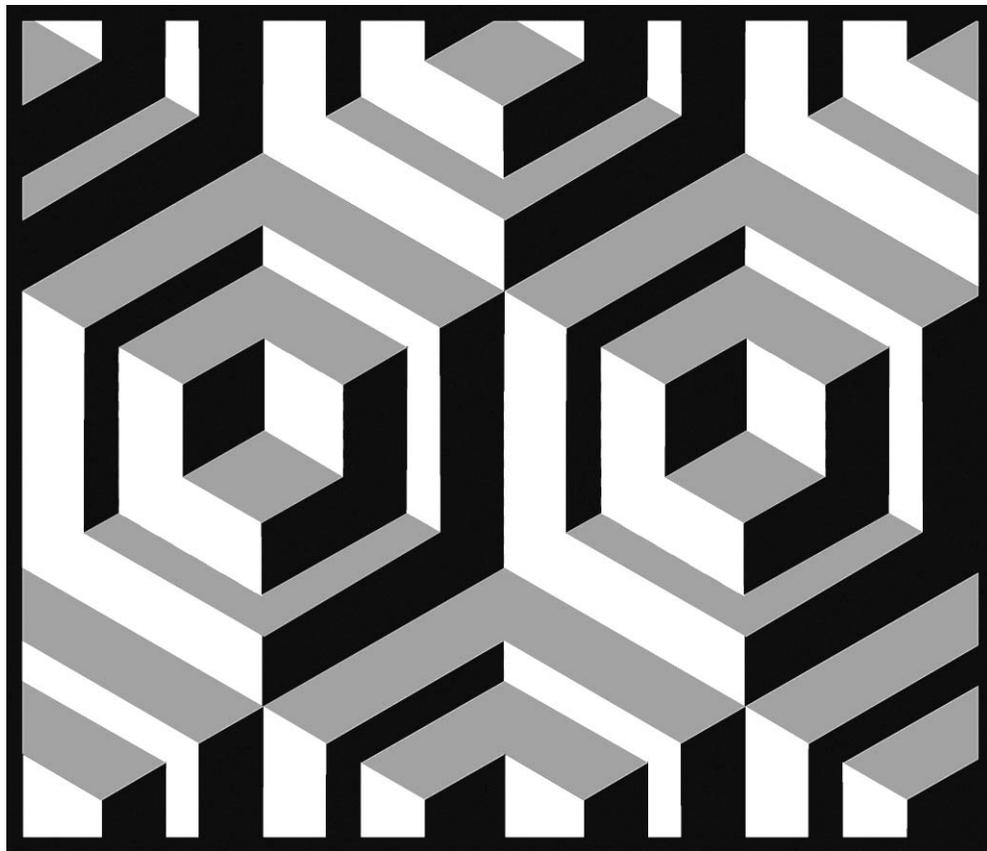


Autism Spectrum Disorder Evaluation and Eligibility Guidelines



2015



PURPOSE OF THE AUTISM SPECTRUM DISORDER (ASD) EVALUATION AND ELIGIBILITY GUIDELINES

The purpose of these Kent ISD *ASD Evaluation and Eligibility Guidelines* is to assist the evaluation team in assuring that the eligibility criteria for the Michigan Administrative Rules for Special Education for Autism Spectrum Disorder (ASD) are followed. These guidelines will provide evaluation teams with information to assist in recommending an appropriate eligibility for an individual student suspected of having an ASD. Although ASD may be defined differently in the Michigan rules than in the *5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, the educational staff recommending special education eligibility for ASD in Michigan must adhere to the Michigan eligibility rules.

However, a problem may occur when students are given clinical diagnoses of disorders that do not necessarily fit in with the categories outlined by the Michigan eligibility rules. It is important that the evaluation team consider clinical diagnoses as one piece of information in a larger process for recommending eligibility for special education.

TABLE OF CONTENTS

Table of Contents.....	i
Superintendent and PSA Endorsement Pages.....	v
ASD Evaluation and Eligibility Guidelines Committee Members.....	vii

INTRODUCTION TO AUTISM SPECTRUM DISORDER (ASD)

Chapter 1 – Introduction to Autism Spectrum Disorder (ASD).....	1
What is Autism Spectrum Disorder (ASD)?.....	1
Common Characteristics of ASD.....	1
Cause(s) of ASD.....	2
Diagnosing ASD.....	3
Michigan’s Definition of Autism Spectrum Disorder.....	3
Discussion of MDE Definition of Autism Spectrum Disorder.....	4
Discussion of IDEA Definition of Autism.....	11

ADDRESSING CONCERNS RELATED TO POSSIBLE ASD

Chapter 2 – Addressing Concerns Related to Possible ASD.....	12
Early Intervention Procedures/Process.....	13
Intervention Strategies.....	14
Transition Problems.....	14
Recess Problems.....	15
Issues with Frustration/Emotional Self-Regulation.....	15
Difficulty Following Directions/Routines.....	16
Sensitivity to Environmental Stimuli.....	16
Activity Level Is Too High or Too Low.....	17
Difficulties with Social Rules/Social Activities.....	17
Difficulties with Organization.....	18
Difficulties with Written Expression.....	18
Recommendation of Eligibility Process.....	19
Special Education Rules Related to Recommendation of Eligibility Process.....	19
Determination of Eligibility.....	20
Review of Existing Evaluation Data and Evaluation Plan (REED).....	20
Eligibility Determination.....	21
REED and Consent to Evaluate Document.....	21
Information Relevant to Determination of ASD.....	22

Personnel Required for Autism Spectrum Disorder Determination.....	22
Roles of Participants	23
ASD Eligibility Flow Chart for Initial Referrals to Special Education.....	25
ASD Eligibility Flow Chart for Students Currently Receiving Services.....	26

ASSESSMENT PROCESS FOR AUTISM SPECTRUM DISORDER

Chapter 3 – Assessment Process for Autism Spectrum Disorder	27
Components of ASD Evaluation	28
Developmental History	28
Communication	28
Social Skills	29
Behavioral Concerns	30
Adaptive Behavior	30
Cognitive Factors	32
Sensory Motor Factors	32
Educationally Relevant Medical Information	33

ASSESSMENT TOOLS FOR AUTISM SPECTRUM DISORDER

Chapter 4 – Assessment Tools for Autism Spectrum Disorder.....	34
Comprehensive Assessment Tools.....	34
Developmental History Instruments.....	35
Autism Specific Instruments	36
Adaptive Behavior Instruments.....	36
Social/Emotional Instruments	37
Communication/Language Instruments.....	37
Cognitive Abilities Instruments.....	38
Sensory Motor Instruments	40
Observations.....	40
Reviews of ASD Tools	40
Adolescent/Adult Sensory Profile, 2002	41
Adolescent Test of Problem Solving (TOPS-A), 1991	42
The Assessment of Basic Language and Learning Skills-Revised (ABLLS-R), 2006	43
Autism Diagnostic Interview-Revised (ADI-R), 2003	44
Autism Diagnostic Observation Schedule (ADOS), 2001	45
Autism Screening Instrument for Educational Planning (ASIEP-2), 1993	46
Childhood Autism Rating Scale (CARS), 1988	47
Children’s Communication Checklist (CCC-2), 2003.....	48
Communication and Symbolic Behavior Scales Developmental Profile.....	
(CSBS DP), 2002.....	49
Elementary Test of Problem Solving (TOPS-E), 1994	50

Functional Communication Profile Revised (FCP-R), 2003	51
Gilliam Autism Rating Scale-Second Edition (GARS-2), 2006	52
Infant/Toddler Sensory Profile, 2002	53
MacArthur Communicative Development Inventories (CDIs), 2005	54
Psycho-Educational Profile – Third Edition (PEP-3), 2005	55
Sensory Profile, 1999	56
Social Responsiveness Scale (SRS), 2005	57
Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), 2008	58
Vineland Adaptive Behavior Scales (VABS), 1984	59
Vineland Adaptive Behavior Scales – Second Edition (VABS-II)	60

ISSUES OF ELIGIBILITY

Chapter 5 – Issues of Eligibility	61
Comparison with Other Special Education Definitions	61
Cognitive Impairment (CI)	61
Reciprocal Social Interaction	62
Communication and Symbol Use	62
Stereotypic Behavior/Restricted Range of Interests	63
Other Features that Help Differentiate ASD from CI	63
Assessment Tool Selection	63
Early Childhood Developmental Delay (ECDD)	63
Emotional Impairment (EI)	64
Inability to Build/Maintain Satisfactory Relationships in the School Environment	65
Inappropriate Types of Behaviors/Feelings Under Normal Circumstances	65
General Pervasive Mood of Unhappiness or Depression	65
Tendency to Develop Physical Symptoms or Fears Associated with Personal or School Problems	66
Speech and Language Impairment (SLI)	67
Consideration of Outside Diagnoses Related to Autism Spectrum Disorder	68
Exclusionary Considerations	68
Adverse Impact	69
Need for Special Education	70
Lack of Instruction or Limited English Proficiency	71
Sharing Evaluation Findings with Families	72
Autism Spectrum Disorder Eligibility Recommendation Procedures	73
Purpose	73
Evaluation Information	73
Diagnostic Assurances	73
Eligibility Recommendation	74
Present Level of Academic Achievement & Functional Performance (PLAAFP)	74
Reports and Documentation	75
Process for Re-evaluation	75

DEVELOPING INDIVIDUALIZED EDUCATION PROGRAMS

Chapter 6 – Developing Individualized Education Programs.....	77
Related Michigan Rule.....	77
IEP Team Report Sections	77
Present Level of Academic Achievement & Functional Performance (PLAAPF)	77
Annual Goals and Short Term Objectives	78
Accommodations and Modifications	79
State and Districtwide Assessments	80
Transportation Needs	80
Extended School Year (ESY)	80

APPENDICES

Appendix A – IDEA Definition of Autism.....	81
Appendix B – Comparison of MI and IDEA Definitions of ASD/Autism	82
Appendix C – Chart of Assessment Tools for Autism Spectrum Disorder	83
Appendix D – Michigan Definition of Cognitive Impairment	85
Appendix E – Michigan Definition of Early Childhood Developmental Delay	86
Appendix F – Michigan Definition of Emotional Impairment.....	87
Appendix G – Michigan Definition of Speech and Language Impairment.....	88
Appendix H – DSM-V Definition of Autistic Disorder.....	89

ASD Guidelines
Local School District Signatures



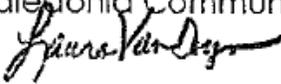
Kevin A. Konarska
Kent Intermediate School District



Daniel Takens
Byron Center Public Schools



Randy Rodriguez
Caledonia Community Schools



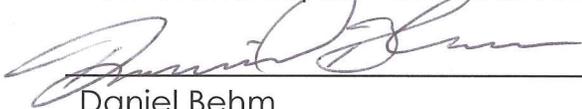
Laura VanDuyn
Cedar Springs Public Schools



Ethan Ebenstein
Comstock Park Public Schools



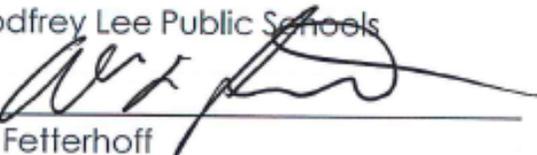
Sara M. Shubel
East Grand Rapids Public Schools



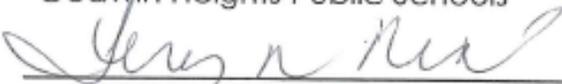
Daniel Behm
Forest Hills Public Schools



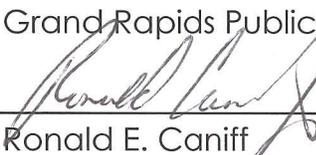
David Britten
Godfrey Lee Public Schools



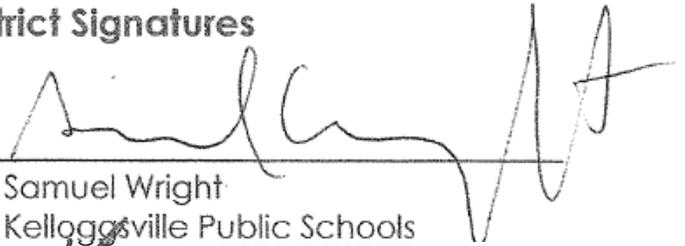
Bill Fetterhoff
Godwin Heights Public Schools



Teresa Neal
Grand Rapids Public Schools



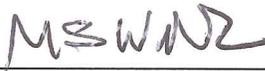
Ronald E. Caniff
Grandville Public Schools



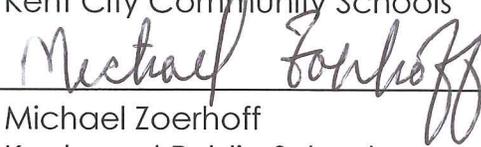
Samuel Wright
Kelloggsville Public Schools



Gerald Hopkins
Kenowa Hills Public Schools



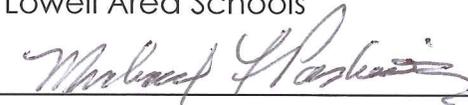
Michael Weiler
Kent City Community Schools



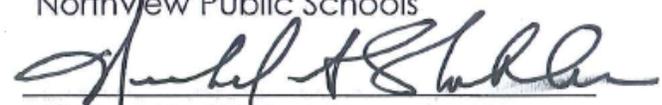
Michael Zoerhoff
Kentwood Public Schools



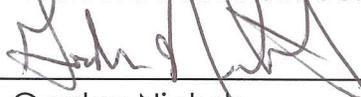
Gregory H. Pratt
Lowell Area Schools



Michael Paskewicz
Northview Public Schools



Michael S. Shibler
Rockford Public Schools



Gordon Nickels
Sparta Area Schools

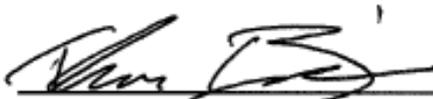


Tom Enslin
Thornapple Kellogg Schools

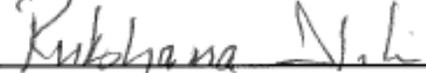


Thomas Reeder
Wyoming Public Schools

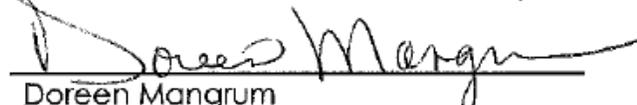
**ASD Guidelines
Public School Academy Signatures**



Tom Berriman
Byren Center Charter School



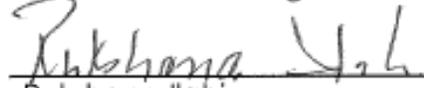
Rukshana Ilahi
Chandler Woods Charter Academy



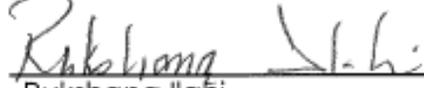
Doreen Mangrum
Covenant House Academy



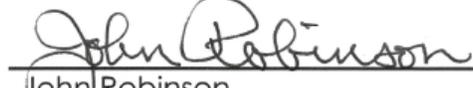
Dan George
Creative Technologies Academy



Rukshana Ilahi
Cross Creek Charter Academy



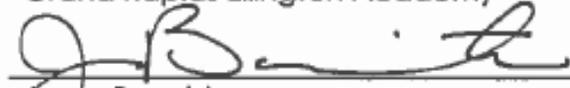
Rukshana Ilahi
Excel Charter Academy



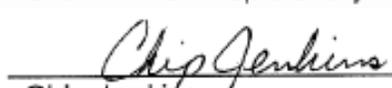
John Robinson
Grand Rapids Child Discovery Center



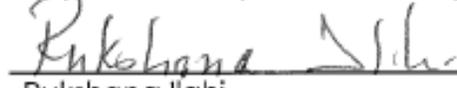
Angela Wallace
Grand Rapids Ellington Academy



Jason Bannister
Grand River Preparatory High School



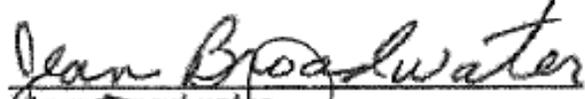
Chip Jenkins
Hope Academy of West Michigan



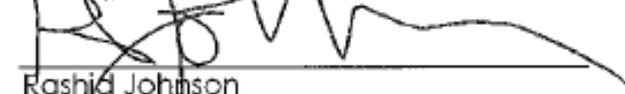
Rukshana Ilahi
Knapp Charter Academy



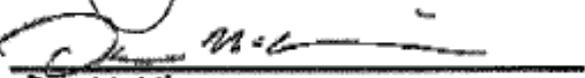
Chip Jenkins
Lighthouse Academy



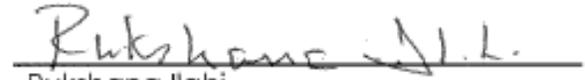
Jean Broadwater
Michigan Virtual Charter Academy



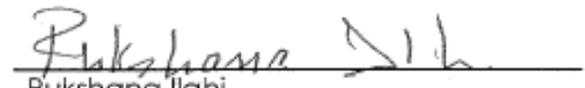
Rashid Johnson
New Branches Charter Academy



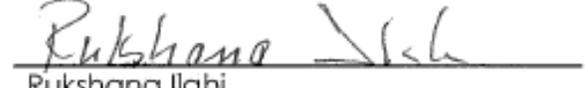
Dan McMinn
Nexus Academy



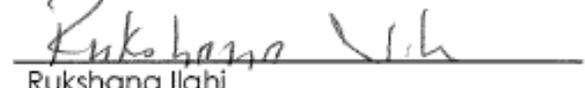
Rukshana Ilahi
Ridge Park Charter Academy



Rukshana Ilahi
River City Scholars Charter Academy



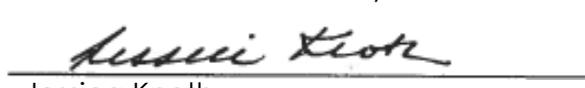
Rukshana Ilahi
Vanguard Charter Academy



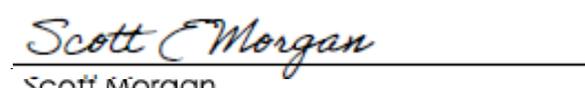
Rukshana Ilahi
Vista Charter Academy



Rukshana Ilahi
Walker Charter Academy



Jessica Knoth
Wellspring Preparatory High School



Scott Morgan
West MI Academy of Envir. Sciences



Pat Cwayna
West Michigan Aviation Academy



Markeith Large
William C. Abney Academy

ASD Evaluation and Eligibility Guidelines Review and Update Committee Members (2014-15)

Kent CAN Committee Members:

Amy Bufka
ASD Teacher
Grand Rapids Public Schools

Sarah Hammer
ASD Teacher
Byron Center Public Schools

Linda Hartman
Speech Pathologist
Grand Rapids Public Schools

Rebecca McIntyre
Assistant Director of Special Education
Kent Intermediate School District

Christie Nutkins
Psychologist
Grand Rapids Public Schools

Peer Review Committee Members:

Denise Brown
Principal – Ken-O-Sha Center Campus
Grand Rapids Public Schools

Paulette Longwell
ASD Program Supervisor
Grand Rapids Public Schools

Melanie Heffner
Speech Pathologist
Caledonia Community Schools

Jennifer Murchison
Speech Pathologist
Grand Rapids Public Schools

Jennifer James
Psychologist
Grandville Public Schools

Kirsten Myers
Special education Director
Rockford Public Schools

Jill Kreuze
Speech Pathologist
Grandville Public Schools

Kathy Wisniewski
Special Education Director
East Grand Rapids Public Schools

Denise LaCroix
ASD Consultant
Northview Public Schools

INTRODUCTION TO AUTISM SPECTRUM DISORDER (ASD)

What is Autism Spectrum Disorder (ASD)?

ASD is the fastest growing and second most common developmental disability, next to cognitive impairment (NECC Website, March 2015), that typically appears during the first three years of life. Within the past 30 years there have been numerous studies on the prevalence rates of autism. On average of 1 in 68 children in the United States have an ASD (CDC Website, March 2014).

It is four and a half times more prevalent in boys (1 in 42) than girls (1 in 188) (CDC Website, March 2014) and knows no racial, ethnic, or social boundaries. Family income, lifestyle, and educational levels do not affect the occurrence of ASD (USDHHS-NIMH, 2004).

Common Characteristics of ASD

Although each person with ASD has a unique personality and combination of characteristics, ASD is often fundamentally described in terms of a triad of characteristics:

- Qualitative impairments in reciprocal social interaction
- Qualitative impairments in communication
- Stereotypic behavior/markedly restricted range of interests

These symptoms and characteristics can range, however, from mild to severe. The DSM-5 has been updated and is combining social interaction and communication. They are referring to it as A1: reflects problems with social initiation and response and A2: reflects problems with non-verbal communication. It is critical that people understand that if you have seen one child with autism, you have seen one child with autism. There are no two cases that are exactly alike when you are looking at children on the autism spectrum.

Cause(s) of ASD

There is no known single cause of ASD. Researchers are investigating a number of theories including the link between heredity, genetics, and medical conditions, but they have not yet identified a single “trigger” that causes ASD to develop. ASD is not caused by the psychological environment in which a child grows up (Tanguay, 2000), and the majority of research has implicated a neurobiological basis. For example, studies have shown that among identical twins, if one child has an ASD, then the other will be affected 36-95% of the time. In non-identical twins, if one child has an ASD, then the other is affected about 31% of the time. Parents who have a child with an ASD have an 18% chance of having a second child who is also affected. It is estimated that about 10% of children with an ASD have an identifiable genetic, neurologic or metabolic disorder, such as fragile X or Down syndrome. As we learn more about genetics, the number of children with an ASD and an identifiable genetic condition will likely increase. The majority (62%) of children that the Autism and Developmental Disabilities Monitoring Network (ADDM) identified as having autism spectrum disorder did not have an intellectual disability (intelligence quotient ≤ 70). (Specific genetic disorders and autism: clinical contribution towards their identification. *J Autism Dev Disord*. 2005 Feb;35(1): 103-16).

Diagnosing ASD

There are no medical tests for diagnosing ASD. An accurate diagnosis must be based on observation of the individual's communication, behavior, and social interaction. Parental input and a developmental history are essential components of an evaluation. Medical providers may make a medical diagnosis of ASD, but that does not guarantee they will meet the criteria for educational services. The child must meet the educational criteria for ASD in order to receive services within the school setting.

Michigan's Definition of Autism Spectrum Disorder

R 340.1715 Autism spectrum disorder defined; determination.

Rule 15: (1) Autism spectrum disorder is considered a lifelong developmental disability that adversely affects a student's educational performance in 1 or more of the following performance areas:

- (a) Academic.
- (b) Behavioral.
- (c) Social.

Autism spectrum disorder is typically manifested before 36 months of age. A child who first manifests the characteristics after age 3 may also meet criteria. Autism spectrum disorder is characterized by qualitative impairments in reciprocal social interactions, qualitative impairments in communication, ~~and~~ restricted range of interests and repetitive behavior.

(2) Determination for eligibility shall include all of the following:

- (a) Qualitative impairments in reciprocal social interactions including at least 2 of the following areas:
 - (i) Marked impairment in the use of multiple nonverbal behaviors including eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
 - (ii) Failure to develop peer relationships appropriate to developmental level.
 - (iii) Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people, for example, by a lack of showing, bringing, or pointing out objects of interest.
 - (iv) Marked impairment in the areas of social or emotional reciprocity.
- (b) Qualitative impairments in communication including at least 1 of the following:
 - (i) Delay in or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication including gesture or mime.

- (ii) Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.
 - (iii) Stereotyped and repetitive use of language or idiosyncratic language.
 - (iv) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
- (c) Restricted, repetitive, and stereotyped behaviors including at least 1 of the following:
- (i) Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
 - (ii) Apparently inflexible adherence to specific, nonfunctional routines or rituals.
 - (iii) Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.
 - (iv) Persistent preoccupation with parts of objects.
- (3) Determination may include unusual or inconsistent response to sensory stimuli, in combination with subdivisions (a), (b), and (c) of subrule 2 of this rule.
- (4) While autism spectrum disorder may exist concurrently with other diagnoses or areas of disability, to be eligible under this rule, there shall not be a primary diagnosis of schizophrenia or emotional impairment.
- (5) A full and individual comprehensive evaluation shall include assessments by a psychologist or psychiatrist, an authorized provider of speech and language under R 340.1745(d), and a school social worker.
(Rule effective as of 9/15/2004.)

Discussion of Michigan Department of Education (MDE) Definition of Autism Spectrum Disorder

The Michigan ASD rule has undergone numerous changes in recent years, most recently in September of 2004 with the change from "Autism" to "Autism Spectrum Disorder." The following commentary provides a more in-depth explanation of the new Michigan definition of ASD.

R 340.1715 (1) Autism spectrum disorder is considered a lifelong developmental disability...Autism spectrum disorder is typically manifested before 36 months of age. A child who first manifests the characteristics after age 3 may also meet criteria...

ASD is a neurological disorder that can occur in any combination of symptoms, and with varying degrees of severity. Indicators of developmental problems may or may not be apparent by early infancy, but usually become obvious during early childhood. This does not mean that the child is diagnosed by 36 months; but in looking back at those first 36 months, indicators should be identified even if not noted at the time or thought to point to something else. In some cases, however, characteristic behaviors manifest themselves after age 3. Once you have seen one child with autism you have seen one child with autism.

R 340.1715 (1) ...that adversely affects a student's educational performance in 1 or more of the following performance areas: (a) Academic (b) Behavioral (c) Social...

Academic - The student's ability to progress in the general education curriculum must be considered. One aspect of adverse affect may be reflected in a student's grades, but that is not the only factor which must be considered. Determination of adverse affect can be based on such evidence as progress in the general education curriculum, academic grades, achievement tests, and social/adaptive functioning.

Behavioral and Social - Children with ASD also demonstrate some degree of delayed development in social, behavioral, and emotional response. They often lack empathy – not understanding how someone else might feel, or what they think or know. They have difficulty engaging in shared enjoyment or reciprocity with others. They may resist touch or attempts to engage them in social activities. Many show a flat, almost mechanical affect, often inconsistent with the setting. They might be aggressive or seemingly rude. Eye contact and facial gazing may be minimal. Deficits in this area make participation in groups and acceptance of others difficult.

R 340.1715 (1) ...Autism spectrum disorder is characterized by qualitative impairments in reciprocal social interactions, qualitative impairments in communication, and restricted range of interests/repetitive behavior.

A triad of pervasive impairments exists in the areas of communication, socialization, and behavior. The degree of qualitative differences will vary widely, depending on the

individual, in both the number and the severity of the behaviors displayed. It is important not to confuse qualitative with quantitative behavior when identifying children with suspected ASD. A qualitative impairment does not mean an absence of skills, but rather a difference in the way skill is demonstrated. For example, children who echo verbal behaviors have language but lack communicative intent. Children who tantrum may have communicative intent but fail to understand nonverbal pragmatics.

R 340.1715 (2) (a) Qualitative impairments in reciprocal social situations, including at least 2 of the following areas:

R 340.1715 (2) (a) (i) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.

Social deficits are a major difficulty for students with ASD. They may often avoid eye contact, and their faces may lack any expression or appropriate affect based on the situation. For example, they may laugh at a very sad situation. They may have repetitive behaviors with the intent of showing excitement or interests. They may not derive meaning from their own or others' nonverbal behaviors.

R 340.1715 (2) (a) (ii) Failure to develop peer relationships appropriate to developmental level.

These children may occasionally try to develop peer relationships, but they may require explicit teaching to develop "give and take" (reciprocity) in their interactions. They rarely move from the level of parallel play without intervention from an adult. Satisfying their own needs is often their primary consideration. The development of peer relationships must be considered in reference to the child's overall developmental level.

R 340.1715 (2) (a) (iii) Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people, for example, by a lack of showing, bringing, or pointing out objects of interest.

Although these children may try to relate to adults and/or peers, their interactions are often rote or one-sided. They may only converse on their own select topics, or seek information from others only to satisfy their own needs, rather than engaging in a sharing of information with others.

R 340.1715 (2) (a) (iv) Marked impairment in the area of social or emotional reciprocity.

Children with ASD have difficulty recognizing and responding to the feelings of others. They lack an understanding of the back and forth flow of interactions between people.

R 340.1715 (2) (b) Qualitative impairments in communication including at least 1 of the following:

R 340.1715 (2) (b) (i) Delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.

Some children have no spoken language at a time when speech should be developing, and they also fail to compensate with facial expressions or through the use of gestures. The child with ASD may use people mechanically as “a means to an end.” For example, the child may take an adult's hand and lead him/her to the refrigerator for some juice without a word or a glance – using the adult as a tool to get what s/he wants. In a few instances, children with ASD begin developing spoken language but then lose the language they have acquired.

R 340.1715 (2) (b) (ii) Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.

Pragmatics is the term used to explain how children use verbal and nonverbal language in social situations. Children with ASD have significant difficulty with the social aspects of language. Some of these problem areas include the following: establishing

and maintaining eye contact, understanding and reacting to the listener's body language, and being either too close or too far away from the listener while talking.

Some children with ASD who have developed verbal speech have a difficult time initiating and sustaining conversation with other people. They can talk for long periods of time about a subject of their liking regardless of the listener's interest. They often have difficulty understanding the interests and desires of others because they do not see things from another person's perspective. The child with ASD may talk "at" another person in a monologue rather than "with" him/her in conversation.

R 340.1715 (2) (b) (iii) Stereotyped and repetitive use of language or idiosyncratic language.

Although not exclusive to ASD, echolalia is a common characteristic. Immediate echolalia refers to a "parrot-like" repetition of what has just been said. For example, if a person asks a child with ASD, "Do you want juice?" he or she might respond by saying, "Do you want juice?", then may or may not answer the question. The immediate echoing of words and phrases is an important part of normal language development in children under the age of two. It becomes abnormal when it is the sole means of communication after the age of two. Delayed echolalia is the repetition of TV commercials, movies, videos, or single words heard minutes, days, weeks, or even months previously. It is common for older children with ASD to incorporate delayed echolalia into their conversational speech. This rehearsed speech may sound more fluent with appropriate intonation and rhythm than the rest of their speech. Some children with ASD may speak with a monotone voice quality and not control their pitch or volume. For example, a student with ASD may speak very loudly in the school media center unaware that one should talk very quietly there.

Children with ASD typically do not fully develop their language skills. They lack the subtleties of speech such as correct use of pronouns and sentence structure.

Children with ASD tend to be very literal, and have difficulty with abstract concepts such as idioms, words with multiple meanings, and complex ideas.

R 340.1715 (2) (b) (iv) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Children with ASD often do not engage in pretend play with toys or elaborate on learned routines. They may line up their cars or trains, or focus on a part of the toy rather than the enjoyment of actually playing with it. Children with ASD do not generally engage in imitative interactions such as a finger play (like the "Itsy Bitsy Spider") without specific teaching and prompts. Verbal children may recite parts of movies or books verbatim and not be able to change the story when asked.

R 340.1715 (2) (c) Restricted, repetitive, and stereotyped behaviors including at least 1 of the following:

R 340.1715 (2) (c) (i) Encompassing preoccupation with one or more stereotyped and restrictive patterns of interest that is abnormal either in intensity or focus.

Individuals with ASD can display patterns of thought and consequential behavior that are abnormal in focus and intensity. They may be preoccupied with certain topic areas, people, or objects. This behavior can manifest itself in repetitive language patterns (talking about the same topic over and over) or preoccupation with the actual object, person, or process. The behavior can be exhibited in persons of all ages with ASD, and a child may carry his/her preoccupation into adult life. These preoccupations can also change over time.

R 340.1715 (2) (c) (ii) Apparently inflexible adherence to specific, nonfunctional routines or rituals.

Variation from a routine may cause significant behavioral distress. Many children with ASD display a need for unwavering adherence to schedules, routines, dress, diets, social interactions, and/or structure of home and school environments. Children with ASD who display this component of behavior can display the same type of obsession for a period of time and then transfer that behavior to another routine, schedule, or preoccupation. Each individual is different, but the underlying common characteristic is displayed with the insistence of sameness and the inflexibility to change within and across environments.

R 340.1715 (2) (c) (iii) Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.

Some individuals with ASD will engage in repetitive motor mannerisms. This pattern of behavior may be attributed to excitement, distress, or any range of emotion. The motor movements can include hand flapping, preoccupation with the fingers, spinning, twirling, or uncharacteristic motor movements. The behaviors can range from being very noticeable to more subtle behaviors such as gentle rocking or fidgeting. The motor mannerisms can be apparent in individuals along the entire autism spectrum.

R 340.1715 (2) (c) (iv) Persistent preoccupation with parts or objects.

Individuals with ASD often become preoccupied with parts, objects, or processes. This behavior exhibits itself in a fascination with how an object works (such as a sprinkler, furnace, or dishwasher). The preoccupation can at times appear to be more focused on how an object actually works than the function that it serves. A child may be focused on one particular part of a toy rather than the enjoyment of actually playing with it as other children would. This preoccupation can create significant behavior challenges in a variety of environments (for example, the need to check out the stove in every restaurant, or the need to see the furnace in every home or building that is visited). The preoccupation with parts of objects can vary in intensity, and be prevalent in individuals of all ages along the entire autism spectrum.

R 340.1715 (3) Determination may include unusual or inconsistent response to sensory stimuli, in combination with subdivisions (a), (b), and (c) of subrule 2 of this rule.

Sensory issues often affect the ability to interact with others. Specific areas of sensation include: touch (tactile), movement (vestibular), input to muscles and joints (proprioception), hearing (auditory), sight (visual), taste (gustatory), and smell (olfactory). People with ASD tend either to seek or avoid certain sensations. Responses to sensory stimuli can be over-reactive/hypersensitive (distress to sound, sensitivity to light, discomfort to different textures, smell and/or taste aversions) or under-reactive/hyposensitive (lack of attention to sound, decreased awareness of pain/injury).

R 340.1715 (4) While autism spectrum disorder may exist concurrently with other diagnoses or areas of disability, to be eligible under this rule, there shall not be a primary diagnosis of schizophrenia or emotional impairment.

Thought disorders (such as schizophrenia) refer to problems in the way a person processes and organizes thoughts. For example, the person with schizophrenia may be unable to connect thoughts into logical sequences. While some characteristics may seem similar to ASD, schizophrenia has its own definition and diagnosis.

R 340.1715 (5) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team including, at a minimum, a psychologist or psychiatrist, an authorized provider of speech and language under R 340.1745 (d), and a school social worker.

See Chapter 2 titled *Addressing Concerns Related to Possible ASD* for a thorough discussion on the early interventions, referral, and evaluation process for students suspected of having ASD.

Discussion of IDEA Definition of Autism

The IDEA definition of Autism can be found in Appendix A. In general, it is a shorter and less involved definition. A comparison of the IDEA and Michigan definitions can be found in Appendix B.

ADDRESSING CONCERNS RELATED TO POSSIBLE ASD

Students both within and outside of the special education system may come to staff members' attention as possibly exhibiting characteristics of an Autism Spectrum Disorder. 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. The following flow charts provide a visual summary of this process for students being referred for an initial special education evaluation, and for those currently receiving special education services who are suspected of having an ASD.

Early Intervention Procedures/Process

The Kent Intermediate School District recommends early interventions 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 have been implemented and documented for a minimum of 45 school days prior to referring a student for special education services.

The early interventions are most effectively identified and conducted by a student study 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 "student support team," "child study team," "building team," "diagnostic/prescriptive team," or other team with a similar function. Regardless of the name, the committees function in a similar manner. It is important to remember that information generated during the implementation of this process provides 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.

Members of a student study team vary by districts and buildings, but generally include diagnostic staff. Teacher consultants for ASD, autism classroom staff, or other staff knowledgeable in ASD are generally not involved in these building based teams but should be consulted for assistance in reviewing information collected, or requested to do an informal classroom observation. This assistance will help the student study team in determining whether there is reason to suspect that the student has an Autism Spectrum Disorder, what early intervention strategies should be attempted, and whether a referral for evaluation should be made.

The student study team may complete checklists, conduct observations, and review previous records. Parent input and participation should also be included. If other medical, genetic and/or behavioral conditions exist, information should be gathered about these conditions.

Intervention Strategies

These strategies are meant to address the communication, behavioral, sensory-processing, 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 has ASD. 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.
5. Utilize a transition object for the students to bring from place to place.

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 s/he 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 in which 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 s/he 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 s/he 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.
6. Utilize a 5 Point Scale for Frustration
7. Be direct and use as few words as possible.
8. Have a plan in place with all providers.

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 s/he needs to do, as with writing a routine for starting the morning.

Sensitivity to Environmental Stimuli

Students participate better and complete more work independently if environmental stimuli are not competing for their attention.

1. Allow the student to wear headphones or earplugs during loud activities.
2. Provide the student with his/her own private "office space" during work activities. Stand a folder up on his/her desk to block out visual stimuli or t the student sit at a desk in a quieter area of the room.
3. Reduce the use of overhead florescent lights, if possible.

Activity Level Is Too High or Too Low

Students can better regulate their activity levels throughout the day when provided with appropriate physical activities.

1. Allow the student to take physical activity breaks during the day (take a walk, do some stretches as a class, run an errand).
2. Provide the student with sensory tools such as stress balls, a seat cushion, stretch bands, etc. to help him/her appropriately manage his/her energy levels.
3. Provide the student with a "Pace Space" in the back of the classroom where s/he can stand/pace during instruction. Use tape on the floor to visually define the area, if needed.
4. Utilize a 5 Point Scale.

Difficulties with Social Rules/Social Activities

Students can follow rules for social behaviors and engage with peers more appropriately when provided with concrete rules and structure for activities.

1. Use reminder/cue cards to reinforce social rules (such as, raise your hand) to speak.
2. Make a rule list or book with the student that highlights the specific social rules the student is having difficulty with. Pictures can aid with comprehension.
3. Assign rules for students during group work activities. Write down the rules for working in groups (no interrupting, talk in a quiet voice, etc).
4. "Caught You" Cards – Decide on a specific social rule or skill to highlight with the class for a period of time (usually a week or more). When you see a student exhibiting that skill, s/he receives a "Caught You" card. The student writes his/her name on the back and enters his/her cards in a drawing for a prize, something like a free time. This is a positive way to help a specific student practice social skills without singling him/her out.
5. Marble Jar – Same idea as above, except each time you see a student practicing the skill appropriately you drop a marble in a jar. When the jar is full (or has a certain number of pre-determined marbles in it) the class wins a prize.
6. Provide a peer or small group of peers to engage with the student during unstructured times.

7. Encourage the student to become involved with extracurricular activities surrounding his/her interest areas.

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 materials 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.
5. Have the students use one binder with all the information readily available to them.

Difficulties with Written Expression

Some 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 paper copy or an electronic 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.

Recommendation of Eligibility Process

The following section contains a discussion of the Evaluation and Re-evaluation (MET) process that should be followed when evaluating a student for ASD. The forms utilized throughout this process are included in this discussion. Please be aware that the names of the forms are applicable to professionals conducting evaluations in Kent ISD. Professionals in other districts will follow the same process, but the name of the forms used will vary depending on the district.

Special Education Rules Related to Recommendation of Eligibility Process

The following rules address issues and definitions related to the ASD evaluation process:

Rule 300.303 Reevaluation.

(a) General. A public agency must ensure that a reevaluation of each child with a disability is conducted in accordance with Sec. 300.304 through 300.311—

(1) If the public agency determines that the educational or related service needs, including improved academic achievement and functional performance, of the child warrant a reevaluation; or

(2) If the child's parent or teacher requests a reevaluation.

(b) Limitation. A reevaluation conducted under paragraph (a) of this section—

(1) May occur not more than once a year, unless the parent and the public agency agree otherwise; and

(2) Must occur at least once every 3 years, unless the parent and the public agency agree that a reevaluation is unnecessary.

Rule 340.1715 (5) Autism spectrum disorder.

A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, including, at a minimum, a psychologist or psychiatrist, an authorized provider of speech and language under R340.1745 (d), a school social worker.

Determination of Eligibility

Review of Existing Evaluation Data and Evaluation Plan (REED) is a process through which a group of individuals, who have a responsibility for evaluating or reevaluating a student with a suspected disability, reviews existing information about the student. This process determines which evaluations are necessary for determining eligibility. This can vary depending on the student's age, physical condition, and nature of the presenting problem.

R 340.1702 "Student with a disability" definition and determination of eligibility.

Rule 2. (1) As used in these rules, "student with a disability" means a person who has been evaluated and found eligible for special education according to the individuals with disabilities education act 20 U.S.C. chapter 33, § 1400 et seq. and these rules this part.

(2) Eligibility and the educational needs of a student shall be determined by an individualized education program team, an individualized family service plan team, or an administrative law judge.

A group of qualified professionals which shall include all of the following:

- (a) A person qualified to interpret the results of evaluations required in R 340.1705 through R 340.1717.
- (b) A person who has knowledge of each suspected disability.
- (c) A parent of the child suspected to be a student with a disability.
- (d) The student's general education teacher qualified to teach a student of his or her age or, for a child less than school age, an individual qualified by the department to teach a child of his or her age.
- (e) A special education teacher.

(3) A student with a disability shall to have 1 or more of the impairments specified in this part that necessitates special education or related services, or both, who is not:

- (a) Be more than 25 years of age as of September 1 of the school year of enrollment., and who has not graduated from
- (b) Have completed the requirements for a regular high school diploma.

(4) A student with a disability who reaches the age of 26 years after September 1 continues to be is a "student with a disability" and is entitled to continue a special education program or service until the end of that school year.

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 gathered during the evaluation process must provide data that supports the presence or absence of an Autism Spectrum Disorder and the resulting adverse effect on educational performance in academics/achievement, social, and behavioral areas. Once a student is determined eligible with an Autism Spectrum Disorder or another Michigan eligibility category, 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.

Eligibility Determination: REED participants gather background information, review the student's education record, collect parents' input related to their part of the Eligibility Recommendation, and review important medical and educational assessments. Observations are another important part of the evaluation and it is critical for REED members to observe the student in several school environments, including the home and other locations when appropriate. It is helpful to interview the students who can communicate. Information also must be collected from teachers, who often provide input to the team through interviews and checklists.

The evaluation team compiles all the information and considers the unique characteristics of the student, and how those characteristics relate to that student's school performance in accordance with the criteria set forth in state law. When making eligibility decisions, the parent(s) and relevant professionals discuss the implications of the information gathered through the assessment process. The REED participants may recommend that the student is eligible for special education under one (or more) of the 13 categories, or may recommend that the student is ineligible. A student referred for evaluation as a possible student with Autism Spectrum Disorder may meet qualifications in other eligibility areas. (See chapter titled "Issues of Eligibility.")

REED and Consent to Evaluate Document

These forms provide the evaluation team with the written permission from the parent(s) showing informed consent for completion of the evaluation. See the Kent ISD *Instructions for Other Special Education Forms* for more information.

When first approaching the parents of a student suspected of having an ASD, the reaction will vary. Great care must be taken to determine the parents' initial understanding of autism and the meaning it may have for examining their child's unique strengths and needs. The evaluation team should discuss these issues prior to beginning its assessment, and should approach each family with sensitivity. It is necessary to help parents understand the difference between an educational eligibility assessment and a medical diagnosis. It is essential to discuss the function of a school-based ASD evaluation with parents, and the process by which the team will consider information provided from outside evaluations.

Information Relevant to Determination of ASD

- Developmental history
- Communication skills and characteristics
- Social skills
- Behavior concerns
- Adaptive behavior
- Cognitive/developmental strengths and/or weaknesses
- Sensory-motor skills
- Educationally relevant medical information

The assessment process for each of these components will be discussed in Chapter 3.

Personnel Required for Autism Spectrum Disorder Determination

Though the law requires only three participants for an ASD evaluation – psychologist/psychiatrist, school social worker, and speech/language pathologist – additional professionals can be involved in the evaluation process.

It is essential for at least one REED participant to have knowledge of Autism Spectrum Disorder and experience with sufficient numbers of students with ASD to ensure an accurate eligibility recommendation or determination. It is easy to over- and under-identify Autism Spectrum Disorder when professionals have limited experience assessing students with ASD. (See *Issues of Eligibility* Chapter)

Roles of Participants

Parent(s) – It is crucial to involve parents in the evaluation process to obtain detailed information on the student's history of development and behaviors, current social and behavioral functioning outside of school, and medical or support services being provided to the student. Reasonable efforts should be made to gain the parent(s) participation in the evaluation.

General and/or Special Education Teacher – Teaching staff will provide specific information regarding the student's academic, behavioral, and social strengths and challenges in their classroom setting.

School Social Worker (SSW) – The SSW provides a comprehensive report, including a developmental history, indicating the student's social and emotional functioning and its impact on the student's academic and behavioral functioning. S/he also interviews the parents and documents their concerns, early developmental history, and sensory issues noting any unusual or inconsistent response to sensory stimuli. It is appropriate for the SSW to assist parents with the completion of rating scales when needed. The SSW may conduct observations of the student in social contexts (recess, group classroom activities, lunchroom, etc.) and utilizes formal assessment instruments when appropriate.

Psychologist – The psychologist may assess the student's cognitive strengths & weaknesses, achievement levels, psychomotor skills, and adaptive behaviors. S/he may also conduct observations of the student. When testing and observation are complete, the psychologist provides a report detailing the valid and reliable diagnostic techniques and assessments used, including enough information to address whether the cognitive profile of strengths and deficits adversely affect the student's educational performance. Deficit areas that may need to be addressed should be included in both the report and in the PLAAFP.

Psychiatrist – When evaluation or diagnostic information from a psychiatrist is included in the evaluation, s/he must provide a report that describes his/her findings and rationale for those findings.

Speech/Language Pathologist (SLP) – The SLP is responsible for completing an evaluation indicating the student's language and communication skills and deficits,

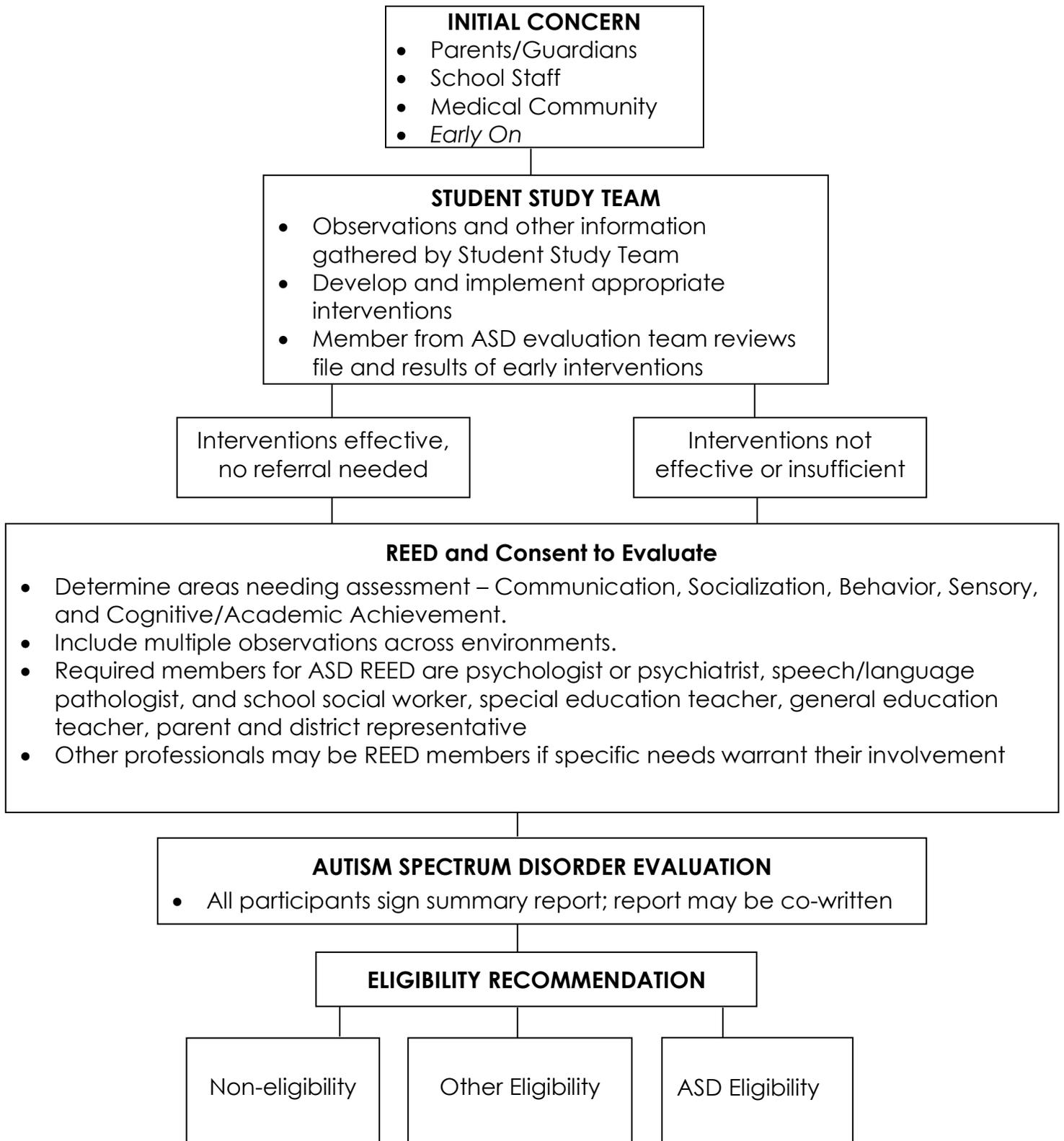
including pragmatics and social interaction skills. S/he will complete standardized testing and/or informal assessment of social communication, expressive language, and receptive language. Skills formally assessed may need to be evaluated in multiple settings to document whether or not the student uses the skills demonstrated in the testing situation. Any gaps in the developmental progression of language should be identified and included in the report.

Occupational Therapist (OT) – The OT is not a required REED participant. However, if there are documented sensory or motor concerns, it is beneficial to include the OT to document those concerns and to assist in determining subsequent strategies and/or goals for the student. When an OT is included on the evaluation team, s/he can evaluate the areas of gross motor, fine motor, motor planning, sensory areas and handwriting as appropriate. The OT may evaluate the student, including the use of checklists completed by parent and/or staff.

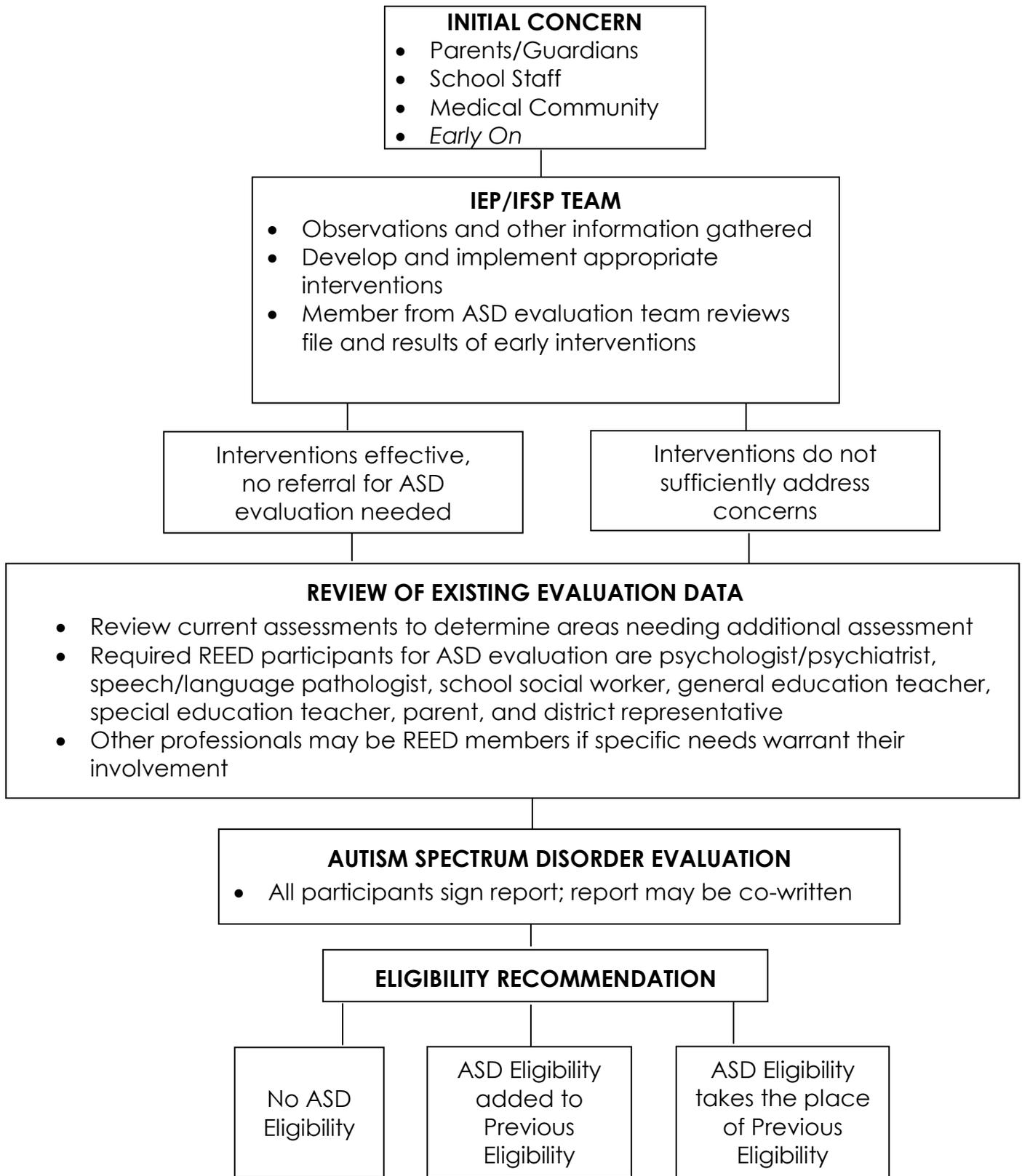
Physical Therapist (PT) – A PT is not a required REED participant, but may be included when there are concerns about a physical delay or difference that may or may not be related to Autism Spectrum Disorder. A PT can also assist in ruling out other orthopedic or neurological conditions that may be responsible for a delay or difference in motor skills. For instance, heel cord tightness or sensory issues can cause toe walking, and it is important to discover the causes of these types of behaviors. A PT may also evaluate the cause of abnormal movement patterns commonly seen in students with an Autism Spectrum Disorder.

ASD Teacher Consultant or Other Consultant – A teacher consultant or other consultant specializing in ASD is not a required REED participant, but may be included when his/her specialized knowledge or training can support the team in the evaluation process. This may especially be the case if there is not a required REED member with sufficient knowledge and experience with ASD to ensure that accurate evaluation and eligibility decisions are made. When a consultant participates as a member of the evaluation team, s/he must provide a report, including observations and results of any formal and informal assessments administered.

Autism Spectrum Disorder Eligibility Flow Chart for Initial Referrals to Special Education



Autism Spectrum Disorder Eligibility Flow Chart for Students Currently Receiving Services



ASSESSMENT PROCESS FOR AUTISM SPECTRUM DISORDER

The evaluation of Autism Spectrum Disorder (ASD) 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 ASD 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 presenting characteristics. Because the recommendation of ASD eligibility is a subjective process, it is essential that at least one member of the evaluation team have a broad experience with individuals on the spectrum to avoid under- or over-identification based on exposure to a limited number of students. Professionals involved in the evaluation process must use their professional judgment, because the determination of many of the characteristics of ASD is based on qualitative components that cannot be quantified by test results.

As discussed in earlier chapters, there is a triad of impairments that defines ASD. The significance of impairments affecting all 3 areas – social interaction and reciprocity, communication, and stereotypic behavior/restricted range of interests – is critical in distinguishing ASD from other potential impairments. In completing a comprehensive evaluation, however, there are additional areas that need to be assessed to acquire a complete picture of a specific student's strengths and needs. Because autistic symptomology changes over the lifespan, it is important to determine a student's level of current functioning in these areas to best address issues of goals and programming. This chapter will detail the specific areas requiring assessment, and the information to collect in each area.

Components of ASD Evaluation

Developmental History

Because symptoms of ASD 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 ASD.” 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 ASD and should be updated as needed during subsequent evaluations:

- 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, and
- Family history of developmental conditions

Communication

Thorough assessment of a student's communication is essential when determining the presence of ASD. Information on communication skills facilitates programming decisions and establishes a baseline for later assessments. While the verbal communication skills of most students with ASD improve over time, these students continue to struggle using their communication skills for the purpose of regulating social interactions. It is generally the case that as students become more communicatively competent, their pragmatic deficiencies become more glaring (Starr et al., 2003). The following components of expressive, receptive, and pragmatic communication require assessment as well as observation in multiple settings:

- Hearing,
- Nonverbal communication such as pointing to desired item, use of eye gaze, or head shakes and nods,
- Integration of nonverbal communication with spoken language,
- Functional use of language such as requesting items or information, responding to requests, and commenting,
- Responses to the communication of others,
- Atypical communication such as echolalia, use of others' hands as "tools" to request items, perseveration, pronoun reversals and idiosyncratic remarks,
- Conversational abilities such as topic maintenance and selection, and appropriate give and take,
- Semantic and/or conceptual difficulties, and
- Intensity, pitch, and intonation of voice

Social Skills

Difficulties in reciprocal social interactions and understanding and using nonverbal behaviors are key features of ASD, and arguably more critical to its determination than the presence of unusual behaviors (Gillham et al., 2000). Researchers have found that while many symptoms of autism decrease with age, individuals with autism continue to experience significant difficulties with social interactions throughout their lifespan (Starr et al., 2003). Reciprocal social behavior requires a child to be cognizant of the emotional and interpersonal cues of others, to appropriately interpret those cues, to respond appropriately to what s/he interprets, and to be motivated to engage in social interactions with others. Based on this conceptualization of social behavior, the following areas require assessment and observation in multiple settings:

- Use of multiple nonverbal behaviors to regulate social interaction and determine other people's intentions, including eye-to-eye gaze, facial expression, body postures, and gestures,
- Imitating actions of others,
- Attachment to caregiver(s),
- Problems relating to other people,
- Establishing joint attention through pointing and showing,

- Social interactions with familiar and unfamiliar adults and peers in familiar and unfamiliar environments,
- Presence of peer relationships appropriate to developmental level,
- Spontaneous seeking to share enjoyment, interests, or achievements with others by exhibiting behaviors such as showing, bringing, or pointing out objects of interest, and
- Skills in the area of social and emotional reciprocity, such as turn taking and changing thoughts and actions based on verbal and nonverbal feedback of partner

Behavioral Concerns

Behaviors that are stereotyped and/or restricted in range, and/or repetitive, are risk factors for ASD and should be noted throughout the assessment process. The severity, frequency, and impact on educational performance of a student's behaviors must be evaluated. The following behaviors require observation and documentation:

- Interests and preoccupations that are more intense or focused than what would be considered normal for the student's developmental level,
- Persistence in carrying out specific non-functional routines or rituals, including an inability or unwillingness to modify those routines or rituals such as lining up toy cars, watching the same five-minute segment of a video over and over, turning off lights when entering a room, and displaying difficulty when transitioning between activities,
- Stereotyped and repetitive motor mannerisms such as hand flapping, flicking fingers in front of eyes, and rocking torso back and forth, and
- Persistent preoccupation with parts of objects such as visually inspecting the wheels of a toy car while spinning them or poking at the eyes on a doll

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 s/he possesses to function within the everyday

environment. These skills are particularly important in individuals with ASD because it is these, rather than cognitive level, that contribute 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).

Research has shown that adaptive behavior is critical to assessment when differentiating ASD from other developmental disorders. Adaptive behavior tends to be impaired relative to cognitive abilities in individuals with ASD. Individuals with ASD typically show an uneven pattern of skill development across adaptive behavior domains with lowest skills in social domains, highest skills in daily living domains, and intermediate skills in communication (Stone, Ousley et al., 1999).

Discrepancies between developmental age and adaptive behavior scores are greater in students with ASD than in students with cognitive impairment, particularly in the areas of socialization and communication. Adaptive behavior scores are generally lower in students with autism relative to IQ-matched comparison groups, meaning that even students considered to have “high functioning” ASD show significant deficits in adaptive behaviors (Carter et al., 1998). Children with ASD do not function in their environment as well as other children with similar cognitive capabilities, and social functioning is specifically impaired, even relative to global functioning (Liss et al., 2001).

Adaptive behavior assessment also assists with the 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, and
- Motor skills (if motor concerns are present)

Cognitive Factors

In assessing a student for ASD, knowing the child's developmental age provides a context for evaluating behavior characteristics, including the presence or absence of symptoms specific to ASD. Information about the student's cognitive level assists the team in determining whether symptoms can be explained on the basis of global delay, or whether there is an uneven or developmental pattern that is present (Vig and Jedrysek, 1999). Assessment of cognitive ability, therefore, can help in differential diagnosis of ASD, cognitive impairment, or a combination of the two. A report published by CDC in 2013, shows that 30-51% (38% on average) of the children who had an ASD also had an Intellectual Disability (intelligence quotient ≤ 70). (Prevalence of Autism Spectrum Disorder – Autism and Developmental Disabilities Monitoring Network, 14 Sites, United, 2008). Standard measures of intelligence may have low validity with some students due to the nature of their disability. For example, performance on standard intellectual measures may under represent or over-represent true ability and not accurately predict academic achievement. However, information on the child's cognitive skills can establish a baseline for later assessments to measure development and progress. Using the REED process, assessment of cognitive factors will vary depending on individual student needs. To date, there is no single cognitive impairment or pattern of cognitive development that occurs in all individuals with ASD.

Sensory Motor Factors

Students with Autism Spectrum Disorder often react differently to sensory stimuli. Research indicates that the level of sensory symptoms present in individuals is not necessarily related to their overall developmental age or IQ. Therefore, it cannot be fairly assumed that student's with higher levels of cognitive functioning have fewer sensory symptoms than students functioning at lower levels of cognitive development, and vice versa (Rogers et al., 2003). Evaluating student responses to various stimuli in multiple environments may be helpful in making the recommendation of ASD. Rinner (2001-02) stated that using a sensory processing frame of reference is important to understanding behavioral manifestations that may mistakenly be viewed in isolation

from precipitating events. Paying attention to sensory issues also expands the possibilities for helpful intervention.

Some key areas to assess, observe, and document when looking at sensory differences include:

- Motor planning,
- Tactile sensitivities such as rubbing surfaces, withdrawing from touch,
- Proprioceptive sensitivities such as seeking deep pressure, violating another's personal space,
- Visual issues such as sensitivity to light or self-stimulation in visual field,
- Vestibular issues such as spinning or rocking, balance problems,
- Olfactory or gustatory sensitivities such as smelling or licking objects, avoiding certain foods, and
- Auditory issues such as sensitivity to noise, making repetitive sounds

In addition, fine and gross motor skills may need to be formally assessed.

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.

ASSESSMENT TOOLS FOR AUTISM SPECTRUM DISORDER

There are no conclusive tests that can determine the presence of ASD. However, there are numerous assessment tools, including standardized and non-standardized assessments, which can assist with determining the presence of characteristics along the autism spectrum. It is crucial to understand the appropriate role each may take in the assessment process, the benefits and limitations of each instrument, and the consideration of such limitations when making eligibility recommendations. A combination of tools should be selected to evaluate each child's unique strengths and needs, as well as characteristics that would indicate ASD. The following section covers specific evaluation tools that may be utilized in determining the presence of ASD.

Comprehensive Assessment Tools

Once an individual student has gone through appropriate referral procedures, the educational team may determine that a more comprehensive evaluation is warranted. Because many students suspected of having an ASD exhibit communication, social, and behavioral difficulties, flexibility is often necessary when assessing these students. Special considerations related to time, environment, and motivation may be necessary to elicit a student's best performance. When these changes are made in the administration of standardized assessments, these deviations should be noted and caution must be taken when interpreting results and making comparisons to peer groups. Performance of students in formal testing situations should be analyzed based not only on the quantitative results, but also on other factors observed during the testing sessions such as:

- Communication style,
- Ability to comprehend verbal and non-verbal communication,
- Patterns of questions the student could or could not answer,
- Sensory differences,
- Level of distractibility,

- Stereotypic behaviors or an insistence on approaching things in a certain way, and
- Willingness to persevere with more challenging items

Flexibility and creativity are critical skills for evaluators completing an ASD evaluation. The following guidelines are beneficial when planning and conducting an evaluation for a student with a suspected ASD:

1. Establish trust and rapport with the student prior to assessment.
2. Allow time for several observations.
3. Adapt communication to the student's level of understanding.
4. Utilize nonverbal communication to help convey meaning.
5. Avoid removing the student from preferred planned activities.
6. Determine motivators ahead of time through discussion with classroom staff and parents, and have these items readily available for use throughout the evaluation sessions.
7. Organize testing materials ahead of time to allow for the most efficient flow of activities during the testing session.
8. Consider the importance of seeing the student at the same time each day versus a variety of times, depending on what is being assessed and the student's need for consistency.
9. Address potential safety concerns by having another trusted adult present during testing, if necessary.

It is critical to select an individualized evaluation protocol based on the specific needs of the child. This plan will be determined through the REED and may include any of the following components in the assessment.

Developmental History Instruments

A thorough developmental history is one of the most important components in the assessment of students with ASD. Understanding the individual student's early development is critical in making the appropriate eligibility recommendation. Professionals or school districts may have their own developmental history form or set of questions to be used during the evaluation process. Additional commercial

questionnaires, such as the *Autism Diagnostic Interview-Revised (ADI-R)*, and Developmental History portion of the *Gilliam Autism Rating Scale – Third Edition (GARS-3)* look specifically at some of the developmental disturbances associated with ASD.

Autism Specific Instruments

Instruments have been designed specifically to assist in determining the presence of social, communication, and behavioral patterns that are consistent with ASD. The formats of these tests vary, and while some of these tools can be used in determining the extent of a student's difficulties, others may be useful for instructional planning. The *Autism Diagnostic Observation Schedule-Second Edition (ADOS-2)* is a semi-structured, standardized assessment of the characteristics associated with autism. It consists of standard activities that allow the examiner to observe behaviors identified as important to the diagnosis of ASD at different developmental levels and chronological ages. The *Gilliam Autism Rating Scale - Third Edition (GARS-3)* is a questionnaire that compares the child's characteristics to those of children that have been formally diagnosed with an ASD. The *Childhood Autism Rating Scale, Second Edition (CARS-2)* also allows an examiner to rate a child's behaviors. Tools specific to ASD that provide information related to educational planning and monitoring of progress include the *Psycho-Educational Profile: Third Edition (PEP-3)*, the *Autism Screening Instrument for Educational Planning–2nd Edition (ASIEP-2)* and the *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)*.

Adaptive Behavior Instruments

In a comprehensive assessment, it is important for adaptive behavior to be examined to make an appropriate eligibility recommendation and to provide helpful information for programming. Certain behavioral characteristics noted by parents, school staff, or others may be risk factors for ASD, while other patterns may suggest different developmental difficulties. The *Vineland Adaptive Behavior Scales (VABS)*, of which there are three forms, *Expanded Interview Edition*, *Survey Edition*, and *Classroom Edition*, are the most researched adaptive behavior assessments in the field of ASD (Paul et al., 2004). The *Vineland Adaptive Behavior Scales – Second Edition (Vineland-*

II) was published in 2005. These instruments can provide information on developmental patterns critical to a complete evaluation for ASD and for assessing skills of independence and socialization that may be important components in developing a comprehensive PLAAPF.

Social/Emotional Instruments

While all assessment instruments designed specifically to assess the presence of ASD explore social characteristics commonly observed in individuals with ASD, it is often important to assess more global aspects of social-emotional development in making the most informed eligibility recommendation. The *Social Responsiveness Scale (SRS)* is a rating scale that looks at a variety of feelings and abilities in the social-emotional domain essential to the differential diagnosis of ASD from other disorders. The *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)* and the *Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)* are criterion-based tests that measure a number of important social skills that are often delayed in individuals with Autism and provide information that can be useful in developing an appropriate educational plan. Other instruments that can provide information in this domain are the *Behavior Assessment System for Children–Second Edition (BASC-2)* and the *Achenbach*, both of which have specific forms for parent and teacher ratings. These two instruments, widely used in school evaluations, are not specific to the evaluation of ASD.

Communication/Language Instruments

Assessment tools specifically designed to address characteristics of ASD will provide an abundance of information relative to possible communication impairment(s) associated with the disorder. There are a variety of tools widely used by speech/language pathologists to assess expressive and receptive communication skills, both non-verbal and verbal. Those that are particularly useful for determining communication characteristics of young and/or lower functioning children are:

- The *Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)*,
- *Children’s Communication Checklist – Second Edition (CCC-2)*,

- *The Communication Matrix Profile for Parents & Professionals,*
- *Communication and Symbolic Behavior Scales – Developmental Profile (CSBS-DP),*
- *MacArthur Communicative Development Inventories (CDIs),*
- *The Pragmatic Profile of Everyday Communication Skills in Children, and*
- *The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP).*

Assessments that are useful for determining communication characteristics of older or higher functioning students include;

- *The Clinical Evaluation of Language Fundamentals-5 (CELF-5),*
- *CELF-5 Pragmatic Profile Subtest and Pragmatic Activities,*
- *Functional Communication Profile,*
- *Test of Pragmatic Language-2 (TOPL-2),*
- *Test of Language Competence (TLC-E), and*
- *The Test of Problem Solving (TOPS-E or A, Revised)*

Assessments selected to address communication with this population should:

- Focus on functions of communication,
- Analyze preverbal communication, i.e. non-symbolic skills such as gestures, gaze, vocalizations,
- Language pragmatics, including initiation, reciprocity and appropriateness of communication,
- Directly observe the child, and not rely solely on parental report, and
- Directly involve caregivers during the assessment

Cognitive Abilities Instruments

There are a number of assessment instruments used to evaluate cognitive abilities in preschool and school-age children. Some of the more widely used instruments include:

- *The Bayley Scales of Infant Development,*
- *The Cognitive Assessment System-Second Edition (CAS-2),*
- *The Wechsler Preschool and Primary Scales of Intelligence-3rd Edition (WPPSI-III),*

- *Wechsler Intelligence Scale for Children-5th Edition (WISC-V)*, and
- *The Stanford-Binet IV*

An issue frequently raised in the assessment of students with ASD is the difficulty in obtaining reliable and valid scores for some students due to their constellation of communication and behavior deficits that may impair their ability to respond in testing situations. In their review of appropriate procedures for the screening and diagnosis of ASD, Filipek et al., (1999) detail important considerations when selecting cognitive assessment tools for younger, low-functioning, or non-verbal individuals with autism.

Cognitive tests should be used which:

- Are appropriate for both developmental age and chronological age.
- Provide a full range (in the lower direction) of standard scores.
- Sample both verbal and nonverbal skills.
- Measure and score separately verbal and nonverbal skills.
- Provide an overall index of ability.
- Have norms which are current and relatively independent of social function.

Because of the concerns related to the reliability and validity of the scores obtained on these measures with many individuals with ASD, it is important to note the limitations when reporting results. Often individuals with communication or behavioral differences obtain scores that are much lower than their learning potential and as such it is critical for others reading the report to have descriptions of factors that may have impacted performances to help prevent them from making assumptions based strictly on scores. REED participants will make the decision for what information is needed. In some cases, cognitive assessment (or select portions of an assessment) may be warranted for the purposes of eligibility or present educational level but cognitive/IQ scores are not reported due to the limitations. For example, inflexible response routines, test taking behaviors, or stereotyped language are often observed during cognitive assessment and may be important for making educational decisions whereas an IQ score falling in the cognitive range for a child with math and reading skills three years above grade level may be irrelevant.

Sensory Motor Instruments

One of the most common instruments used in the assessment of sensory differences is the *Sensory Profile*. There are currently three versions of this tool available: *Infant Toddler Sensory Profile* for ages birth-36 months, *Sensory Profile – 2nd Edition* for ages 3-10 years, and *Adolescent/Adult Sensory Profile* (including a self-report form) for ages 11 and older. Each of these assessments provides a valid reflection of sensory responsivity in students for its age ranges. Results on these measures can be beneficial for both differential diagnosis and educational planning.

Observations

The most important component of a comprehensive educational evaluation for eligibility under the Autism Spectrum Disorder designation is behavior observation. It is recommended that multiple observations of the student are completed across environments with more than one professional completing observations. The emphasis of these observations is documentation of how the individual's communication, social interactions and stereotyped/restricted/repetitive behaviors impede their functioning within a general education setting. Performance should be evaluated in the areas of academics, behavior and social functioning.

Reviews of ASD Tools

This section contains reviews of current research-based assessment tools useful in the evaluation of ASD. This section will be updated as current tools are revised and new instruments are developed. A summary chart of these assessment tools is included in Appendix C. Many of these are available for use through the Kent CAN Lending Library.

Adolescent/Adult Sensory Profile, 2002

Author: Winnie Dunn

Publisher Information: Harcourt Assessment
19500 Bulverde
San Antonio, TX 78259
800-211-8378
www.harcourtassessment.com

Age Range: 11 to 65+

Administration Time: 15 minutes

Areas Assessed

- Sensory processing
- Modulation
- Behavioral and emotional responses

Description of Instrument

- 60 items for individual to complete based on how s/he generally responds to sensations
- Students are characterized by their responsiveness to sensory input including
 - Taste/smell
 - Movement
 - Visual
 - Touch
 - Activity level
 - Auditory

Strengths

- Allows older students and adults to perform self-evaluation of need areas

Recommended Use of Instrument

- Professional with background in sensory processing should administer and score
- Can be useful in discrimination of characteristics related to a variety of disorders
- Allows examiner to evaluate the role sensory processing plays in the student's daily performance patterns
- Allows for the development of student awareness and strategies to optimize the desired sensory environment

Cost: \$99.00

Adolescent Test of Problem Solving (TOPS-A), 1991

Authors: Linda Bowers, Rosemary Huisingsh, Mark Barrett, Jane Orman, Carolyn LoGiudice

Publisher Information: LinguSystems
3100 4th Avenue
East Moline, IL 61244-9700
800-776-4332

Age Range: 12 to 17-11

Administration Time: 40 minutes

Areas Assessed

- Evaluating
- Fair-mindedness
- Analyzing
- Thinking independently
- Clarifying
- Affect

Description of Instrument

- The TOPS-A is designed to examine the adolescent's overall approach to dealing with situations to assess the interaction of his/her language and critical thinking skills
- The test uses a picture stimulus book along with verbal and written stories to limit the affects of poor auditory memory or reading deficiencies
- Test items are based on Richard Paul's research on critical thinking, and are based on relevant situations that adolescents frequently encounter

Strengths

- High reliability and validity accurately identifies students with language-learning disorders
- Assesses communication and thinking skills that are necessary for appropriate educational planning

Recommended Use of Instrument

- Part of a comprehensive communication assessment

Cost: \$99.95

The Assessment of Basic Language and Learning Skills-Revised (ABLLS-R), 2006

Author: James W. Partington, Ph.D., BCBA

Publisher Information: Behavior Analysts, Inc.
1941 Oak Park Blvd, Suite 30
Pleasant Hill, CA 94523
www.behavioranalysts.com

Age Range: No Specific Range (Measures criterion-referenced skills that help to identify where to begin language intervention. Not meant to provide age norms, but most typically developing children have all of these skills by the end of kindergarten)

Administration Time: Several Hours

- Cooperation & Reinforcer Effectiveness
- Visual Performance
- Receptive Language
- Motor Imitation
- Vocal Imitation
- Requests
- Labeling
- Intraverbals
- Spontaneous Vocalizations
- Syntax and Grammar
- Play and Leisure
- Social Interaction
- Group Instruction
- Classroom Routines
- Generalized Responding
- Reading
- Math
- Writing
- Spelling
- Dressing
- Eating
- Grooming
- Toileting
- Gross Motor
- Fine Motor

Description of Instrument:

- Criterion-referenced assessment that can also function as a curriculum guide and skill monitoring system
- Goal is to teach a child to "learn to learn"
- Measures over 500 specific skills that are often challenging for children with autism and other developmental disabilities.

Strengths:

- Assesses a comprehensive range of skills and helps provide specific starting points for instruction (Parents can be involved in this assessment process)
- Tracking Grids provide a parent-friendly method of displaying student progress
- Revision incorporates subtle skills of social development previously ignored in many behavioral programs.

Potential Concerns:

- Not an exhaustive list of skills and doesn't identify all steps in teaching skills.
- Doesn't provide age norms or compare learner skills to a particular peer group,

Recommended Use:

- Would not be used for diagnostic purposes, but is an excellent source for gaining instructional starting points, developing IEP goals, and monitoring student progress.

Cost: \$64.95-Manual and Protocol

Other Considerations:

- A web-based version of the program is available that provides video clips modeling all of the skills assessed. (Cost up to \$150.00 per student per year)
- High price per individual student protocol (\$39.95), but this can follow student for several years.

Autism Diagnostic Interview - Revised (ADI-R), 2003

Authors: Michael Rutter, Ann LeCouteur, Catherine Lord

Publisher Information: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
800-648-8860

Age Range: 2 to Adult

Administration Time: 1-2 hours

Areas Assessed

- 3 Domains
 - Language and communication
 - Reciprocal social interactions
 - Restricted, repetitive, and stereotyped behaviors and interests
- 8 Content Areas
 - Background
 - Early development
 - Acquisition/loss of language or other skills
 - Language and communication functioning
 - Social development and play
 - Interests and behaviors
 - Behaviors of clinical importance

Description of Instrument

- 93-item parent interview scored by examiner using diagnostic algorithms
- Parent(s) or caregiver must be familiar with both current behavior and developmental history

Strengths

- Exceptionally comprehensive - considered a "gold standard" diagnostic tool for assessment of ASD; particularly when used in conjunction with the ADOS
- Excellent interrater and test-retest reliability
- Able to differentiate ASD from non-autistic developmental disorders if child's mental age is above 2 years

Potential Concerns

- Though it has been tested with children under age 2 years, results are not as reliable for children with a chronological or mental age under 2

Recommended Use

- Developmental history for an initial comprehensive assessment for ASD, and subsequent educational planning
- Use in conjunction with ADOS

Cost: \$175.00

Other Considerations: Training videos and materials available through publisher

Autism Diagnostic Observation Schedule (ADOS), 2001

Authors: Catherine Lord, Michael Rutter, Pamela D. DiLavore, Susan Risi

Publisher Information: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
800-648-8860

Age Range: 2 to Adult

Administration Time: 30-45 minutes

Areas Assessed

- Communication
- Reciprocal social interaction
- Imagination/creativity
- Stereotyped behaviors and restricted interests

Description of Instrument

- Consists of 4 modules, each of which contains a schedule of activities designed for use with children and adults at a particular developmental and language level
 - Module 1 – For participants who do not consistently use phrase speech
 - Module 2 – For participants who use some phrase speech, but who are not verbally fluent
 - Module 3 – For children whose toy play is age-appropriate and who are verbally fluent
 - Module 4 – Intended for verbally fluent adolescents and adults
- Each module consists of structured activities which provide standard contexts in which to observe social interactions, communication, and behaviors relevant to ASD

Strengths

- Considered a “gold standard” diagnostic tool for assessment of ASD; particularly when used in conjunction with the ADI-R
- Excellent interrater and test-retest reliability

Potential Concerns

- Longer than average training and practice required to attain mastery with instrument
- High cost of instrument

Recommended Use

- Part of a comprehensive assessment of communication, social interaction, and behaviors associated with ASD, and for subsequent educational planning
- Use in conjunction with ADI-R

Cost: \$1,345.00 for complete kit containing all required forms and materials

Other Considerations: Training videos and materials available from publisher

Autism Screening Instrument for Educational Planning – Second Edition (ASIEP-2), 1993

Authors: David Krug, Joel R. Arick, Patricia Almond

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

Age Range: 18 months to Adulthood

Administration Time: Varies depending on number of tests administered

Areas Assessed

- Behaviors
- Vocal behavior
- Interaction skills
- Classroom skills
- Rate of learning

Description of Instrument

- Five separate tests used for diagnosis, educational planning, and progress monitoring
 - *Autism Behavior Checklist (ABC)* – Checklist of 57 behaviors
 - *Sample of Vocal Behavior* – 50 spontaneous utterances
 - *Interaction Assessment* – Observation of play situations that assesses child's skills in relating to others
 - *Educational Assessment* – staying in seat, receptive language, expressive language, body concept, and speech imitation
 - *Prognosis of Learning Rate* – consists of a sequencing task
- It is appropriate for use with cognitive impairment, ASD, deaf/blindness, or emotional impairment

Strengths

- Sound research basis for content
- Assesses a broad range of skills necessary for appropriate educational planning

Potential Concerns

- Not all portions are applicable for higher functioning students
- Not as comprehensive as the ADOS

Recommended Use of Instrument

- Appropriately used by a multidisciplinary team to address issues of program development and monitoring
- ABC should be used for screening purposes *only*

Cost: \$204.00 for kit

Childhood Autism Rating Scale (CARS), 1988

Authors: Eric Schopler, Robert Reichler, Barbara Renner

Publisher Information: Western Psychological Services
12037 Wilshire Blvd.
Los Angeles, CA 90025-1251
www.wpspublish.com

Age Range: No age limits

Administration Time: 15-20 minutes

Areas Assessed

- Relating
- Body use
- Emotional response
- Object use
- Verbal and nonverbal communication

Description of Instrument

- Consists of 15 items rated on a 7-point scale indicating the degree to which the child's behavior deviates from that of a non-impaired child of the same age
- Parents, other caregivers, and/or school staff complete based on experience with student
- Ratings can also be completed based on examiner's observations
- Scores falling below the autism cut-off can be divided into two categories – mild-to-moderate autism and severe autism

Strengths

- Quick and easy to complete and score
- Excellent measure of change in severity of symptoms and in treatment effectiveness over time

Potential Concerns

- Developed prior to the DSM-IV-TR conceptualization of ASD
 - Cannot distinguish among PDD subgroups
 - Does not include same conceptualization of a triad of impairments, which can lead to over-identification of children with cognitive impairment
- Assesses some areas not specific to ASD, such as language delay and activity level
- May underestimate ASD in older higher functioning students

Recommended Use of Instrument

- Level 2 screening tool to determine need for further evaluation

Cost: \$70.00 for starter kit

Other Considerations: Video training available from publisher

Children's Communication Checklist – Second Edition (CCC-2), 2003

Author: Dorothy Bishop

Publisher Information: Harcourt Assessment
32 Jamestown Road
London, NW1 7BY, UK
© Harcourt Assessment
www.harcourt-uk.com

Age Range: 4 to 16 years

Administration Time: 5-15 minutes

Areas Assessed

- Speech
- Syntax
- Semantics
- Coherence
- Inappropriate initiation
- Stereotyped language
- Use of context
- Nonverbal communication
- Social relations
- Interests

Description of Instrument

- 70-item checklist that assists in identifying communication problems, and may also be used as a secondary diagnostic assessment to distinguish between children with a typical SLI versus pragmatic disorder such as that seen in Autism Spectrum Disorder
- Completed by an adult who has regular contact with the child
- Two composite scores are derived
 - General Communication Composite is used to identify children likely to have clinically significant communication problems
 - Social Interaction Deviance Composite can assist in identifying children with a communication profile characteristic of autism

Strengths

- Good consistency between parent and professional ratings
- Assesses pragmatic communication skills that are typically difficult to measure

Potential Concerns

- Available only through UK-based publisher

Recommended Use of Instrument

- Screening for children who are likely to have language impairment
- Identifying pragmatic impairment in children with communication problems
- Identifying children who should receive further assessment for ASD

Cost: Approximately \$120.00 for complete assessment kit (based on current exchange rate)

Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP), 2002

Authors: Amy Wetherby, Barry Prizant

Publisher Information: Brookes Publishing
PO Box 10624
Baltimore, MD 21285-0624
800-638-3775
www.brookespublishing.com

Age Range: 6 months to 6 years; Functional age 6-24 months

Administration Time: 50-75 minutes

Areas Assessed

- Communicative functions
- Gestural communicative means
- Verbal communicative means
- Reciprocity
- Social-affective signaling
- Symbolic behavior

Description of Instrument

- Administered by speech language pathologist, early interventionist, psychologist, or other professional trained to assess developmentally young children
- 24-item checklist for primary caregiver
- Behavior sampling observation
- 4-page caregiver questionnaire

Strengths

- Norm referenced on a culturally diverse group of children
- Good validity
- Meets virtually all of the recommended characteristics of a communication assessment for developmentally young children

Recommended Use

- Checklist can serve as a good initial screening tool
- Behavior sampling observation and caregiver questionnaire can be used for in-depth assessment of communication, social skills, and behaviors

Cost: \$599.00 for complete kit, including all toys and other materials needed

Other Considerations: Video training available from publisher

Elementary Test of Problem Solving (TOPS-E), 1994

Authors: Linda Bowers, Rosemary Huisingh, Mark Barrett, Jane Orman,
and Carolyn LoGiudice

Publisher Information: LinguSystems
3100 4th Avenue
East Moline, IL 61244-9700
800-776-4332

Age Range: 6 to 11 years

Administration Time: 35 minutes

Areas Assessed

- Problem solving
- Determining solutions
- Drawing inferences
- Empathizing
- Predicting outcomes
- Using context cues
- Vocabulary comprehension

Description of Instrument

- The TOPS-E is designed to examine the elementary age student's overall approach to dealing with situations in order to see the interaction of his/her language and critical thinking skills
- Black and white photographs provide the stimulus for questions that focus on critical thinking skills and assess how students use their language to think
- Test items are based on the research of Benjamin Bloom, Richard Paul, Howard Gardner, and others
- *Classroom Problem Solving Scale* is completed by the classroom teacher and provides information about a student's problem-solving skills in the classroom

Strengths

- Assesses communication and thinking skills that are necessary for appropriate educational planning

Recommended Use of Instrument

- Part of a comprehensive communication assessment

Cost: \$99.95

Functional Communication Profile - Revised (FCP-R), 2003

Author: Larry I. Kleiman

Publisher Information: LinguiSystems
3100 4th Avenue
East Moline, IL 61244-9700
800-776-4332

Age Range: 3 to Adult

Administration Time: 45-90 minutes depending on student variables; can be administered over several sessions

Areas Assessed

- Sensory
- Speech
- Attentiveness
- Voice
- Pragmatic/social
- Expressive language
- Receptive language
- Fluency
- Oral
- Non-verbal communication

Description of Instrument

- Assesses a wide range of communication skills and communication effectiveness
- Can be used with all students with developmental delays; particularly relevant to ASD
- Establishes level of impairment in each area as normal, mild, moderate, severe, or profound

Strengths

- Can be used with students regardless of the form of communication (sign, nonverbal, augmentative, etc.)
- Provides summaries of each skill area that are beneficial for goal writing and program development

Recommended Use of Instrument

- Part of a comprehensive communication assessment
- Educational program planning and goal writing

Cost: \$41.95

Gilliam Autism Rating Scale-Second Edition (GARS-2), 2006

Authors: James Gilliam

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

Age Range: 3 to 22 years

Administration Time: 5 to 10 minutes

Areas Assessed:

- Stereotyped Behaviors
- Communication
- Social Interaction
- Parental Interview (Development and Abnormal Behavior)

Description of Instrument:

- 52 item, norm-referenced behavior rating scale for parents(s) and/or school staff
- Parents can complete the interview portion that examines development and abnormal behaviors
- Scores used to determine the likelihood that the child has autism

Strengths:

- Technical adequacy has improved from previous version. (Standardization used a large, representative population of students diagnosed with autism.)
- Reliability and validity remain strong
- Provides much more detailed information than other measures for autism
- Administration is quick and easy
- Includes a manual that can assist with developing instructional objectives

Potential Concerns:

- Some of the terms or phrases used may need to be described to individuals unfamiliar with autism
- Multiple individuals familiar with the child should complete the ratings to help reduce bias

Recommended Use:

- Single part of a comprehensive assessment of communication, social interaction, and behaviors associated with ASD

Cost: \$131.00

Infant/Toddler Sensory Profile, 2002

Author: Winnie Dunn

Publisher Information: Harcourt Assessment
19500 Bulverde
San Antonio, TX 78259
800-211-8378
www.harcourtassessment.com

Age Range: Birth to 36 months

Administration Time: 15 minutes

Areas Assessed

- Sensory processing
- Modulation
- Behavioral and emotional responses

Description of Instrument

- 36 items for children birth to 6 months
 - Sensation seeking
 - Sensation avoiding
 - Sensory sensitivity
 - Low registration
- 48 items for children 7 to 36 months
 - Auditory processing
 - Visual processing
 - Tactile processing
 - Vestibular processing
 - Oral sensory processing
- Completed by parent or caregiver who has daily contact with child; items rated according to frequency with which various behaviors occur

Strengths

- Standardized on a large number of children
- Provides valid and reliable scores

Recommended Use of Instrument

- Professional with background in sensory processing should administer and score
- Intervention and treatment planning

Cost: \$149.00

MacArthur Communicative Development Inventories (CDIs), 2005

Authors: Donna Jackson-Maldonado, Elizabeth Bates, Donna Thal

Publisher Information: Brookes Publishing
PO Box 10624
Baltimore, MD 21285-0624
800-638-3775
www.brookespublishing.com

Age Range: 8 to 30 months; developmentally younger students functioning in this range

Administration Time: 20-40 minutes

Areas Assessed

- Language and communication skills

Description of Instrument

- Parents/caregivers complete report forms
- *Words and Gestures* form – ages 8-16 months
- *Words and Sentences* form – ages 16-30 months

Strengths

- Good reliability and validity
- Normed on 1,800 children in multiple locations
- Meets virtually all of the recommended characteristics of a communication assessment for developmentally young children

Recommended Use

- Assessment of expressive and receptive communication

Cost: \$90.00

Psycho-Educational Profile – Third Edition (PEP-3), 2005

Authors: Eric Schopler, Margaret Lansing, Robert Reichler, Lee Marcus

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

Age Range: 2 years, 0 months through 7 years, 5 months
(Educational planning information but not standardized scores can be obtained for lower functioning students above the age range)

Administration Time: varies widely; can take up to two hours

Areas Assessed:

- Cognitive Verbal/Preverbal
- Expressive Language
- Receptive Language
- Fine Motor
- Gross Motor
- Visual-Motor Imitation
- Affective Expression
- Social Reciprocity
- Characteristic Motor Behaviors
- Characteristic Verbal Behaviors
- Adaptive Behaviors
- Problem Behaviors
- Personal Self-Care

Description of Instrument:

- Performance section that has 172 items which directly test the student's skills.
- 38-Item Caregiver Report that should be administered prior evaluation.
- Items assigned rating of 0, 1, or 2 (failing/severe, emerging/mild, or passing/appropriate).

Strengths:

- Significant improvements made from prior editions of this test
- Standardized using a relatively large and representative norm sample of children on the autism spectrum.
- Though it has some limitations, the technical adequacy is superior to other measures currently available to assess behaviors associated with ASD.
- Provides some useful information for instructional planning.

Potential Concerns:

- May require multiple sessions to complete

Recommended Use:

- Single part of a comprehensive assessment of communication, social interaction, and behaviors associated with ASD
- Use to provide general information to help begin instructional planning

Cost: \$450.00 for complete kit

Other Considerations: Multiple professionals could be involved in an assessment using the PEP-3

Sensory Profile, 1999

Author: Winnie Dunn

Publisher Information: Harcourt Assessment
19500 Bulverde
San Antonio, TX 78259
800-211-8378
www.harcourtassessment.com

Age Range: 3 to 10 years

Administration Time: 15 minutes for short profile

Areas Assessed

- Sensory processing
- Modulation
- Behavioral and emotional responses

Description of Instrument

- 125 questions for parents/caregivers designed to help the examiner understand the student's sensory processing patterns
- *Short Sensory Profile* available as an abbreviated format of the *Sensory Profile*
- Students are characterized by their responsiveness to sensory input including
 - Sensory seeking
 - Emotional reactive
 - Low endurance/tone
 - Oral sensory sensitivity
 - Inattention/distractibility
 - Poor registration
 - Sensory sensitivity
 - Sedentary
 - Fine motor/perceptual

Strengths

- Based on research on over 1,000 children, including children with disabilities, ADHD, and autism

Potential Concerns

- Lengthy – may want to consider using the *Short Sensory Profile* in certain situations

Recommended Use of Instrument

- Professional with background in sensory processing should administer and score
- Can be useful in discrimination of characteristics related to a variety of disorders
- Useful as a discriminative set of data for educational planning

Cost: \$149.00

Social Responsiveness Scale (SRS), 2005

Author: John N. Constantino

Publisher Information: Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
800-648-8860
www.wpspublish.com

Age Range: 4 to 18 years

Administration Time: 15-20 minutes

Areas Assessed

- Social awareness
- Social information processing
- Capacity for reciprocal social communication
- Social anxiety/avoidance
- Autistic preoccupations and traits

Description of Instrument

- 65-item scale measuring the severity of autism spectrum symptoms as they occur in natural social settings
- Completed by parent(s) or school staff

Strengths

- Sensitive and reliable across a wide range of symptom severity
- Measures impairment on a quantitative scale across a wide range of severity, rather than a "yes" or "no" format, which is consistent with the concept of autism as a spectrum disorder
- Helpful in diagnosing milder autism spectrum conditions

Potential Concerns

- New instrument – Just released in March 2005

Recommended Use

- Level 2 screening tool
- Part of a comprehensive evaluation of social development – *Need to give this prior to the ADI-R or other detailed interviews to avoid bias*
- Measuring response to intervention

Cost: \$82.50

Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), 2008

Author: Mark L. Sundberg, Ph.D.

Publisher Information: AVB Press (Advancements in Verbal Behavior)
4425-C Treat Blvd. Suite #210
Concord, CA 94521
www.avbpress.com

Age Range: No specific range, measures criterion-referenced skills that help to identify where to begin intervention. Skills correspond to typical language development that occurs between 0 and 48 months.

Administration Time: Several Hours

- Mand
- Tact
- Listener Skills
- Visual Perceptual Skills & Matching to sample
- Play
- Social
- Imitation
- Echoic
- Vocal
- Listener Responding by Function, Feature, and class
- Intraverbal
- Group Learning Classroom Skills)
- Linguistics
- Reading
- Writing
- Math

Description of Instrument:

- **Milestones Assessment** evaluates 170 measurable learning and language milestones that are sequenced and balanced across 3 developmental levels (0-18 months, 18-30 months, and 30-48 months). Some skills can be observed, others must be tested and some require timed observations.
- Contains a **Barriers Assessment** which looks at 24 common learning and language acquisition barriers.
- **Transition Assessment** has 18 assessment areas that help to identify if a child is making meaningful progress and has acquired skills needed for learning in a less restrictive environment
- **Task Analysis and Skills Tracking** provides a further breakdown of each skill and contains approximately 900 specific skills that can be taught in the 16 target areas.
- **Placement and IEP Goals** corresponds to the four assessments and provides direction for instruction and suggestions for IEP goals.

Strengths:

- Examines a comprehensive range of skills which help to provide a direction for instruction and helps to identify barriers to instruction as well as skills needed to learn in a less restrictive environment.
- Milestone Master Scoring Form allows for repeated assessments and provides a visual method of displaying student progress over time.

Potential Concerns:

- Would be challenging to administer without ABA or Verbal Behavior background.

Recommended Use:

- Would not be used for diagnostic purposes, but is an excellent source for gaining instructional starting points, developing IEP goals, and monitoring student progress.

Cost: \$69.95 for Manual and Protocol (Discounts for purchasing in larger quantities)

Other Considerations:

- Can be used for children with language delays and developmental disabilities other than autism.

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
800-328-2560

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

Administration 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

Vineland Adaptive Behavior Scales – Second Edition (VABS-II)

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

Publisher Information: American Guidance Service, Inc.
4201 Woodland Road
Circle Pines, MN 55014-1796
1-800-328-2560 FAX: 1-800-471-8457

Age Range: Survey Interview Form: Birth through 90 years
Parent/Caregiver Rating Form: Birth through 90 years
Expanded Interview Form: Birth through 90 years
Teacher Rating Form: 3 through 21-11 years

Administration Time

- Survey Interview and Parent/Caregiver Rating Forms: 20-60 minutes
- Expanded Interview Form: 60-90 minutes
- Teacher Rating Form: 20-30 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 (internalizing, externalizing, other)

Description of Instrument

- Semi-structured interview and teacher rating formats gather multiple measures/perspectives of an individual's skills in areas necessary for everyday living.
- Interview editions are completed with parent/caregiver while teacher rating form is a questionnaire completed by teacher(s)
- Survey Interview Form – open-ended questions designed to assess all areas of adaptive behavior
- Expanded Interview Form – more in-depth interview aimed at exploring functioning in each domain in greater detail
- Parent/Caregiver Rating Forms – same content as the Survey Interview, but in a rating scale format; appropriate for when time or access to parents is limited
- Teacher Rating Form – content specific to each adaptive behavior domain in the school setting

Strengths

- This updated version of the VABS builds on the established reliability and validity of the original version. It is a highly research-based and accurate resource for assessing skill delays associated with cognitive impairment, autism, and Asperger's syndrome, among other diagnoses.
- The addition of a parent/caregiver rating form allows for wider use of this tool for parents who are not available to participate in a lengthy interview process.
- Supplementary Norm groups available for specific population, including Autism Spectrum Disorders
- Computer ASSIST scoring programs available

Recommended Use

- Comprehensive assessment of adaptive behavior
- Part of a comprehensive assessment of communication, social interaction, and behaviors associated with ASD
- Useful for educational program planning and monitoring of progress

Cost: \$230.00 for Starter Set including a manual, survey forms, and teacher rating forms
\$550 for Starter Set with ASSIST computerized scoring and reporting software

Other Considerations: Video training and materials available from publisher

ISSUES OF ELIGIBILITY

The following is a review of various disability categories that share characteristics of autism and must be considered relative to Michigan's educational definition of Autism Spectrum Disorder. Following the discussion of other special education categories is a discussion of considerations that should be made if a student has an outside diagnosis of ASD or other disorder. When considering the most appropriate eligibility for a student, it is recommended that the discussion of the ASD definition in Chapter 1 serve as a foundation for making eligibility decisions concerning ASD. The definition includes the impairment triad of 1) qualitative impairments in reciprocal social interaction, 2) qualitative impairments in communication, and 3) stereotypic behavior/restricted range of interests.

Comparison with Other Special Education Definitions

Cognitive Impairment (CI)

Students can be found eligible for special education as having a cognitive impairment if their development rate is at or approximately two standard deviations below the mean on a test of intellectual ability. (See Appendix D for the Michigan definition of CI.) Another requirement for eligibility as CI is scoring at or below the 6th percentile on academic achievement tests in reading and math. There must also be impairment in adaptive behavior.

Cognitive impairment and Autism Spectrum Disorder often occur together.

Determining eligibility for cognitive impairment is based on cognitive functioning, academic achievement, and adaptive behavior. Determining eligibility for Autism Spectrum Disorder is based on qualitative differences in reciprocal social interaction, communication, and stereotypic behavior/restricted range of interests.

Students with cognitive impairment may display autistic features without being eligible under the ASD category. Research has shown that children with Pervasive Developmental Disorders (PDD) and lower verbal intelligence scores have been shown to display more motor mannerisms and impairments in social skills and language than children with PDD with a higher IQ (Vig and Jedrysek, 1999). This suggests that some of these features may be more related to the child's cognitive level than to the presence of an Autism Spectrum Disorder. Charak and Stella (2001-2002) noted that diagnosticians tend to over-diagnose children with significant cognitive delays as having autism. This is particularly true for children who are nonverbal and function below the mental age of 18 months.

The following are important issues to consider when distinguishing Autism Spectrum Disorder from cognitive impairment:

Reciprocal Social Interaction

1. A student of comparable mental age with ASD has greater difficulty with the development of joint attention than does a student with CI.
2. Difficulty understanding self versus other concepts and sharing emotions is more prevalent in a student with ASD than with CI.
3. Students with ASD have a greater degree of impairment in social interaction and awareness than students with CI of the same mental age.

Communication and Symbol Use

1. Students with ASD demonstrate less verbal and physical imitation than students with CI.
2. Showing objects and integrating gaze with gestures are behaviors commonly seen in students with cognitive impairment, but not in students with ASD when comparing children of comparable mental age. The student with ASD is more likely to hold an adult's wrist and push it toward the desired item.
3. Students with ASD show more ritualistic forms of play compared to students with cognitive impairment.

4. Students with ASD tend to engage in simple manipulation of toys instead of pretend play compared to mental age peers with CI.

Stereotypic Behavior/Restricted Range of Interests

Repetitive motor mannerisms are seen in both ASD and cognitive impairment, but the reasons for these mannerisms may be different. The student with cognitive impairment may have a limited behavioral repertoire and be displaying behavior typical of a child at an earlier developmental age.

Other Features that Help Differentiate ASD from CI

1. Students with ASD tend to display an uneven profile of cognitive development and adaptive behavior, while students with CI tend to have more even developmental profiles.
2. Young children with ASD are more likely to ignore the human voice than children with CI of the same mental age.
3. Students with ASD are more likely to be sensitive to noise.

Assessment Tool Selection

Because there are limitations with the reliability and validity of some instruments used when evaluating both populations it is important that the considerations are made and noted in the teams documentation.

Early Childhood Developmental Delay (ECDD)

The Early Childhood Developmental Delay (ECDD) eligibility may only be given to students through seven years of age whose primary delay cannot be differentiated through other existing special education criteria. This is a type of “rule out” category, and all other eligibility categories should be considered first. (See Appendix E for the Michigan definition of ECDD.)

When an evaluation team assesses young students, and the results manifest a delay in one or more areas of development equal to or greater than one-half of the expected development, ECDD may be considered.

If a young student clearly fits the ASD category, then s/he should be found eligible as a student with ASD in order to best describe his/her constellation of deficits. If, however, a student has ASD characteristics but does not clearly meet the full ASD criteria, ECDD would be an appropriate label. The diagnostic “picture” of a student may become clearer over time, and ASD or another specific eligibility area may be more evident before their eighth birthday.

If a student requires special education, ECDD eligibility provides the opportunity for a student to receive appropriate services. Determining a student eligible as ECDD also allows professionals to obtain a longitudinal picture to determine whether s/he truly meets the criteria for ASD.

Emotional Impairment (EI)

According to Michigan's Revised Administrative Rules for Special Education, students with an emotional impairment manifest behavior problems primarily in the affective domain over an extended period of time which adversely affect the student's education so that s/he cannot profit from regular learning experiences without special education support. (See Appendix F.) Students with an emotional impairment primarily have difficulty with emotional stability, interaction with and response to others, problem-solving, and self-control. Although students with an emotional impairment may have problems outside of the affective domain, no other major domain is a required part of the EI definition. In contrast, the ASD definition requires a triad of impairments in three domains – reciprocal social interaction, communication, and stereotypic behavior/restricted range of interests.

Students with an emotional impairment must manifest their problems for an extended period of time, which is operationally defined as 90 days or more. In contrast, students

with Autism Spectrum Disorder (ASD) are considered to have a lifelong developmental disability. It is possible for a student with an emotional impairment to not manifest his/her disability until middle school, while a student with ASD generally displays characteristics at a much younger age.

The problems present in students with an emotional impairment result in behavior manifested by one or more of the following characteristics:

Inability to Build/Maintain Satisfactory Relationships in the School Environment – Some examples of this characteristic found in students with EI include physical and/or verbal aggression, alienation of others, and excessive attention-seeking. In many instances, students with EI interact back and forth with others but in an inappropriate manner. Students with ASD generally lack skills for engaging in back and forth exchanges.

Inappropriate Types of Behaviors/Feelings Under Normal Circumstances – Students with EI who demonstrate this characteristic may exhibit:

- Rage, extreme overreaction, or panic in response to everyday occurrences
- Distorted or excessive affect
- Delusions, hallucinations, paranoia, or thought disorders
- Extreme mood swings
- Inappropriate sexually-related behavior

While some of the behaviors listed may be present in students with ASD, most of these behaviors would be considered secondary to the required triad of impairments (lack of reciprocal interaction, communication disorder, and stereotypic behavior/restricted range of interests).

General Pervasive Mood of Unhappiness or Depression – Students with EI who qualify under this characteristic exhibit depressive symptoms that typically involve changes in all of these four major areas:

1. *Affective Behavior* – May express feelings of worthlessness, excessive guilt, extreme sadness, and/or suicidal ideation

2. *Motivation* – May demonstrate loss of interest in familiar or new activities, decline in academic performance, and/or refusal to attempt tasks
3. *Physical/Motor Functioning* – May display loss of appetite, experience new problems sleeping, and/or display a deterioration in appearance
4. *Cognition* – May experience changes in attending, thinking, and concentration.

Although students with ASD may have co-occurring depression, the characteristics listed above are insufficient for a diagnosis of ASD.

Tendency to Develop Physical Symptoms or Fears Associated with Personal or School Problems – Very few students with EI establish eligibility under this characteristic.

Students with irrational fears tend to exhibit intense, disabling anxiety that often reaches panic proportions. Physical symptoms could include frequent or severe somatic complaints including severe headaches, stomach problems, or racing heart. Students with ASD may display some fear reactions but the nature, severity, and reporting of these symptoms is different in students with ASD because of their communication impairment. While students with EI can describe their fears and the feelings associated with them, it is difficult for many students with ASD to identify their own internal states and describe them to others (Tsai, 2001).

As discussed above, ASD can co-occur with some behaviors typically associated with an emotional impairment. However, to determine an eligibility of ASD the other two defining features, communication disorder and stereotypic behavior/restricted range of interests, must also be present. On the other hand, if the emotional impairment (including schizophrenia) appears to be the primary presenting concern for a student, s/he may not also be declared as eligible for special education under the Autism Spectrum Disorder label. If a student with ASD has co-occurring emotional difficulties that present unique and specific challenges beyond the ASD, and meet the eligibility requirements for EI, then the student may be given a secondary eligibility of EI.

Speech and Language Impairment (SLI)

A speech and language impairment (SLI) is a communication disorder that adversely affects educational performance in articulation, fluency, voice, and/or language. An articulation impairment may include omissions, substitutions, or distortions of speech sounds. Fluency interferes with effective communication through abnormal rate, speech interruptions, and/or repetitions. Voice impairments may involve pitch, loudness, and/or voice quality. A language impairment interferes with the understanding and use of language in one or more of the following areas: phonology, morphology, syntax, semantics, or pragmatics. (See Appendix G for Michigan's definition of Speech and Language Impairment.)

Students being evaluated for an ASD typically will have some type of language disability. When distinguishing between ASD and SLI, the evaluation team must consider the multiple facets of ASD. Students who only exhibit speech and language impairment do not exhibit qualitative impairments in reciprocal social interactions and stereotypic behavior/restricted range of interests. These individuals may present with an outside DSM-5 diagnosis of Social (Pragmatic) Communication Disorder. In these cases the evaluation team should consider the more limited eligibility of speech and language impairment.

If a student qualifies under the eligibility area of ASD it is unnecessary to consider SLI eligibility because the definition of ASD includes qualitative impairments in communication. Students labeled with ASD may have additional articulation, fluency, and/or voice disorders, but these are not defining features of ASD. In such cases, speech and language services would be designed and delivered based on the individual student's needs.

Consideration of Outside Diagnoses Related to Autism Spectrum Disorder

The following information is provided to assist evaluation teams in the process of considering outside evaluations and diagnoses. Students often receive evaluations and diagnoses from outside evaluators. When this documentation is received, the team is then responsible for considering this information in its evaluation of the student. The REED process will need to be completed to determine what, if any additional information is necessary for determining eligibility and developing an appropriate educational plan. The educational team may elect to use some components of the outside evaluation (e.g. ADOS-2 results, developmental history, etc.) or they may decide to complete their own evaluations to gain the information needed to make educational decisions. It is beneficial to have a basic understanding of related clinical diagnoses, and the *Diagnostic and Statistical Manual Fifth Edition (DSM-5)* criteria used to determine them. Understanding these criteria assists professionals in helping parents understand how their child's outside diagnosis may or may not correlate with special education eligibility. Children who meet the DSM-5 definition of Autism Spectrum Disorder may or may not meet Michigan's educational definition of Autism Spectrum Disorder depending on the number of symptoms they present with, the severity of the symptoms and stringency with which the evaluator followed the DSM-5 guidelines. The DSM-5 definition of Autism Spectrum Disorder can be found in Appendix H. Dahle (2003) reported that the differences in psychiatric and educational classification systems tend to result in confusion for parents, educators, and professionals involved with the person with Autism Spectrum Disorder. Dahle recommended ongoing education of parents and professionals in both education and mental health systems to facilitate collaborative interventions.

Exclusionary Considerations

In addition to considering the eligibility for special education criteria within the state and federal definitions of autism, 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 autism spectrum disorder or a related disorder, s/he may not automatically *qualify* for special education.
2. Even though Autism Spectrum Disorder is considered a lifelong disability, a student with ASD 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 autism needs accommodations only, consider providing those through a Section 504 plan.

Adverse Impact

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

Rule 340.1715 (1) Autism spectrum disorder is considered a lifelong developmental disability that adversely affects a student's educational performance in 1 or more of the following performance areas: (a) Academic (b) Behavioral (c) Social.

The IDEA regulations state the following:

300.7 (c) (1) (i) Autism means a developmental disability . . . that adversely affects the child's educational performance.

Courts and hearing officers have addressed the matter of adverse impact in special education cases involving a number of diagnoses. Case law has determined that even when the specific conditions could be the basis for special education eligibility under various eligibility categories, the diagnoses themselves do not automatically

trigger eligibility. Rather, the impact of the disorders is 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 ASD 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 has been evaluated and found eligible for special education according to....a group of qualified professionals...

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

Rule 300.7(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 s/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 for 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 ASD 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 1965); (B) lack of instruction in math; or (C) limited English proficiency.

Sharing Evaluation Findings with Families

The process of allowing one's child to undergo an evaluation for an Autism Spectrum Disorder can be a difficult and emotional one for many families. Even when a parent suspects his/her child may be on the spectrum, it becomes all the more real once the evaluation has concluded and eligibility decisions are being made. Families also have varying levels of knowledge and understanding about what ASD is, and what it may mean for their child and family. For all of these reasons, it is critical to approach eligibility discussions and decisions with the needs of the specific family in mind.

When an initial evaluation for ASD has been completed, it is often beneficial for one or more staff members familiar with the family to meet and discuss the evaluation results with the parent(s) prior to holding the IEP. This allows parents time to ask questions and express their emotions within a less formal setting. The preliminary meeting can take place on a day prior to the official IEP, or at a time just prior to the meeting with the larger group, depending on the team's assessment of what is most appropriate for each family. This type of meeting allows parents some time to process the information prior to attending the IEP team meeting where formal eligibility decisions will be made. The team should consider the benefit of sending a report via mail/email prior to this preliminary meeting versus presenting and discussing the report with them at the same time. Sometimes a preliminary meeting to discuss evaluation results is impractical. In that case, it is appropriate for a member of the team familiar with the parents to contact them by phone to explain the findings and to inform them they will receive the completed report(s) via mail/email prior to the IEP. Regardless of whether or not a preliminary meeting is held, parents should receive a copy of the completed report(s) at least one day prior to the official IEP meeting.

Autism Spectrum Disorder Eligibility Recommendation Procedures

These procedures identify all of the requirements for eligibility as a student with an Autism Spectrum Disorder. An explanation of each section is provided below:

Purpose

A recommendation for either initial eligibility, change in eligibility or ongoing special education eligibility must be made.

Evaluation Information

The team must address the reason for assessment, background information, current education/developmental level, relevant behavior observations, information from parents, educationally relevant medical information and communication functioning.

Diagnostic Assurances

The diagnostic assurance statements must indicate the following along with the report and date in which this information is found:

- The presence of at least 2 in the list of qualitative impairments in reciprocal social situations
- The presence of at least 1 in the list of qualitative impairment in communication
- The presence of at least 1 in the list of restricted, repetitive, and stereotyped behavior
- No evidence of a primary disability of Schizophrenia or Emotional Impairment
- That the disability is not due to lack of English proficiency or lack of instruction in math or the essential components of reading
- That the student requires special education programs and services

Additional assurances include the recommendation of eligibility and agreement or disagreement of each of the necessary participants. These participants include a

psychologist or psychiatrist, an authorized provider of speech and language services and a school social worker.

Eligibility Recommendation

The evaluation team members review the evaluation findings, including input from parents, as well as the diagnostic assurance statements. The evaluation team makes a recommendation of eligibility to the IEP team. The IEP team then reviews all of the information provided and makes a determination of eligibility.

Present Level of Academic Achievement and Functional Performance (PLAAPF)

If the evaluation team recommends that the student be determined eligible under the Autism Spectrum Disorder rule (R340.1715), it must describe the student's present level of academic achievement and functional performance. This statement describes the student's deficit areas as defined through the evaluation findings and serves as the starting point for instruction.

The Michigan Special Education Rule R340.1721a(2)(b) states that the report of the MET must include information needed to determine a student's present level of academic assessment and functional performance and educational needs that necessitate special education programs and/or services.

With the uneven development typically found in the profile of a student with Autism Spectrum Disorder, it is critical to determine areas of need and performance levels. By definition, communication and social skills would be affected. Other areas that may be affected include academic achievement, behavior, and motor functioning. In the present level of academic achievement and functional performance (PLAAPF), it is important to look at all documented areas of need requiring special education programs and services. The deficit areas must directly relate to each area checked under the *Diagnostic Assurance Statements* Section. Hence, by nature of the eligibility recommendation, a PLAAPF for a student with an ASD eligibility must address

difficulties in reciprocal social interaction, communication and restricted, repetitive or stereotyped behaviors.

Reports and Documentation

All of the information listed in the *Evaluation Information* section must be clearly described in the eligibility recommendation forms or included in a corresponding report. It is recommended that report sections be clearly labeled to identify this information and that within these sections observations are included that clearly describe each of the deficit areas associated with an Autism Spectrum Disorder. When reports are written, the evaluation team may include separate reports or one co-authored report with all participants' signatures. Every person who signed the *Eligibility Recommendation* must have information included in the attached report(s) or included within the appropriate sections of the *Eligibility Recommendation* form. The minimum required participants (psychologist or psychiatrist, school social worker and a speech/language pathologist) must include written documentation.

Process for Re-evaluation

If a student already receiving special education services is suspected to have an Autism Spectrum Disorder, a Review of Existing Evaluation Data (REED) and Evaluation Plan must be completed. A REED is also required for a student with Autism Spectrum Disorder eligibility who is due for a three-year redetermination of eligibility. When completing the REED, it is important to have an in-depth discussion about the student's needs, giving consideration to the previous evaluations and/or interventions attempted, to determine what additional information, if any, is needed to complete the process. It is not necessary to duplicate interviews, histories, and evaluations previously completed. However, it is important to update previous findings based on new information.

The overall questions to consider during the REED process are: Is the student successful in his/her current educational curriculum/setting? If not, what prevents him/her from being successful, and what interventions/supports are needed?

After reviewing pertinent information, the team may determine that there is sufficient documentation to re-determine eligibility without additional information, or they may determine that further assessment is needed in some or all areas associated with the eligibility recommendation. In addition to the eligibility recommendation, the team must also have enough current information to determine the student's present levels of academic achievement and functional performance, which may require additional assessment. Typically, this will include documented summaries of classroom-based or curriculum-based assessments, and updated observations.

The IEP team, including the parent, and other qualified professionals as appropriate, will develop the REED, which may include the following in its review of existing evaluation data:

- Parent input, including consideration of any reports or evaluations they have provided from outside clinicians
- Current educational assessments and observations
- Observations by related service providers
- Previous Special Education Eligibility Recommendations and Corresponding Reports

The parent is a key member of the REED team, and may offer or request additional information.

A challenge in determining re-evaluation needs is the “lifelong” nature of Autism Spectrum Disorder. The question of continued eligibility may not be in question unless there is a concern about the validity of the original determination, or the adverse impact of the disability has diminished to the point that the student no longer needs special education.

DEVELOPING INDIVIDUALIZED EDUCATION PROGRAMS

Related Michigan Rule

Rule 340.1721e (2) Individualized education program team meeting; ... individualized education program. An individualized education program shall be based on all diagnostic, medical and other evaluative information requested by the team, or provided by the parent or student who is disabled and shall include all of the following information in writing: (a) A statement of the student's present level of educational performance. (b) A statement of annual goals, including short-term objectives. (c) Appropriate objective criteria and evaluation procedures and schedules for determining whether the objectives are being achieved...

IEP Team Report Sections

Present Level of Academic Achievement and Functional Performance (PLAAFP)

The PLAAFP for an IEP that follows an initial or three-year re-determination should be taken from the Eligibility Recommendation (formerly called MET Summary) form. The PLAAFP should also, however, reflect any additional information that is provided at the IEP team meeting. The evaluation team members who completed the assessment, and the IEP team members who work with the student should develop the PLAAFP collaboratively. In subsequent IEP team reports, it is expected that progress has been made on goals and objectives, and the PLAAFP statement should be updated to reflect the student's progress.

The PLAAFP is a statement that addresses the student's areas of need as defined under the *Diagnostic Assurance Statements* on the Eligibility Recommendation form, and should include the following:

1. Baseline assessment data such as achievement tests, classroom performance data, documented observations

2. A specific narrative summary that will serve as a starting point for instruction and the writing of goals and objectives
3. A statement regarding the extent to which the student can be involved in and make progress in the general education curriculum
4. Statements regarding any other needs related to the disability

Annual Goals and Short Term Objectives

Areas of need identified in the PLAAFP statement must be addressed with either an annual goal, through the supplementary aids/services, or through the development of a transition plan. In Michigan every annual goal written must include at least two short-term objectives.

Social goals – By definition, students with ASD will have deficits in the social domain that will require at least one annual goal. Examples include, but are not limited to, initiation of social interaction, turn taking, and appropriate participation in group projects.

Communication goals – Students with ASD have deficits in the communication domain that will require at least one annual goal. Examples include, but are not limited to, requesting a desired item, appropriately communicating frustration, and maintaining a conversational topic.

Academic and Learning goals – Students with ASD may have academic and learning needs. Goals and objectives must be developed for academic areas that the PLAAFP defines as specific deficits for the student. Annual goals should not be developed for those subjects in which the student does not have an academic deficit. Examples of possible learning goals include, but are not limited to, organization of materials and completion of assignments.

Adaptive Behavior goals – Students with ASD may have needs related to self-care skills and community participation. Examples include, but are not limited to, feeding, dressing, using transportation appropriately, and eating in a restaurant.

Other Goals - Other goals may be necessary when additional deficits are determined, such as in the areas of motor development or sensory needs. Examples include, but

are not limited to, handwriting, participation in sensorimotor routines, and transitioning between activities.

Objective criteria and evaluation procedures; Schedules for determining whether the objectives are being achieved. – All annual goals must include at least two short-term objectives. These objectives must be measurable, and include the schedule for evaluation as well as the criteria for success.

Responsibility for Goals and Objectives – All annual goals should include the title(s) of the person(s) who will be working with the student on this goal. Staff recorded here are responsible for work on the goals and objectives with the student, keep data related to the student's progress, and report progress on goals and objectives in the manner determined by the IEP team. Shared responsibility for goals with teachers and related service staff is encouraged as a practice, since students with ASD will generalize skills better when implemented by multiple people across multiple settings.

Reporting Progress – All service providers must collect individual data and report progress on IEP goals and objectives at the same frequency as report cards for same age peers in the school. When responsibility is shared for a goal, all providers must document progress and collaborate on the progress report. Progress report comments and data are essential to provide sufficient information to assess a student's progress. If the progress is not sufficient for the student to meet his/her goals and objectives, an IEP team meeting must be convened to review the student's program and re-evaluate/re-determine appropriate goals.

Accommodations and Modifications

34CFR§300.346 Development, review and revision of IEP (2) Consideration of special factors. The IEP team also shall – (i) In the case of a child whose behavior impedes his or her learning or that of others, consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior.

If the student requires a positive behavior intervention support plan, it should be referenced in the *Accommodations and Modifications* section of the IEP team report. This section requires that the frequency and location of the plan be defined. Most often, a positive behavior intervention support plan will be implemented daily. Locations may vary depending upon the plan. Examples may include on the bus, in all settings, in non-structured settings like recess/lunch/passing time, and in general education classes.

State and Districtwide Assessments

All students must be given access to state and districtwide assessments. The IEP team must consider appropriate accommodations or an alternate assessment as needed by the student.

Transportation Needs

Students with ASD may require special transportation due to safety factors related to the student's behavior or difficulty with social judgment. Some students with ASD may require special transportation provisions, like an assigned seat, securement, or special pickup and drop-off considerations.

Extended School Year (ESY)

The regulations implementing the Individuals with Disabilities Education Act (IDEA) define extended school year (ESY) services as “special education and related services that are provided to a child with a disability beyond the normal school year of the public agency in accordance with the child's IEP; and at no cost to the parents of the child.” IDEA requires each school district to ensure that ESY services are available for individual students if the IEP team determines that ESY services are necessary for the student to receive a free appropriate public education. This is a decision based upon the individual student's need(s). See the *Kent ISD Guidelines for Determining the Need for Extended School Year Services* for more information.

APPENDIX A – IDEA DEFINITION OF AUTISM

300.7 **Child with a disability**

(c)(1)(i) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (b)(4) of this section.

(ii) A child who manifests the characteristics of "autism" after age 3 could be diagnosed as having "autism" if the criteria in paragraph (c)(1)(i) of this section are satisfied.

300.7 (a) **General**

...The term child with a disability means... who, by reason thereof, needs special education and related services.

300.534 (b) A child may not be determined eligible under this part if (1) the determinant factor for that eligibility determination is (i) Lack of instruction in reading or math, or (ii) Limited English proficiency.

APPENDIX B – COMPARISON OF MICHIGAN AND IDEA DEFINITIONS OF AUTISM SPECTRUM DISORDER/AUTISM

Michigan Definition	IDEA Definition
Autism Spectrum Disorder is considered a lifelong developmental disability... Autism Spectrum Disorder is typically manifested before 36 months of age. A child who first manifests the characteristics after age 3 may also meet criteria.	Autism means a developmental disability... generally evident before age 3. A child who manifests the characteristics of "autism" after age 3 could be diagnosed as having "autism" if the criteria... are satisfied.
...That adversely affects a student's educational performance in 1 or more of the following areas: a) Academic. b) Behavioral. c) Social.	... That adversely affects a child's educational performance.
Autism Spectrum Disorder is characterized by qualitative impairments in reciprocal social interactions, qualitative impairments in communication...	... significantly affecting verbal and nonverbal communication and social interaction.
... And restricted range of interests/repetitive behavior.	Other characteristics... are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines,...
Determination may include unusual or inconsistent response to sensory stimuli.	... unusual responses to sensory experiences.
...To be eligible under this rule, there shall not be a primary diagnosis of schizophrenia or emotional impairment.	The term does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance.
	... The term child with a disability means... who, by reason thereof, needs special education and related services...
	A child may not be determined eligible under this part if the determinant factor for that eligibility determination is (A) lack of instruction in reading including the essential components of reading instruction; (B) lack of instruction; or (C) limited English proficiency
A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team including, at a minimum, a psychologist or psychiatrist, an authorized provider of speech and language... and a school social worker.	

APPENDIX C – CHART OF ASSESSMENT TOOLS FOR AUTISM SPECTRUM DISORDER

Name of Instrument	Age Range	Areas Assessed	Page #
Adolescent & Adult Psycho-Educational Profile (AAPEP), 1992	12 and older	Vocational skills, Independent functioning, Leisure skills, Vocational behavior, Functional communication, Interpersonal behavior	41
Adolescent/Adult Sensory Profile, 2002	11 to 65+	Sensory processing, Modulation, Behavioral and emotional responses	42
Adolescent Test of Problem Solving (TOPS-A), 1991	12 to 17-11	Evaluating, Fair-mindedness, Analyzing, Thinking independently, Clarifying, Affect	43
Asperger's Syndrome Diagnostic Scale (ASDS), 2201	5 to 18 years	Language, Social skills, Maladaptive behavior, Sensorimotor, Cognitive	44
Australian Scale for Asperger's Syndrome Screening Tool, 1998	Higher functioning school-age students	Social/emotional, Communication, Cognitive, Specific interest, Movement, Other characteristics	45
Autism Diagnostic Interview-Revised (ADI-R), 2003	2 to adult	Language and communication, Reciprocal social interactions, Restricted, repetitive, and stereotyped behaviors and interests, Background/early development, Acquisition/ loss of language or other skills, Language and communication functioning, Social development and play, Interests and behaviors, Behaviors of clinical importance	46
Autism Diagnostic Observation Schedule (ADOS), 2001	2 to adult	Communication, Reciprocal social interaction, Imagination/ creativity, Stereotyped behaviors and restricted interests	47
Autism Screening Instrument for Educational Planning-Second Edition (ASIEP-2), 1993	18 months to adulthood	Behaviors, Vocal behavior, Interaction skills, Classroom skills and Rate of learning	48
Childhood Autism Rating Scale (CARS), 1988	No age limits	Relating, Body use, Emotional response, Object use, Verbal and nonverbal communication	49
Children's Communication Checklist-Second Edition (CCC-2), 2003	4 to 16 years	Speech, Syntax, Semantics, Coherence, Inappropriate initiation, Stereotyped language, Use of context, Nonverbal communication, Social relations, Interests	50
Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP), 2002	6 months to 6 years	Communicative functions, Gestural communicative means, Verbal communicative means, Reciprocity, Social-affective signaling, Symbolic behavior	51

Elementary Test of Problem Solving (TOPS-E), 1994	6 to 11 years	Problem solving, Determining solutions, Drawing inferences, Empathizing, Predicting outcomes, Using context cues, Vocabulary comprehension	52
Functional Communication Profile – Revised (FCP-R), 2003	3 to adult	Sensory, Speech, Attentiveness, Voice, Pragmatic/social, Expressive language, Receptive language, Fluency, Oral, Non-verbal communication	53
Gilliam Asperger’s Disorder Scale (GADS), 2003	3 to 22 years	Social interaction, Restricted patterns of behaviors, Cognitive patterns, Pragmatic communication skills, Developmental disturbances (optional subtest)	54
Gilliam Autism Rating Scale (GARS), 1995	3 to 22 years	Stereotyped behaviors, Social interaction, Communication, Developmental disturbances (optional subtest)	55
Infant/Toddler Sensory Profile, 2002	Birth to 36 months	Sensory processing, Modulation, Behavioral and emotional responses	56
MacArthur Communicative Development Inventories (CDIs), 2005	8 to 30 months	Language and communication skills	57
Parent Interview for Autism (PIA), 2002	Preschool level and below	Social relating, Affective responses, Peer interactions, Motor imitation, Communication, Object play, Imaginative play, Sensory responses, Motoric behaviors, Need for sameness	58
Psycho-Educational Profile-Revised (PEP-R), 1990	6 months to 7 years, 7 to 12 who are below 1 st grade	Imitation, Perception, Fine motor, Eye-hand integration, Cognitive performance, Cognitive verbal skills	59
Sensory Profile, 1999	3 to 10 years	Sensory processing, Modulation, Behavioral and emotional responses	60
Social Communication Questionnaire (SCQ), 2003	Above age 4, mental age above 2	Communication skills, Social functioning	61
Social Responsiveness Scale (SRS), 2005	4 to 18 years	Social awareness, Social information processing, Capacity for reciprocal social communication, Social anxiety/avoidance, Autistic preoccupation and traits	62
Vineland Adaptive Behavior Scales (VABS), 1984	<i>Interview Edition:</i> birth through 18-11 and low-functioning adults <i>Classroom Edition:</i> 3 through 12-11	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 <i>Interview editions</i> , optional domain)	63

APPENDIX D – MICHIGAN 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.

APPENDIX E – MICHIGAN DEFINITION OF EARLY CHILDHOOD DEVELOPMENTAL DELAY

R 340.1711 Early childhood developmental delay defined; determination.

Rule 11. (1) “Early childhood developmental delay” means a child through 7 years of age whose primary delay cannot be differentiated through existing criteria within R 340.1705 to R 340.1710 or R 340.1713 to R 340.1716 and who manifests a delay in 1 or more areas of development equal to or greater than 1/2 of the expected development. This definition does not preclude identification of a child through existing criteria within R 340.1705 to R 340.1710 or R 340.1713 to R 340.1716.

(2) A determination of early childhood developmental delay shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team.

APPENDIX F – MICHIGAN DEFINITION OF EMOTIONAL IMPAIRMENT

R 340.1706 Emotional impairment; determination; evaluation report.

Rule 6. (1) Emotional impairment shall be determined through manifestation of behavioral problems primarily in the affective domain, over an extended period of time, which adversely affect the student's education to the extent that the student cannot profit from learning experiences without special education support. The problems result in behaviors manifested by 1 or more of the following characteristics:

(a) Inability to build or maintain satisfactory interpersonal relationships within the school environment.

(b) Inappropriate types of behavior or feelings under normal circumstances.

(c) General pervasive mood of unhappiness or depression.

(d) Tendency to develop physical symptoms or fears associated with personal or school problems.

(2) Emotional impairment also includes students who, in addition to the characteristics specified in subrule (1) of this rule, exhibit maladaptive behaviors related to schizophrenia or similar disorders. The term "emotional impairment" does not include persons who are socially maladjusted, unless it is determined that the persons have an emotional impairment.

(3) Emotional impairment does not include students whose behaviors are primarily the result of intellectual, sensory, or health factors.

(4) When evaluating a student suspected of having an emotional impairment, the multidisciplinary evaluation team report shall include documentation of all of the following:

(a) The student's performance in the educational setting and in other settings, such as adaptive behavior within the broader community.

(b) The systematic observation of the behaviors of primary concern which interfere with educational and social needs.

(c) The intervention strategies used to improve the behaviors and the length of time the strategies were utilized.

(d) Relevant medical information, if any.

(5) A determination of impairment shall be based on data provided by a multidisciplinary evaluation team, which shall include a comprehensive evaluation by both of the following:

(a) A psychologist or psychiatrist.

(b) A school social worker.

APPENDIX G – MICHIGAN DEFINITION OF SPEECH AND LANGUAGE IMPAIRMENT

R 340.1710 Speech and language impairment defined; determination.

Rule 10. (1) A “speech and language impairment” means a communication disorder that adversely affects educational performance, such as a language impairment, articulation impairment, fluency impairment, or voice impairment.

(2) A communication disorder shall be determined through the manifestation of 1 or more of the following speech and language impairments that adversely affects educational performance:

(a) A language impairment which interferes with the student’s ability to understand and use language effectively and which includes 1 or more of the following:

- (i) Phonology.
- (ii) Morphology.
- (iii) Syntax.
- (iv) Semantics.
- (v) Pragmatics.

(b) Articulation impairment, including omissions, substitutions, or distortions of sound, persisting beyond the age at which maturation alone might be expected to correct the deviation.

(c) Fluency impairment, including an abnormal rate of speaking, speech interruptions, and repetition of sounds, words, phrases, or sentences, that interferes with effective communication.

(d) Voice impairment, including inappropriate pitch, loudness, or voice quality.

(3) Any impairment under subrule (2) (a) of this rule shall be evidenced by both of the following:

(a) A spontaneous language sample demonstrating inadequate language functioning.

(b) Test results on not less than 2 standardized assessment instruments or 2 subtests designed to determine language functioning which indicate inappropriate language functioning for the student’s age.

(4) A student who has a communication disorder, but whose primary disability is other than speech and language may be eligible for speech and language services under R 340.1745(a).

(5) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team, which shall include a teacher of students with speech and language impairment under R 340.1796 or a speech and language pathologist qualified under R 340.1792.

APPENDIX H – DSM-V DEFINITION OF AUTISTIC DISORDER

Diagnostic criteria for 299.00 Autistic Disorder

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
- (1) qualitative impairment in social interaction, as manifested by at least two of the following:
 - (a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - (b) failure to develop peer relationships appropriate to developmental level
 - (c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - (d) lack of social or emotional reciprocity
 - (2) qualitative impairments in communication as manifested by at least one of the following:
 - (a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - (b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - (c) stereotyped and repetitive use of language or idiosyncratic language
 - (d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
 - (3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - (a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - (b) apparently inflexible adherence to specific, nonfunctional routines or rituals
 - (c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - (d) persistent preoccupation with parts of objects
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another

mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, “In Partial Remission” should be specified.