

# Chapter 16

## Miscellaneous IDEA Categories and Section 504

### 16.1 Overview

This chapter briefly covers several IDEA categories including Visual Impairment, Hearing Impairment, Orthopedic Impairment and Traumatic Brain Injury (TBI). Additionally, it will cover 504 eligibility, offering two sample reports of children deemed eligible under Section 504. The chapter begins with a discussion of Section 504.

### 16.2 Section 504

The Office for Civil Rights within the US Department of Education oversees and enforces Section 504 in programs and activities that receive Department of Education financial assistance including public school districts, institutions of higher education, and other state and local education agencies (34 C.F.R. Part 104). The Section 504 regulations require a school district to provide a free appropriate public education (FAPE) to each qualified student with a disability who is in the school district's jurisdiction, regardless of the nature or severity of the disability. Under Section 504, FAPE consists of the provision of regular or special education and related aids and services designed to meet the student's individual educational needs as adequately as the needs of nondisabled students are met. Section 504 is distinct from IDEA but has a degree of overlap if a child struggles with learning, cognitive abilities, and certain behavioral and emotional conditions. Slightly broader than IDEA, Section 504 requires that children with a disability be afforded access to extracurricular activities such as sports and band participation. Therefore, a child who struggles with a suspected disability and who may not receive accommodations under IDEA should be considered for Section 504 eligibility.

### 16.2.1 Definition

Section 504 states that

No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service (29 U.S.C. § 794).

It requires that a local educational agency, vocational agency, or other school system receiving federal assistance adhere to the strictures of this law.

Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794.

According to section 504 the definition of an impairment includes including any physical or mental disability that substantially limits one or more of the following major life activities:

Caring for one's self	Walking	Seeing	Speaking
Breathing	Sleeping Standing	Lifting	Reading
Concentrating	Thinking	Communicating	Working Helping
Eating	Bending Performing	Manual tasks	Learning

Operation of a bodily function (bladder, bowels, endocrine, circulatory, etc.)  
Other

The following additional strictures are required:

1. Has a record of such an impairment.
2. Is regarded as having such an impairment.  
34 C.F.R. 104.3 and 42 U.S.C. 12102(4)(a)(2)(A).

A physical or mental impairment is defined as (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities (34 C.F.R. 104.3).

### ***16.2.2 Identification and Psychoeducational Assessment***

The identification for Section 504 services must be based upon an evaluation and conducted by a team of individuals knowledgeable about the student. Section 504 plans are generally the responsibility of general education while IDEA falls under the auspices of special education. The threshold for qualification is an impairment in a major life function. The child does not need to have a disability for eligibility for a 504 plan.

The determination of whether an impairment substantially limits a major life activity is to be made as if a child is not using what are called mitigating measures. Mitigating measures are defined as follows:

- (A) Medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies;
- (B) Use of assistive technology;
- (C) Reasonable accommodations or auxiliary aids or services; or
- (D) Learned behavioral or adaptive neurological modifications. 42 U.S.C. 12102(4)(a)(4)(E)(i).

Many students, but not all, who qualify for a classification under IDEA may also meet eligibility requirements under Section 504. In other situations, a student may not meet eligibility requirements under IDEA but may qualify for a Section 504 plan. The determination for eligibility is made on a case-by-case basis. If the impairment involves a major life activity such as learning, reading, concentrating, thinking, speaking or communicating, then the team should consider referring the student for a full evaluation to determine eligibility under IDEA. As with the IDEA evaluation process, a periodic reevaluation of the 504 plan is required. Some school districts may choose to review at 3 year intervals or more frequently as needed.

### ***16.2.3 Conclusion***

Section 504 was reinvigorated with the 2009 amendment and increasingly school districts will be required to consider the regulations in their provision of FAPE to students. A comprehensive guide that is available free of charge off the Internet may be downloaded from the following site:[http://doe.sd.gov/oess/documents/sped\\_section504\\_Guidelines.pdf](http://doe.sd.gov/oess/documents/sped_section504_Guidelines.pdf)

This document offers additional information regarding Section 504 including detailed forms for school districts to remain compliant with Section 504 regulations.

## **16.3 Traumatic Brain Injury (TBI)**

### ***16.3.1 Overview***

The term traumatic brain injury (TBI) encompasses injuries to the head that result in total or partial disability that adversely affects a child's educational performance. More than one million children sustain a TBI annually resulting in approximately 150,000 hospitalizations and 5,000 deaths (Langlois, Rutland-Brown, & Thomas, 2005). Glang, Tyler, Pearson, Todis, and Morvant (2004) estimate more than 130,000 children with TBI have functional limitations significant enough to receive special education services yet less than 20 % of those children receive such support under the TBI category. The lack of school psychologists' training in and understanding of TBI has been cited for the low rate of classification of TBI (Hooper, 2006). The incomplete understanding of TBI has an additional problem. It hampers recovery through inappropriate educational and interventional planning.

### ***16.3.2 Definition***

Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma. [34 Code of Federal Regulations §300.8(c)(12)].

### ***16.3.3 Correlates of TBI***

The sequelae of brain injury can vary depending upon location and severity of injury. Children who experience a brain injury may face physical, cognitive, behavioral, and social-emotional difficulties. The following chart is illustrative of possible sequelae, but it is not intended to be exhaustive.

## Possible Sequelae of Traumatic Brain Injury

Physical symptoms	Cognitive	Social-emotional/behavior
Problems speaking	Short-term memory	Mood
Seeing and hearing	Long-term memory	Anxiety
Headaches and fatigue	Concentration and attention	Aggression
Muscle contraction/tightening	Slow processing	Depression
Writing and drawing	Ordering and sequencing	Restless
Balancing and walking	Judgment	Limited emotional control
Partial or full paralysis		

The complications from brain injury can range from mild to severe. There is often a gradient relationship between severity of brain injury and outcome, with moderate to severe brain injuries associated with more negative sequelae (Yeates & Taylor, 2006). Early intervention following a concussion or brain injury is critically important and can mitigate adverse outcomes. There are specific head injury protocols that need to be assiduously followed. These protocols often recommend rest for the child and avoidance of overstimulating activities (e.g., video games; no late nights) and athletic activities (e.g., soccer, bicycle riding) that can increase risk for additional head injury. It is the subsequent head injuries following a concussion that pose grave risk for permanent brain injury. The school psychologist is an important point of contact as she helps students transition and reintegrate back to school. The school psychologist can also monitor recovery and remain vigilant for possible future manifestation of problems as sequelae may develop over a period of days, months and years following injury (Gfroerer, Wade, & Wu, 2008; Yeates & Taylor, 2006). In fact, sequelae may remain dormant for an extended time period only to manifest at a later point. As the child develops, teachers and other school professionals may notice new problems as prior brain injury may interfere with acquisition of new skills. Parents and educators may misattribute this difficulty to a learning disability or another other IDEA classification category when it was related to the prior brain injury.

### 16.3.4 Guidance Regarding Psychoeducational Assessment

The assessment and evaluation of traumatic brain injury will require a multifaceted approach from a team of professionals, some of whom reside outside of the educational setting. This may include physicians, neurologists, rehabilitation counselors, occupational therapists, physical therapists, and neuropsychologists. The school psychologist will also be involved in reviewing the information furnished by the

outside professionals, undertaking a traditional psychoeducational evaluation, and continuously monitoring the child's progress toward recovery including whether the child will manifest later sequelae. It is important to keep in mind that children who experience head injury may experience symptoms months to years later (Telzrow, 1991). School psychologists and other school professionals will have to remain vigilant for this occurrence. A neuropsychological evaluation, if it has not been conducted, may be an important adjunct to the psychoeducational evaluation. Neuropsychology had its origins in and evolved from the understanding of head injury so it is particularly well-suited for the evaluation of TBI.

### ***16.3.5 Conclusion***

School psychologists may be ill-prepared to evaluate, work with, and monitor students with TBI (Hooper, 2006). Additional education may be necessary. This is important because the cognitive, academic, behavioral, social-emotional, and adaptive difficulties following a head injury may not manifest until months or years later. A multidisciplinary team approach that includes outside medical specialists, occupational therapists, physical therapists, and neuropsychologists may be necessary.

## **16.4 Visual Impairment/Blindness**

### ***16.4.1 Overview***

School psychologists will not be in the position to diagnose a visual impairment. This is beyond the scope of their expertise and within the realm of the ophthalmologist, a medical doctor who specializes in the diagnosis and treatment of disorders of the eye. However, the psychologist, as part of a multidisciplinary team, will be responsible for determining whether the visual issue is creating an adverse impact on educational functioning and which accommodations the child might need. The school psychologist may be in the position to assess the child's cognitive and academic abilities via norm referenced instruments. However, rigid adherence to standardized protocol may be inappropriate. Only the auditory aspects of a test of cognitive ability or achievement may be able to be administered to some youth with visual impairments.

### ***16.4.2 Definition***

Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness [§300.8(c)(13)].

The more commonly recognized visual impairments include near-sightedness and far-sightedness. However, there are additional visual impairments of which psychologists and other school professionals should be aware:

Strabismus—the eyes look in different directions and do not focus simultaneously on a single point.

Congenital cataracts—the lens of the eye becomes cloudy.

Retinopathy of prematurity—A condition of prematurity where the retina has not developed sufficiently to accommodate light.

Retinitis pigmentosa—A heritable disease that slowly destroys the retina.

Coloboma—A section of the structure of the eye is missing.

Optic nerve hypoplasia—An optic nerve condition that impacts depth perception, sensitivity to light, and visual acuity.

Cortical visual impairment (CVI)—Damage to the visual cortex that results in an impairment to vision. The eyes are intact.

Adapted from National Dissemination Center for Children with Disabilities (NICHCY) (2012). *Disability Fact Sheet#13. Visual impairments, including blindness*. NICHCY: Washington, DC.

Keep in mind that the term blindness does not necessarily mean that the individual cannot see anything at all. A child who is legally blind may have partial sight and be able to see light, colors and objects.

### ***16.4.3 Identification and Psychoeducational Assessment Considerations***

The identification of a visual impairment or blindness occurs outside the school setting by an ophthalmologist or optometrist. This information is then reviewed by a school multidisciplinary team to determine appropriate educational planning. Within the school setting, additional evaluation procedures are undertaken including those by the school psychologist. A teacher of students who are visually impaired and the orientation and mobility specialist will likely undertake a functional vision assessment (FVA) and a learning media assessment (LMA). The FVA evaluates the best way to present material to a child to accommodate their vision. The LMA discusses which learning and literacy media (e.g., reading and writing) is appropriate for supporting a child's learning. An expanded core curriculum assessment may also be undertaken. The expanded core curriculum assessment determines the child's needs to be successful in school and in postgraduate pursuits. There is often overlap among the types of assessment. Finally, the school psychologist may administer a revised battery of assessment instruments, depending upon the level of visual impairment, in an attempt to determine cognitive and academic functioning.

The following offers a general overview of the components of the FVA, LMA and expanded core curriculum needs assessment that is undertaken by various professionals in the school:

Functional vision assessment	Learning media assessment	Expanded core curr. assessment
– Review of eye-care professional reports	– Reading, writing, and listening skills	– Orientation and mobility
– Interviews with parents, teachers, and students	– Readability of materials	– Social interaction
– Student observations	– Functional vision	– Independent living
– Appearance of the eyes	– Reading level of students	– Recreation and leisure
– Visual reflexes	– Availability of materials	– Career education
– Visual response to light	– Environments	– Assistive technology
– Visual response to objects	– Print size assessment	– Sensory efficiency
– Muscle imbalance and eye preference	– Near and distance reading and writing	– Self-determination
– Functional peripheral and central fields		– Compensatory/functional academic skills including communication modes (top priority)
– Color and contrast discrimination		
– Light sensitivity and preference		
– Depth perception		
– Developmental and visual perception screening		
– Near acuity and discrimination		
– Identification of common objects		
– Behavioral abnormalities		
– Distance acuity and discrimination		
– Oculomotor behaviors (fixation, convergence, tracing, tracking, scanning, shifting gaze)		

Adapted and reprinted with permission from Steciw (2012)

Each of these evaluations requires specialized training and knowledge. Additional resources are available on these topics and provide more in-depth information than the generalized guidance provided above (See Bradley-Johnson & Morgan, 2008).

Most school psychologists may not be trained or experienced in evaluating children with visual impairments. This makes it extremely critical to collaborate throughout the process with specialists in visual assessment. School psychologists may need to learn how to present test items to blind or visually impaired children while respecting the child's personal space, communication methods, and any additional needs including environmental.

Degree of vision loss will impact the type of evaluation that may be conducted. For example, if there is complete vision loss, then the attempted administration of nonverbal (i.e., performance related subtests such as block design) will be inappropriate. The clinician should attempt to use tests or subtests that can be made accessible to the child. It will be necessary to use clinical judgment when deciding whether to continue to administer items with visual stimuli. If the items or the instrument is modified in any way, then the instrument should be interpreted qualitatively. Let's consider the use of an IQ test. The verbal portion may be administered to yield a verbal IQ. When visual-spatial portions of tests are administered in most cases the score should not be reported as this can inappropriately depress the full scale score and subsequently be misinterpreted and misused by other professionals. Instead, visual-spatial portions of a test should be used qualitatively in an effort to gather additional information about a child's capacity in this area.

#### ***16.4.4 Conclusion***

Children with visual impairments need to learn the same subjects and academic skills that children in the general education curriculum learn. They must also learn additional skills that are distinct to visual impairments including how to safely and independently move around their environment, use whatever residual vision they have, read and write in Braille, and use assistive technologies. The overall evaluation of the child with visual impairment or blindness including that aspect conducted by the school psychologist should help to determine how to best furnish educational and adaptive accommodations.

## **16.5 Hearing Loss and Deafness**

### ***16.5.1 Overview***

The school psychologist is unlikely to be involved in the actual determination of whether a child has a hearing impairment. This will be determined by an otolaryngologist and audiologist who have specialized training regarding disorders of the ear.

The school psychologist will be involved in the determination of whether the child's hearing impairment is having an impact on educational performance. As part of this process, the psychologist may administer a battery of tests to better understand the child's present level of functioning. This may include IQ tests, achievement tests and additional norm-referenced instruments as appropriate.

Depending upon the child's hearing capacity the psychologist will need to enlist the help of an expert in sign language. This individual should be instructed in the approach to standardized testing and told to avoid coaching and other inappropriate standardized test behavior. For instance, acknowledging correctness or wrongness of a response (unless otherwise specified in the standardized directions), coaching, and giving additional chances or guesses is clearly inappropriate. Individuals with deafness or a hearing impairment may struggle relative to age typical peers particularly with language based topics (Bradley-Johnson & Morgan, 2008). This is a result of their disability and should not be misconstrued as having lower cognitive capacity.

### ***16.5.2 Definition***

Hearing impairment means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but that is not included under the definition of deafness in this section.

Deafness means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification that adversely affects a child's educational performance.

### ***16.5.3 Degree of Hearing Loss***

Hearing loss is classified by the amount of acuity loss measured in decibels (dB).

The following chart depicts the level of hearing loss and a degree of insight into accommodations that will be necessary.

Mild (16–40 dB): Soft noises may not be heard. Speech may be difficult to hear in loud environment. Background noises may interfere with detection of speech unless hearing aids and an FM amplification system is used.

Moderate (41–70 dB): Amplification becomes critically important without which class discussion and conversation is missed. The tone, pitch, and quality of a child's speech may also be impacted. Speech therapy may be required.

Severe (71–90 dB): Full time amplification will be necessary. The child may not understand speech (if the speech loss was before language acquisition) or there may be significant difficulties with speech, writing, and language skills. An interpreter may be necessary as will a hearing aide.

Profound (90+dB): Amplification such as hearing aids may not work. Vision will be the primary modality for learning and communication. The child may need placement in a special program and exposure to deaf culture.

#### ***16.5.4 Identification and Psychoeducational Assessment Considerations***

Students may enter the school system with an outside, documented hearing loss. If not, professionals within the school district sometimes refer a child for an audiological evaluation when hearing difficulties are suspected. For a child to obtain services and to assist with educational planning, a written report from an outside professional will be required. Individuals involved in the identification of hearing impairment include but are not limited to a physician, an audiologist, a speech language therapist, and American Sign Language/Deaf studies teacher, and a school psychologist.

School psychologists who may be involved in the evaluation of children who are deaf or hard of hearing must recognize limits of competence and seek consultation where appropriate. The evaluation of a child with a hearing impairment entails greater understanding of numerous factors including proper use of interpreters, proper selection of assessment instruments (e.g., the UNIT), and understanding of the deaf culture. Optimally, a school psychologist who understands sign language or who can communicate in the student's communication mode should be used to conduct the evaluation. When unavailable, the school psychologist should enlist the assistance of an interpreter. The interpreter should have experience with the psychoeducational assessment process. If not, the psychologist is responsible for training the interpreter in the nuances of standardized administration procedures and how to serve in an adjunctive capacity with respect to the evaluation process.

#### ***16.5.5 Conclusion***

The evaluation of children who are deaf or hard of hearing requires a highly specialized skill set. Multiple professionals including a physician, an audiologist, a speech-language pathologist, a teacher versed in ASL and a school psychologist may be involved in determining eligibility for hearing impairment/deafness. Outside documentation from an audiological specialist (e.g., physician, audiologist) will be a

necessary, but insufficient aspect of eligibility. Additional needed information may include norm-referenced and informal assessment to determine whether and where the hearing impairment is having an adverse educational impact. For this purpose, the school psychologist will play a role. An interpreter may be a necessary participant in the eligibility identification process unless the school psychologist is versed in communication modes (e.g., ASL) familiar to the child. Children who are found eligible under the category hearing impaired or deaf will require specially designed services and accommodations which may include an amplification system, services from an interpreter, captioning for oral media, introduction to the deaf culture, preferential seating to assist with lip reading, and a notetaker.

## **16.6 Orthopedic Impairment**

### ***16.6.1 Overview***

Orthopedic impairments are experienced by 0.12 % (approximately 54,000) of all students attending kindergarten through 12th grade (Skull & Winkler, 2011). Orthopedic impairments have varied etiology. Causes of orthopedic impairment range from congenital (i.e., existing at birth) anomalies to accidents and injuries. Congenital causes include cerebral palsy, osteogenesis imperfecta, joint deformity, and muscular dystrophy. Other causes include premature birth, motor vehicle accidents and sports related injuries. The need for accommodation often varies based upon the severity of the orthopedic impairment. Some children wear braces, prosthetics and orthotic devices while others will require a walker or wheelchair for mobility. Children with severe disabilities sometimes have a concomitant orthopedic impairment requiring a multiple disabilities classification.

### ***16.6.2 Definition***

Orthopedic impairment means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

Specific examples of more prevalent orthopedic impairments are as follows:

Spina bifida—A birth defect resulting from an incomplete closure of the spinal column.

**Scoliosis**—Curvature of the spine with no known etiology that causes shoulders and hips appear uneven.

**Cerebral Palsy**—Injury to the brain that often occurs during the prenatal and perinatal period resulting in too tight or loose muscles. Mobility is either mildly impaired or severely impaired.

**Muscular Dystrophy**—A genetic disease that is progressive in nature resulting in muscle weakness and rapid deterioration.

### ***16.6.3 Psychoeducational Assessment Considerations***

Most children with orthopedic impairments enter school with documentation of a physical disability that makes them eligible for an orthopedic impairment classification. A smaller subset will be overlooked and will be suspected as having a disability within a school setting when school personnel notice signs of poor coordination, awkward gait, frequent accidents, or complaints of pain. When an orthopedic impairment is suspected by the school, then the child should be referred for a medical evaluation by a physician with specialized training in that area. The school will be responsible, in part, to assess how the orthopedic impairment affects the child's ability to learn in the school setting. Additional assessment considerations include transportation to and from school, mobility within the school including how to get to and from classes, how to fulfill required physical education curricula, and social, emotional, and behavior issues that might result from the orthopedic impairment. Professionals undertaking the assessment may include a speech-language pathologist, a physical therapist and an occupational therapist to evaluate and make recommendations regarding speech, fine motor and gross motor skills deficits including need for adaptive equipment. A psychologist will be responsible for evaluating the child's cognitive, academic, adaptive, social, emotional, behavioral, and physical needs.

### ***16.6.4 Conclusion***

The symptoms and characteristics of children with orthopedic impairments are varied. No two orthopedic impairments are alike making it difficult to extrapolate symptom characteristics from one to the next. One child may be paralyzed from the waist down while another child may be able to walk but with a gait. Other children may be unable to use writing tools or turn pages in a book. Still, other children may have concomitant speech impairments. A comprehensive evaluation from multiple professionals will determine what types of symptoms to expect and what accommodations will be necessary to support the child's functioning in the school.

## Appendix: Section 504 Report Example

### Psychological Report Confidential

Name: Billy Smith  
Date of Birth: 10/21/07  
Grade: 2  
Name of Examiner: Stefan C. Dombrowski, Ph.D.

Date of Report: February 7, 2016  
Chronological Age: 8 years 3 months  
School: Smith Public School

Parent Name and Address: Patty Smith  
1234 Briar Cliff Lane  
Philadelphia, PA, 19138

Phone: 609-585-1234

#### Reason for Referral:

Billy was referred for a comprehensive evaluation following concerns about his progress in the classroom. This evaluation was conducted to determine Billy's present level of functioning and recommendations that may be appropriate for him.

#### Assessment Methods and Sources of Data

*Reynolds Intellectual Assessment Scales (RIAS)*

*Woodcock–Johnson Test of Achievement—Fourth Edition (WJ-IV)*

*Bender Visual Motor Gestalt, Second Edition (Bender-2)*

*Behavior Assessment System for Children, Second Edition (BASC-2)*

– Ms. Cynthia Pleasant

*ADHD Rating Scale IV*

– Ms. Cynthia Pleasant (Second Grade Teacher)

– Ms. Patty Smith (Grandmother)

*Teacher Interview*

– Ms. Cynthia Pleasant (Second Grade Teacher)

*Parent Interview*

– Ms. Patty Smith (Grandmother)

*Student Interview*

– Billy Smith

*Review of Lower School Discipline Report*  
*Review of TSS Worker Intake Report*  
Classroom Observations (1/31/16)  
Review of School Records

### **Background Information and Developmental History**

Billy Smith is an 8-year-old second grade student at Smith Public School (SPS). He has experienced considerable behavioral difficulties including aggression (both verbal and physical) toward other students, oppositionality, rule noncompliance, and disregard of teacher requests. Billy will require continued structure and support for his behavioral and social difficulties. He will not qualify for a special education classification due to solid academic progress.

*Prenatal, Perinatal, and Early Developmental History:* Ms. Smith noted that Billy was born at full term. All Billy's developmental milestones were attained within normal limits and met all his early developmental milestones.

*Medical:* Billy has been diagnosed with Attention-Deficit/Hyperactivity Disorder, Combined Type (ADHD; 314.01) and Disruptive Behavior Disorder (312.91). Billy takes Concerta (27 mg) and Tenex for the management of his behavioral symptoms. He has been assigned a TSS worker and a behavior specialist coordinator. Billy has no other medical concerns at this time. His hearing and vision are intact. Billy has neither experienced a head injury nor a major infection.

*Cognitive, Academic, and Language Functioning:* Billy progress in the curriculum is at grade expected levels despite several suspensions and behavioral incidents that may begin to interfere with his progress.

*Social-Emotional and Behavioral Functioning:* Billy struggles with impulsivity, hyperactivity, and inattentiveness. Billy receives behavioral support from both a Behavior Specialist Coordinator and a TSS worker. Billy has a few friends at school, but tends to alienate himself from them because of his impulsive style and tendency to physically aggress. Billy also seeks to do what he wants, as he pleases, which gets him into trouble at school.

*Strengths:* Billy's strengths include solid cognitive ability and being a sweet, kind child.

*Summary:* Billy has deficits in the social-emotional and behavioral areas. He does not have any current academic concerns and is performing at a grade expected level in the curriculum.

## Cognitive and Academic Functioning

### *Reynolds Intellectual Assessment Scale (RIAS)*

Billy was administered the Reynolds Intellectual Assessment Scales (RIAS). The RIAS is an individually administered measure of intellectual functioning normed for individuals between the ages of 3 and 94 years. The RIAS contains several individual tests of intellectual problem solving and reasoning ability that are combined to form a Verbal Intelligence Index (VIX) and a Nonverbal Intelligence Index (NIX). The subtests that compose the VIX assess verbal reasoning ability along with the ability to access and apply prior learning in solving language-related tasks. Although labeled the Verbal Intelligence Index, the VIX is also a reasonable approximation of crystallized intelligence. The NIX comprises subtests that assess nonverbal reasoning and spatial ability. Although labeled the Nonverbal Intelligence Index, the NIX also provides a reasonable approximation of fluid intelligence and spatial ability. These two indexes of intellectual functioning are then combined to form an overall Composite Intelligence Index (CIX). By combining the VIX and the NIX into the CIX, a strong, reliable assessment of general intelligence (*g*) is obtained. The CIX measures the two most important aspects of general intelligence according to recent theories and research findings: reasoning or fluid abilities and verbal or crystallized abilities.

The RIAS also contains subtests designed to assess verbal memory and nonverbal memory. Depending upon the age of the individual being evaluated, the verbal memory subtest consists of a series of sentences, age-appropriate stories, or both, read aloud to the examinee. The examinee is then asked to recall these sentences or stories as precisely as possible. The nonverbal memory subtest consists of the presentation of pictures of various objects or abstract designs for a period of 5 s. The examinee is then shown a page containing six similar objects or figures and must discern which object or figure has previously been shown. The scores from the verbal memory and nonverbal memory subtests are combined to form a Composite Memory Index (CMX), which provides a strong, reliable assessment of working memory and may also provide indications as to whether or not a more detailed assessment of memory functions may be required. In addition, the high reliability of the verbal and nonverbal memory subtests allows them to be compared directly to each other.

Each of these indexes is expressed as an age-corrected standard score that is scaled to a mean of 100 and a standard deviation of 15. These scores are normally distributed and can be converted to a variety of other metrics if desired.

Following are the results of Billy's performance on the RIAS.

	Composite IQ	Verbal IQ	Nonverbal IQ	Memory index
RIAS index	96	98	96	92
Percentile	39th	45th	39th	30th
Confidence interval (95 %)	92–100	91–105	92–106	87–100

On testing with the RIAS, Billy attained a Composite Intelligence Index of 82. On the RIAS, this level of performance falls within the range of scores designated as below average and exceeds the performance of 12 % of individuals at Billy’s age. Billy attained a Verbal Intelligence Index of 98 (45th percentile), which exceeds 45 % of individuals Billy’s age. His Nonverbal IQ was 96 (39th percentile). Billy attained a Composite Memory Index (CMX) of 92, which falls within the average range of working memory skills and exceeds the performance of 30 out of 100 individuals Billy’s age.

***Woodcock–Johnson Tests of Achievement-IV (WJ-IV)***

The WJ-IV is an achievement test used to measure basic reading, writing, oral language, and mathematics skills. The Reading subtest includes letter and word identification, vocabulary, and comprehension skills. The Writing subtest includes spelling, writing fluency, and simple sentence writing. The Mathematics subtest includes calculation, practical problems, and knowledge of mathematical concepts and vocabulary.

Billy obtained the following scores in each of the areas of measurement:

	Standard	Confidence	Descriptive	
	Score	Percentile	Interval (95 %)	Classification
<i>Broad reading</i>	91	27	86–94	Average
Letter-word ID	93	32	88–98	Average
Passage comprehension	90	25	82–98	Average
Sentence reading fluency	97	42	86–108	Average
<i>Broad mathematics</i>	87	21	80–93	Low average
Calculation	84	14	72–95	Low average
Math facts fluency	90	24	83–96	Average
Applied problems	92	29	84–99	Average
<i>Broad written language</i>	92	29	85–99	Average
Spelling	92	30	85–100	Average
Sentence writing fluency	99	48	86–112	Average
Writing samples	90	25	80–100	Average

Standardized achievement results revealed low average mathematics skills with average performance in reading, and writing.

***Bender Visual-Motor Gestalt Test, Second Edition (Bender-II)***

The Bender-II measures visual-motor integration skills, or the ability to see and copy figures accurately. A quantitative and qualitative analysis of Billy’s drawings suggests that his visual-motor integration abilities (e.g., fine motor skills for paper and pencil tasks) are average (Copy Standard Score = 100; 50th percentile).

## Social-Emotional and Behavioral Functioning

### *Behavior Assessment System for Children, Second Edition (BASC-2)*

The Behavior Assessment System for Children, Second Edition (BASC-2) is an integrated system designed to facilitate the differential diagnosis and classification of a variety of emotional and behavioral conditions in children. It possesses validity scales and several clinical scales, which reflect different dimensions of a child's personality. Scores in the Clinically Significant range ( $T$ -Score  $>70$ ) suggest a high level of difficulty. Scores in the At-Risk range ( $T$ -Score 65–69) identify either a significant problem that may not be severe enough to require formal treatment or a potential of developing a problem that needs careful monitoring. On the Adaptive Scales, scores below 30 are considered clinically significant while scores between 31 and 40 are considered at-risk.

### Ms. Pleasant

Clinical scales	$T$ -Score	Percentile
Hyperactivity	69*	94
Aggression	94**	99
Conduct problems	86**	98
Anxiety	42	22
Depression	50	50
Somatization	47	48
Attention problems	72**	86
Learning problems	44	32
Atypicality	46	35
Withdrawal	63	86
Adaptability	39*	10
Social skills	38*	10
Leadership	44	32
Study skills	38*	10
Functional communication	49	49
Externalizing problems	85**	98
Internalizing problems	45	35
Behavioral symptoms index	68*	93
Adaptive skills	40	20
School problems	53	62

\*At-risk

\*\*Clinically significant

BASC-2 ratings suggested clinically significant elevations across the externalizing composite with an at-risk rating on the behavioral symptoms index. BASC-2 ratings suggest a clinically significant elevation on the aggression, inattention and conduct problems scales with an at-risk rating on the hyperactivity scale, adaptability, and social skills scales.

### ***ADHD Rating Scale IV***

The ADHD Rating Scale IV is a rating scale consisting of ADHD symptoms based on the DSM V diagnostic criteria. In general, scores between the 85<sup>th</sup> and 93<sup>rd</sup> percentile are considered above average or “at-risk” for symptom cluster compared to the normative sample. Scores above the 93<sup>rd</sup> percentile are generally considered clinically significant. Billy received the following scores:

Scale	Teacher	Parent
	Percentile	Percentile
Hyperactivity/impulsivity	95th (clinically significant)	95th (clinically significant)
Inattention	94th (clinically significant)	97th (clinically significant)
Combined	97th (clinically significant)	98th (clinically significant)

### **Interview Results**

*Parent Interview (February 7, 2016):* Ms. Patty Smith, Billy’s grandmother, was interviewed to ascertain her impressions of Billy’s cognitive, academic, social, and behavioral progress. Ms. Smith explained, “I have a concern because Billy has ADHD.” She noted that she has had Billy since 18 months. Ms. Smith noted that Billy’s mother is also back in his life (since 2007). Commenting on Billy’s behavior, Ms. Smith explained that Billy will do what he wants to do. She noted that he likes to be in control and needs structure, support, and clear expectations. Ms. Smith explained that if provided, Billy will comply “but if you turn your back he’ll do what he wants.” As an example, she indicated that Billy took a pack of gum from school without asking because other kids had gum on the bus and he wanted it. Ms. Smith explained that at home, Billy listens and reads. She expressed that he wants to be older than what he is and this can put him into bad situations. Ms. Smith noted that without structure, Billy struggles. She explained that Billy has a behavior specialist coordinator and a TSS worker. Commenting on Billy’s social progress, Ms. Smith indicated that “he wants everybody to be his friend, but when they’re not he can be a bully and become upset.” She explained that Billy struggles with boundaries when making new friends. Ms. Smith noted, “he does not realize that he cannot jump in someone’s face and then all of sudden become their friends.” She also explained that we had to teach him how to work as a team, noting that Billy always wants to be first. Ms. Smith noted that “academically, Billy is okay. But I’m concerned about his behavior and how it takes away from his education. I want him to have the best and wonder if a more structured school would be better for him.” Ms. Smith indicated that Billy’s areas of strength include being sweet, kind, and bright. His areas of need include attention, social skills, following directions, and following classroom rules particularly during times transition times.

*Student Interview (February 1, 2016):* Billy was interviewed to ascertain impressions of his progress at SPS. Billy indicated that he likes SPS. He stated that he likes everything about SPS. Billy said that he does well in school in every subject. Billy then indicated that he does well with mathematics and reading but only “sometimes good with writing.” Billy noted that he sometimes gets into trouble at school and

described in precise detail what he needs to do. Billy noted that he needs to treat his friends more kindly and must learn how to deal with people that are mean to him. Billy stated that he generally only gets into trouble when he stands up for his friends when they are picked on. Billy explained that his interests include playing with video games and with his cousins. Billy also indicated that he enjoys basketball, baseball, and football.

*Teacher Interview (January 6, 2016):* Ms. Cynthia Pleasant, Billy's 3rd grade teacher was interviewed regarding Billy's academic, behavioral, social, and emotional functioning. Ms. Pleasant expressed that Billy's greatest issue is behavioral and that he is generally on-target academically. Ms. Pleasant noted that Billy has a tendency to physically aggress. She explained that he punches other children, kicks, slaps, and one time has been observed to choke another child. Ms. Pleasant noted that Billy engages in inappropriate behavior. For instance, he once yelled out that one student had sex with another student. Ms. Pleasant noted that Billy becomes interested in a girl at school and then tends to say inappropriate things to that girl. Ms. Pleasant indicated that his conflicts in the classroom are generally with other girls. Ms. Pleasant mentioned that Billy had a TSS worker (part-time) in kindergarten, but Billy did not have one in first grade because his behavior tended to appear only during transitions and not during class time last year. Ms. Pleasant explained that this year, Billy has been caught engaging in inappropriate behavior but he has been somewhat sneaky about it. Ms. Pleasant explained that Billy struggles with peer interaction as a result of his interpersonal style. She noted that some children in the class are turned off by him. Others just tolerate his behavior. Ms. Pleasant mentioned that Billy is generally involved in a conflict whenever there is free play or a group activity. Ms. Pleasant stated that Billy is at or slightly above grade level academically. She explained that his strengths include knowing what he is supposed to do and his display of good behavior earlier in the year. Ms. Pleasant noted that Billy's needs include greater interpersonal skills to manage conflicts. She also mentioned that Billy tends to test boundaries with adults and classroom rules. She explained that over the past 2 months, Billy's behavior has deteriorated.

### **Observations**

*Classroom Observation (January 31, 2016):* Billy was observed in Ms. Cynthia Pleasant's class for 20 min. The initial part of the observation occurred during silent reading time. Billy had gone to the bathroom and returned approximately 5 min later. Billy required prompting on two occasions to return to class as soon as he finished using the bathroom. Upon returning to class, Billy approached his new TSS worker. The two greeted each other and then Billy was instructed to go over to his group to begin a group activity. Billy worked within a small group for the next 10 min. He required several redirections to remain on task. Impressions of the observation were that Billy required considerable structure and support to sustain his attention on the activity.

*Observation during Assessment:* Billy was active and impulsive throughout the testing session. He required considerable structure and support to sustain his attention on the testing session. At times, Billy would attempt to peer over the administration book to see what the examiner was doing. He also asked on numerous occasions when the testing session would be completed. With considerable prompting, structure and support, Billy was able to complete the testing. The results are considered to be a valid indication of his abilities.

### **Conceptualization and Classification**

Multiple data sources and methods of assessment inform the conceptualization of Billy's cognitive, academic, social-emotional, and behavioral functioning include whether he qualifies for special education support. Details in support of these findings are offered below.

*Cognitive and Academic Functioning:* Billy's performance on measures of cognitive ability was in the average range (RIAS Composite IQ=96; 39th percentile) with an average verbal intelligence index (Std. Score=98; 45th percentile) and non-verbal intelligence index (Std. Score=96; 39th percentile). Billy's performance on the WJ-IV was in the average range in reading and writing with a low average range on the mathematics composite. Billy is presently performing at or slightly above second grade level standards in the classroom setting.

*Social-Emotional Functioning:* Billy is a child who experiences considerable behavioral difficulties at school. He has an outside diagnosis of Attention-Deficit/Hyperactivity Disorder, Combined Type (ADHD; 314.01) and Disruptive Behavior Disorder (312.91). Billy takes Concerta (27 mg) and Tenex for the management of his behavioral symptoms. He has been assigned a TSS worker and a behavior specialist coordinator. Billy has been suspended, written up or sent to CARES on numerous occasions for behaviors that include hitting, kicking, rough housing, fighting, slapping, bullying, and pinching other students. He has also received discipline reports for other behaviors including destroying property of others, inappropriate touching, disregard of school rules, lying, and using inappropriate behavior. Background reports reveal that Billy faces difficulties with attention, impulsivity, hyperactivity, rule compliance, aggression toward others, and social skills. The end result has been consistent need for structure and behavioral support. Despite Billy's behavioral and social difficulties, his academic attainment across both standardized achievement and classroom measures suggests grade appropriate progress. As a result, a special education classification is not appropriate at this time. Instead, Billy may benefit from a Section 504 plan for his behavioral and social difficulties.

*Summary:* Billy is performing at grade expected levels in the classroom. He faces behavioral and social difficulties at school for which he has received a TSS worker and a behavior specialist coordinator. Although Billy faces behavioral and social difficulties at school, these difficulties do not appear to be impairing his educational progress.

### Conclusions and Recommendations

Billy Smith is a child who is experiencing considerable behavioral and social difficulties at school. His academic progress is at grade expected levels. Considering Billy's performance on measures of achievement, cognitive ability and behavior, combined with actual classroom performance, academic grade reports, parent interviews, behavior observations, and teacher interviews, Billy is not eligible for special education support. However, he will benefit from a Section 504 plan. The following might benefit Billy.

1. *Individual Counseling and Behavioral Support*: Billy will benefit from counseling and behavioral support for the following difficulties:
  - (a) Boundary awareness.
  - (b) Low frustration tolerance.
  - (c) Oppositionality and rule noncompliance.
  - (d) Social skills difficulties including aggression toward other students.
  - (e) Being disrespectful to adults in the classroom.
  - (f) Impulsivity, hyperactivity, and inattentiveness (see below).
2. *Strategies for difficulties with Attention, Distractibility, and Loss of Focus*: Background reports indicate that Billy experiences difficulty with attention, impulsivity and distractibility. As such, the following recommendations might be beneficial for him:
  - (A) *Check In, Check Out, and Behavior Report Card*: Billy should have his behavioral expectations reviewed at the beginning of the school day. He should check in with an adult periodically throughout the day to determine whether his goals are being met. At the end of the day, Billy should check out with that same adult and receive a behavior report card that acknowledges his behavioral performance and is sent home to his caregivers.
  - (B) *Provision of Directions by Teacher*: When Billy's teachers interact with him, he should be encouraged to repeat and explain instructions to ensure understanding. The provision of directions to Billy will be most effective when the teacher makes eye contact, avoids multiple commands, is clear and to the point, and permits repetition of directions when needed or asked for.
  - (C) *Positive Reinforcement and Praise for Successful Task Completion*: Billy's teachers should provide positive reinforcement and immediate feedback for completion of desired behaviors or tasks. Initially, praise and reinforcement should be offered for successful effort on a task or behavior regardless of quality of performance.
  - (D) *Time on Task*: Communicate to Billy how long he will need to engage in or pay attention on a particular task. Open ended expectations can be distressing to any child, let alone one with attentional difficulties.
  - (E) *Prepare Student Discreetly for Transitions*: Furnish Billy with verbal prompts and visual cues that a new activity or task is about to start. This should be accomplished discreetly so as to avoid student embarrassment.

- (F) *Recess Time*: Billy should be permitted to participate in recess. Recess should not be a time to complete unfinished classwork or homework.
- (G) *Extended Time, Teacher Check In's, Assignment Adjustment, and Frequent Breaks*: Billy should be permitted additional time to complete academic tasks and projects. Billy's teachers should also consider review of classwork as Billy progresses on an assignment or project to assist Billy in avoiding careless mistakes. He may benefit from chunking assignments or assignment reduction. More frequent breaks than what is typical may also reduce careless mistakes and help to maintain focus.
3. *Psychotropic Medication Compliance and Monitoring*: Billy will benefit from continued compliance with his physician-determined medication plan. Since he recently changed medication from Ritalin to Concerta, it might be beneficial for Ms. Smith to consult with Billy's physician regarding a monitoring plan to determine the effectiveness of his medication.

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