

# **ATTENTION:**

THE FIRST PART OF THIS BOOKLET CONTAINS:

**HANDOUTS** FOR THE  
AUTISM TELECONFERENCE

**PRINT THESE 29 PAGES (which includes this page)  
TO HAVE FOR THE PROGRAM**

THE SECOND PART OF THIS BOOKLET CONTAINS:

**OPTIONAL** RELEVANT RESOURCE MATERIAL

This section is 99 pages total – PRINT AS NEEDED

Behavioral Treatment

Behavior Modification

Autism & Hope

Vocational & Educational Services

Transitional Services

# **Working with Children with Autism – What Caseworkers Need to Know**

*Thursday, October 28, 2010*

**Handout Materials**



**New York State  
Office of  
Children & Family  
Services**

New York State  
Office of Children and Family Services  
and  
PDP Distance Learning Project

# **WORKING WITH CHILDREN WITH AUTISM: WHAT CASEWORKERS NEED TO KNOW**

**October 28, 2010  
Teleconference**

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**Working with Children with Autism:  
What Caseworkers Need to Know**



**Dr. James S. Vacca**



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**Purpose:** This 2 hour teleconference for Child Welfare and Child Protective Services Staff will help participants:

- Learn the definitions and parameters of autism and other common developmental disabilities.
- Better understand the factors which may predispose young people with developmental disabilities to be abused and/or maltreated.
- Improve skills associated with knowing when to refer children with autism for evaluation and assessment, and to possess a general understanding of autism and other developmental disability.
- Acquire helpful techniques and strategies necessary in working with parents/relative caregivers/foster parents/adoptive parents of children with developmental disabilities.
- Acquire information related to a variety of useful social, medical, and educational programs and resources related to autism and other developmental disabilities.



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**Autism the problem**

Autism has become one of the nation's most serious public health problems and a major challenge to our schools. The Chicago Tribune reported, on October 5, 2009, that according to the Centers for Disease Control estimate about 1 in 100 8-year-old children in the U.S. have been diagnosed with autism spectrum disorder.



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## So...what Is It About Autism???



- Children with Special Needs.
- No noticeable physical indication of impairment in appearance.
- History of unsubstantiated claims regarding cause and treatment of autism –refrigerator moms and gluten free diet.
- Inconsistent quality of education because schools do not have teachers and administrators who are adequately trained to deal with the problem.

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## So...what Is It About Autism-Cont. ???



Children and adults with autism exhibit:

- Atypical, repetitive behaviors and deficits in social and communication skills.
- It is usually diagnosed during the first three years of life.
- It is four to five times more prevalent in boys than in girls. It knows no racial, ethnic or social boundaries.
- **Autism, Asperger's Disorder and PDDNOS (Pervasive Developmental Disorder - Not Otherwise Specified)** are commonly referred to as Autism Spectrum Disorders or ASDs. This label conveys the continuum of ability levels, but is not itself an official diagnosis.

Fombonne, E. (2005). The changing epidemiology of Autism. Journal of Applied Research in Intellectual Disabilities, 18, 281-294.

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## The Autism Spectrum



Similarities = Difficulties in 3 areas

- ✓ Social Functioning
- ✓ Communication/Language
- ✓ Restricted activities and interests

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## Prevalence and Incidence



- Recent increase in diagnosis-Autism spectrum disorders affect approximately 1 in 150 individuals. (Fombonne, E. (2005). The changing epidemiology of Autism. Journal of Applied Research in Intellectual Disabilities, 18, 281-294).
- 3 to 4 males per female.
- Consistency of prevalence across cultures ((Newschaffer CJ, Croen LA, Daniels J *et al.* 2007).
- Between 76% and 89% of children with autism are also diagnosed with mental retardation (Newschaffer CJ, Croen LA, Daniels J *et al.* . 2007).
- The increase is largely attributable to changes in diagnostic practices, referral patterns, availability of services, age at diagnosis, and public awareness.

Newschaffer CJ, Croen LA, Daniels J *et al.* [The epidemiology of autism spectrum disorders](#) [PDF]. *Annual Review of Public Health*. 2007;28:225-58. doi:10.1146/annurev.pubhealth.28.021406.144007

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## What are characteristics of a child with Autism that a caseworker should look for?



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## Impairments or abnormalities in:



- Limited or Abnormal Communication
- Poor Social Skills/Unusual Behavior
- Pronounced Sensory issues

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## Limited or Abnormal Communication



- Delayed speech/language-their vocabulary may consist of a few words or many words; sentences may be simple (one or two words) or complex.
- Common speech abnormalities include echolalia (immediate or delayed repeating of information), unconventional word use, and unusual tone, pitch, and inflection.
- When more complex speech is acquired, they typically have poor conversational skills.
- They may also have difficulty understanding common, nonverbal cues such as body language, facial expressions, and eye contact.
- Children with Autism having difficulty with functional speech will learn to communicate through picture boards, computers, sign language, and other augmentative devices.

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## Poor Social Skills/Unusual Behavior



- Lack of social/emotional reciprocity such as not spontaneously reaching out to others to share information or feelings.
- Problem maintaining and initiating interactions; lack of friendships-they often do not know how to engage in simple social interactions, such as sharing an experience with another person.
- Interest in activities, for example, a five-year-old may only play with his or her toy train to the exclusion of all other toys.
- Engaging in peculiar, sustained play activities such as spinning the wheels on a toy car rather than pretending to drive it, or finding a shoestring and dangling it in front of his or her eyes for long periods of time.

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## Poor Social Skills/Unusual Behaviors Continued



- Failure to develop age-appropriate friendships
- Deficits in reciprocal conversation such as sharing an experience with another person- no back and forth, no give and take- a three-year-old child with autism may not point to an animal so that his sister will notice it, too.
- Tendency to treat others in ritualized ways (misunderstanding of boundaries, expecting others to respond in specific manner).
- Very resistant to changes in routine. A minor change could upset to a child or adult with autism.

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## Restricted, repetitive behavior patterns



Children with Autism display many forms of repetitive or restricted behavior, which the Repetitive Behavior Scale-Revised (RBS-R) categorizes as follows.

- **Stereotypy** is repetitive movement, such as hand flapping, making sounds, head rolling, or body rocking.
- **Compulsive behavior** is intended and appears to follow rules, such as arranging objects in stacks or lines.
- **Sameness** is resistance to change; for example, insisting that the furniture not be moved or refusing to be interrupted.
- **Ritualistic behavior** involves an unvarying pattern of daily activities, such as an unchanging menu or a dressing ritual. This is closely associated with sameness and an independent validation has suggested combining the two factors.
- **Restricted behavior** is limited in focus, interest, or activity, such as preoccupation with a single television program, toy, or game.
- **Self-injury** includes movements that injure or can injure the person, such as eye poking, skin picking, hand biting, and head banging. A 2007 study reported that self-injury at some point affected about 30% of children with ASD (Dominick et. Al. 2007)

Dominick KC, Davis NO, Lainhart J, Tager-Flusberg H, Folstein S. Atypical behaviors in children with autism and children with a history of language impairment. *Res Dev Disabil.* 2007;28(2):145-62.

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## Restricted, Repetitive Behavior patterns Cont.



- Preoccupation with restricted patterns of interest
- Inflexible adherence to specific routines and rituals
- Repetitive motor mannerisms
- Preoccupation with parts of objects
- Difficulties with transition and change

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## Other Associated Features



No single individual with autism will display all of its possible characteristics. Instead, each person will demonstrate a unique combination of symptoms.

- Little or no eye contact
- Acts as though deaf
- Uneven development of skills
- Marked physical hyperactivity and/or extreme passivity
- Lack of demonstration of typical signs of affection
- Little or no apparent fear of real dangers
- Unusual responses to sensations, including a high tolerance for pain
- Inappropriate laughing or crying
- Inappropriate attachments to objects
- Eating, sleeping, and toileting difficulties
- Savant abilities (present in less than 2% of individuals diagnosed with autism)- (<http://www.autismnj.org/AboutAutism.aspx>)

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## Autism and Aspergers



Asperger's Syndrome is a condition that was initially described by Dr. Hans Asperger's 1944 doctoral thesis. It was not until 37 years later, in 1981, however, that Dr. Lorna Wing used the term "Asperger's Syndrome" in a paper that helped to introduce this condition to the English-speaking world.

As described by Dr. Wing, the primary clinical features of Asperger's Syndrome include:

- Naïve, inappropriate, one-sided social interactions
- limited ability to establish relationships
- Poor non-verbal communication
- A lack of emotional empathy
- Pedantic, finicky, obscure or plodding repetitive speech
- Intense absorption in certain subjects
- Clumsy, un-coordinated movements
- Odd postures

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## Students with Autism Need



- Structure
- Communication skills and strategies
- Sensory accommodations
- Individualized programming
- Inclusion/social integration /access to the general curriculum

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## Inclusion



Every human being has an entitlement to personal, social intellectual development and must be given an opportunity to achieve his/her potential in learning

Educational systems should be designed to take into account these wide diversities

Those with exceptional learning needs and/or disabilities should have access to high quality and appropriate education

Every human being is unique in terms of characteristics interests, abilities, motivation and learning needs

NASEN 2001

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## James Fisher (2000) wrote about his son Charlie who has autism



Charlie was late to roll over, sit by himself, walk (he did not crawl but scooted around in a sitting position, propelled by his hands). From the time he was ten months old, he "read" all the books Kristina had set up as his "library." My mother was the first to raise concerns at how long Charlie would sit—forty-five minutes and more—absorbed in the colorful stiff pages of his board books or looking quietly out the window....These were not the feats of your average two-year-old. Yet Charlie did not do many of the things other toddlers could. He had no language other than a baby's babble and cries; he seemed to understand even less. He stared for long periods at a picture of a little Asian-American girl in one of his books but never looked at, much less acknowledged, the other children on the playground. Subtle changes in routine—turning right down the sidewalk instead of left—led to tantrums in which he would flip himself backwards, headfirst. Once he walked back and forth, back and forth, before a stone wall, eyes averted, until we dragged him away screaming. "No" was my wife's answer when, at an appointment for one of Charlie's many ear infections, our pediatrician asked, "Does he know what his hands are? Does he know his name?" Charlie did not know how to wave, much less how to say "bye-bye."

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## Role of the Case Worker with Individual Cases



- Be aware of the characteristics and needs of children with Autism when they are working with School District Committees on Special Education (CSE), children, parents, relative caregivers, and foster parents.
- Make sure that parents/relative caregiver/foster parents understand what the CSE is.
- They always need to ask for the IEP (Individualized Education Program).
- They need to know when parents/foster parents need help and support.
- When parents/foster parents need an advocate, make sure that they know how to help find them one..

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## CASE #1



Eric is a 6 year old and is entering grade one. As a preschooler he was classified as OHI (Other Health Impaired) and for three years received Speech, OT (Occupational Therapy) and PT (Physical Therapy) on a daily basis. Eric made considerable progress and was declassified at the conclusion of preschool-age 5. He was in regular K full time and has regressed since the beginning of the school year. He was recently diagnosed as having the Asperger's type of Autism. He is slated to attend a regular grade one class in the fall.

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## Teaching Points-Case 1



- As an infant Eric had no eye contact with his parents and siblings, no spoken language until age three, and no social/emotional interaction.
- Parents were extremely upset and felt helpless.
- He was diagnosed with Asperger Syndrome at the age of four.
- A considerable amount of time has been spent with providing Eric with appropriate therapy and related services in the preschool program.
- Eric has made a considerable amount of growth with communication, social and emotional skills.
- A written transition plan had to be created for Eric from his preschool program to the regular Kindergarten program at the new public school.
- It is important for caseworkers to discuss the importance of the transition plan with relative caregivers/foster parents.

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## Transition Plans Based on Student's Needs



Before a new program is introduced, a transition plan should be created that is based on the child's educational, social, emotional, and physical needs, taking into account the child's strengths, preferences, and interests. The plan should also take into account settings, schedules, routines and people that the child is familiar with.

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## Case # 2



Susan is 12 years old foster child and is currently in grade 7. She was diagnosed with Autism in grade 3 and was in five different self-contained classes since entering school on grade one. She has also moved to 5 different homes.

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## Teaching Points-Case 2



- A High mobility rate-She lived in five different home and schools.
- There is no consistency in her home life and educational program.
- Susan was exposed to a variety of different routines and settings.
- Susan did not have a transition plan for any of her moves.
- Unless she receives a consistent, structured home and school program, Susan will not make any improvement.

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## Case # 3



Robert is a 17 year old foster child. He has a history of poor socialization skills and has been bullied and picked on by peers since elementary school. Robert has attended an Alternate Learning Program in another school district since grade 6. He plans to attend college in the fall.

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## Teaching Points-Case 3



- High mobility rate having attended multiple schools and living in several foster homes
- No consistent direct instruction from teachers using the same educational plan and instructional techniques or strategies.
- As an Asperger's type of Autism, Robert has average or above average intelligence
- Robert will need a transition plan to help guarantee that he will have success in his final year of high school and with selecting an appropriate college to meet his needs.

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### Case # 4



John is a 15 year old foster child and he attends a special school for children with autism in a BOCES school. He has never been in a public school setting. His foster parents and caseworker have asked John's School District CSE to place him at the local high school for grade 9. John has no history of behavioral problems and currently reads and performs math skills at the 4/5<sup>th</sup> grade level.

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### Teaching Points-Case 4



- Foster parents and caseworker need to meet with the school District Committee on Special Education (CSE).
- The School District needs to provide John a placement in the Least Restrictive Environment.
- The school district is required to provide current evaluation data for John.

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### Reflection and Questions



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## SAMPLE TRANSITION PLAN FOR A BOY WITH AUTISM WHO MOVING TO A NEW SCHOOL PALCEMNT

Dr. James S. Vacca

1. Establish who the new teacher will be and permit time for the parent to meet with him/her.
2. Establish who the role of the teacher aide in the new classroom/school setting and daily schedule.
3. Set up a time of day for the child to visit/work in the new class with the current aide/teacher in order to become familiar with the new surroundings. Depending on the child's behavior, the amount of time in the class can be from 5-15 minutes with continuous reinforcement, gradually decreasing reinforcement with time. Because this is a new classroom, school building, and students, the teacher may have to establish a task analysis in which the first step could simply be walking the child to the new class without even going in (these are the transitions that will take more time).
4. Once the child is comfortable in the new class with his current aide/teacher, the teacher and aide should develop a classroom plan to work as a team and be sure they are reinforcing the same behaviors, as well as correcting the same behaviors.
5. If the child has a appropriate behavior plan in the new classroom, a specific reinforcement system (i.e. token boards, charts, etc), it is important that the teacher, consultant or aide (the professional most familiar with all aspects of the child's behavior) inform any new staff who come in contact with the child how to correctly implement the behavior plan in the exact same manner.
6. The IEP goals that will be carried over to the new placement should provide the new teacher/aide with a set of instructional procedures and techniques can be used to effectively teach the child in the classroom. This should also include plans to eventually mainstream the child in another classroom. If need be, I believe it is always smart for the new teacher to discuss the program with the former teacher to be sure there will not be any discrepancies (it is important to remember that at times, the smallest change can be incredibly detrimental in the child's learning).
7. If the former teacher has found a way in which the child learns a specific subject matter best (i.e., math using manipulatives), this information should be shared with the new teacher. Objects that the student may or may not find reinforcing should be relayed as well.

A step-by-step transition plan for the child requires collaboration between the parent and the school professionals. In my opinion, collaboration and continuity from the beginning of the transition to the end are incredibly important to the child's overall academic, social and behavioral performance in school. Collaboration between all professionals working with the child on a daily basis and how this information is reported to the parent is imperative as well. We must remember that sometimes the smallest change in child's life can cause him a great deal of anxiety. Any steps to prevent the child's anxiety toward school should be reviewed.

In conclusion, I believe that the child deserves a plan that best meets his individual needs. He is a fragile boy with tremendous resilience. A great amount of time has already gone into discussing his needs and progress. I believe that it will be a disservice to him if a change of placement is rushed into without consideration of an effective transition plan.

## AUTISTIC CHILDREN CAN BE TAUGHT TO READ

**James S. Vacca**  
*Long Island University*

*In most elementary classrooms, students with autistic characteristics are too often dismissed from the literate community. The autistic child is frequently asked to practice memorizing sight words while classmates are introduced to literature. Although autistic children are increasingly being taught in general education classrooms, they are often excluded from rich and meaningful literacy experiences like storytelling, play-acting, journal-keeping, and writing workshop. In fact, it is not unusual for students with autism in these classrooms to follow a different curriculum than the one offered to their classmates. This study examines the difficulties that autistic children have in learning to read and it asks answers the following questions: What Are the Obstacles in Teaching Reading to Autistic Children? and How Can the Child with Autism Be Taught to Read?*

In most elementary classrooms, students with autistic characteristics are too often dismissed from the literate community (Kliewer, 1998). The autistic child is frequently asked to practice memorizing sight words while classmates are introduced to literature. Kluth & Darmody-Latham (2003) maintain that as autistic children are increasingly being taught in general education classrooms, they are often excluded from rich and meaningful literacy experiences like storytelling, play-acting, journal-keeping, and writing workshop. In fact, the authors also state that it is not unusual for students with autism in these classrooms to follow a different curriculum than the one offered to their classmates (Kluth, 1998).

Students with autism face a number of challenges when learning to read, including difficulties with attention, lack of motivation, and problems with word decoding (Learning Upgrade, 2007). These challenges are exemplified in the following story written by James Fisher (2000) about his autistic son Charlie:

Autism is a neurobiological disorder marked by severe delays in speech, repetitive or ritualized behaviors, and especially by profound impairments in social interaction. Charlie was late to roll over, sit by himself, walk (he did not crawl but scooted around in a sitting position, propelled by his hands). From the time he was ten months old, he "read" all the books Kristina had set up as his "library." My mother was the first to raise concerns at how long Charlie would sit--forty-five minutes and more--absorbed in the colorful stiff pages of his board books or looking quietly out the window.... These were not the feats of your average two-year-old. Yet Charlie did not do many of the things other toddlers could. He had no language other than a baby's babble and cries; he seemed to understand even less. He stared for long periods at a picture of a little Asian-American girl in one of his books but never looked at, much less acknowledged, the other children on the playground. Subtle changes in routine--turning right down the sidewalk instead of left--led to tantrums in which he would flip himself backwards, headfirst. Once he walked back and forth, back and forth, before a stone wall, eyes aslant, until we dragged him away screaming. "No" was my wife's answer when, at an appointment for one of Charlie's many ear infections, our pediatrician asked, "Does he know what his hands are? Does he know his name?" Charlie did not know how to wave, much less how to say "bye-bye. (p.1)

Charlie's characteristics fall within the Individuals with Disabilities Education Act (IDEA) definition of autism as a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, which adversely affects a child's performance. Many

children with autism who are mainstreamed into regular classrooms can be challenging, yet the mainstream or an Inclusion class experience can be incredibly stimulating for the autistic children in the learning of reading skills.

#### *What Are the Obstacles in Teaching Reading to Autistic Children?*

Teaching autistic children reading skills can be an overwhelming task. Some of these children will never read, but many higher functioning children with autism can learn to some extent and can become excellent readers (Evans, 2007). Autistic children have a very unique set of challenges that requires a parent or teacher to have a lot of patience. Sometimes they can be very cooperative, but for the most part, autistic children have significant problems with attention span, lack any type of motivation to learn to read, and have problems with figuring out the rules of reading and grammar when compared to children who do not have autism. Finally, learning to read should be fun for any child, but when it comes to autistic children, you have to reach them on their level, so make sure you chose a method that meets their needs. (Evans, 2007)

According to Diehl et al., (2006), one of the defining characteristics of autism is a qualitative impairment in communication (American Psychiatric Association [APA], 1994). Many children with autism are initially referred for evaluation because of delayed language (Dahlgren & Gillberg, 1989). Language also plays an important role in distinguishing autism from other psychiatric disorders (Lord & Venter, 1992), and functional language by the age of 5 has been shown to be a predictor of positive outcomes in children with autism (Rutter, 1970).

Lord and Paul (1997) found that previous research on children with autism showed that high-functioning children with autism spectrum disorders have noticeable difficulty with practical aspects of language, including their own personal intentions, conjecture, and social conversation. The authors also maintained that one way of measuring pragmatic language abilities is through the autistic child's creative use of language. Lord and Paul suggested that the narrative communication of children with autism is marked by deficiencies in organization, comprehension recall and coherence.

A significant number of autistic children do not acquire functional language (Lord & Paul, 1997). The autistic children who do acquire verbal skills appear to have intact grammatical development, but have particular difficulties in their functional use of language, although there is considerable heterogeneity of language abilities in this population (Tager-Flusberg, 2004).

According to Diehl et al., (2006), recent reviews of language studies indicate that autistic children have delayed, yet intact phonological, morphological, and syntactic development. There is also evidence that autistic children have significant and pervasive pragmatic deficits throughout development and across communicative domains, including nonverbal communication, conversation, and narrative skills (Tager-Flusberg, 2001).

Bennetto (2006) stated that the research has shown that children with autism have trouble answering questions that require inferences to be made about a story, even though they are able to answer factual questions (Norbury & Bishop, 2002). They have difficulty with inferential questions but perform more positively with factual questions (Young et al., 2005). Bennetto (2006) maintained that inferences provide some of the more global links that are integral to understanding the substance of a story. The author used an example from the children's book *Frog, Where Are You?* In this story the reader learns at the beginning of the story that a boy's frog has escaped, and is told at the end that the frog has a family. The reader needs to infer that having a family is the reason why the frog escaped, because this link is not provided by the story. Thus, although the children with autism performed well in their recall of important events, this does not necessarily imply that they had a good understanding of the important events (e.g., as measured by inferential reasoning) or were able to successfully convey their understanding of the story to their others. Bennetto believed that because many of the stories told by children with autism had fewer causal links, their intact ability to recall important events may not be aiding them much in terms of their overall storytelling ability.

#### *How Can the Child with Autism Be Taught to Read?*

##### *I. Make Reading an Enjoyable Activity by Using Authentic High Interest Visual Materials*

Providing structure and organization in classrooms or any other learning environment on a student's level of understanding can help to alleviate or moderate these problems and the resultant ineffective learning situations. Grandin (2002) says that autistic children are visual thinkers. The author says that

autistic children think in pictures and do not think in language. She says that their thoughts are like videotapes running in their imagination. Pictures are their first language, and words are their second language. Nouns were the easiest words to learn because they can make a picture in the mind of the word. The author maintains that to learn words like *up* or *down*, the teacher should demonstrate them to the child. For example, take a toy airplane and say *up* as you make the airplane take off from a desk. Some children will learn better if cards with the words *up* and *down* are attached to the toy airplane. The *up* card is attached when the plane takes off. The *down* card is attached when it lands.

According to Evans (2007), learning to read should be an enjoyable activity for most children. For autistic children, however, reading has to be taught at their level with a method that meets their needs. The author says that some autistic children can be taught sounds through the use of music and games. Evans believes that programs that use music and singing help a child with autism learn many things and these interactive methods usually help with attention span and interest, two of the biggest obstacles in this endeavor.

Often, children with autism learn visually and are enriched by classrooms with bright, colorful pictures and vivid images. Allowing the autistic children to be creative, especially in the art environment, is one of the most important aspects of teaching children with autism (Medevitt, 2004).

The staff of the Treatment of Autistic and Related Communication-Handicapped Children Program at the University Of North Carolina School Of Medicine (2007) maintains that Autistic Children respond well to structure. They believe that teachers must effectively structure their classrooms in order to effectively teach autistic students. The TEReceptive language difficulty is characteristic of autism. Many times a student cannot understand language as well as a teacher believes he can, and so may demonstrate aggressive behaviors or lack of initiative. He/she also may lack the necessary language to communicate messages appropriately, and so can not let the teacher know when he/she is tired, hot, hungry, finished, or bored except by tantrumming or aggression. The student may have a poor sequential memory and so cannot keep the order of even familiar events in mind or is not sure when something different will happen. Often the student feels more comfortable staying with familiar activities and will resist learning new activities or routines. Many times he/she is unable to organize or put limits on his/her own behavior and does not understand or acknowledge society's rules. This can result in trying to get others' attention in inappropriate ways or preferring to be alone. Because of lack of social relatedness, the student may be unmotivated to please others or unrewarded by praise, and consequently seems resistant to learning. Hypersensitivity to sensory input can often lead to disturbing behaviors. Being easily distracted and lacking skills in perception and organization of time can also lead to behaviors that get in the way of learning.

Abisgold (2007) states that that autistic children's ability to think imaginatively is impaired and creative writing and reading are very challenging for them. It is important to teach to their strengths and ask factual questions. For example, *what is happening here, what will happen next?* The author believes that teachers should use reading materials that talk about practical and authentic experiences rather than fantasy. Abisgold further maintains that the teaching of reading to autistic children is successfully developed in relation to using non-fiction materials that are within the child's area of interest. For example, the author suggests that instructions like those in a recipe or in the construction of something are good ways that autistic children can learn information and facts.

Abisgold believes that it is important that the teaching of reading to autistic children always start by addressing the child's interests. The author uses the example of asking the child to design his/her own cartoon strips writing a caption under each picture. This task, the author suggests, can become increasingly more complex as the child masters the skill and will ultimately involve both reading and writing that can be displayed or made into a book to praise his/her efforts.

Abisgold concluded that all children have individual interests, and autistic children are no different. If they like trains, for example, the teacher can use cars as a visual point of reference or guide in helping the child to learn how to read. If the child is interested in the topic, he/she is more likely to pay attention for longer periods of time and is more willing to learn because the topic is personally interesting.

## II. Use a Phonetic Approach

The use of phonological awareness and its relation to reading acquisition has also been recognized as a valuable teaching technique (Smith 2007). Glaser (2007) believes that reading through phonics is vital in helping the autistic child acquire language. Each autistic child is different and will learn at a different pace and in a different manner. While some autistic children read phonetically, many are natural sight readers. They gain new words by reading labels on household objects, dictionaries (books and software) and closed-caption television. They are eager to read books that are based on their specific interests, commonly, trains, animals, food, calendars or television characters. Both commercial and homemade read-along audio tapes strengthen the reading of their favorite stories.

According to Joseph and Seery (2004) children with mental retardation and developmental disabilities like autism can learn and use phonetic-analysis strategies and can benefit from many different types of phonics instruction. One complication that arises in teaching phonemic awareness and phonics to children with autism, however, is that many of the students rely on alternative and augmentative communication (AAC). Instruction in phonemic awareness and phonics skills expect that students will produce sounds in letters and words (Ahlgrim-Delzell et al, 2006).

Grandin (1995) says that some autistic children will learn reading more easily with phonics, and others will learn best by memorizing whole words. The author is autistic and maintains that she learned how to read words by being taught phonics rules and by sounding out words. According to Grandin, some children with autism will learn best if flash cards and picture books are used so that the whole words are associated with pictures. It is important to have the picture and the printed word on the same side of the card. When teaching nouns the child must hear you speak the word and view the picture and printed word simultaneously. An example of teaching a verb would be to hold a card that says *jump*, and you would jump up and down while saying *jump*.

## III. Use Relevant Context Clues, Social Stories and Comic Strip Sequences

Siegel (1998) believes that significant progress for the autistic child occurs in language development when the child must begin to comprehend words for which there is no set physical or visual representation. The author states that the first words acquired by autistic children are usually nouns. These are words that represent things that the child wants, usually followed by classifications of things like numbers and letters. Using pictures, gestures, signs, and actions, Siegel states the teacher can also teach most verbs like walking, running, and eating and relational words like big and small, and first and last. Prepositions can be taught with physical models too, like showing *on* and *under*, or *in* and *out*.

Siegel maintains that children with autism and PDD are more likely to have more persistent problems with *wh* words like *what*, *where*, *which*. The author states that the autistic child is more likely to make a good guess about the *wh* question if he/she is familiar with the situation or context from which the question comes from. For example, *Where's the kitty?* or *What do you want to eat?* Finally, Siegel believes that teachers can create practice materials for *wh* question drills by using difficult pictures where some *wh* questions can be asked. The author uses the examples of questions developed from the Sesame Street characters Bert and Ernie. Questions like *Which one is Bert?*, *Which one is Ernie?*, *Who has the cookie?* & *What is Bert doing?* Being exposed to familiar stories and pictures, Siegel suggests, helps the autistic child make progress understanding the overall context of the story.

The understanding of story context and context clues by autistic children was investigated by Myles and Rogers (2001). The authors found that children with Asperger Syndrome (AS) have difficulty attending to and understanding social cues. In addition, they have difficulty in (a) understanding the beliefs of others, (b) shifting attention, (c) sharing attention with others, and (d) distinguishing relevant from irrelevant stimuli. The significance of attending to and understanding social cues is essential because an understanding of the world most often comes from others' verbal cues, gestures, facial expressions, and so forth (Attwood, 1998; Myles & Simpson, 1998).

Gray (1995) developed two visual techniques for teaching autistic children to read,--social stories and comic strip conversations. Both techniques are intended to demonstrate and infer social situations and provide support to students who struggle to comprehend the quick exchange of information which occurs in a conversation. These techniques turn an abstract situation into a concrete representation that allows for reflection. Social Stories use a brief narrative that describes a situation, relevant social cues, and responses. Comic strip conversations promote social understanding by incorporating simple figures

and other symbols in a comic strip format. An educator can draw or assist a student who illustrates a social situation in order to facilitate understanding.

According to Gray (2007) a Social Story describes a situation, skill, or concept in terms of relevant social cues, perspectives, and common responses in a specifically defined style and format. The goal of a Social Story™ is to share accurate social information in a patient and reassuring manner that is easily understood by its audience. Half of all Social Stories™ developed should affirm something that an individual does well. Although the goal of a Story™ should never be to change the individual's behavior, that individual's improved understanding of events and expectations may lead to more effective responses. Examples of Social Story topics are listed below

Why do adults forget?

What helps them remember?

Running errands (car wash, gas station, bank, library, grocery store)

Checking out in line

Visiting places (zoo, beach, video store, movie theatre)

Eating out in a restaurant (waiting, using a booster seat, a menu, utensils)

Going to school (bus, drivers, teachers)

Going to the doctor

#### *Final Thoughts*

Susan is an eleven year old foster child. She is in fifth grade and since September she began attending a highly regarded suburban Elementary School on Long Island, New York. From her first day at the school, Susan has been experiencing great success in her classroom and in her social relationships with her classmates. Susan is classified for special education services for Asperger's Disorder. This is the sixth school that she has attended since first starting kindergarten at the age of five. Susan was placed in foster care when she was four years old because her mother and father abandoned her. Since entering the foster care system she has lived in six different foster homes.

Susan was identified as a special education student at the end of second grade. When she began second grade, Susan was placed in a self-contained classroom because the district Committee on Special Education believed that she was in need of individual academic assistance and they also believed that her social and behavioral needs could be better met in a class with a smaller class size. Susan has always been characterized as socially isolated with eccentric type behavior. She exhibits difficulty with two-sided social interaction and non-verbal communication and her speech sounds peculiar due to abnormalities of inflection and repetitive patterns. Susan has always been physically clumsy with her gross motor behavior. Her interests are also limited to non age appropriate areas like airplanes and space travel.

In the middle of third grade Susan moved to her fifth school and a new foster home. She encountered difficulty adjusting to the new school and foster home. The difficulties began when she was registered in school by her foster parents. They were told by the school district that Susan's records were incomplete and that she could not start school until the school district received all her official records. With the assistance of a thorough caseworker's help, Susan was finally enrolled in school after waiting about five weeks at home. When Susan was permitted to attend school, the foster parents were told that she needed to be placed in a self contained classroom, pending a CSE meeting, again because of her social and behavioral needs.

When Susan was finally placed in her classroom the school district CSE assigned her a one-on- one aide because they worried that her social and behavioral needs were an issue outside the self contained classroom. She was placed in an adaptive physical education program, and she received all of her academic classes in language arts, science, and math from her special education teacher.

Within the first two months of this placement, Susan began to demonstrate problems both in school and at home. She had no friends and having the one-on-one aide by her side in school all day made her feel different from the other children. At home she began to exhibit daily acting out behavior, and the foster care parents told Susan's caseworker that they could not care for her needs. In this home placement, Susan was living with two other children that were also under foster care.

By the end of fourth grade, Susan had an emotional breakdown and was removed from her foster home. Susan was then placed in a Residential Treatment Program and she was under psychiatric care for three

months. Following her discharge from the Residential Treatment Program Susan was placed in the current school and foster home. She is now placed in a self contained classroom, but is mainstreamed for some regular academic classes including physical education. She has been greeted compassionately by the school's administrators, teachers and other students. She continues to receive the services of a one-to-one teacher aide and the school has welcomed the participation of Susan's case worker in planning her academic program.

Although success is finally being achieved in school, there are problems in the foster home, and Susan again faces the possibility of moving to another home. If this does happen, it will mean that Susan will have to again move to a new school for sixth grade. Because of Susan's frequent moves, she experienced a fragmented educational program. Her reading math skills are on grade level, but she lacks the necessary background experience and knowledge in most subject areas to fully keep pace with her classmates. She has learned to compensate for her reading comprehension deficiencies in the content subjects by using her listening skills and the assistance of her one to one aide as a note taker. She receives additional help from a reading specialist and from her special education teacher. Reading Comprehension for Susan, however, is often very frustrating, and it prevents her from experiencing success in her other academic classes.

The author an Educational Advocate for foster children for many years, has observed that many children with Asperger's Disorder are not much different than Susan. They are subjected to many obstacles during their education in public schools (Vacca, 2007). These children usually have inappropriate classroom placement and they are in need of Special Education or Remedial services that are often delayed in their implementation. These blocks to the education of the child with Asperger's Disorder are compounded if the school staff has a negative perception about the child because of his/her previous academic and social history.

The author believes that learning how to read is the one problem that most children with Asperger's Disorder face that has the most significant affect on their academic success. He also believes that schools for the most part can do a better job in teaching children with autism how to read. Although further research is needed in this area, the following is a summary in ten ways in which I believe that teachers can improve the reading achievement of children with autism. Unless these and other approaches are considered, children with autism, he maintains, will not achieve their full potential in school.

### **Ten Ways to Improve the Reading Achievement of Children with Autism**

- Create and plan active, authentic, directed, structured visual and purposeful instruction for children with autism.
- Create a mindset that autistic students "can learn."
- Spark Enthusiasm for learning when teaching reading to the autistic child.
- Teaching reading skills to students with autism should be based on their interests and prior knowledge.
- Help autistic students make connections to self, text and the outside world.
- Create multisensory instructional activities for children with children with autism that are consistent and repetitive opportunities for learning.
- Model what the autistic students need to know and how they need to learn.
- When possible, integrate language arts skills into content instruction.
- Collaborate with colleagues when planning reading instruction.
- Provide students with autism opportunities for practice.

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<http://www.csaac.org/>

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<http://www.cesa7.k12.wi.us/sped/issues-IEPissues/writingiep/WritingIEPs.htm>

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<http://www.autism.ca/teach.htm>

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OPTIONAL RESOURCE

MATERIAL

# Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children

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Autism is a serious psychological disorder with onset in early childhood. Autistic children show minimal emotional attachment, absent or abnormal speech, retarded IQ, ritualistic behaviors, aggression, and self-injury. The prognosis is very poor, and medical therapies have not proven effective. This article reports the results of behavior modification treatment for two groups of similarly constituted, young autistic children. Follow-up data from an intensive, long-term experimental treatment group ( $n = 19$ ) showed that 47% achieved normal intellectual and educational functioning, with normal-range IQ scores and successful first grade performance in public schools. Another 40% were mildly retarded and assigned to special classes for the language delayed, and only 10% were profoundly retarded and assigned to classes for the autistic/retarded. In contrast, only 2% of the control-group children ( $n = 40$ ) achieved normal educational and intellectual functioning; 45% were mildly retarded and placed in language-delayed classes, and 53% were severely retarded and placed in autistic/retarded classes.

Kanner (1943) defined autistic children as children who exhibit (a) serious failure to develop relationships with other people before 30 months of age, (b) problems in development of normal language, (c) ritualistic and obsessional behaviors ("insistence on sameness"), and (d) potential for normal intelligence. A more complete behavioral definition has been provided elsewhere (Lovaas, Koegel, Simmons, & Long, 1973). The etiology of autism is not known, and the outcome is very poor. In a follow-up study on young autistic children, Rutter (1970) reported that only 1.5% of his group ( $n = 63$ ) had achieved normal functioning. About 35% showed fair or good adjustment, usually required some degree of supervision, experienced some difficulties with people, had no personal friends, and showed minor oddities of behavior. The majority (more than 60%) remained severely handicapped and were living in hospitals for mentally retarded or psychotic individuals or in other protective settings. Initial IQ scores appeared stable over time. Other studies (Brown, 1969; DeMyer et al., 1973; Eisenberg, 1956; Freeman, Ritvo, Needleman, & Yokota, 1985; Havelkova, 1968) re-

port similar data. Higher scores on IQ tests, communicative speech, and appropriate play are considered to be prognostic of better outcome (Lotter, 1967).

Medically and psychodynamically oriented therapies have not proven effective in altering outcome (DeMyer, Hingtgen, & Jackson, 1981). No abnormal environmental etiology has been identified within the children's families (Lotter, 1967). At present, the most promising treatment for autistic persons is behavior modification as derived from modern learning theory (DeMyer et al., 1981). Empirical results from behavioral intervention with autistic children have been both positive and negative. On the positive side, behavioral treatment can build complex behaviors, such as language, and can help to suppress pathological behaviors, such as aggression and self-stimulatory behavior. Clients vary widely in the amount of gains obtained but show treatment gains in proportion to the time devoted to treatment. On the negative side, treatment gains have been specific to the particular environment in which the client was treated, substantial relapse has been observed at follow-up, and no client has been reported as recovered (Lovaas et al., 1973).

The present article reports a behavioral-intervention project (begun in 1970) that sought to maximize behavioral treatment gains by treating autistic children during most of their waking hours for many years. Treatment included all significant persons in all significant environments. Furthermore, the project focused on very young autistic children (below the age of 4 years) because it was assumed that younger children would be less likely to discriminate between environments and therefore more likely to generalize and to maintain their treatment gains. Finally, it was assumed that it would be easier to successfully mainstream a very young autistic child into preschool than it would be to mainstream an older autistic child into primary school.

It may be helpful to hypothesize an outcome of the present study from a developmental or learning point of view. One may assume that normal children learn from their everyday environ-

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ments most of their waking hours. Autistic children, conversely, do not learn from similar environments. We hypothesized that construction of a special, intense, and comprehensive learning environment for very young autistic children would allow some of them to catch up with their normal peers by first grade.

## Method

### Subjects

Subjects were enrolled for treatment if they met three criteria: (a) independent diagnosis of autism from a medical doctor or a licensed PhD psychologist, (b) chronological age (CA) less than 40 months if mute and less than 46 months if echolalic, and (c) prorated mental age (PMA) of 11 months or more at a CA of 30 months. The last criterion excluded 15% of the referrals.

The clinical diagnosis of autism emphasized emotional detachment, extreme interpersonal isolation, little if any toy or peer play, language disturbance (mutism or echolalia), excessive rituals, and onset in infancy. The diagnosis was based on a structured psychiatric interview with parents, on observations of the child's free-play behaviors, on psychological testing of intelligence, and on access to pediatric examinations. Over the 15 years of the project, the exact wording of the diagnosis changed slightly in compliance with changes in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980). During the last years, the diagnosis was made in compliance with DSM-III criteria (p. 87). In almost all cases, the diagnosis of autism had been made prior to family contact with the project. Except for one case each in the experimental group and Control Group 1, all cases were diagnosed by staff of the Department of Child Psychiatry, University of California, Los Angeles (UCLA) School of Medicine. Members of that staff have contributed to the writing of the DSM-III and to the diagnosis of autism adopted by the National Society for Children and Adults with Autism. If the diagnosis of autism was not made, the case was referred elsewhere. In other words, the project did not select its cases. More than 90% of the subjects received two or more independent diagnoses, and agreement on the diagnosis of autism was 100%. Similarly high agreement was not reached for subjects who scored within the profoundly retarded range on intellectual functioning (PMA < 11 months); these subjects were excluded from the study.

### Treatment Conditions

Subjects were assigned to one of two groups: an intensive-treatment experimental group ( $n = 19$ ) that received more than 40 hours of one-to-one treatment per week, or the minimal-treatment Control Group 1 ( $n = 19$ ) that received 10 hours or less of one-to-one treatment per week. Control Group 1 was used to gain further information about the rate of spontaneous improvement in very young autistic children, especially those selected by the same agency that provided the diagnostic work-up for the intensive-treatment experimental group. Both treatment groups received treatment for 2 or more years. Strict random assignment (e.g., based on a coin flip) to these groups could not be used due to parent protest and ethical considerations. Instead, subjects were assigned to the experimental group unless there was an insufficient number of staff members available to render treatment (an assessment made prior to contact with the family). Two subjects were assigned to Control Group 1 because they lived further away from UCLA than a 1-hr drive, which made sufficient staffing unavailable to those clients. Because fluctuations in staff availability were not associated in any way with client characteristics, it was assumed that this assignment would produce unbiased groups. A large number of pretreatment measures were collected to test this assumption. Subjects did not change group assignment. Except for two families who left the experimental group within the first 6 months

(this group began with 21 subjects), all families stayed with their groups from beginning to end.

### Assessments

Pretreatment mental age (MA) scores were based on the following scales (in order of the frequency of their use): the Bayley Scales of Infant Development (Bayley, 1955), the Cattell Infant Intelligence Scale (Cattell, 1960), the Stanford-Binet Intelligence Scale (Thorndike, 1972), and the Gesell Infant Development Scale (Gesell, 1949). The first three scales were administered to 90% of the subjects, and relative usage of these scales was similar in each group. Testing was carried out by graduate students in psychology who worked under the supervision of clinical psychologists at UCLA or licensed PhD psychologists at other agencies. The examiner chose the test that would best accommodate each subject's developmental level, and this decision was reached independently of the project staff. Five subjects were judged to be untestable (3 in the experimental group and 2 in Control Group 1). Instead, the Vineland Social Maturity Scale (Doll, 1953) was used to estimate their MAs (with the mother as informant). To adjust for variations in MA scores as a function of the subject's CA at the time of test administration, PMA scores were calculated for a CA at 30 months ( $MA/CA \times 30$ ).

Behavioral observations were based on videotaped recordings of the subject's free-play behavior in a playroom equipped with several simple early-childhood toys. These videotaped recordings were subsequently scored for amount of (a) *self-stimulatory behaviors*, defined as prolonged ritualistic, repetitive, and stereotyped behavior such as body-rocking, prolonged gazing at lights, excessive hand-flapping, twirling the body as a top, spinning or lining of objects, and licking or smelling of objects or wall surfaces; (b) *appropriate play behaviors*, defined as those limiting the use of toys in the playroom to their intended purposes, such as pushing the truck on the floor, pushing buttons on the toy cash register, putting a record on the record player, and banging with the toy hammer; and (c) *recognizable words*, defined to include any recognizable word, independent of whether the subject used it in a meaningful context or for communicative purposes. One observer who was naive about subjects' group placement scored all tapes after being trained to agree with two experienced observers (using different training tapes from similar subjects). Interobserver reliability was scored on 20% of the tapes (randomly selected) and was computed for each category of behavior for each subject by dividing the sum of observer agreements by the sum of agreements and disagreements. These scores were then summed and averaged across subjects. The mean agreement (based both on occurrences and nonoccurrences) was 91% for self-stimulatory behavior, 85% for appropriate play behavior, and 100% for recognizable words. A more detailed description of these behavioral recordings has been provided elsewhere (Lovaas et al., 1973).

A 1-hr parent interview about the subjects' earlier history provided some diagnostic and descriptive information. Subjects received a score of 1 for each of the following variables parents reported: no recognizable words; no toy play (failed to use toys for their intended function); lack of emotional attachment (failed to respond to parents' affection); apparent sensory deficit (parents had suspected their child to be blind or deaf because the child exhibited no or minimal eye contact and showed an unusually high pain threshold); no peer play (subject did not show interactive play with peers); self-stimulatory behavior; tantrums (aggression toward family members or self); and no toilet training. These 8 measures from parents' intake interviews were summed to provide a sum pathology score. The intake interview also provided information about abnormal speech (0 = normal and meaningful language, however limited; 1 = echolalic language used meaningfully [e.g., to express needs]; 2 = echolalia; and 3 = mute); age of walking; number of siblings in the family; socioeconomic status of the father; sex; and neurological examinations (including EEGs and CAT scans) that resulted in findings of pathology. Finally, CA at first diagnosis and at the beginning of the

present treatment were recorded. This yielded a total of 20 pretreatment measures, 8 of which were collapsed into 1 measure (sum pathology).

A brief clinical description of the experimental group at intake follows (identical to that for Control Group 1): Only 2 of the 19 subjects obtained scores within the normal range of intellectual functioning; 7 scored in the moderately retarded range, and 10 scored in the severely retarded range. No subject evidenced pretend or imaginary play, only 2 evidenced *complex* (several different or heterogeneous behaviors that together formed one activity) play, and the remaining subjects showed *simple* (the same elementary but appropriate response made repeatedly) play. One subject showed minimal appropriate speech, 7 were echolalic, and 11 were mute. According to the literature that describes the developmental delays of autistic children in general, the autistic subjects in the present study constituted an average (or below average) sample of such children.

Posttreatment measures were recorded as follows: Between the ages of 6 and 7 years (when a subject would ordinarily have completed first grade), information about the subjects' first-grade placement was sought and validated; about the same time, an IQ score was obtained. Testing was carried out by examiners who were naive about the subjects' group placement. Different scales were administered to accommodate different developmental levels. For example, a subject with a regular educational placement received a Wechsler Intelligence Scale for Children-Revised (WISC-R; Wechsler, 1974) or a Stanford-Binet Intelligence Scale (Thorndike, 1972), whereas a subject in an autistic/retarded class received a nonverbal test like the Merrill-Palmer Pre-School Performance Test (Stutsman, 1948). In all instances of subjects having achieved a normal IQ score, the testing was eventually replicated by other examiners. The scales (in order of the frequency of usage) included the WISC-R (Wechsler, 1974), the Stanford-Binet (Thorndike, 1972), the Peabody Picture Vocabulary Test (Dunn, 1981), the Wechsler Pre-School Scale (Wechsler, 1967), the Bayley Scales of Infant Development (Bayley, 1955), the Cattell Infant Intelligence Scale (Cattell, 1960), and the Leiter International Performance Scale (Leiter, 1959). Subjects received a score of 3 for *normal functioning* if they received a score on the WISC-R or Stanford-Binet in the normal range, completed first grade in a normal class in a school for normal children, and were advanced to the second grade by the teacher. Subjects received a score of 2 if they were placed in first-grade in a smaller *aphasia* (language delayed, language handicapped, or learning disabled) class. Placement in the aphasia class implied a higher level of functioning than placement in classes for the autistic/retarded, but the diagnosis of autism was almost always retained. A score of 1 was given if the first-grade placement was in a class for the autistic/retarded and if the child's IQ score fell within the severely retarded range.

### Treatment Procedure

Each subject in the experimental group was assigned several well trained student therapists who worked (part-time) with the subject in the subject's home, school, and community for an average of 40 hr per week for 2 or more years. The parents worked as part of the treatment team throughout the intervention; they were extensively trained in the treatment procedures so that treatment could take place for almost all of the subjects' waking hours, 365 days a year. A detailed presentation of the treatment procedure has been presented in a teaching manual (Lovaas et al., 1980). The conceptual basis of the treatment was reinforcement (operant) theory; treatment relied heavily on discrimination-learning data and methods. Various behavioral deficiencies were targeted, and separate programs were designed to accelerate development for each behavior. High rates of aggressive and self-stimulatory behaviors were reduced by being ignored; by the use of time-out; by the shaping of alternate, more socially acceptable forms of behavior; and (as a last resort) by the delivery of a loud "no" or a slap on the thigh contingent upon the presence of the undesirable behavior. Contingent physical aversives were not used in the control group because inadequate staffing

in that group did not allow for adequate teaching of alternate, socially appropriate behaviors.

During the first year, treatment goals consisted of reducing self-stimulatory and aggressive behaviors, building compliance to elementary verbal requests, teaching imitation, establishing the beginnings of appropriate toy play, and promoting the extension of the treatment into the family. The second year of treatment emphasized teaching expressive and early abstract language and interactive play with peers. Treatment was also extended into the community to teach children to function within a preschool group. The third year emphasized the teaching of appropriate and varied expression of emotions; preacademic tasks like reading, writing, and arithmetic; and *observational learning* (learning by observing other children learn). Subjects were enrolled only in those preschools where the teacher helped to carry out the treatment program. Considerable effort was exercised to mainstream subjects in a normal (average and public) preschool placement and to avoid initial placement in special education classes with the detrimental effects of exposure to other autistic children. This occasionally entailed withholding the subject's diagnosis of autism. If the child became known as autistic (or as "a very difficult child") during the first year in preschool, the child was encouraged to enroll in another, unfamiliar school (to start fresh). After preschool, placement in public education classes was determined by school personnel. All children who successfully completed normal kindergarten successfully completed first grade and subsequent normal grades. Children who were observed to be experiencing educational and psychological problems received their school placement through Individualized Educational Plan (IEP) staffings (attended by educators and psychologists) in accordance with the Education For All Handicapped Children Act of 1975.

All subjects who went on to a normal first grade were reduced in treatment from the 40 hr per week characteristic of the first 2 years to 10 hr or less per week during kindergarten. After a subject had started first grade, the project maintained a minimal (at most) consultant relationship with some families. In two cases, this consultation and the subsequent correction of problem behaviors were judged to be essential in maintaining treatment gains. Subjects who did not recover in the experimental group received 40 hr or more per week of one-to-one treatment for more than 6 years (more than 14,000 hr of one-to-one treatment), with some improvement shown each year but with only 1 subject recovering.

Subjects in Control Group 1 received the same kind of treatment as those in the experimental group but with less intensity (less than 10 hr of one-to-one treatment per week) and without systematic physical aversives. In addition, these subjects received a variety of treatments from other sources in the community such as those provided by small special education classes.

Control Group 2 consisted of 21 subjects selected from a larger group ( $N = 62$ ) of young autistic children studied by Freeman et al. (1985). These subjects came from the same agency that diagnosed 95% of our other subjects. Data from Control Group 2 helped to guard against the possibility that subjects who had been referred to us for treatment constituted a subgroup with particularly favorable or unfavorable outcomes. To provide a group of subjects similar to those in the experimental group and Control Group 1, subjects for Control Group 2 were selected if they were 42 months old or younger when first tested, had IQ scores above 40 at intake, and had follow-up testing at 6 years of age. These criteria resulted in the selection of 21 subjects. Subjects in Control Group 2 were treated like Control Group 1 subjects but were not treated by the Young Autism Project described here.

## Results

### Pretreatment Comparisons

Eight pretreatment variables from the experimental group and Control Group 1 (CA at first diagnosis, CA at onset of treat-

Table 1  
Means and *F* Ratios From Comparisons Between Groups on Intake Variables

Group	Diagnosis CA	Treatment CA	PMA	Recognizable words	Toy play	Self-stimulation	Sum pathology	Abnormal speech
Experimental	32.0	34.6	18.8	.42	28.2	12.1	6.9	2.4
Control 1	35.3	40.9	17.1	.58	20.2	19.6	6.4	2.2
<i>F</i> <sup>a</sup>	1.58	4.02*	1.49	.92	2.76	3.37	.82	.36

Note. CA = chronological age; PMA = prorated mental age. Experimental group,  $n = 19$ ; Control Group 1,  $n = 19$ .

<sup>a</sup>  $df = 1, 36$ .

\*  $p < .05$ .

ment, PMA, sum pathology, abnormal speech, self-stimulatory behavior, appropriate toy play, and recognizable words) were subjected to a multivariate analysis of variance (MANOVA; Brecht & Woodward, 1984). The means and *F* ratios from this analysis are presented in Table 1. As can be seen, there were no significant differences between the groups except for CA at onset of our treatment ( $p < .05$ ). Control subjects were 6 months older on the average than experimental subjects (mean CAs of 35 months vs. 41 months, respectively). These differences probably reflect the delay of control subjects in their initiation into the treatment project because of staff shortages; analysis will show that differential CAs are not significantly related to outcome. To ascertain whether another test would reveal a statistically significant difference between the groups on toy play, descriptions of the subjects' toy play (taken from the videotaped recordings) were typed on cards and rated for their developmental level by psychology students who were naive about the purpose of the ratings and subject group assignment. The ratings were reliable among students ( $r = .79, p < .001$ ), and an *F* test showed no significant difference in developmental levels of toy play between the two groups.

The respective means from the experimental group and Control Group 1 on the eight variables from the parent interview were .89 and .74 for sensory deficit, .63 and .42 for adult rejection, .58 and .47 for no recognizable words, .53 and .63 for no toy play, 1.0 and 1.0 for no peer play, .95 and .89 for body self-stimulation, .89 and .79 for tantrums, and .68 and .63 for no toilet training. The experimental group and Control Group 1 were also similar in onset of walking (6 vs. 8 early walkers; 1 vs. 2 late walkers), number of siblings in the family (1.26 in each group), socioeconomic status of the father (Level 49 vs. Level 54 according to 1950 Bureau of the Census standards), boys to girls (16:3 vs. 11:8); and number of subjects referred for neurological examinations (10 vs. 15) who showed signs of damage (0 vs. 1). The numbers of favorable versus unfavorable prognostic signs (directions of differences) on the pretreatment variables divide themselves equally between the groups. In short, the two groups appear to have been comparable at intake.

#### Follow-Up Data

Subjects' PMA at intake, follow-up educational placement, and IQ scores were subjected to a MANOVA that contrasted the experimental group with Control Groups 1 and 2. At intake, there were no significant differences between the experimental group and the control groups. At follow-up, the experimental group was significantly higher than the control groups on educa-

tional placement ( $p < .001$ ) and IQ ( $p < .01$ ). The two control groups did not differ significantly at intake or at follow-up. In short, data from Control Group 2 replicate those from Control Group 1 and further validate the effectiveness of our experimental treatment program. Data are given in Table 2 that show the group means from pretreatment PMA and posttreatment educational placement and IQ scores. The table also shows the *F* ratios and significance levels of the three group comparisons.

In descriptive terms, the 19-subject experimental group shows 9 children (47%) who successfully passed through normal first grade in a public school and obtained an average or above average score on IQ tests ( $M = 107$ , range = 94–120). Eight subjects (42%) passed first grade in aphasia classes and obtained a mean IQ score within the mildly retarded range of intellectual functioning ( $M = 70$ , range = 56–95). Only two children (10%) were placed in classes for autistic/retarded children and scored in the profoundly retarded range (IQ < 30).

There were substantial increases in the subjects' levels of intellectual functioning after treatment. The experimental group subjects gained on the average of 30 IQ points over Control Group 1 subjects. Thus the number of subjects who scored within the normal range of intellectual functioning increased from 2 to 12, whereas the number of subjects within the moderate-to-severe range of intellectual retardation dropped from 10 to 3. As of 1986, the achievements of experimental group sub-

Table 2  
Means and *F* Ratios for Measures at Pretreatment and Posttreatment

Group	Intake PMA	Follow-up	
		EDP	IQ
	Means		
Experimental	18.8	2.37	83.3
Control 1	17.1	1.42	52.2
Control 2	17.6	1.57	57.5
	<i>F</i> ratios <sup>a</sup>		
Experimental × Control 1	1.47	23.6**	14.4**
Experimental × Control 2	0.77	17.6**	10.4*
Control 1 × Control 2	0.14	0.63	0.45

Note. PMA = prorated mental age; EDP = educational placement. Experimental group,  $n = 19$ ; Control Group 1,  $n = 19$ ; Control Group 2,  $n = 21$ .

<sup>a</sup>  $df = 1, 56$ .

\*  $p < .01$ . \*\*  $p < .001$ .

Table 3  
Educational Placement and Mean  
and Range of IQ at Follow-Up

Group	Recovered	Aphasic	Autistic/Retarded
Experimental			
<i>N</i>	9	8	2
<i>M</i> IQ	107	70	30
Range	94-120	56-95	—*
Control Group 1			
<i>N</i>	0	8	11
<i>M</i> IQ	—	74	36
Range	—	30-102	20-73
Control Group 2			
<i>N</i>	1	10	10
<i>M</i> IQ	99	67	44
Range	—	49-81	35-54

Note. Dashes indicate no score or no entry.

\* Both children received the same score.

jects have remained stable. Only 2 subjects have been reclassified: 1 subject (now 18 years old) was moved from an aphasia to a normal classroom after the sixth grade; 1 subject (now 13 years old) was moved from an aphasia to an autistic/retarded class placement.

The MA and IQ scores of the two control groups remained virtually unchanged between intake and follow-up, consistent with findings from other studies (Freeman et al., 1985; Rutter, 1970). The stability of the IQ scores of the young autistic children, as reported in the Freeman et al. study, is particularly relevant for the present study because it reduces the possibility of spontaneous recovery effects. In descriptive terms, the combined follow-up data from the control groups show that their subjects fared poorly: Only 1 subject (2%) achieved normal functioning as evidenced by normal first-grade placement and an IQ of 99 on the WISC-R; 18 subjects (45%) were in aphasia classes (mean IQ = 70, range = 30-101); and 21 subjects (53%) were in classes for the autistic/retarded (mean IQ = 40, range = 20-73). Table 3 provides a convenient descriptive summary of the main follow-up data from the three groups.

One final control procedure subjected 4 subjects in the experimental group (Ackerman, 1980) and 4 subjects in Control Group 1 (McEachin & Leaf, 1984) to a treatment intervention in which one component of treatment (the loud "no" and occasional slap on the thigh contingent on self-stimulatory, aggressive, and noncompliant behavior) was at first withheld and then introduced experimentally. A within-subjects replication design was used across subjects, situations, and behaviors, with baseline observations varying from 3 weeks to 2 years after treatment had started (using contingent positive reinforcement only). During baseline, when the contingent-aversive component was absent, small and unstable reductions were observed in the large amount of inappropriate behaviors, and similar small and unstable increases were observed in appropriate behaviors such as play and language. These changes were insufficient to allow for the subjects' successful mainstreaming. Introduction of contingent aversives resulted in a sudden and stable reduction in the inappropriate behaviors and a sudden and stable increase in appropriate behaviors. This experimental intervention helps to establish two points: First, at least one compo-

nent in the treatment program functioned to produce change, which helps to reduce the effect of placebo variables. Second, this treatment component affected both the experimental and control groups in a similar manner, supporting the assumption that the two groups contained similar subjects.

Analyses of variance were carried out on the eight pretreatment variables to determine which variables, if any, were significantly related to outcome (gauged by educational placement and IQ) in the experimental group and Control Group 1. Pro-rated mental age was significantly ( $p < .03$ ) related to outcome in both groups, a finding that is consistent with reports from other investigators (DeMyer et al., 1981). In addition, abnormal speech was significantly ( $p < .01$ ) related to outcome in Control Group 1. Chronological age at onset of our treatment was not related to outcome, which is important because the two groups differed significantly on this variable at intake (by 6 months). The failure of CA to relate to outcome may be based on the very young age of all subjects at onset of treatment.

Conceivably, a linear combination of pretreatment variables could have predicted outcome in the experimental group. Using a discriminant analysis (Ray, 1982) with the eight variables used in the first multivariate analysis, it was possible to predict perfectly the 9 subjects who did achieve normal functioning, and no subject was predicted to achieve this outcome who did not. In this analysis, PMA was the only variable that was significantly related to outcome. Finally, when this prediction equation was applied to Control Group 1 subjects, 8 were predicted to achieve normal functioning with intensive treatment; this further verifies the similarity between the experimental group and Control Group 1 prior to treatment.

## Discussion

This article reports the results of intensive behavioral treatment for young autistic children. Pretreatment measures revealed no significant differences between the intensively treated experimental group and the minimally treated control groups. At follow-up, experimental group subjects did significantly better than control group subjects. For example, 47% of the experimental group achieved normal intellectual and educational functioning in contrast to only 2% of the control group subjects.

The study incorporated certain methodological features designed to increase confidence in the effectiveness of the experimental group treatment:

1. Pretreatment differences between the experimental and control groups were minimized in four ways. First, the assignment of subjects to groups was as random as was ethically possible. The assignment apparently produced unbiased groups as evidenced by similar scores on the 20 pretreatment measures and by the prediction that an equal number of Control Group 1 and experimental group subjects would have achieved normal functioning had the former subjects received intensive treatment. Second, the experimental group was not biased by receiving subjects with a favorable diagnosis or biased IQ testing because both diagnosis and IQ tests were constant across groups. Third, the referral process did not favor the project cases because there were no significant differences between Control Groups 1 and 2 at intake or follow-up, even though Control Group 2 subjects were referred to others by the same agency.

Fourth, subjects stayed within their groups, which preserved the original (unbiased) group assignment.

2. A favorable outcome could have been caused not by the experimental treatment but by the attitudes and expectations of the staff. There are two findings that contradict this possibility of treatment agency (placebo) effects. First, because Control Group 2 subjects had no contact with the project, and because there was no difference between Control Groups 1 and 2 at follow-up, placebo effects appear implausible. Second, the within-subjects study showed that at least one treatment component contributed to the favorable outcome in the intensive treatment (experimental) group.

3. It may be argued that the treatment worked because the subjects were not truly autistic. This is counterindicated by the high reliability of the independent diagnosis and by the outcome data from the control groups, which are consistent with those reported by other investigators (Brown, 1969; DeMeyer et al., 1973; Eisenberg, 1956; Freeman et al., 1985; Havelkova, 1968; Rutter, 1970) for groups of young autistic children diagnosed by a variety of other agencies.

4. The spontaneous recovery rate among very young autistic children is unknown, and without a control group the favorable outcome in the experimental group could have been attributed to spontaneous recovery. However, the poor outcome in the similarly constituted Control Groups 1 and 2 would seem to eliminate spontaneous recovery as a contributing factor to the favorable outcome in the experimental group. The stability of the IQ test scores in the young autistic children examined by Freeman et al. (1985) attests once again to the chronicity of autistic behaviors and serves to further negate the effects of spontaneous recovery.

5. Posttreatment data showed that the effects of treatment (a) were substantial and easily detected, (b) were apparent on comprehensive, objective, and socially meaningful variables (IQ and school placement), and (c) were consistent with a very large body of prior research on the application of learning theory to the treatment and education of developmentally disabled persons and with the very extensive (100-year-old) history of psychology laboratory work on learning processes in man and animals. In short, the favorable outcome reported for the intensive-treatment experimental group can in all likelihood be attributed to treatment.

A number of measurement problems remain to be solved. For example, play, communicative speech, and IQ scores define the characteristics of autistic children and are considered predictors of outcome. Yet the measurement of these variables is no easy task. Consider play. First, play undoubtedly varies with the kinds of toys provided. Second, it is difficult to distinguish low levels of toy play (simple and repetitive play associated with young, normal children) from high levels of self-stimulatory behavior (a psychotic attribute associated with autistic children). Such problems introduce variability that needs immediate attention before research can proceed in a meaningful manner.

The term *normal functioning* has been used to describe children who successfully passed normal first grade and achieved an average IQ on the WISC-R. But questions can be asked about whether these children truly recovered from autism. On the one hand, educational placement is a particularly valuable measure of progress because it is sensitive to both educational accomplishments and social-emotional functions. Also, continual

promotion from grade to grade is made not by one particular teacher but by several teachers. School personnel describe these children as indistinguishable from their normal friends. On the other hand, certain residual deficits may remain in the normal functioning group that cannot be detected by teachers and parents and can only be isolated on closer psychological assessment, particularly as these children grow older. Answers to such questions will soon be forthcoming in a more comprehensive follow-up (McEachin, 1987).

Several questions about treatment remain. It is unlikely that a therapist or investigator could replicate our treatment program for the experimental group without prior extensive theoretical and supervised practical experience in one-to-one behavioral treatment with developmentally disabled clients as described here and without demonstrated effectiveness in teaching complex behavioral repertoires as in imitative behavior and abstract language. In the within-subjects studies that were reported, contingent aversives were isolated as one significant variable. It is therefore unlikely that treatment effects could be replicated without this component. Many treatment variables are left unexplored, such as the effect of normal peers. Furthermore, the successful mainstreaming of a 2-4-year-old into a normal preschool group is much easier than the mainstreaming of an older autistic child into the primary grades. This last point underscores the importance of early intervention and places limits on the generalization of our data to older autistic children.

Historically, psychodynamic theory has maintained a strong influence on research and treatment with autistic children, offering some hope for recovery through experiential manipulations. By the mid-1960s, an increasing number of studies reported that psychodynamic practitioners were unable to deliver on that promise (Rimland, 1964). One reaction to those failures was an emphasis on organic theories of autism that offered little or no hope for major improvements through psychological and educational interventions. In a comprehensive review of research on autism, DeMyer et al. (1981) concluded that "[in the past] psychotic children were believed to be *potentially* capable of normal functioning in virtually all areas of development . . . during the decade of the 1970s it was the rare investigator who even gave lip-service to such previously held notions . . . infantile autism is a type of developmental disorder accompanied by severe and, to a large extent, permanent intellectual/behavioral deficits" (p. 432).

The following points can now be made. First, at least two distinctively different groups emerged from the follow-up data in the experimental group. Perhaps this finding implies different etiologies. If so, future theories of autism will have to identify these groups of children. Second, on the basis of testing to date, the recovered children show no permanent intellectual or behavioral deficits and their language appears normal, contrary to the position that many have postulated (Rutter, 1974; Churchill, 1978) but consistent with Kanner's (1943) position that autistic children possess potentially normal or superior intelligence. Third, at intake, all subjects evidenced deficiencies across a wide range of behaviors, and during treatment they showed a broad improvement across all observed behaviors. The kind of (hypothesized) neural damage that mediates a particular kind of behavior, such as language (Rutter, 1974), is not consistent with these data.

Although serious problems remain for exactly defining autism or identifying its etiology, one encouraging conclusion can be stated: Given a group of children who show the kinds of behavioral deficits and excesses evident in our pretreatment measures, such children will continue to manifest similar severe psychological handicaps later in life unless subjected to intensive behavioral treatment that can indeed significantly alter that outcome.

These data promise a major reduction in the emotional hardships of families with autistic children. The treatment procedures described here may also prove equally effective with other childhood disorders, such as childhood schizophrenia. Certain important, practical implications in these findings may also be noted. The treatment schedule of subjects who achieved normal functioning could be reduced from 40 hr per week to infrequent visits even after the first 2 years of treatment. The assignment of one full-time special-education teacher for 2 years would cost an estimated \$40,000, in contrast to the nearly \$2 million incurred (in direct costs alone) by each client requiring life-long institutionalization.

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## **Including Children with Autism in General Education Classrooms: A Review of Effective Strategies**

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Children with autism can benefit from participation in inclusive classroom environments, and many experts assert that inclusion is a civil right and is responsible for nurturing appropriate social development. However, most children with autism require specialized supports to experience success in these educational contexts. This article provides a review of the empirical research that has addressed procedures for promoting successful inclusion of students with autism. Strategies reviewed include antecedent manipulations, delayed contingencies, self-management, peer-mediated interventions, and other approaches that have been demonstrated in the literature to be useful. The article concludes with a discussion of future research needs.

## **Including Children With Autism in General Education Classrooms**

### **A Review of Effective Strategies**

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**The educational inclusion of students with autism** and other disabilities has been a fiercely controversial topic (Harrower, 1999; Kauffman & Hallahan, 1995). Historically, students with disabilities have been segregated from their peers, even from society as a whole (Karagiannis, Stainback, & Stainback, 1996). More recently, however, there has been an increasing trend to include students with autism and other disabilities in general education classrooms along with their typically developing peers (McDonnell, 1998). This trend has stemmed largely from theoretical arguments related to social development and legal issues related to the civil rights movement (for a review, see Harrower, 1999).

The purpose of this article is to provide a review of data-based strategies for facilitating the educational inclusion of students with autism. First, research on inclusion as an independent variable will be briefly

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reviewed with respect to social and academic outcomes. Second, intervention strategies that have been documented as successful in the process of including students with autism in general education classrooms will be presented. The intervention strategies that will be reviewed in this section include antecedent procedures, delayed contingencies, self-management strategies, peer-mediated interventions, and multicomponent strategies. We will also cover some empirically validated strategies that are not necessarily designed for use in inclusive settings but that may be very useful in some contexts. Last, a brief discussion of worthwhile areas for future research efforts in facilitating the inclusion of students with autism will be presented.

#### **RESEARCH ON INCLUSION AS AN INDEPENDENT VARIABLE**

One of the contributing factors in the controversy over inclusion has been the limited number of studies that have focused directly on procedures for facilitating educational inclusion (Hunt & Goetz, 1997). Before considering effective strategies, however, it is reasonable to question the extent to which inclusion results in the benefits that its proponents anticipate. The little research available that considers inclusion as an independent variable has documented generally, though not exclusively, positive results. This area of research has focused on both the social and the academic outcomes based on educational placement of children with autism.

With regard to the potential social outcomes of students with autism schooled in general versus special education settings, researchers have evaluated students with autism on a number of dependent variables, holding educational placement as the independent variable. For example, researchers have documented that students with disabilities, including students with autism, who are fully included (a) display higher levels of engagement and social interaction, (b) give and receive higher levels of social support, (c) have larger friendship networks, and (d) have developmentally more advanced individualized education plan goals than their counterparts in segregated placements (Fryxell & Kennedy, 1995; Hunt, Farron-Davis, Beckstead, Curtis, & Goetz, 1994).

Yet researchers have also found mixed results among students with autism in general education classrooms. For example, researchers have found that some fully included students with disabilities, including autism, are rated by their classmates as being among the most popular in class, whereas others are not (Evans, Salisbury, Palombaro, Berryman, & Hollowood, 1992). The study by Evans and colleagues (1992) also documented that students with disabilities were observed more frequently to be on the receiving, rather than the giving, end of social interactions, and this tendency was amplified over the course of the school year. Thus, studies addressing social behavior have yielded encouraging yet variable results (Evans et al., 1992; Hunt et al., 1994).

Relatively few studies have been conducted evaluating academic outcomes for students with autism as a result of educational placement (Hunt & Goetz, 1997). In one such study, Harris, Handleman, Kristoff, Bass, and Gordon (1990) compared five children with autism enrolled in a segregated preschool classroom, five children with autism in an inclusive classroom, and four typically developing peers in the inclusive classroom on measures of language ability before and after language instruction. Results failed to show significant differences in language ability between the children with autism in either setting (Harris et al., 1990). These types of findings have generally been interpreted as supporting educational inclusion, as segregated educational placements have historically been purported to provide more intensive educational opportunities for students with disabilities (Harrower, 1999).

Authors often note that the mere placement or proximity to typical peers and the general education curriculum may be beneficial, but it is insufficient in achieving an appropriate education for students with disabilities (e.g., Hunt & Goetz, 1997; Kohler, Strain, & Shearer, 1996). For this reason, many researchers have advocated for educational inclusion as a reallocation of specialized educational services, not merely as an intervention in and of itself (Sailor, 1996). Thus, the focus of the inclusion debate may best be reframed from segregated versus inclusive education to how to provide appropriate supports in inclusive settings. For inclusive placements to be successful, educators must have knowledge of and access to empirically validated strategies that will assist them in this process. Therefore, the following dis-

discussion provides a review of intervention strategies that have been documented as effective in supporting students with autism in inclusive educational contexts.

### **REVIEW OF STRATEGIES FOR FACILITATING THE INCLUSION OF STUDENTS WITH AUTISM**

Prior to beginning a discussion of strategies for promoting inclusion, a few important considerations are warranted. As has been widely noted, autism is a highly heterogeneous disability with regard to level of functioning (G. Dunlap & Bunton-Pierce, 1999; Gillberg, 1999; Koegel, Valdez-Menchaca, Koegel, & Harrower, 2001). Thus, the level and intensity of supports required for a given student with autism will depend largely on the characteristics of the student's functioning. It would be beyond the scope of this review (and the status of the literature) to delineate specific strategies that are more or less appropriate for varying levels of functioning. In addition, much of the research on inclusion of students with autism has been conducted with young children. There is a lack of pertinent research on including students with autism at the middle school and high school levels. Again, it is not the purpose of this article to prescribe intervention strategies based on age or grade level. The purpose is to provide a review of documented strategies that can then be individually tailored to meet the idiosyncratic needs of particular students with autism participating in inclusive educational placements.

#### **ANTECEDENT PROCEDURES**

By modifying discriminative stimuli for both appropriate and inappropriate behavior, antecedent procedures can be designed to prevent and reduce challenging behavior. One very positive aspect of antecedent procedures is that they are proactive. Since these strategies all involve altering routines or environments, they address challenging behavior prior to its occurrence. Antecedent procedures that have been used specifically for students with autism in general education classrooms include priming, prompt delivery, and picture scheduling.

*Priming.* Priming, or prepractice, has been documented as an effective classroom intervention for children with autism. Priming consists of previewing information or activities that a child is likely to have difficulties with before the child actually engages in that activity (Wilde, Koegel, & Koegel, 1992). For example, if a child is having difficulties during circle activities where the teacher is reading the class a story, each day's story could be read to the child individually before the child experiences the story in the presence of the entire class. Priming is important in facilitating the inclusion of students with autism in that it links individual instruction to larger classroom group activities, a common feature of general education classrooms. Research has focused on using priming to improve social interactions between children with autism in regular education classrooms, and priming has been shown to be effective in increasing the initiations of social interaction with typical peers (Zanolli, Daggett, & Adams, 1996).

*Prompt delivery.* Prompting strategies have been successful in facilitating the inclusion of students with autism. Often, when teaching children with autism, in order to elicit an appropriate response in a targeted academic or behavioral activity, one must provide prompts that supplement the general instructional routine. Using various prompting strategies is important in facilitating the inclusion of students with autism, as these students may not respond to traditional instructions delivered in general education classrooms. For example, Sainato, Strain, Lefebvre, and Rapp (1987) compared the effectiveness of two prompting strategies for facilitating school transition times with three preschool boys with autism. In the peer buddy condition, the classroom teacher provided prompts and modeling to a typically developing student, who then provided prompts to the student with autism. The classroom teacher did not deliver prompts to the children with autism. In the antecedent condition, the classroom teacher alone provided prompts to the students with autism, instructing the peer buddies not to assist. Both conditions yielded increases in appropriate behaviors, with the teacher-only condition revealing superior results in all transition settings. Both conditions also resulted in significant reductions in teacher prompts over time, suggesting that the students began to make transitions independently.

Other types of prompting strategies have also been documented to improve outcomes for students with autism in inclusive classrooms. For example, Taylor and Levin (1998) examined the effects of a tactile prompting device for increasing the verbal initiations of a 9-year old student with autism. The device, carried in the student's pocket, made a slight vibration at prespecified time intervals, and this served as a prompt for the student to make a verbal initiation regarding his play activities. Increases in verbal initiations were observed not only toward an adult in a variety of play contexts but also during follow-up probes conducted during cooperative learning activities with typically developing peers in the student's general education classroom.

*Picture schedules.* Picture schedules are often used as a strategy for increasing predictability and as an alternative to verbal and written instruction. Transitioning from one activity to another can be problematic for some students with autism yet is a very common occurrence in general education classrooms. Picture schedules can serve as effective cues alerting students with autism to upcoming changes in activities. For example, Hall, McClannahan, and Krantz (1995) used a picture book schedule describing the daily general education classroom activities for three students with disabilities, including one with autism. Results demonstrated that, along with reductions in prompt use by classroom aides, the students followed their activity schedules 90% to 100% of the time. Furthermore, these strategies received high ratings of social validity in that the aides indicated that they would use the strategies with other students and would recommend their use to other aides.

#### **DELAYED CONTINGENCIES**

One goal of education is to increase the independent academic functioning of students. This has often been a daunting goal for educators working with students with autism. While successes have been well documented for students with autism under conditions of close adult supervision, there has also been evidence that the removal of supervision often leads quickly to a reappearance of challenging behavior and/or a decrease in appropriate behavior (Marholin &

Steinman, 1977; Stahmer & Schreibman, 1992). This failure of behavioral gains to generalize has been linked to the removal of contingencies (e.g., positive reinforcement) that typically accompany the removal of supervision. Thus, some researchers have examined the extent to which instruction using delayed or unpredictable contingencies can facilitate the generalization of behavior in the absence of direct supervision (G. Dunlap & Johnson, 1985; G. Dunlap, Koegel, Johnson & O'Neill, 1987). For example, G. Dunlap and Johnson (1985) used an unpredictable schedule of supervision with three children with autism and found that levels of on-task behavior and productivity were significantly higher during periods of no supervision than when a predictable schedule of supervision was in place.

Delayed and unpredictable contingencies were used by G. Dunlap, Plienis, and Williams (1987) to establish fully independent task completion by a young man with autism and profound intellectual disabilities after a gradual process of thinning reinforcement schedules and delaying the delivery of corrective feedback. These procedures were also used by G. Dunlap, Koegel, et al. (1987) to establish appropriate responding in inclusive educational settings for two boys with autism and one young man with autism in an integrated work setting. In these three instances, the participants' appropriate behavior was successfully maintained over extended periods of time without the need for close supervisory attention.

#### SELF-MANAGEMENT STRATEGIES

Self-management has been described as a viable intervention strategy for promoting independence in the classroom, as it shifts some responsibility for behavior management from the teacher to the student (L. K. Dunlap, Dunlap, Koegel, & Koegel, 1991), increasing a teacher's ability to focus on instruction. Self-management consists of teaching the student to (a) discriminate between appropriate and inappropriate behaviors, (b) evaluate her or his own behavior, (c) monitor her or his behavior over time, and (d) reinforce her or his behavior when prespecified criteria are met. Not only has self-management been documented to be an effective strategy for a variety of target behaviors, but research has also shown that teaching a child to self-

manage behavior in the classroom can result in independent functioning to the point where the student is no longer relying on the teacher or on a one-on-one aide (Koegel, Harrower, & Koegel, 1999). As a result of this decreased dependency on adult intervention, the student has increased opportunity to interact with classmates without the potential stigma of having a one-on-one aide. Thus, self-management allows students with disabilities to become actively involved in the intervention process and more involved in their classroom environments. For these reasons, self-management has been suggested in the literature as an ideal intervention for children with disabilities participating in full inclusion classroom settings (Reid, 1996).

Although documentation of the use of this intervention with students with autism and other disabilities participating in inclusive classrooms has been scarce (Reid, 1996), the studies that have implemented self-management interventions for students with autism in these settings have reported encouraging results. For example, self-management has been successfully utilized for improving social skills and reducing disruptive behavior (Koegel, Koegel, Hurley, & Frea, 1992), increasing independent work skills (Sainato, Strain, Lefebvre, & Rapp, 1990), and improving the social interactions of children with autism participating in integrated academic settings (Strain, Kohler, Storey, & Danko, 1994). In particular, Koegel et al. (1992) used self-management to improve the responsiveness of four children with autism to verbal initiations from others in community, home, and school settings without the presence of a treatment provider. The children were taught to use a wrist counter to record their correct responses to questions, which were then rewarded. The results demonstrated improvements in these students' independent responsiveness to others, along with concomitant reductions in disruptive behavior.

In another study, Sainato et al. (1990) evaluated the effects of a self-management intervention package on the independent work skills of children with autism participating in an integrated preschool classroom. Results of this study showed immediate and substantial improvements in the students' behavior and also showed that these gains were maintained after each intervention component was systematically withdrawn. Similarly, Strain et al. (1994) examined the effects

of a self-management intervention package on the social interactions of three preschool boys with autism. This intervention consisted of adult prompts, reinforcement, and self-monitoring and was implemented in the inclusive classroom setting and extended to the home setting for two of the three students. Results indicated that the intervention increased and improved each boy's social interactions with siblings and typically developing classmates. In addition, Callahan and Rademacher (1999) used a self-management strategy to increase rates of on-task behavior for a second-grade boy with autism participating in a full inclusion classroom. Although most of the literature on self-management and children with autism has focused on verbal children, Pierce and Schreibman (1994) taught daily living skills to three nonverbal boys with autism via pictorial self-management.

The combination of self-management strategies with functional assessment in supporting students with autism in full inclusion settings is a potential area for future research. In an initial demonstration of this approach, Frea and Hughes (1997) conducted functional analyses for two high school students with mental retardation in order to determine the function of the students' problem behaviors. Once the function was determined, a response that was functionally equivalent to the problem behavior (e.g., request a break, request for attention) was targeted for each student in a self-management intervention package. The results demonstrated increases in the use of the alternative behaviors with concomitant decreases in problem behavior (Frea & Hughes, 1997). This combination of methodologies has been used to teach students with disabilities in inclusive educational settings to self-manage their use of functionally equivalent responses, resulting in more functional reinforcement (Frea & Hughes, 1997; Todd, Horner, & Sugai, 1999).

#### **PEER-MEDIATED INTERVENTIONS**

Due to common deficiencies in the social relationships of children with autism, peer-mediated interventions have been advocated as potentially useful approaches for facilitating the participation of children with autism in general education classrooms. Utilizing typical

peers to support the academic functioning of students with autism has the potential to reduce the need for continuous one-on-one adult attention, thus allowing students with autism to function with increased autonomy and in a manner that more closely matches that of their typical classmates (Putnam, 1993).

*Peer tutoring.* Peer tutoring consists of pairing two students together to work on any instructional strategy, with one student providing assistance, instruction, and feedback to the other (DuPaul & Eckert, 1998). Peer tutoring strategies have been shown to be effective in producing increases in on-task behavior, math performance, and social interactions for children with disabilities in inclusive classrooms (DuPaul & Henningson, 1993; Locke & Fuchs, 1995). In classwide peer tutoring (CWPT), all children in the class are paired and work simultaneously. The purpose of CWPT is to increase the amount of instructional time that all students engage in academics and to provide pacing, feedback, immediate error correction, high mastery levels, and content coverage (Fuchs, Fuchs, Mathes, & Simmons, 1997).

In a study examining the effects of CWPT in reading instruction among three students with autism participating in regular education classrooms, results of reading assessments revealed gains in reading fluency and correct responses to reading comprehension questions (Kamps, Barbeta, Leonard, & Delquadri, 1994). Furthermore, in unstructured free-time activities, increases in the duration of social interactions between the students with autism and their nondisabled peers were observed after the implementation of CWPT (Kamps et al., 1994). However, there is some evidence suggesting that increasing the rate of social interaction among children with disabilities by implementing CWPT programs may be insufficient in producing enduring changes across unprogrammed settings (Hundert & Houghton, 1992). Thus, even though this strategy appears ideal for use in inclusive classroom settings, more research is needed to assess the generality of findings as well as to verify the effects on social and academic achievement among children of different ages with different needs in general education classrooms.

*Utilizing peer supports.* A number of researchers have focused on recruiting typically developing students to serve as peer supports for students with autism (Haring & Breen, 1992; Odom & Strain, 1986). The goal of this strategy is similar to that of peer tutoring but with the focus being on improving the social interaction skills of students with autism. Odom, Hoyson, Jamieson, and Strain (1985) evaluated the effects of peer initiations on the social interactions of preschoolers with autistic-like symptoms. Teachers prompted and reinforced social initiations made by identified peer supports. Results showed increased frequencies of positive social interaction, and although these results maintained when the teachers faded their reinforcement of peer-initiated interactions, there were decreases in interactions when teacher prompts were withdrawn. Furthermore, the results were not observed to generalize to other classroom settings.

In another study, Odom and Strain (1986) found that when typical children initiated contact with their peers with autism, social responses by the students with autism increased, and that when teachers prompted the social interactions, both social responses and initiations increased. These findings suggest the potential of multicomponent intervention strategies in producing improvements in a variety of behaviors among students with autism in inclusive classrooms (Odom & Strain, 1986).

In some circumstances, simply training nondisabled peers to interact with classmates with autism has been shown to improve spontaneous social interactions between students with autism and their trained and untrained peers (Brady, Shores, McEvoy, Ellis, & Fox, 1987). In addition, Goldstein, Kaczmarek, Pennington, and Shafer (1992) found that simply having peers attend to, comment on, and acknowledge the behavior of their classmates with autism resulted in improved rates of social interaction. Haring and Breen (1992) involved nondisabled peers in weekly discussions with an adult integration facilitator to increase opportunities for social interaction for two 13-year old students, one with autism and one with mental retardation. The nondisabled peers participated in the implementation of social skills interventions and used self-monitoring strategies to record the quantity and quality of interactions with classmates with disabilities. Results of this study revealed increases in the frequency of interac-

tions, number of opportunities for interactions, and overall appropriateness of the interactions with their peers with disabilities.

*Cooperative learning.* A number of studies have demonstrated that teaching social and academic skills to children with autism and their nonhandicapped peers in cooperative groups in integrated settings results in increased frequency, duration, and quality of social interactions (Kamps et al., 1992; Kohler et al., 1995). Cooperative learning groups have been used in inclusive classroom settings as an instructional activity for increasing both academic success and social interaction (see Putnam, 1993).

In one such study, Dugan et al. (1995) evaluated cooperative learning groups during fourth-grade social studies activities, where the group activities consisted of tutoring on key words and facts, a team activity, and a whole class wrap-up and review. This resulted in improvements in test scores and academic engagement and increased duration of student interaction between children with autism and their nondisabled classmates. Similarly, Hunt, Staub, Alwell, and Goetz (1994) used cooperative learning groups to support three fully included second-grade students with multiple severe disabilities, including one with autism and an intellectual disability. Results showed that with gradually fading assistance from the teacher, the nondisabled members of the learning groups provided cues, prompts, and consequences that assisted the students with disabilities in demonstrating targeted basic skills in the original cooperative learning group as well as in a newly formed group. Furthermore, achievement tests indicated that the nondisabled students who participated in cooperative groups performed as well as members of groups that did not include a student with a disability. In addition, Kamps, Leonard, Potucek, and Garrison-Harrell (1995) conducted two experiments related to cooperative learning groups and their academic effects on including students with autism in general education classrooms. In both, cooperative learning groups were implemented and consisted of activities that included comprehension questions, academic games, and peer tutoring on vocabulary words. Results of both experiments in this study revealed increased reading gains, academic engagement, and peer interaction among students with autism and their peers par-

ticipating in general education classrooms. Researchers have also used sociodramatic scripts during social routines for various play activities between students with autism and their typical peers and found increases in theme-related social behaviors, even when new scripts were introduced and the play groups were rearranged (Goldstein & Cisar, 1992).

Many researchers have used cooperative groups specifically for improving the social skills of students with autism in inclusive classrooms. For example, Kamps et al. (1992) investigated the use of social skills groups to facilitate the increase of social interactions among three boys with autism who were integrated into a general education first-grade classroom. Group members were taught how to (a) initiate, respond, and keep interactions going; (b) greet others and converse on a variety of topics; (c) give and accept compliments; (d) take turns and share; (e) ask for help and help others; and (f) include others in activities. Results demonstrated increases in the frequency of, time engaged in, and duration of social interactions, as well as in the responsiveness of students and peers to each other (Kamps et al., 1992). Similarly, Kohler et al. (1995) used a group-oriented contingency to reinforce peers to share, provide assistance, and organize play exchanges with their preschool classmates with autism. Results revealed increases in these social and supportive interactions.

Peer-mediated interventions not only have been documented as effective in facilitating the educational inclusion of children with autism but have also been identified as having social validity. Research on the social validity of peer-mediated interventions has documented positive ratings made by typical peers regarding their perceptions of peer-mediated interventions (Kamps et al., 1998) and positive academic outcomes for typical students who participated in peer-mediated interventions (Cushing & Kennedy, 1997).

#### MULTICOMPONENT INTERVENTIONS

Some intervention strategies have made use of multiple research-based techniques to facilitate the educational inclusion of students with autism. Because multicomponent approaches may be more common in practice than single-component interventions, it is appropriate

to include an example in this review. Hunt, Alwell, Farron-Davis, and Goetz (1996) evaluated a comprehensive individualized intervention consisting of (a) ongoing information to classmates about various aspects of the disability experienced by the target student during naturally occurring interactions or in weekly “club” meetings, (b) various media used for communicative interactions, and (c) the establishment of a rotating buddy system. This multicomponent intervention was found to dramatically increase reciprocal interactions and target student-initiated interactions for students with significant physical and intellectual challenges and sensory impairments. These findings have been replicated for students within the autism spectrum participating in full inclusion classrooms (Hunt, Farron-Davis, Wrenn, Hirose-Hatae, & Goetz, 1997). Specifically, the multicomponent intervention used in this replication study consisted of the development and use of conversation books, rotating peer buddies, weekly class meetings, media-related activities, and staff prompting. Results demonstrated increases in exchanges with peers, with the focus students more frequently initiating the interactions and providing information, as compared to being the recipients of communication and assistance. Overall, interactions between the focus students and their peers were observed to closely approximate those between nondisabled students as a result of the intervention (Hunt et al., 1997).

### **ADDITIONAL STRATEGIES FOR FACILITATING THE INCLUSION OF STUDENTS WITH AUTISM**

Although the strategies that will be discussed in this section have considerable empirical support documenting their effectiveness in teaching children with autism, they have not been specifically designed to support participation in inclusive classrooms. Rather, the strategies are effective teaching techniques that could be used when supporting a student with autism in a general education classroom. We include them in this review because they constitute well-researched strategies that can be used to improve the responding of students with autism and because the relevant research includes at least some extensions to inclusive educational contexts.

### **PRETASK SEQUENCING**

High-probability (high-P) requesting has a long history of empirical support as an effective antecedent-based strategy for increasing responsiveness to requests among individuals with disabilities (Singer, Singer, & Horner, 1987). This antecedent procedure involves preceding a difficult request with a rapid series of short, easy requests and reinforcing compliance with these easy requests. By preceding a difficult task with a series of short and easy tasks that have a high probability of being followed, a child will achieve repeated success and build momentum for improved responding through obtaining repeated reinforcement (Mace et al., 1988; Singer et al., 1987). Although task interspersal procedures have typically focused on increasing compliance to adult-initiated directives, many researchers have suggested the utility of such interspersal procedures when incorporated into a variety of instructional techniques for a variety of target behaviors (Davis & Brady, 1993). For example, Davis, Brady, Williams, and Hamilton (1992) investigated the effects of high-P requests on the acquisition and generalization of responding to low-P requests among two boys with disabilities, including one with autism and mental retardation. Results demonstrated not only increases in appropriate responding to adult requests but generalized appropriate responding to low-P requests by adults not involved in the delivery of the high-P sequence. Davis, Brady, Hamilton, McEvoy, and Williams (1994) later replicated and extended these findings to include generalization of responsiveness to requests to initiate social interaction, along with increases in unprompted initiations and extended interactions with peers in inclusive settings.

### **PIVOTAL RESPONSE TRAINING AND NATURALISTIC TEACHING STRATEGIES**

Incidental teaching approaches and pivotal response training (PRT), which focus on increasing motivation to learn among children with autism by incorporating choices, reinforcing attempts, using adequate modeling, and providing natural consequences, have also been used as strategies for facilitating the inclusion of children with autism in general education classrooms (McGee, Almeida, Sulzer-Azaroff, &

Feldman, 1992; Pierce & Schreibman, 1995, 1997; Thorp, Stahmer, & Schreibman, 1995). Both incidental teaching approaches and PRT focus on using conditions of natural language teaching interactions such that (a) stimulus items are functional and varied, (b) natural reinforcers are employed, (c) communicative attempts are reinforced, and (d) trials are conducted within a natural interchange (Koegel, Koegel, Harrower, & Carter, 1999; McGee, Morrier, & Daly, 1999). Yet, although incidental teaching approaches and PRT share these commonalities, PRT also focuses on targeting motivational variables, incorporating child choice, interspersing maintenance trials, increasing responsiveness to multiple cues, teaching self-management, and teaching self-initiations (see Koegel, Koegel, et al., 1999). Both incidental teaching and PRT have been used with peer-mediated strategies and documented as successful multicomponent intervention strategies that can be used for facilitating the inclusion of children with autism in general education classrooms.

An example was reported by McGee and her colleagues (1992), who used peer-delivered incidental teaching strategies to promote reciprocal social interactions between preschool students with autism and their typical peers. Peer tutors were identified and used incidental teaching to elicit verbal labels of preferred toys by students with autism. Adult assistance was successfully faded, with improvements in social interactions being maintained. In addition, teachers and peers in this inclusive preschool made positive ratings regarding the strategies and their effectiveness, supporting their social validity. Similarly, Pierce and Schreibman (1995) found that by utilizing typical peers to implement naturalistic teaching strategies (PRT) in the absence of direct supervision in a general education classroom environment, students with autism engaged in prolonged interactions, initiated play and conversations, increased engagement in language and joint attention behaviors, and displayed positive changes in social behaviors as reported by their teachers. Although these gains were documented to maintain over time and generalize to some unprogrammed settings, generalization did not tend to occur across untrained peers (Pierce & Schreibman, 1995). Generalization across untrained peers was achieved when multiple peers were involved in implementing the PRT strategies (Pierce & Schreibman, 1997). Teachers have also embed-

ded naturalistic language procedures within their classrooms to facilitate the inclusion of children with autism. For example, Smith and Camarata (1999) demonstrated that general education teachers could successfully implement naturalistic language procedures to improve intelligibility in language skills and spontaneous language use among students with autism.

### FUTURE DIRECTIONS AND CONCLUSION

In one way or another, research on behavior analytic supports for students with autism in inclusive contexts has been in progress for nearly two decades. It is a very large and complex undertaking, and there are many questions to ask and problems to solve. None of the questions and none of the answers is simple.

As this review has shown, a number of studies have demonstrated encouraging findings for some children with autism in some inclusive classrooms. The studies have explored and implemented a diverse technology of behavior analysis, with interventions ranging from antecedent manipulations to delayed contingencies, peer-mediated strategies and programs of self-management. Together, these studies provide a rich source of intervention options, and it is likely that one or more of the options could be used to improve the responding of any child identified as being in need of systematic support.

Although the literature offers an encouraging research base, there is a great deal of applied study that needs to occur for us to advance the opportunities of students with autism in inclusive classroom environments. In general, it is important for researchers to look at the diversity of students with autism, including differences in intellectual and behavioral functioning and cultural and economic backgrounds (G. Dunlap & Kern, 1997). For instance, a growing number of students with Asperger's syndrome display unusual patterns of behavior (e.g., compulsive and perseverative responding) that constitute great challenges for educators, in spite of these students' other competencies. At the same time, there are students who have severe intellectual and/or behavioral disabilities, whose inclusion may require very extensive attention and partial participation. Research that distin-

guishes these students' support needs would be welcomed by the educational community (G. Dunlap & Fox, in press; Sailor, 1996).

There will continue to be a need for the detailed behavior analytic research of the kind that has been responsible for the progress to date. In particular, research should connect the technology of functional assessment with strategies for promoting inclusion (cf. Frea & Hughes, 1997), and it should examine team approaches for planning and implementing individualized behavior support plans (e.g., Kincaid, 1996; Nickels, 1996). It would be a significant contribution to have parametric analyses of the existing technology so that procedures could be matched to the settings, the resources, and the child and family circumstances.

Research is also needed at the systems level. Inclusion can only work well if the educational system (at the district, school building, and classroom levels) is designed to encourage and support its success. For instance, systems need to have workable strategies for delivering the ready availability of experts in autism and behavior analysis in inclusive classrooms, and the teachers responsible for implementing special strategies need to have adequate resources and social support, or they are likely to burn out and fail to address the need for systematic interventions.

Inclusion for children with autism is important because education and socialization for children with autism is important. It can be argued that our failures to produce quality inclusion for these students are tantamount to our failures to provide them with a quality education. Our successes possess an analogous equivalency. With a concerted focus on relevant research and a diligent approach to application, combined with a philosophical commitment to optimal and socially inclusive outcomes, we can anticipate further progress in our efforts to support students with autism in appropriate educational settings.

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Newspaper article; The Washington Times, November 23, 2005.

## **Autism and Hope.**

Byline: C.A. Garland, Michael O'Hanlon and Dr. Barbara Firestone,  
SPECIAL TO THE WASHINGTON TIMES

**Autism** spectrum disorders are the fastest-growing severe developmental disabilities facing children - and thus future generations of adults - in the U.S. today. More than 1 in 200 young children may now be affected by **autism**, pervasive development disorder, or Asperger's syndrome.

While highly variable in type and severity, these disorders tend to include obsessive behaviors, excessive rigidities, limited **social skills** and communications deficits.

There is some good news. Over the last 20 years, early intervention regimens for **autism** spectrum disorders (ASD) have become much more effective. Given intensive early intervention, ideally before age 3, many children with ASD now have prospects for productive, fulfilling lives with meaningful personal relationships and career opportunities. Even the more severely challenged can do much better than before.

However, availability and affordability of intensive early intervention vary greatly in our country. More than 100,000 American children under age 5 are believed affected by ASD, but only a small fraction - perhaps 10 percent - get the rigorous therapy the National Academy of Sciences, American Academy of Pediatrics and other professional groups have documented are needed.

Enormous public policy challenges need to be overcome if early and intensive interventions are to be made available to every child on the spectrum. Notably, even where available, the major **autism** therapy methods are generally not affordable. Costs can reach or exceed \$50,000 a year. They are not routinely covered either by health insurance or by federal, state and local programs. Some localities provide coverage, but it is often incomplete, reaching only some affected children or providing perhaps 10 to 20 percent of the recommended intensity of intervention (optimally 25 to 40 hours a week).

An example is found in two of us who have a child on the **autism** spectrum living in Montgomery County, Md. Because our daughter was deemed relatively high-functioning, she was offered only two hours a week of intervention when diagnosed at age 2. Private insurance paid for another hour a week of speech therapy. The other 90 percent of her treatment, which included one-on-one tutoring (through a method known as Applied Behavior Analysis), as well as various exercises targeting her **social** and play **skills** (known as Floortime and Relationship Development Intervention), was funded entirely out of pocket. But we are lucky; we can scrape by and afford it. Many clearly cannot (and if the Congress cuts Medicaid to pay for Katrina relief, even fewer will be able to do so).

Now contrast our situation to those of some families in Los Angeles. That is where one of us (Barbara Firestone) oversees the Help Group that includes a wide range of specialized day school programs serving 550 children with ASD.

These programs apply numerous specialized education strategies and therapies, including those noted above. These services are offered at no cost to parents whose children are deemed to need the program by local school districts.

The HELP Group's Young Learners Preschool is dedicated to children with ASD ages 3 through 5. This innovative, intensive, six-hour daily, five days per week program provides a comprehensive, individualized program for each child. But this is still the exception, not the rule.

Several policy initiatives are possible to redress this sorry state of affairs, and in fact some combination of them is probably optimal. They could include the following illustrative ideas:

- \* Support for ongoing efforts to have the Office of Personnel Management mandate that federal government health plans cover certified intervention programs carried out by qualified professionals - in hopes the idea will then spread to the broader insurance market.

- \* Federal legislation mandating coverage of treatment costs by all health insurance plans (akin to the federal legislation on parity for mental health conditions of the 1990s, as well as federal mandates on minimum length of hospital stays after childbirth). Even if not passed promptly, proposed federal legislation may be very useful as a model for state legislation.

\* Efforts to ensure that, under the IDEA legislation and/or the EPSDT provisions of Medicaid, an autistic disorder diagnosis leads to assurance of available services for any afflicted child. These laws and regulations often do not have their promised effect. Parents end up paying for, or children going without, services not only promised but mandated by law.

**Autism** and hope are no longer mutually exclusive. While we press to find causes and cures, we must also emphasize the compelling need to ensure effective treatment strategies are available as soon as possible to all children with **autism** spectrum disorders across the United States.

C.A. Garland and Michael O'Hanlon, senior fellow at the Brookings Institution, are parents of a child with ASD. Dr. Barbara Firestone is president and chief executive officer of The Help Group in Los Angeles. Mr. O'Hanlon and Dr. Firestone will host a Dec. 16 "**Autism** and Hope" conference at Brookings focused on the issues raised above.

# OFFICE OF VOCATIONAL AND EDUCATIONAL SERVICES FOR INDIVIDUALS WITH DISABILITIES

**PROGRAM:** Office of Vocational and Educational Services for Individuals with Disabilities (VESID)

**DESCRIPTION:**

VESID's mission is to promote educational equity and excellence for students with disabilities while ensuring that they receive the rights and protections to which they are entitled; assure appropriate continuity between the child and adult services systems; and provide the highest quality vocational rehabilitation and independent living services to all eligible persons as quickly as those services are required to enable them to work and to live independent, self-directed lives.

State Operations

VESID promotes educational and vocational achievement for students with disabilities, ages 3 to 21, and for adults. It administers special education programs and services in New York's school system and provides support for families, educators and other staff. VESID's Vocational Rehabilitation (VR) Program provides specialized programs and services that assist youth and adults with disabilities in preparing for, finding, and adjusting to employment. VESID administers 39 Independent Living Centers (ILCs) and 15 Early Childhood Direction Centers across the State and operates the New York State School for the Blind and the New York State School for the Deaf. VESID also oversees statewide networks responsible for providing training and information to parents, educators, and others involved in educating preschool and school-age students with disabilities.

**REGENTS GOALS:** 1; 2; 3; 4; 5; 6

**AUTHORITY:**

- Federal Statute:** (see specific programs)
- Federal Regulation:** (see specific programs)
- State Statute:** (see specific programs)
- State Regulation:** (see specific programs)

**FUNDING SOURCE(S):**

State-	56.2%
Federal-	42.6%
Special Revenue-	1.2%
Total-	\$2,045m

NUMBER OF INDIVIDUALS SERVED: n/a

**CONTACT OFFICE 1:** Deputy Commissioner's Office

**TELEPHONE:** (518) 474-2714

**FAX:** (518) 474-8802

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**PROGRAM:** Allowances to State-Supported Schools for the Blind, Deaf, Orthopedically and Emotionally Disabled

**DESCRIPTION:**

The allowances to 11 State-supported schools provide for the education of students who are deaf, blind, severely orthopedically or emotionally disabled under §4201 of the Education Law and Chapter 1060 of the Laws of 1974. The State-supported schools receiving aid under this Program are:

Schools for the Deaf

- Cleary Deaf Child Center, Inc., Ronkonkoma (Suffolk County)
- Lexington School for the Deaf, New York (Queens)
- Mill Neck Manor School for the Deaf, Mill Neck
- New York School for the Deaf, White Plains
- Rochester School for the Deaf, Rochester
- St. Francis DeSales School for the Deaf, New York (Brooklyn)
- St. Joseph's School for the Deaf, New York (Bronx)
- St. Mary's School for the Deaf, Buffalo

Schools for the Blind

- New York Institute for Special Education, New York (Bronx)\*
- Lavelle School for the Blind, New York (Bronx)

Schools for Orthopedically Disabled Children

- Henry Viscardi School, Albertson

\*This school also serves students with emotional disabilities.

Chapter 1066 of the Laws of 1974, which added §4204-a to the Education Law, provides for State reimbursement of tuition costs for the education of deaf infants below the age of three attending programs approved by the Commissioner at various public and private facilities, including schools for the deaf listed in §4201 of the Education Law.

The annual appropriation for the §4201 program funds 35 percent of the prior school year operating expense and 65 percent of the current school year operating expense. In addition, the appropriation covers costs for the Deaf Infant Program, Boards of Cooperative Educational Services grants, payments to the New York State Dormitory

Authority for approved capital projects, and the retirement costs of employees of the 11 State-supported schools.

**REGENTS GOALS:** 1; 3; 5; 6

**AUTHORITY:**

**Federal Statute:**

**Federal Regulation:**

**State Statute:** Education Law Sections 4201 and 4204-a

**State Regulation:** 8NYCRR Part 200

**FUNDING SOURCE(S):**

State-	100%
Federal-	0%
Special Revenue-	0%
Total-	\$118.1M

**NUMBER OF INDIVIDUALS SERVED:** Approximately 1,650 students each year.

**CONTACT OFFICE 1:** VESID Special Education Quality Assurance

**TELEPHONE:** (518) 473-6108

**FAX:** (518) 473-5769

**PROGRAM:** Case Services

**DESCRIPTION:**

Case Services appropriations for the basic Vocational Rehabilitation Program provide educational and vocational services to persons whose disabilities impose barriers to employment. The Program provides a wide range of services to people with disabilities including evaluation, job training, equipment and technology, counseling and guidance, and placement. The primary goal of the Program is to enable people with disabilities to achieve gainful employment. When employment is achieved, the investment pays dividends to the State. The annual wages earned by those same people exceeded \$200 million and will grow each year. These earnings form the base for their tax contributions and stimulation of the economy.

The savings to State agencies, the tax contributions and the economic stimulus of these workers' spending recur and grow every year that these people work. Therefore, the return on the initial investment continues over the individual's working life.

Professional vocational rehabilitation counselors across New York State in Vocational and Educational Services for Individuals with Disabilities' (VESID) 15 District Offices and 10 satellites help people with disabilities choose careers that are consistent with

their individual strengths, priorities, concerns, abilities, capabilities, interest, informed choices and that meet current and future job market opportunities.

Purchased case services make up the largest single area within VESID's program. Examples of case services include evaluation; training and related supports at such places as community rehabilitation agencies, boards of cooperative educational services (BOCES), trade schools, colleges and universities; transportation; and vehicle modifications. The combination of federal funding (Title I Section 110 of the Rehabilitation Act) and State matching funds supports the entire VESID program including vocational counseling, purchased case services, unified contract costs, related administrative costs and indirectly applied charges. Federal funding is formula driven. State case services funding is required in concert with the basic federal award to meet the costs of VESID's increasing demand for services, and to meet the federal matching and maintenance of State effort requirements..

The following are some of the highlights of VESID's 2007-2008 accomplishments in meeting its goals:

- 13010 people with disabilities received assistance in obtaining employment.
- 9,492 people were placed in integrated employment with no supports, including self-employment.
- The number of individuals placed in supported employment or integrated employment with supports increased from 2,951 in SFY 2006-2007 to 2,973 in SFY 2007-2008.

**REGENTS GOALS:** 3; 4; 5; 6

**AUTHORITY:**

**Federal Statute:** Rehabilitation Act - Title I  
**Federal Regulation:** 34 CFR 361 Et. Seq.  
**State Statute:** Education Law Sections 1001-1008  
**State Regulation:** 8NYCRR Parts 246 and 247

**FUNDING SOURCE(S):**

State- 30.6%  
Federal- 69.4%  
Special Revenue- 0%  
Total- \$178M

NUMBER OF INDIVIDUALS SERVED: 96,181

**CONTACT OFFICE 1:** Administration and Operations  
**TELEPHONE:** (518) 486-4038 **FAX:** (518) 486-4154

**PROGRAM:** Early Childhood Direction Centers (ECDCs)

**DESCRIPTION:**

ECDCs provide information, training and referral assistance to families and professionals in linking children with disabilities, birth through age five, to needed community services. This includes assistance in securing evaluation and assessment services, preschool special education programs and services, transportation, medical services, funding, social services and parent education/support programs. The Education Department is the single State agency responsible for this Program. The ECDCs assist parents and provide follow-up calls and match children with appropriate services. They respond to requests for information from families, agencies and professionals each year. Information is provided in a neutral manner, so all appropriate options for services are provided, including the option of receiving services in integrated settings with nondisabled peers.

**REGENTS GOALS:** 4; 5; 6

**AUTHORITY:**

**Federal Statute:**

**Federal Regulation:**

**State Statute:**

**State Regulation:**

**FUNDING SOURCE(S):**

State-	22.9%
Federal-	77.1%
Special Revenue-	0%
Total-	\$2.8M

**CONTACT OFFICE 1:** Program Development and Support Services

**TELEPHONE:** (518) 486-7462

**FAX:** (518) 473-5769

**PROGRAM:** Education of Children with Disabilities – Preschool and Summer Programs

**DESCRIPTION:**

§4410 Preschool Services

Pursuant to federal IDEA and §4410 of Education Law, school districts are responsible for assuring the provision of special education services to eligible preschool children with disabilities (ages 3-4 years). Counties contract with approved programs and service providers selected by local boards of education and make 100 percent payment to providers. Pursuant to Chapter 642 of the Laws of 1996, counties are reimbursed by the State for 59.5 percent of the approved costs for services.

#### §4408 Summer School Services

Children with disabilities, ages 5-21 years, may receive special programs and/or services during July and August, if recommended by the Committee on Special Education to prevent substantial regression. The county of residence is responsible for 10 percent of the cost and the local school district is responsible for 20 percent of the cost. The State is responsible for the remaining 70 percent of the cost. Costs incurred for services provided during July and August to children with disabilities in the State schools in Rome and Batavia and the State-supported §4201 schools are included. Also included in this account are payments for students receiving July/August special education services who are placed in Office of Mental Health residential treatment facilities. Pursuant to Chapter 82 of the Laws of 1995, beginning in 1995-1996, no single payee may receive more than 45 percent of the appropriation for this Program. In addition, no payments will be made after July 1, 1996 based on a claim submitted later than three years after the end of the school year in which services were rendered except in cases where such payment is the result of a court order, judgment, or final audit.

**REGENTS GOALS:** 1; 2; 5; 6

**AUTHORITY:**

**Federal Statute:** IDEA, Part B  
**Federal Regulation:** 34 CFR  
**State Statute:** Education Law Sections 4408 and 4410  
**State Regulation:** 8NYCRR Part 200

**FUNDING SOURCE(S):**

State-	100.0%
Federal-	0%
Special Revenue-	0%
Total-	\$946.9M

NUMBER OF INDIVIDUALS SERVED: 63,966

**CONTACT OFFICE 1:** VESID Office of Special Education Services  
**TELEPHONE:** (518) 473-6108      **FAX:** (518) 486-7693

**PROGRAM:** Independent Living Centers (ILCs)

**DESCRIPTION:**

Independent Living is a program providing individual and systems change services through 39 not-for-profit ILCs across New York State. ILCs are nonresidential programs that provide a range of services to support New Yorkers with disabilities with living, learning and working in their communities. ILCs also work to increase program and physical access to all services available to the general public.

ILCs are based on a self-help model and State law requires that the majority of all ILC boards of directors be comprised of individuals with disabilities. ILCs provide an array of services to enable people with disabilities to choose lifestyles and services that maximize their independence and self-direction. Core services include: information and referral, peer counseling, individual advocacy, independent living skills development, personal assistance services, employment housing, transportation and related services.

On the systems level, ILCs have led their local communities in implementing the Americans with Disabilities Act and in program development to support individuals in least restrictive living environments. ILC expertise and services are in high demand and will remain so for the foreseeable future. Two particular populations benefiting from ILC services are youth in transition from school to adult life and individuals seeking supports to leave or circumvent admission to instructional settings.

**REGENTS GOALS:** 3; 4; 5; 6

**AUTHORITY:**

**Federal Statute:** Rehabilitation Act - Title VII  
**Federal Regulation:** 34 CFR 367  
**State Statute:** Education Law Sections 1120-1124  
**State Regulation:** 8NYCRR Part 248

**FUNDING SOURCE(S):**

State-	93.6%
Federal-	6.4%
Special Revenue-	0%
Total-	\$13.9M

NUMBER OF INDIVIDUALS SERVED: 71,200

**CONTACT OFFICE 1:** Independent Living Services Unit  
**TELEPHONE:** (518) 474-2925      **FAX:** (518) 473-6073

**PROGRAM:** Individuals with Disabilities Education Act (IDEA)

**DESCRIPTION:**

IDEA makes it possible for states and local educational agencies to receive federal funds to assist in the education of students with disabilities ages 3-21. In order to remain eligible for federal funds under the law, states must have policies and procedures in effect that comply with federal requirements including, but not limited to, policies and procedures that demonstrate:

- All children and youth with disabilities, regardless of the severity of their disability, will receive a free appropriate public education at public expense.
- Education of children and youth with disabilities will be based on a complete and individual evaluation and determination of eligibility.
- An Individualized Education Program is developed and reviewed annually for every child or youth found eligible for special education.
- To the maximum extent appropriate, all children and youth with disabilities will be educated in the least restrictive environment and a continuum of alternative placements will be available.
- The rights of children with disabilities and their parents are protected through procedural safeguards.
- Children suspected of having disabilities are located through child find procedures.
- Confidentiality of personally identifiable information will be ensured and protected.
- The State has appropriate professional requirements that establish suitable qualifications for personnel providing special education and related services.

The Federal government allocates funds to New York State based on a historical count of children ages 3-21 in the State, adjusted for population and poverty. A portion of the funds is allocated to schools based on the total school enrollment and the district's poverty rate.

Each year, special education services are provided to approximately 83,040 students with disabilities, ages 3-5, and 390,675 students with disabilities, ages 6-21. Federal discretionary dollars support initiatives such as statewide training and resources networks, parent centers, general oversight and monitoring activities, quality assurance and federal compliance.

**REGENTS GOALS:** 3; 4; 5; 6

**AUTHORITY:**

**Federal Statute:** Individuals with Disabilities Education Act, Part B, 601-682, as amended, PL 108-446

**Federal Regulation:** Title 34 CFR 300

**State Statute:** Article 89, Article 81

**State Regulation:** 8NYCRR Parts 200 and 201

**FUNDING SOURCE(S):**

State- 0%  
Federal- 100%  
Special Revenue- 0%  
Total- School Age Total - \$712M; Preschool Total - \$34M

NUMBER OF INDIVIDUALS SERVED: 452,286

**CONTACT OFFICE 1:** VESID Special Education Policy Unit

**TELEPHONE:** (518) 473-2878 **FAX:** (518) 473-5387

**PROGRAM:** Supported Employment

**DESCRIPTION:**

Through the passage of Chapter 515 of the Laws of 1992, integrated employment, including supported employment, is implemented through a collaborative interagency process. This legislation designated Vocational and Educational Services for Individuals with Disabilities (VESID) as having the primary responsibility for the coordination of program development and administration of integrated employment. VESID accomplishes this in collaboration with its interagency partners through innovative approaches directly with business, industry and labor and through enhancements in the provision of supported employment services. Collaboration with interagency partners to implement the State's workforce development efforts is also critical.

Supported employment provides job-based training and support services to individuals with the most significant disabilities to enable them to obtain and maintain competitive employment in integrated work settings in the community. For administrative and funding purposes, the Program is conceived as having two phases: intensive and extended services. Intensive services assist individuals to obtain jobs and become proficient in the performance expectations of an employment setting. Extended services provide individuals with the services and supports needed for the long-term retention of their employment upon completion of their intensive training phase.

**REGENTS GOALS:** 4; 5; 6

**AUTHORITY:**

**Federal Statute:** Rehabilitation Act  
**Federal Regulation:** 34 CFR Parts 361, 363  
**State Statute:** Education Law Section 1004  
**State Regulation:** 8NYCRR Parts 246 and 247

**FUNDING SOURCE(S):**

State-	92.4%
Federal-	7.6%
Special Revenue-	0%
Total-	\$17.5M

NUMBER OF INDIVIDUALS SERVED: Extended - 4,500; Intensive - approximately 5,000 a year with 3,000 at any given time

**CONTACT OFFICE 1:** Vocational Rehabilitation Operations

**TELEPHONE:** (518) 486-4031

**FAX:** (518) 473-6073

**PROGRAM:** New York State Schools for the Blind and for the Deaf

**DESCRIPTION:**

The New York State School for the Blind (NYSSB) at Batavia provides 12-month educational and residential services to students who are blind and have additional disabilities. NYSSB offers a day program along with a five-day residential option. Consideration for admission to the school is given to school-age students (5 - 21 years of age) who are blind, residents of New York State and who have an additional disability. A Multidisciplinary Team (MDT), acting in coordination with the Committee on Special Education (CSE) from the district of residence, reviews the individual evaluation conducted at the school, develops an Individualized Education Program (IEP) and determines the Least Restrictive Environment (LRE). The Program addresses The New York State Learning Standards and Alternate Performance Indicators for Students with Severe Disabilities.

The school conducts the annual registration of all students in New York State classified as legally blind for procurement of special media materials produced by the American Printing House. This annual census is used to determine New York State's eligibility for Federal Quota Funds used to purchase these specialized materials and textbooks in alternate formats. The school facilitates the purchase of these specialized products and also maintains and circulates a library of textbooks in large print and Braille to students throughout the State. It offers weekend and week-long short-term, skill-based programs to students classified as legally blind that attend programs in their local school district. The school circulates resource information, as needed, to school district personnel and to teachers of the visually impaired throughout the State. A variety of training opportunities are offered to district staff that provides services to students.

The New York State School for the Deaf (NYSSD) at Rome provides 10 and 12-month educational and residential services to students who are deaf. NYSSD offers a deaf infant program (birth to age 3) that provides home-based services, a day program and a

five-day residential option. Consideration for admission to the school is given to students, ages 3 through 21, who are deaf and residents of New York State. A MDT, acting in coordination with the CSE from the district of residence, reviews the individual evaluation conducted at the school, develops an IEP and determines the LRE. The school offers an elementary unit that provides appropriate educational programs to students ages 3 through 13; a high school unit that provides educational services to students ages 14 through 21; an alternative education program that includes job and life skills training to transitioning students 14 through 21 years of age; and a Cochlear Implant Program, along with early intervention services for deaf infants under 3 years of age. NYSSD is proud of its wide array of after class activities and interscholastic sports teams.

**REGENTS GOALS:** 1; 3; 5; 6

**AUTHORITY:**

**Federal Statute:**

**Federal Regulation:**

**State Statute:** Education Law Sections 4301-4357

**State Regulation:** 8NYCRR Part 200

**FUNDING SOURCE(S):**

State-	1.2%
Federal-	0%
Special Revenue-	98.8%
Total-	\$19.7M

NUMBER OF INDIVIDUALS SERVED: 57 NYSSB and 89 NYSSD = 146

**CONTACT OFFICE 1:** School for the Blind at Batavia

**TELEPHONE:** (585) 343-5384                      **FAX:** (585) 344-5557

**CONTACT OFFICE 2:** School for the Deaf at Rome

**TELEPHONE:** (315) 337-8400                      **FAX:** (315) 336-8859

**PROGRAM:** Readers Aid Program

**DESCRIPTION:**

Eligible students who are deaf, deafblind, or blind; are residents of New York State; and are matriculated in a degree-granting program may receive a monetary grant to employ readers, notetakers, or interpreters to provide access to information vital to their studies, enabling them to succeed in their academic undertaking. During the 2007-2008

academic year, 411 students attending 41 institutions of higher education received Readers Aid Program funds; 215 were deaf, 222 were blind, and 4 were deafblind.

**REGENTS GOALS:** 3; 4; 5; 6

**AUTHORITY:**

**Federal Statute:**

**Federal Regulation:**

**State Statute:** Education Law Section 4210

**State Regulation:** 8NYCRR Part 147

**FUNDING SOURCE(S):**

State- 100%

Federal- 0%

Special Revenue- 0%

Total- \$0.3M

NUMBER OF INDIVIDUALS SERVED: 421

**CONTACT OFFICE 1:** Program Development and Support Services

**TELEPHONE:** (518) 474-5652

**FAX:** (518) 473-5769

**PROGRAM:** Social Security Reimbursement Account

**DESCRIPTION:**

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) assists eligible Social Security beneficiaries by providing them with work preparation, employment placement and counseling services. The Social Security Administration is authorized by law to pay for vocational rehabilitation services for Social Security Income (SSI) and Social Security Disability Insurance (SSDI) recipients who become employed and no longer receive Social Security disability benefits. VESID files claims to receive reimbursement for the cost of each of these individual's rehabilitation services.

**REGENTS GOALS:** 3; 5

**AUTHORITY:**

**Federal Statute:** Federal Social Security Act

**Federal Regulation:**

**State Statute:**

**State Regulation:**

**FUNDING SOURCE(S):**

State-	0%
Federal-	100%
Special Revenue-	0%
Total-	\$4.5M

NUMBER OF INDIVIDUALS SERVED: 40,000

**CONTACT OFFICE 1:** Fiscal and Administrative Services Team

**TELEPHONE:** (518) 486-4038

**FAX:** (518) 486-1027

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# Transition Services:

## A Planning and Implementation Guide

January, 1993

Dear Colleague:

The inclusion of transition services in Article 89 of the Laws of New York State, as amended by Chapter 699 of the Laws of 1993, affirms the *Individuals with Disabilities Education Act* (IDEA). Educators, parents and students are now provided with the opportunity and methods to prepare secondary students with disabilities for living, learning, working, and participating much more successfully in the community as adults.

This booklet contains guidelines for helping you to implement a planning process that enhances the results of the individualized education program (IEP) for each student with a disability in your district. The process enables parents, students, adult agency representatives, and other members of the school and community to work together in new ways to develop and carry out services that help students make successful transitions to adult life.

Transition principles parallel the initiatives of the Board of Regents as stated in the *New Compact for Learning* and the *Policies on Linking Services for Individuals with Disabilities*. We look forward to working with you to reexamine and strengthen the services that

are provided to students with disabilities with a focus on preparing them to achieve their goals for integrated employment, post secondary education and community living.

Sincerely,

Thomas Neveldine  
Executive Coordinator  
for Special Education Services  
Office of Elementary, Middle  
and Secondary Education

Edmund Cortez  
Assistant Commissioner  
for Policy and Program Development  
Office of Vocational and Educational  
Services for Individuals With Disabilities

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## I. INTRODUCTION

- |                                       |  |
|---------------------------------------|--|
| <b>What does this handbook cover?</b> | The purpose of this guide is to summarize the key components of transition services and to assist districts with planning and implementing the new federal and State requirements under the Individuals with Disabilities Education Act (IDEA) and Article 89 of New York State Education Law. The handbook highlights applicable law and regulations and provides a logical process that addresses the requirements for transition services for special education students. Boxed material contains State and/or federal requirements that pertain to transition, with new language highlighted in bold print. The appendices provide sample documents to assist with this process. |
| <b>Why plan for transition?</b>       | Transition into the adult world can present challenges for all young people. The process of transition is more difficult for many youth with disabilities and requires unique strategies to enable each student to achieve the maximum possible independence in working, living and participating in the community as adults.  |
| <b>What are transition services?</b>  | The IDEA and Article 89 define transition services as a coordinated set of activities which are designed to prepare the student for outcomes that are envisioned for the student in adult life. Outcomes may   |

include postsecondary education, employment, vocational training, adult education, adult services, independent living, and community participation. The set of activities for each student needs to be based on the student's individual needs, preferences, and interests. The activities must include instruction, community experiences, and development of employment or other post-school adult living objectives.

**What students receive these services?**

As part of their Individualized Education Program (IEP) all secondary education students with disabilities, ages 15 through 21, and younger if determined appropriate, who are eligible to receive special education services must be provided with transition services. For students younger than age 15 who are considered to be at risk of dropping out of school, or who could benefit from transition services, this process should be initiated earlier. The transition planning process must be delivered in a manner that is sensitive to the participation of students and their families from all cultural and linguistic backgrounds.

**When must districts comply?**

School districts are currently required to provide transition services for all students with disabilities aged 15 to 21. Key laws and regulations are summarized below:

- The New York State Board of Regents, through its *Policies for Linking Services for Individuals with Disabilities* (1990) required transition planning and services for students with disabilities, including both those who are served in special education and those served through regular education.
- The IDEA amendments became effective in 1990 and included a requirement for districts to provide transition services for all students with disabilities age 16 and older. (20 USC 1401(a)(19))
- The federal regulations implementing the IDEA, which were published on September 29, 1992, require districts to provide transition services to all students with disabilities aged 16-21, or younger if the student is thought to be at risk. (34 CFR 300.18 and 300.346 (b))
- In August, 1993, Article 89 of NYS Education Law was amended to include transition services. (NY Educ. L. Sec 4401 (2)(7) and (9))

- In September, 1993, the NYS Board of Regents passed State regulations conforming with federal requirements for transition services. (8 NYCRR 200.1 (rr), 200.4 (C)(2)(V), and 200.4 (f)(2)(iv)(b)(4))

**Are federal and State requirements for transition services consistent?**

Federal and State requirements defining transition services for students with disabilities are consistent. The key difference is that New York State requires that transition services be provided by age 15 rather than 16, as federal law provides.

**How can districts initiate the process?**

Districts are advised to develop a strategic plan for incorporating transition services within the Individualized Education Program (IEP) process. To implement transition planning and services, the CSE will need a method for identifying post-school outcomes for each student and for incorporating activities in the IEP that prepare the student to fully participate in adult life in the community.

**What is the intent of this requirement?**

The transition planning and service process encourages Committees on Special Education to look beyond the traditional educational focus of the IEP. The intent of transition planning is to enable youth with disabilities to live, work, and continue to learn in the community with supports if necessary as adults. The process of developing transition plans involves the following quality components:

- Students are actively involved in transition planning and are supported in achieving their desired adult goals.
- Family members and other community service agencies, as appropriate, are informed, involved, and invested in transition planning.
- Transition planning addresses services and supports across all areas of one's life.
- A documented, sequential process is followed.
- Services and supports are provided in a timely manner as specified in the IEP, as agreed to by the student and family.

- Unmet needs are identified and addressed through an ongoing commitment to each person.
- The accomplishment of outcomes is measured in terms of students successfully achieving their post-school living, learning and working goals.
- Services provide maximum inclusion for students from linguistically and culturally diverse backgrounds.

Paragraph adapted from Onondaga Council, 1992

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## II. LAWS, REGULATIONS AND POLICIES

### Special Education Definition.

"**Special Education**" means specially designed individualized or group instruction or special services or programs, as defined in subdivision 2 of section 4401 of the Education Law, provided at no cost to the parent, to meet the individual needs of students with disabilities.

1. Such instruction included but is not limited to that conducted in classrooms, in homes, hospitals and institutions, and **in other settings**.

(8 NYCRR 200.1(kk); see also 34 CFR 300.17)

"Special services or programs" include:

- a. Special classes, transitional support services, resource rooms, direct and indirect consultant teacher services, **transition services...**, home instruction, and special teachers to include itinerant teachers as provided by the schools of the district of residence with such terms and services to be defined by regulations of the commissioner.

(NY Educ L 4401 (2)(a))

**Transition  
Services  
Definition.**

**"Transition Services" means a coordinated set of activities for a student with a disability, designed within an outcome oriented process, that promotes movement from school to post-school activities, including, but not limited to, postsecondary education, vocational training, integrated competitive employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities must be based on the individual student's needs, taking into account the student's preferences and interests, and shall include needed activities in the following areas:**

- 1. instruction;**
- 2. community experiences;**
- 3. the development of employment, and other post-school adult living objectives; and**
- 4. if appropriate, acquisition of daily living skills and functional vocational evaluation.**

(8 NYCRR 200.1(rr); see also 34 CFR 300.18)

As a result of these changes in definition of special education in federal and State law and regulations, transition services in community settings may be funded as special education services.

**Federal  
Comments and  
Interpretations**

Notes to federal regulations (34 CFR 300.18) indicate that:

- Transition services may be special education if they are specially designed instruction, or related services, if they are required to assist a student with a disability to benefit from special education.
- The list of "activities" is not intended to be exhaustive but are only examples of different types of post-school activities.

The Secretary of Education defines key terms in the provision of transition services as follows:

- The term "coordinated" means both
  1. the linkage between each of the component activities that comprise transition services, and
  2. the interrelationship between the various agencies that are involved in the provision of transition services to a student.

- The term outcome as used in the phrase "outcome-oriented process", refers to the results, or intended effect, of the activities on a student.

### **Related Services Definitions**

The definition of related services has been amended to incorporate rehabilitation counseling services. In addition, social work services in schools has been redefined. These changes expand the options for transition services. Key sections are highlighted below.

**Related Services Definition.** **"Related Services"** means speech pathology and audiology, psychological services, physical therapy, occupational therapy, counseling services, **including rehabilitation counseling services**, medical services as defined in this section, parent counseling and training, school health services, school social work, other appropriate developmental or corrective support services, appropriate access to recreation and other appropriate support services.

(8 NYCRR 200.1 (gg); see also 34 CFR 300.16)

To define specific related services for New York State students who are classified as having a disability, the State relies on the wording found in the federal regulations. The definitions for rehabilitation counseling and social work services are provided below.

**Rehabilitation Counseling is a new Related Service.** **"Rehabilitation counseling services"** means **services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability. The term also includes vocational rehabilitation services provided to students with disabilities by vocational rehabilitation programs funded under the Rehabilitation Act of 1973, as amended.**

(34 CFR 300.16)

**Social Work as a Related Service has been** **"Social work services in schools"** includes preparing a social or developmental history on a child with a disability; group and individual counseling with the child and family; working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school; and **mobilizing school and community resources to**

**expanded.**            **enable the child to learn as effectively as possible in his or her educational program.**

(34 CFR 300.16)

Note additionally that in New York State, rehabilitation teaching and orientation and mobility training for students with legal blindness are considered related services.

### **Content of the Individualized Education Program**

The federal and State regulations describe how the content of the Individualized Education Program (IEP) must address needed transition services, including district and other participating agency responsibilities. In addition, New York State law and regulations reinforce the decision of the New York State Board of Regents, as stated in the *1990 Policies for Linking Services for Individuals with Disabilities*, to provide transition planning and services for all students with disabilities beginning at age 15. The effect of this change in New York State is that at age 15, or earlier if appropriate, a shift should occur in the focus of a student's IEP to holistically address transition throughout the student's educational program. The IEP should include long term adult outcomes from which annual goals and objectives are defined.

#### **IEP Content Shall Indicate...**

- i. ... present levels of performance and ... the individual needs of the student...
- ii. ... classification of the disability;
- iii. ... annual goals that are consistent with the student's needs and abilities and short-term instructional objectives and evaluative criteria, evaluation procedures and schedules to be followed during the period beginning with placement and ending with the next scheduled review by the committee. Such short-term instructional objectives shall be measurable, intermediate steps between present levels of educational performance and the annual goals that are established for a student with a disability;
- iv. ... the recommended program ... the class size, if appropriate, and the extent to which the student will participate in regular education programs, including:
  - a. physical education or adaptive physical education;
  - b. occupational education, if appropriate; and
  - c. the regular education classes in which the student will receive consultant teacher services.
- v. **... for those students age 15 (and at a younger age, if determined appropriate) a statement of the needed transition services ... including, if applicable, a statement of the responsibilities of the school district and participating agency for the provision of such services and activities that promote movement from school to post school opportunities, or both, before the student leaves the school setting. Activities shall be provided in each area (instruction, community experiences, and the development of employment and other post-school living objectives) or the recommendation shall state the**

**reasons upon which the determination was made that such activities are not needed in each area;**

- vi. ... projected date for initiation of special education and related services, the amount of time per day the student will receive such services, whether the student is eligible for a twelve-month special service and/or program and the identity of the provider of services during the months of July and August, and the projected date of the review of the student's need for such services;
- vii. ... any specialized equipment and adaptive devices needed for the student to benefit from education;
- viii. ... those testing modifications to be used consistently by the student in the recommended educational program; and
- ix. ... the recommended placement.

(8 NYCRR 200.4(c)(2); see also 34 CFR 300.346)

- The inclusion of transition services on IEP's applies to all eligible students including those who are placed in other settings pursuant to Education Law Section 4005 (8 NYCRR 200.4 (f)(2)(iv)(4)). Section 4005 addresses the obligation of CSE's to develop an IEP for students referred by a Family Court judge, a probation department, a social services district, the Division for Youth, or a preadmission certification committee established under section 9.51 (d) of the Mental Hygiene Law.
- Transition services should be designed to systematically prepare students to pursue their desired long term adult outcomes through a variety of activities including instruction, community experiences, and the development of employment or other post-school adult living objectives, and, if appropriate, activities of daily living and functional vocational evaluation. When such activities are considered special education, statements of annual goals and objectives in the IEP will incrementally address the development of skills. The IEP will also reflect that assistance is being provided for students to connect to appropriate adult service systems. The IEP should describe the mutual roles and responsibilities of the school districts and participating agencies. In response to questions from the field regarding how these various levels of required detail will be addressed in an IEP, the following approach is suggested:
  - **Long term adult outcomes** = Long term adult outcome statements in the IEP will reflect the student's employment, postsecondary education, and community living aspirations. Options may include the post-school activities listed in the transition services definition: i.e., ... including postsecondary education, vocational training, competitive integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. Outcomes should be specific to each student's unique needs, preferences, and interests.

- **Statement of transition services** = A statement of transition services that is responsive to the student's needs, preferences and interests should specify the service and/or funding source for the service and the participating agency providing the service. The beginning date for the service should be provided if the date of initiation is different than the date of initiation for the IEP.
- **Annual goals and objectives** = Annual goals and objectives for special education will incrementally address the long term adult outcomes. The following 10 areas, as appropriate to the individual student's needs, preferences and interests, should be considered when planning activities and services that address annual goals: education, legal/advocacy, personal independence/residential, recreation/leisure, financial/income, medical/health, employment, transportation, post-secondary/continuing education, and other support needs.
- **Coordinated Set of Activities** = The IEP, as a whole, must demonstrate the use of varied strategies, i.e, instruction, community experiences, and the development of employment or other post-school adult living objectives as the means by which the student can achieve the long term adult outcomes. If one of these activities is not included in the IEP in a particular year, then the IEP must explain why that activity is not reflected in any part of the student's program. Activities of daily living and functional vocational evaluation activities should also be included where appropriate to the student's needs.

### **Participants Involved In Planning for Transition Services**

Whenever transition services are discussed at Committee on Special Education (CSE) meetings, the school district must ensure participation of students and families, as well as participation of those agencies that may provide transition services.

#### **Composition of the Committee on Special Education**

The board of education or trustees of each school district, shall establish committees on special education, as necessary to ensure timely evaluation and placement of pupils.... Such committees shall be composed of at least the child's teacher as defined by applicable federal regulations, a school psychologist, a representative of such school district who is qualified to provide or administer or supervise special education, a school physician, a parent of a handicapped child residing in the school district, provided such parent shall not be employed by or under contract with the school district, and such other persons as the board of education or the board of trustees shall designate. The school physician need not be in attendance at any meeting of the committee on special education unless specifically requested.... The committee shall invite the appropriate professionals most familiar with a child's handicap or handicaps to attend any meeting concerning the education program for such child.

(NY Educ L 4402(1)(b)(1))

**CSE  
Participation**

Such (IEP) recommendations shall be developed in meetings of the committee on special education. The student's parent and, where appropriate, the student shall be given an opportunity to attend the meeting. Meeting locations must be physically accessible. The committee shall ensure that the parent understands the proceedings of the meeting and shall arrange for the presence of an interpreter, if necessary.

Placement shall be based on the student's individualized education program and determined at least annually....

If the recommended placement is to be in a school operated by an agency or school other than the school district in which the student would normally attend if the student did not have a disability or if the education of a student residing in a facility operated or supervised by a State department or agency is the responsibility of the school district, a representative of that agency or school shall be given the opportunity to attend. In the event that such persons are unable to attend such meetings, the committee shall attempt alternative means allowing for their participation, such as individual or conference telephone discussions, and such attempts shall be documented....

(8 NYCRR 200.4(c)(3))

**IEP meeting  
participants if the  
IEP meeting will  
discuss transition.**

**If a purpose of the meeting is to consider the need for transition services, the school district shall invite the student and a representative of the agencies likely to be responsible for providing or paying for transition services.**

- i. **If the student does not attend, the district shall take steps to ensure that the student's preferences and interests are considered.**
- ii. **If an agency invited to send a representative to a meeting does not do so, the district shall take steps to involve the other agency in the planning of any transition services.**

(8 NYCRR 200.4(c)(4); see also 34 CFR 300.344)

**Definition of**

**"Participating agency" means a State or local agency, other than the public agency responsible for a student's education, that is financially and legally responsible for providing transition services to the student.**

## Participating Agency

(8 NYCRR 200.1 (ss))

Prior to the CSE meeting to determine transition planning, CSE members should have knowledge of the services provided by any participating agency expected to send a representative. This will enable the CSE to invite appropriate agencies to participate in discussions regarding the provision of transition services for each student.

Existing provisions of State and federal regulations provide that in addition to annual reviews, if the parent, teacher, school administrator, or agency administrator believe that a placement or program recommended in the IEP is no longer appropriate, the individual may refer the student to the CSE for a review. The student's current placement remains the same pending the development of a new recommendation, unless other arrangements are mutually agreed upon by the board of education and the parent. Similarly, the CSE must reconvene to consider other strategies to meet the transition objectives, should the participating agency fail to deliver agreed upon services.

**What if the participating agency fails to provide services as planned?**

**If a participating agency fails to provide agreed-upon transition services contained in the student's IEP, the district responsible for the student's education shall, as soon as possible, initiate a meeting to identify alternative strategies to meet the transition objectives, and if necessary, revise the student's IEP. Nothing in this Part shall relieve any participating agency of its responsibility to provide or pay for any transition service that the agency would otherwise provide to students with disabilities who meet its eligibility criteria.**

(8 NYCRR 200.4 (3); see also 34 CFR 300.347)

## Notification Requirements

Under existing regulations, the committee on special education must notify parents when an initial evaluation, review or reevaluation is being conducted. Notices must be received by parents at least five days prior to a meeting of the CSE and must indicate the date, time, location and the name and title of people expected to attend the meeting. Parents must be informed of their opportunity to participate, and that they have the right to request an interpreter, translator or reader at the meeting and to be accompanied by such individuals as they wish to invite. The notice must notify the parents of their rights to review records and to appeal if they disagree with the CSE's recommendations. The notification letter must be written in the primary language of the parents, and alternative steps must be taken to ensure the parent understands the content of notices if the parent's principal mode of communication is not a written

language. All due process procedures under Section 200.5 of the Regulations of the Commissioner apply to transition planning and the provision of services.

When the purpose of the meeting is to discuss and plan for transition services, the notice to the parents must also specify this purpose, and indicate that the student and participating agencies have been invited. The student must be invited separately. A sample notice letter to the parent and the student is included in the appendix.

**Notice requirement when transition will be discussed.**

**If the purpose of the meeting is to consider transition services, the notice must also:**

- a. **indicate this purpose;**
- b. **indicate that the district will invite the student; and**
- c. **identify any other agency that will be invited to send a representative.**

**(8 NYCRR 200.5 (1)(a)(xii); see also 34 CFR 300.345)**

**Federal regulations indicate options if parents can't attend the meetings.**

- If neither parent can attend, the district shall use other methods to ensure parent participation, including individual or conference telephone calls.
- A meeting may be conducted without a parent in attendance if the district is unable to convince the parents that they should attend. In this case the district must have a record of its attempts to arrange a mutually agreed on time and place such as: detailed records of telephone calls made or attempted and the results of those calls; copies of correspondence sent to the parents and any responses received; and detailed records of visits made to the parent's home or place of employment and the results of those visits.

**(34 CFR 300.345)**

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### **III. STUDENT AND FAMILY PARTICIPATION**

Effective planning for transition services necessitates involving the student and family to the greatest degree possible in determining what the IEP should address. Involvement is critical for developing transition services that truly meet the needs of the student. Listed below are steps that families can take to assist the process at home and in conjunction with the school.

**What are the roles of students and families in transition generally?**

- Help school and other personnel to increase their awareness of how to work effectively with families.
- Explore and let others know about useful community resources.

Advise the CSE regarding community values and opportunities that should be considered in the planning process.

- Inform other families about transition options.
- Providing peer support to other parents.

Adapted from California Transition Guide

**What is the role of the student in planning for transition services?**

- Look for information about occupational, educational and living options; talk with people; and try new experiences to develop awareness of student needs, preferences and interests for the future.
- Work with the school and the family to find ways to increase student academic, career, and personal independence skills.
- Make informed choices and set achievable goals.
- Develop the ability to communicate needs, preferences and interests to the family, school staff, and other professionals.
- Learn the kinds of things a student can do independently and the kinds of things where assistance is needed. Develop the ability to explain to others the kinds of help which are useful.
- Participate actively in meetings with the school and other professionals. Learn to contribute ideas as well as to listen to the ideas of others. Follow through on plans that have been agreed upon. Ask questions or share information with the teacher or guidance counselor throughout the student's program.

Adapted from California Transition Guide

**What is the role of**

- Plan and prepare for future financial, medical and housing resource needs, as appropriate by: (a)

**families in  
planning for  
transition  
services?**

assisting with application for Social Security Disability or Supplemental Security Income (SSI) benefits; (b) developing a will; (c) determining guardianship; (d) applying for financial aid for post-secondary education or training.

- Assist the student to obtain key identification documents, as appropriate: e.g., a social security card; driver's license or non-driver identification card.
- Help the student develop independent decision-making and communication skills, by helping the student explore options, set realistic goals for the future and developing the ability to communicate these to school staff.
- Support positive self-esteem and assist the student to develop independence, including self-reliance, self-advocacy and self-management skills.
- Use home-life opportunities to assist in teaching the student daily living skills: e.g., banking, shopping, cooking, cleaning, laundry. Promote good money management, budgeting, and saving by the student.
- Encourage the student to become aware of the world of work, such as by talking with neighbors and family about their job experiences or by helping the student to locate and obtain a part-time job.
- Reinforce work-related behaviors at home (grooming, etiquette, following directions, completing chores, etc.).
- Provide opportunities for leisure time activities such as participation in sports, daily exercise, or hobbies, and encourage student social activities with peers. Teach the student how to access community-based resources (library, recreation, transportation, stores, etc.)
- Work actively with the CSE to plan and monitor the effectiveness of the student's transition program. Attend CSE and other meetings and communicate with school personnel to contribute information about the student's life skills, interests, aptitudes, progress and needs. Follow up and complete activities for which the student and family are responsible. Contact the student's teacher with any questions or to share further information as the program unfolds.

Adapted from California Transition Guide

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## IV. STEPS IN THE IEP PROCESS WHEN TRANSITION SERVICES ARE CONSIDERED

To assist school districts in coordinating transition planning and services, following is an outline of actions recommended at key points in the process.

### Creating the Climate

- a. *Identify resources, programs, and options available within the school and the community.*
  - o Many resource directories are available that describe such services. Check with your regional Transition Coordination Site, Special Education Training Resource Center (SETRC), or local social service organizations. Local agencies can typically be found in the yellow pages of the phone book under "Social and Human Services."
  - o Consider involving students in this task, to build their research and self-direction skills, while benefitting the district in terms of building a list of potential resources.
- b. *Identify and orient potential participants to the process, roles, responsibilities, and purpose, including:*
- c. *District Staff (e.g., teachers, guidance personnel, CSE members and others).*
  - o Provide key district staff with training and orientation regarding: networking; the collaborative service delivery process; how to apply vocational assessment information; how to work with students and parents, businesses, and community service agencies; and curriculum planning.
- d. *Parents and Students.*
  - o Help students and their parents identify goals and interests; identify possible adult service options and resources; obtain signed consent when sharing information to enable districts to consult with public and private agencies as needed; and explain to parents and students their role in the transition process. (Note: pre-planning with these participants is critical to the success of the meeting and the completeness of the IEP.)
- e. *Community Service Providers and Representatives of local and State agencies.*
  - o Help other service representatives understand the educational service system, including: law, regulations and policies relating to transition services; roles and responsibilities of families and district personnel, roles of local or regional interagency planning teams; and the roles now expected of other service agencies in the transition process.

### Before the Meeting, the CSE should:

- a. Send letters to parents, students, appropriate staff and public and private agencies explaining how the meeting will address transition services. Include a checklist for student and family to identify needs, preferences and interests for discussion at the meeting.
- b. Schedule meetings and send notices.
  - o Invite the student to attend.
  - o When transition services is the topic, notify parents of the purpose of the meeting, indicate that the student is invited to attend, and that participating agencies are invited to send a representative.
  - o Consider scheduling meetings on specific students to coincide with service planning schedules of adult service agencies (e.g., Office of Vocational and Educational Services for Individuals with Disabilities, Commission for the Blind and Visually Handicapped). This may avoid the need for families being asked to meet with every agency separately, and increase collaboration in service planning.
- c. Compile and review information regarding: student needs, preferences and interests; previous evaluation information (including vocational assessment); teacher recommendations; annual guidance reviews; student aptitudes and accomplishments, plus any other information, including family and student goals.
- d. Prepare a suggested list of service options to address skill development or resource planning concerns. Consider which of the following activities will be useful in meeting the student outcomes noted in the IEP.
  - i. Instruction;
  - ii. Community Participation;
  - iii. Development of Employment/Postsecondary Education Objectives;
  - iv. And if appropriate,
    - Activities of Daily Living (ADL) development, and
    - Functional Vocational Assessment.

### **During the Meeting**

- a. *Make introductions.*
  - o Introduce CSE members, students, families, other participating agency representatives to each other.
  - o Explain the reasons for transition planning and services and the anticipated roles and responsibilities of participating agency representatives.
- b. *Select Priority Student Outcomes.*
  - o Discuss student needs, preferences and interests from all participant perspectives.

- Review present levels of performance.
- Determine long term adult outcomes, skill development and resource concerns, and possible methods.
- c. *Identify Opportunities to Achieve Adult Outcomes.*
  - Determine what differences exist between WHAT IS (present level of performance) and WHAT SHOULD BE (vision) in order to pursue adult outcomes.
  - Choose activities to eliminate/reduce barriers, increase opportunities and/or create programs or services to achieve long term adult outcomes.
- d. *Identify Transition Services and Incremental Annual Goals and Objectives.*

Develop transition services and the annual goals and objectives that guide the provision of special education. This will incrementally build toward long term adult outcomes.

- e. *Identify Supports.*

Identify resources, programs, services, or supports to achieve both long term outcomes and annual goals.

- f. *Develop Individualized Education Program (IEP).*
  - Specify needed transition services.
  - Write short term objectives.
  - Determine and specify responsibilities (include participating agencies).
  - Establish timelines (initiation, duration, annual review).
  - Review the IEP to insure that activities have been provided in each of the areas of instruction, community experiences and employment; if not, a statement should be provided for the basis of this decision.
  - If within 2 years of the student's planned exit from school and where VESID/CBVH services are likely to be needed, coordinate development of the IEP with VESID/CBVH Individualized Written Rehabilitation Program (IWRP).

## **After the Meeting**

- a. *Implement IEP.*
  - Arrange for specific activities as described in the IEP.
  - Provide skills training, knowledge, experiences and supports to the student.

b. *Monitor Outcomes.*

- Maintain ongoing communication with student, family teachers, and service providers.
- Periodically review and monitor progress toward meeting goals.
- Determine if participating agencies are providing and/or paying for agreed upon services.

If a participating agency fails to provide agreed-upon transition services contained in the student's IEP, the district responsible for the student's education shall, as soon as possible, initiate a meeting to identify alternative strategies to meet the transition objectives, and if necessary, revise the student's IEP.

- Compile information regarding the quality and effectiveness of services provided by agencies and the methods used. Refer to this information as a basis for future planning.

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## V. TRANSITION PLANNING TIMELINE

From an individual student perspective, the following is a series of events that may need to be considered during the student's transition process. All items will not be applicable to all students. The list is provided to serve as an optional planning tool.

<u>Action</u>	<u>Suggested Age Range</u>
_____ Administer initial vocational assessment	12
_____ Discuss the following curriculum areas at IEP meetings:	12-15
• Academic	
• Social	
• Language/communication	
• Occupational	

- Self-help skills
- Self advocacy skills

_____	Develop and implement strategies to increase responsibilities and independence at home.	12-15
_____	Complete periodic vocational evaluations.	12-21
_____	Introduce & discuss Transition Services	14
_____	Notify parents that transition services will be incorporated into the IEP beginning at age 15	14
_____	Assure that copies of work-related documents are available:	14-16
	<ul style="list-style-type: none"> <li>• Social security card</li> <li>• Birth certificate</li> <li>• Obtain working papers (if appropriate)</li> </ul>	
_____	Obtain parental consent so that the appropriate adult agency representative can be involved	14-16
_____	Develop transition component of IEP and annually thereafter	15+
_____	Discuss adult transition with CSE	15-21
_____	Consider summer employment/ volunteer experience	15-20
_____	Explore community leisure activities	15-21
_____	Consider the need for residential opportunities, including completing applications, as appropriate.	15-21

_____	Obtain personal ID card	16-18
_____	Obtain driver's training & license	16-18
_____	Develop Transportation/Mobility Strategies:	16-21
	<ul style="list-style-type: none"> <li>• Independent Travel Skills Training</li> <li>• Public or Paratransit Transportation</li> <li>• Needs for Travel Attendant</li> </ul>	
_____	Investigate SSDI/SSI/Medicaid programs	16-18
_____	Consider guardianship or emancipation	16-18
_____	Develop & update employment plans	16-21
_____	Involve VESID/CBVH, as appropriate, within 2 years of school exit	16-21
_____	Research possible adult living situations	16-18
_____	Investigate post-school opportunities (further educational vocational training, college, military, etc.)	16-18
_____	Seek legal guardianship	18
_____	Apply for post-school college & other training programs	17-21
_____	Male students register for the draft. (No exceptions)	18
_____	Register to vote	18
_____	Review health insurance coverage: inform insurance company of son/daughter disability & investigate rider of continued eligibility	18

Complete transition to employment, further education or training, and community living, affirming arrangements are in place for the following

18-21

1. Post-Secondary/Continuing Education
2. Employment
3. Legal/Advocacy
4. Personal Independence/Residential
5. Recreation/Leisure
6. Medical/Health
7. Counseling
8. Financial/Income
9. Transportation/Independent Travel Skills
10. Other:

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## **VI. VOCATIONAL ASSESSMENT**

Assessment is an ongoing responsibility for the district special education program, beginning with assessing referrals for special education services and continuing throughout subsequent annual reviews. The planning and delivery of transition services includes the

CSE's development of post-school employment objectives based on student needs, preferences and interests. These can be identified through an effective, student-centered vocational assessment process.

**Transition services are defined on the basis of student needs, preferences, and interests.**

The coordinated set of activities must be based on the individual student's needs, taking into account the student's performance and interests; and shall include need activities in the following areas:

1. Instruction;
2. Community experiences;
3. The development of employment and other post-school adult living objectives; and
4. If appropriate, acquisition of daily living skills and functional vocational evaluation.

(8NYCRR 200.1 (rr))

**Vocational assessments are integral to the special education process in the State.**

Students age 12 and those referred to special education for the first time who are age 12 and over, shall receive an assessment that includes a review of school records and assessments, and parent and student interviews to determine vocational skills, aptitudes and interests.

**What is vocational assessment?**

Vocational assessment involves the systematic collection and analysis of information about a student's vocational aptitudes, skills, expressed interests, and occupational exploration history (volunteer experiences, part-time or summer employment, club activities). The collection of this information should also take into account the student's language, culture and family. Based on the student's age, abilities, expressed interests, and needs, an appropriate vocational assessment may include the review of existing school information and the conduct of informal interviews (a Level I type of assessment), the administration of one or more formal vocational evaluations (Level II), or job and student performance analyses made in real or simulated work settings as reported by the student, employer, job coach or vocational evaluator (Level III).

**How does vocational assessment relate to transition planning during the student's school career?**

The vocational assessment process yields information needed by students, families, schools, participating agencies and employers to identify appropriate options and plan for each student's successful post-school transition to integrated employment or post-secondary education. The process should not be used to limit student's educational or career options, but should be designed to allow districts to begin providing developmental opportunities at an earlier age than traditionally has been done. If planned effectively, the cumulative record of vocational assessments and vocational experiences over time will reflect a portfolio of career exploration and the development of a resume of skills and experiences upon which the student can build a viable career.

**How does it ease the transition to other services ?**

The clarity and comprehensiveness of documents reporting vocational assessment and experiences can smooth the transition to adult services and employment by making it unnecessary for such service agencies to request further, duplicative assessments of students as a prerequisite for sponsorship in further training after exiting school. The CSE's early identification of needs, preferences and interests for post-school life can enable adult service agencies to get to know the student prior to school exit and develop appropriate services that will begin on a timely basis, and be coordinated with the student's exit from school.

**Who is responsible for vocational assessments?**

Vocational assessments as needed to plan appropriate transition services are the responsibility of the CSE and the school district. The CSE is responsible for completing a Level I assessment that includes a review of school records, teacher assessments, and parent and student interviews to determine vocational skills, aptitudes and interests of all students with disabilities beginning at age 12 and, as appropriate, annually thereafter. As a result, by the time transition services begin at age 15, the school, family and student should be familiar with the results of Level I vocational assessments and be able to discuss the student's emerging aptitudes, skills and interests at the CSE meeting. The use of different types of vocational assessment depends upon the student's needs determined by the CSE, and may include such additional options as situational assessments, work experience progress reports, or postsecondary education assessments. For students with limited English proficiency, assessments should be conducted in the student's primary language, with preference given to situational types of assessment.

**Level I Assessment is conducted at age 12, then annually, as appropriate.**

The Level I assessment does not require any specialized testing or vocational evaluation instruments, but rather takes a look at the student from a vocational perspective. A trained vocational evaluator, a special education teacher or a guidance counselor knowledgeable of the world of work and the functional implications of disabilities should be assigned by the local school district to collect the Level I assessment data. That individual should gather and analyze existing information: e.g., interview student, parent/guardian, and teachers; review special education eligibility data; and review cumulative records. Assessments could include a review of student aptitudes, achievements, interests, learning styles, behaviors, and occupational exploration activities. The informal student interview might consider vocational interest, interpersonal relationship skills, and adaptive behavior.

**Level II Assessment is conducted at any age, as deemed appropriate by the**

Based upon the information gathered from a Level I assessment and the student's needs, a Level II assessment may be recommended by the CSE at any time to determine the level of a student's vocational skills, aptitudes, and interests. Though it is recommended that a trained vocational evaluator or rehabilitation counselor administer or supervise this level of assessment, an experienced guidance counselor, special education teacher,

**CSE.**

or occupational education instructor can also be trained to conduct the assessment. Collected data should include: interest inventory, perception (visual/auditory/tactile), motor (dexterity, speed, tool use, strength, coordination), spatial discrimination, verbal (reading, writing, speaking, numerical (measurement, money skills), comprehension (task learning, problem solving), attention (staying on task), and learning styles. This should be accomplished through standardized or functional assessment techniques with emphasis placed on the techniques which prove to be most meaningful to the student and accurately reflect ability.

**Level III  
Assessment is  
conducted at any  
age, as appropriate.**

This is a comprehensive vocational evaluation that uses work, real or simulated, as the basis for assessment and vocational counseling. A trained vocational evaluator should administer or supervise this level of assessment. Level III assessment options include:

*Vocational Evaluation* - Acquired abilities, aptitudes and interests are compared with specific performance criteria to predict potential vocational success. Work samples must be valid and reliable.

*Situational Vocational Assessment* - Real work settings are used to enable the student to explore vocational aptitudes, to demonstrate the types of support services needed to enhance optimal performance, or to assist the student to acquire specific skills and abilities. This on-the-job assessment considers what has been learned and how, what aptitudes are demonstrated and what training and support strategies are necessary for developing competencies.

Adapted from Vocational Assessment Guidelines, 1989

**How do reports  
from work study  
experiences fit in?**

A standard reporting mechanism for work-related experiences should be used in vocational assessment and transition planning. This is the responsibility of individuals who supervise students with disabilities in work settings (e.g., rehabilitation counselors, work study coordinators, occupational education personnel, job coaches, employers). The standard mechanism should include a structured observation of performance and behavior, including work behaviors, independence, self-advocacy (rights and responsibilities) and social skills. Progress reports from supervisors or mentors provide information similar to that derived from work samples.

But, as with situational assessments, reports reflect student skills and adjustment observed in real work situations. A sample form is attached in Appendix G, and will be especially helpful to forward to adult agencies who may need to build subsequent employment services based on what the district has initiated.

**What types of assessments are helpful for students who plan postsecondary educational outcomes?**

Students who plan postsecondary educational outcomes may benefit from two types of assessments:

1. General Assessments of Postsecondary Education Skills - These assessments determine general needs, directions, requirements for reasonable accommodations, academic skills, critical thinking skills, social behaviors, interpersonal skills, self-advocacy and self-determination skills, learning strategies, time management or organizational skills. Options to obtain this information may consultation with peers or teachers, or a self-evaluation.
2. Assessments Specific to Field of Study or Setting - Assessments of the student's needs in relation to campus or class settings may identify additional skills or accommodations that must be planned for the student to participate effectively in the specific post-secondary education settings or fields of study (continuing education course vs. two- or four-year college levels, dormitory living vs. commuting, lab work, large lecture vs. seminar courses). Options may include visiting campuses or meeting with experienced students or postsecondary education personnel to obtain advice and information.

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## **VII. CONFIDENTIALITY RELEASE PROCESS: INVOLVING OTHER SERVICE AGENCIES IN PLANNING**

**How is confidentiality related to transition**

Schools are required to invite adult service representatives to participate in transition planning meetings, or otherwise participate in the planning process when the other agencies will provide or fund transition services. This must be accomplished while preserving rights of confidentiality of personally identifiable information under the Family Education Rights and Privacy Act (FERPA), (aka the Buckley Amendment).

## **planning?**

### **What is the purpose of a confidentiality release?**

The parents or guardians may give permission to the school to disclose student information to others by signing a consent to release information form. Disclosure means the release, transfer or other communication of education records, or the personally identifiable information contained in those records. Disclosures covered by the Act include those released by any means including, oral, written or electronic.

### **Discuss confidentiality at orientation.**

To involve the expertise of non-school personnel in the planning process, it is recommended that confidentiality be discussed with families during the orientation phase, and that parents or guardians have sufficient information to give written consent to release student information prior to scheduling the initial transition planning meetings. The expertise, benefits and resources available from the particular agency should be considered in determining whether or not to sign a release permitting other agencies to help with the planning process. It is important that parents understand that signing the release allows for dialogue and consultation, it does not commit the individual or the family to particular services if they later decide they don't want them.

### **Points to keep in mind.**

A sample consent form is contained in the Appendix of this document. Points to keep in mind in completing it include the following:

- Specify the records to be released;
- State the purpose of the disclosure;
- Identify the parties or class of parties to whom the disclosure may be made;
- State that the permission can be withdrawn and indicate how;
- Give the parent or eligible student access to a copy of any records disclosed; and
- Note on all confidentiality release forms that once a student turns 18, it is the student and not the parent who is authorized to sign for the release of educational records unless appropriate letters of guardianship

have been awarded to the parents by the courts.

**Acknowledge student and family concerns.**

In discussing the release of information process with students and parents, be sure to discuss and acknowledge their concerns about confidentiality of information. The discussion below addresses typical areas of concern about how adult agencies use information and suggests responses.

In regard to privacy protection, publicly-funded service agencies, including schools, are required to protect the confidentiality of personally identifiable information being discussed. Personally identifiable information cannot be released without the person's or their parent's consent. Once the adult agency has the information, their confidentiality rules limit access to personally identifiable information to only authorized personnel, such as case managers or program overseers. The general public does not have access to personally identifiable information.

In regard to any possible stigma associated with disclosing to adult service programs, information pertaining to the student's disability, confidentiality rules for adult service programs require that information be used in the best interests of the person being served. Permitting the district to share information with the adult service program may enable the student to be found eligible for needed services where services are targeted for assisting individuals with specific disabilities. Also, understanding the nature of the disability can help the adult agency case manager to more effectively plan for programs and services, including arranging for accommodations that will help the student participate successfully in spite of his or her disability.

A part of the initial discussion between the student and the case service representative should include the student asking about how information will be used and confidences protected. Ideally case service personnel in adult service agencies are trained to value the individual's confidences, interests, goals, abilities, and needs. In practice, they should involve the individual actively in planning his or her own services in accordance with the person recognizing his or her own needs, preferences, and interests. Where an individual believes that he or she is not being treated fairly or if the person disagrees with recommendations for services, each system should have informal and formal processes for resolving concerns.

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## VIII. ROLES AND RESPONSIBILITIES OF SCHOOL DISTRICT STAFF

The implementation of transition may impact on the way that district staff define their roles. Following is a summary of how roles may be different:

**What can special education teachers and other school staff do?**

Acquire detailed knowledge about community service agencies by obtaining resource guides, attending resource fairs and other public presentations, or calling individually to inquire about service options.

Provide a supportive atmosphere for the student and family to communicate with school staff, enabling the ready exchange of information between school and home that will help all parties to be working together toward mutually agreed upon adult outcomes.

Assist the student and family to clarify desirable outcomes, and encourage their active participation in transition planning and transition activities. Help the student to understand assessment information and be able to discuss that information as it applies to planning adult outcomes.

Provide information on the student's language proficiency and recommend strategies to improve learning opportunities for second language learners.

Provide ongoing assessment of functional levels related to transition, i.e., academic skills, work behaviors, social skills, independent living, self-advocacy skills and vocational skills. Provide assessment information in a form that is as readily understood by the student and family as by other professionals.

Design new or revise existing curriculum to teach the skills needed for obtaining desired student outcomes. Include assignments that apply knowledge to adult life roles, and consider community experiences as a teaching tool.

Document the process through the IEP.

Adapted from California Transition Guide

**What can district administrators do?**

Provide or facilitate district-wide staff development on transition services. Enable access to technical assistance, and disseminate information on implementation of law and regulations. Increase staff awareness about fiscal and programmatic resources and flexibility of options.

Implement a comprehensive functional curriculum focusing on vocational/occupational training, personal management, and recreation/leisure skills for all students with disabilities.

Encourage regional, state, and national networking of district staff, students, families, service providers, post-secondary education programs, and employers. For example, facilitate the development of regional or local memoranda of understanding with other community agencies. Facilitate development of local interagency transition policy/planning teams.

Develop a database of information about student needs during the years prior to graduation and inform adult agencies about potential needs for services.

Follow-up with those who leave school to determine the effectiveness of transition services in preparing them for participation in integrated employment, postsecondary education, and community living.

Include special education administrators and personnel on career pathways projects and other curriculum and occupational education task forces and projects.

Provide leadership to staff in examining existing CSE process to determine better ways to fulfill student planning and service requirements.

Adapted from California Transition Guide

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## IX. CREATING COLLABORATIVE INTERAGENCY ARRANGEMENTS

School districts are not expected to work alone in developing and delivering transition services. Districts are encouraged to network with other service systems and formalize relationships that can be called upon for advice, provision of services, and resources, as appropriate. This section summarizes some methods for establishing or participating with interagency planning groups on transition, as well as summarizing key points of State and federal level interagency agreements that may be of help to schools in accessing services.

**What factors contribute to successful collaboration?**

Decisions are made jointly by consumers, families, and professionals who are involved with the student.

There is increased emphasis on innovativeness and flexibility.

A clear commitment for local cooperation comes from the top administrative levels of collaborating agencies.

Written policies describe ongoing roles and responsibilities to sustain organizational relationships even when personnel changes occur within one or more of the agencies.

Local agreements are kept current and there is a concerted effort to keep lines of communication open by maintaining active participation at regular meetings.

One agency serves as a team leader to facilitate local programming.

There is coordinated analysis of needs assessment data from each agency.

Sufficient time is allocated by agency administrators for staff to participate. Agency representatives meeting with the group are empowered to recommend policy. Participation is driven by interest in improving interagency

linkages to enhance services.

Evaluation criteria are identified when planning activities are initiated (measurable short- and long-term goals).

There is ongoing follow-up of students who leave school to indicate program effectiveness.

**What are the purposes of an interagency planning group?**

An interagency transition planning council is one mechanism to increase the availability, access, and quality of transition services through the development and improvement of policies, procedures, systems, funding, and other mechanisms for providing services to youth with disabilities and their families. It is recommended that the council focus on the successful transition of all students with disabilities with sub-groups addressing specific topics. It is helpful to develop formalized relationships with written agreements.

**What are goals for interagency councils?**

Coordinate services to ensure nonduplication and cost-effectiveness of service delivery. This includes combining resources to maximize funding.

Share responsibility for assisting students through the maze of services.

Provide a quality, local service delivery system that includes providing more effective services to students and families.

Provide information on the services needed as predicted by aggregate data forms.

Increase positive student outcomes in adult living, learning, and working roles.

Develop a pool of adult service agency representatives who can attend CSE meetings and act as resources regarding the variety of service options available from different systems to aid in the transition process.

**How can interagency linkages be built?**

To facilitate the coordination of services, schools should collaborate with other public and private schools and agencies and the Regional Transition Coordination Site on forming interagency transition planning councils. Potential members include:

NYS VESID/CBVH	Board of Cooperative Educational Services
District Offices	Vocational and Applied Technology Education Act (VATEA) coordinators
Educational Institution	Special Education Training & Resource Centers
Linkages Unit of VESID	Special Education Administrator Leadership Training Academies
NYS Office of Mental Retardation & Developmental Disabilities	Bilingual Education Technical Assistance Centers (BETAC's)
NYS State Employment Service	Two-year and four-year colleges Job Training Partnership Act
NYS Office of Mental Health	(JTPA) Private Industry Councils (PIC)
NYS Division for Youth	Local employers
County Mental Health	Adult and Continuing Education Programs
County Department of Social Services	
County Probation Department	
Family members	

Students

Independent Living Centers

Local, County, and State Support Groups

**What are the roles and responsibilities of members of interagency planning councils?**

Identify local needs and develop local solutions. This includes identifying and addressing conflicts and gaps in services and service delivery patterns.

Share information about eligibility requirements for services and establish a local referral-eligibility process for students.

Provide information about, and advocate for, local options for living arrangements, transportation, employment, leisure activities, case management, and financial resources.

Be informed about the IEP and IWRP processes.

Enter into formal and informal interagency agreements or understandings to coordinate service delivery to students.

Review aggregate data to determine current and future needs for services, and develop plans for providing services.

Develop service directories to clarify/describe organizational structures, including:

- Goals, objectives and agency responsibilities
- Referral process
- Confidentiality process for exchanging individual student information
- Services and programs provided

- Due Process and appeal
- Program evaluation
- Eligibility
- Methods of assessment
- Staff profile: experience, professional training, functions
- Community access.

Adapted from California Transition Guide

**Are there existing statewide interagency agreements that schools should know about?**

Specific agreements, whose terms are summarized below, affect the practice of transition at the school district level:

Joint EMS-VESID Agreement on the Provision of Transition Services (1992), which was amended to include CBVH (1993), describes how the state and local level education, special education and vocational rehabilitation systems will be working together in a new relationship on behalf of transition.

SED-OMRDD Memorandum of Understanding describes how the systems providing education and developmental disabilities services will interact around lifelong learning issues, including transition.

SED-OMH Memorandum of Agreement describes how the systems providing education and mental health services will interact around lifelong learning issues, including transition.

**What is the EMS-VESID-CBVH Joint Agreement on the Provision of Transition Services?**

The Joint Agreement establishes the basic principles under which the New York State Education Department and vocational rehabilitation service systems are implementing federal and State requirements for transition services. The parties involved are the Office of Elementary, Middle and Secondary Education (EMS) and the Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the New York State Department of Social Services Commission for the Blind and Visually Handicapped (CBVH). The agreement covers the four areas of:

- Increasing successful transition outcomes;
- Enhancing vocational assessments;
- Implementing transition planning procedures; and,
- Implementing functional referral criteria for schools to refer students to VESID and to CBVH.

**What are key provisions of the EMS-VESID-CBVH Joint Agreements?**

Provisions describe the respective roles of EMS, VESID, CBVH schools and counselors, including the following:

On a systems basis, VESID continues to be responsible to develop and coordinate access for individuals with disabilities to lifelong learning systems, including adult and higher education beyond high school.

EMS, VESID, and CBVH will jointly work with schools and other State agencies to coordinate approaches for providing transition services, including removal of duplicative assessment, services and reporting procedures.

District transition planning and services are expected to produce outcomes that reflect preparation for students in employment, further education and community living when they leave schools.

Districts have the primary planning, programmatic, and financial responsibilities for the provision of transition services as mandated by federal or State laws and regulations.

VESID and CBVH counselors are responsible for providing consultation regarding planning, on request, and for providing eligible individual students with vocational rehabilitation services not otherwise mandated through special education requirements.

Referrals to VESID and CBVH counselors for case opening will be made on the basis of consistent, functional criteria defined in the text of the agreement, including a projected school exit within two years.

The building principal (or his/her designee) has been identified as a consistent point of contact with districts for VESID and CBVH counselors.

Each VESID and CBVH District office has identified a Transition Liaison to identify appropriate counselors and to work at the community level to coordinate local VESID and CBVH efforts with schools, families, other service systems and resources.

**What are key provisions of the SED-OMRDD Memorandum of Understanding (MOU)?**

This interagency agreement describes the mutual commitment of the New York State Education Department (SED) and the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) to carry out joint initiatives to assist families with young children to access appropriate services, enhance integration of services within schools, and broaden vocational as well as lifelong learning opportunities. Specific commitments include the provision of:

- technical assistance for students, families, and school personnel;
- collaboration in providing assistive technology;
- enhanced integration of Medicaid services with school services;
- expanded employment and independent living options;
- support for family preservation through social and education supports to help children stay at home or in their home communities; and
- streamlined access to lifelong support services.

This agreement was signed in February, 1992, and distributed to schools in April 1992. OMRDD's regional offices, called Developmental Disabilities Service Office's (DDSO's) or in New York City Borough Developmental Disabilities Services Office's (BDSO's) are working actively with schools and SED to identify and pilot local collaborative projects.

**What are key**

This interagency agreement describes the mutual commitment of the NYS Education Department (SED) and the

**provisions of the  
SED-OMH  
Memorandum of  
Agreement?**

NYS Office of Mental Health (OMH) to jointly develop a complementary system of education, vocational rehabilitation, independent living and mental health services. Specific commitments to districts by OMH include the provision of:

- cross agency training;
- consultation or technical assistance;
- mental health assessment and referral; and
- help with service linkages.

Possible activities include development of mental health treatment and support services within the student's natural environment (e.g., classrooms and worksites) to eliminate duplication of services, and the provision of assistance in maintaining children in their homes and community-based school programs.

This agreement was signed in November, 1992, and distributed to schools and County Mental Health Directors in February 1993. School districts and County Mental Health Directors are encouraged to discuss current and needed mental health treatment and support services as may be required locally for students.

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## **X. QUESTIONS AND ANSWERS**

**Q. When does the responsibility of the Committee on Special Education end regarding transition planning and services for students?**

A. Districts are responsible for providing transition planning and services as part of the student's Individualized Education Program (IEP) beginning at age 15 and ending when the student either receives a local or Regents diploma or at the end of the school year in which the student turns 21.

**Q. Does the Individuals with Disabilities Education Act (IDEA) specify whom the district must designate to coordinate transition planning and services?**

A. IDEA does not require a district to designate an individual to coordinate transition planning and services. It is the district's responsibility to insure that transition planning and services are incorporated within the student's IEP and to ensure that these services are being provided appropriately to meet the student's needs, preferences and interests in the least restrictive environment.

**Q. How frequently must CSE meetings be held to discuss transition planning and services?**

A. Transition planning and services should be discussed at the CSE meeting for each student beginning no later than age 15. Transition services must be reviewed by the CSE at least annually.

**Q. Should a student with a disability attend a CSE meeting in which transition planning and services are discussed?**

A. Beginning no later than age 15, all students with disabilities must be invited to attend the CSE meeting and be given an opportunity to provide input regarding his or her preferences and interests before a decision about transition services is made.

**Q. Does the IEP include only special education and related services or does it describe the total educational program for a student with disabilities age 15 or over?**

A. The IEP should include all aspects of the student's special education and related services. At age 15 and older, students with disabilities will have transition planning and services incorporated within their IEP. The IEP must also include the coordinated set of activities and address the student's transition needs through instruction; community experiences; the development of employment and other post-school adult living objectives; and if appropriate, acquisition of daily living skills and functional vocational evaluation. If regular education and vocational education services, as well as any community or business experiences are part of these activities, then the IEP must include a statement that addresses such activities.

**Q. Must the district directly provide all transition services described in the IEP?**

A. No. However, the district is responsible for coordinating all transition services. The district may work with other State agencies, organizations, community groups, businesses, and colleges to ensure that appropriate transition services are provided to meet the needs of the student age 15 and older.

**Q. Is the IEP a performance contract?**

A. No. Section 300.350 of the federal regulations makes it clear that the IEP is not a performance contract that imposes liability on a teacher or school district if a child with a disability does not meet the IEP objectives. While the district must provide special education and related services in accordance with the IEP, the Act does not hold the district, the teacher or other persons accountable if the student does not achieve the growth projected in the written statement.

**Q. Are secondary students with disabilities who are not classified by the CSE supposed to receive transition planning and services also?**

A. Yes, all secondary students with disabilities, ages 15 through 21, and earlier as appropriate, should be provided with transition planning and services. Students who are eligible to receive special education services are served through the IEP process, as described in this guide. Students who have disabilities and who are not eligible for special education services must be provided with transition planning and services as part of their annual guidance review and planning process.

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## **XI. RESOURCES**

### **Regional Transition Coordination Sites**

Regional Transition Coordination Sites have been set up in New York State to assist local communities to implement transition planning and services. The core objectives of Site activities are to:

- Coordinate existing resources within the geographical area of each Site in order to provide information, training and technical assistance to local districts, families, students and community agencies in their implementation of transition planning; and
- Assist at the local and community levels in expanding services to enhance transition of students with disabilities from school to postsecondary educational opportunities, adult vocational rehabilitation services and employment.

**Region & County**

**Contact Staff**

**Address**

**Long Island**

Nassau, Suffolk.

Brian McIlvain

516-286-6577

John Volonts

516-286-6755

Valerie Krizel

516-472-6455

John Volonts

Long Island Transition

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Bellport, NY 11713

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Queens, Richmond.

Maureen Piccoli-Kerne

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Sonia Braniff

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Coordinator of Vocational &

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NYC Board of Education

400 First Avenue, Room 62C

New York City, NY 10010

**Hudson Valley**

Albany, Columbia,

Dutchess, Greene,

Orange, Putnam,

Rensselaer, Rockland,

Schenectady, Schoharie,

Sullivan, Ulster,

Westchester.

Kerry McKenna

914-949-9331

Kerry McKenna, Facilitator

Hudson Valley Transition

Coordination Site

BOCES Southern Westchester

26 Legion Drive

Valhalla, NY 10595

**Southern Tier**

Broome, Chemung,

Thomas Golden

Susanne Bruyere

607-255-2731

Thomas Golden Southern Tier Transition &

Technical Assistance Center

c/o Program on Employment & Disability

Chenango, Delaware,  
Otsego, Schuyler,  
Steuben, Tioga,  
Tompkins

TDD 607-255-2891

Cornell University  
105 ILR Extension  
Ithaca, NY 14853-3901

**Central/Northern**

Cayuga, Clinton, Cortland,  
Essex, Franklin, Fulton,  
Hamilton, Herkimer,  
Jefferson, Lewis, Madison,  
Montgomery, Oneida,  
Onondaga, Oswego,  
Saratoga, Warren,  
Washington, St. Lawrence.

Eric Bright  
315-353-6687  
Robert Shepherd  
315-353-6687

Robert Shepherd  
Coordinator for Northern Region  
BOCES St. Lawrence/Lewis  
Special Education Office  
P.O. Box 330  
Norwood, NY 13668

**Buffalo**

Allegany, Cattaraugus,  
Chautauqua, Erie,  
Genesee, Niagara,  
Orleans, Wyoming.

Sandy Smith  
716-878-7282, or  
800-462-7653

Sandy Smith  
Early Childhood Direction Center  
Robert Warner Rehabilitation Ctr  
Children's Hospital of Buffalo  
936 Delaware Avenue  
Buffalo, NY 14209

**Rochester**

Livingston, Monroe,  
Ontario, Seneca, Wayne,

Eileen Collins  
Therese Zona  
716-377-4660 ext. 273

Therese Zona  
Regional Coordinator for Transition Services  
BOCES Monroe I  
41 O'Connor Road

Yates.

Fairport, NY 14450

## **Statewide Information Regarding Transition**

### ***Special Education Policies***

Lawrence T. Waite  
Nancy Lauria  
NYS Education Department  
Special Education Services  
One Commerce Plaza, Room 1610  
Albany, New York 12234

Phone 518-474-5548

### ***Vocational Rehabilitation and Related Services***

Debra A. Colley  
Doris Jamison  
NYS Education Department  
VESID  
One Commerce Plaza Room 1613  
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518-474-3060

Mary Ann Van Alstyne  
Laurie Munro  
NYS CBVH  
40 North Pearl Street  
Albany, NY 12243

518-473-1774

## **XII. REFERRAL FOR VOCATIONAL REHABILITATION SERVICES PROVIDED BY STATE AGENCIES**

**What are the State vocational rehabilitation agencies?**

The Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the Commission for the Blind and Visually Handicapped (CBVH) are the State agencies that provide vocational rehabilitation services to eligible individuals in keeping with the federal Rehabilitation Act Amendments of 1992. VESID and CBVH are similar in purpose and scope of services. They differ in who they serve: CBVH provides vocational rehabilitation services to youth and adults who are legally blind, who may also have additional disabilities, while VESID provides vocational rehabilitation services to individuals from all other disability groups.

**What are the roles of VESID and CBVH?**

Services provided through VESID and CBVH assist individuals with disabilities to prepare for, enter, engage in or retain gainful employment. Vocational rehabilitation services include evaluations, vocational planning and counseling, skills development training, adaptive equipment, occupational tools, support services while completing training, and employment services such as job seeking skills, employment referrals and on-the-job services including job coaching or planning work site modifications. The services that an individual receives will vary depending on what is needed to achieve the planned employment outcome. The Individual Written Rehabilitation Program (IWRP) is the planning document that guides the delivery of vocational rehabilitation services. This document describes long term goals, intermediate objectives and services to meet the objectives. The IWRP is developed jointly by the counselor and the individual and may be amended as needs or circumstances change.

**What are examples of VESID or CBVH services that might be provided for**

While an eligible student is still in school, the IWRP will be written to coordinate closely with the district IEP or guidance plan. VESID and CBVH provide services to in-school youth that do not duplicate services or programs that are mandated for districts to provide. Examples of services that

**in-school youth?**

VESID or CBVH may provide to in-school youth may include vocational guidance and counseling, resource information, and the preparation of post high school vocational rehabilitation service plans. Also, depending on individual needs or resource considerations, VESID or CBVH may be able to provide job related occupational tools, to purchase low vision aids, to purchase adaptive equipment for a personal auto to commute to employment, to assist in obtaining employment, including preparing certifications for Civil Service set-aside placements, to facilitate referral to summer employment, and to assist with the transition into extended supported employment.

**How is eligibility determined?**

Eligibility is based on showing that the person has a disability that is a substantial impediment to employment, has the ability to benefit from VESID or CBVH services, and will require VESID or CBVH services to enable the person to achieve an appropriate employment outcome. VESID or CBVH staff assist applicants with the eligibility process, including obtaining further clarifying evaluations as may be needed. Although not every student who has a disability is eligible for VESID or CBVH services, the school's referral of relevant documents will greatly expedite the process for determining eligibility and planning appropriate vocational rehabilitation services for students.

**Is family income a factor in determining eligibility?**

Family income is not a factor in determining eligibility. However, once it is decided that a person is eligible for VESID or CBVH services, funding for some services may be based on financial need. As an example, a family may be expected to share in the cost of college expenses. Examples of VESID or CBVH services that can be provided without considering economic need include services related to eligibility determination, service planning, vocational guidance and counseling, vocational assessment/evaluation, identification and referral to community services, and employment services.

**How can districts identify students who may be appropriate to refer?**

Potential student referrals may be identified when the district's individual assessment and planning processes reveal that VESID or CBVH services will be necessary to help the student successfully achieve employment, either immediately upon leaving school or following additional vocational

training or post-secondary education. Indicators for VESID or CBVH participation in planning for transition include:

- the student's need for an in-school vocational rehabilitation service that is not mandated for districts to provide;
- the student's need for adult vocational rehabilitation services after he/she completes the district program.

**What are the criteria for making referrals to VESID or CBVH?**

The *Joint Agreements Between the Office of Elementary, Middle, and Secondary Education (EMS), VESID and CBVH* identify criteria for referring youth with disabilities to VESID or CBVH. Referrals to VESID or CBVH of a student with disabilities should be made when:

1. The student is expected to exit school within two years;
2. The school, student, and/or parents (or legal guardians) jointly recognize that the student's disability will interfere with the student's ability to work in the community and that adult vocational rehabilitation services are necessary to help the student successfully achieve employment; and
3. The vocational rehabilitation services that the student requires are not available through programs and services mandated for the school to provide.

It is critical that the referral be the result of an active transition planning and service process. This is evident when:

- For a special education student, transition services are indicated in the IEP; or
- For a student with disabilities who is not receiving special education services, the student's annual guidance plan reflects desired adult outcomes, transition planning and services.

Parents and students can apply directly for services from CBVH or VESID without a referral from the

school. If the student is 18 or older and has no legal guardian, the student can make this decision independently.

**What is the process for making referrals to CBVH or VESID?**

When referring students to VESID or CBVH, the school district must ensure that certain steps have been followed:

- Referrals from Committees on Special Education, guidance personnel or other school staff should be routed consistently through the building principal or his/her designee who is assigned to be the liaison with CBVH and VESID.
- The referral is the result of a thorough assessment and planning process (e.g., annual guidance review or IEP annual review) that recommends adult vocational rehabilitation services are necessary to assist students with disabilities to successfully achieve adult employment.
- Consent for referral and for release of information has been obtained by the school from the parent, legal guardian or from the student, as applicable.

The CSE or guidance counselor transmits through the building liaison complete referral information including:

- a. A referral transmittal sheet (see Appendix J) or letter that explains the purpose for the referral; and,
- b. Selected documents that describe the student's disability, needs, preferences, interests, and skills (e.g., interpersonal, work, academic, independent living). Preferred documentation is that which describes the student's current abilities, work-related limitations and service needs in functional terms that are relevant to vocational rehabilitation and achieving employment.

**What are examples of the**

To the maximum degree possible, instead of asking students to go for new assessments, information

**kinds of school documents that CBVH and VESID will find useful?**

that already exists among school records will be used by VESID and CBVH to determine whether the student's circumstances meet eligibility criteria. Examples of documents for schools to selectively include in referral packages are listed below:

- the most current IEP or guidance plan containing information about transition planning and services;
- language proficiency assessment reports;
- student medical and health screening reports, including the most current psychological, psychiatric, or other specialist's disability assessment, if available and relevant;
- reports from related services interventions (e.g., occupational therapy, speech therapy, physical therapy, orientation and mobility instruction, rehabilitation teaching, or social work.)
- reports indicating special equipment or other accommodations and/or behavioral supports needed.
- indicators of academic achievement, such as transcripts, grades, academic achievement testing;
- career assessment information including: Level I, II or III vocational assessment reports, work experience or work study progress reports, career assessment portfolios, mentor or work supervisor evaluations, occupational education assessment reports.

**Where are local VESID and CBVH offices?**

Appendix J contains the referral transmittal sheet that can be used to transmit information to the local VESID or CBVH office. The list of these offices, their addresses, and other contact information is also listed in this Appendix.