NASET Q & A Corner

I was talking to a parent about her son's recent referral for an evaluation for a suspected learning disability. She said she gave consent to do it. Is consent just a parental signature or is there more to it? What does it really take to give "consent"?

There are many times when the school district must notify a parent in writing of its proposed action and ask for written consent (permission) to carry out this action. One of those times is when the initial evaluation for a suspected disability and eligibility for special education is requested. In general, informed written consent means that the parents have been given all the information that is needed to make a knowledgeable decision about a proposed activity by the school district regarding their child's education and that they agree in writing to that proposed activity. Parents have the right not to give their consent. They also have the right to revoke their consent at any time.

Under IDEA 2004, consent means:

1. That the parent has been fully informed, in his or her native language or other mode of communication, of all information relevant to the activity for which consent is sought.

2. The parent understands and agrees in writing (the parent's signature) to the carrying out of the activity for which the parent's consent is sought.

3. The consent describes that activity and lists any records that will be released and to whom.

4. The parent understands that the granting of consent is voluntary and may be revoked prior to the action requiring consent transpiring

Note: Parental Consent is not required:

- before reviewing existing data (information) as part of an initial evaluation or a reevaluation.
- administering (giving) a test or other evaluation that is given to all students (unless parents of all students must give consent before the test is given).
- to conduct a reevaluation if the school district can show that it has taken reasonable measures to get a parent's consent, and the parent did not respond.

It is important to understand that written consent to evaluate a child for the first time is not the same as the consent that places a child into special education and gives him/her related services. A separate written consent is required to begin a child's special education program. Parental consent for evaluation should not be construed as consent for placement or receipt of special education and related services.

If a parent refuses consent for an initial evaluation, the child cannot be evaluated. If a parent refuse permission for the school district to conduct either an initial evaluation, the school district

may request mediation or a due process hearing. If the mediation results in parental consent to evaluate, or a hearing officer decision indicates that testing is appropriate and the parent does not appeal, then the child may be evaluated.

If a refuse written consent for any proposed activity for which written consent is required, the child's current educational placement will not change unless the parent and the school district reach agreement on a different course of action or until due process procedures have been completed.

I was recently speaking to a parent of an 18 month old boy. She is knowledgeable about signs of autism when children are 2 or 3 years of age but wanted to know what the most common early indicators of autism were. Are there any "early indicators" of autism?

Early indicators of autism include the following symptoms exhibited by a child:

1. May appear to be deaf. Does not have typical startle response. Does not turn when you come into the room. Seems unaware of sounds in the room, etc.

2. May be an extremely "good" baby - seldom cries, is not demanding, seems very content to be alone OR is a very fussy, colicky baby - cries a lot, has sleep problems, is not easily comforted.

3. May "hand-gaze," look at lights through fingers, or have other self-stimulatory behavior.

4. May be a fussy eater.

5. Does not have anticipatory response. Does not extend his/her arms to be picked up. Does not seem to want to be held.

6. Seems to avoid actively looking at people.

7. Seems to "tune out" a lot. Is not aware of what is happening around him/her.

8. Wants things to "stay the same." May have difficulty adapting to winter coat or boots. Wants to wear the same clothes. Does not want furniture or toys to be "out of place."

9. Does not begin to talk or use words in a communicative way at the appropriate age. Fails to develop language or uses echolalic speech without really understanding the meaning of the words.

10. Often seems to be a perfectionist. Wants everything to be "just right." If he/she tries to make something work and it does not, he/she gets upset and will quit, or will get angry and refuse to try the activity again.

11. Often has "splinter skills" in areas like music, or can do puzzles extremely well, or has excellent gross motor skills, or is very interested in numbers and letters.

12. May have very high tolerance for pain. May get hurt but not come to an adult for comfort.

13. May become very upset by changes in routine.

14. May not spontaneously imitate the play of other children.

15. May have difficulty applying information from one setting to another.

16. May experience extreme sensory sensitivity.

Recently at an IEP meeting for a child, the child's foster parent attended. Is this person consider the "parent" under IDEA 2004?

A parent or guardian of a student with a disability can include:

- A natural or adoptive parent or guardian of a student
- A foster parent or guardian, unless state law, regulations, or contractual obligations with a state or local entity prohibit a foster parent or guardian from acting as a parent or guardian
- A guardian (but not the state if the student is a ward of the state)
- An individual acting in the place of a natural or adoptive parent or guardian (including a grandparent-guardian, stepparent-guardian, or other relative) with whom the student lives, or an individual who is legally responsible for the student's welfare
- A surrogate parent or guardian who has been appointed in accordance with IDEA regulations, sometimes referred to as an educational surrogate parent (ESP) (An ESP is a trained volunteer who is appointed as an advocate for a student who is in state custody, such as foster care, and whose parent or guardians are unable or unwilling to advocate for that student.)

Also note that if a judicial decree or order identifies a specific person or persons to act as the parent or guardian of a student or to make educational decisions on behalf of a student, then such person or persons is considered to be the parent or guardian for the purposes of §20 U.S.C. 1401(23).

I'm looking at an educational report of a child and it reports stanines. What is that?

A stanine, an abbreviation for "standard nines," is a type of standard score that has a mean of 5 and a a standard deviation (SD) of 2. Stanine scores can range from 1 to 9. If a student performs at the average level, he receives a stanine score of 5. A stanine of 7 is 1 SD above the mean (5 + 2). Astanine of 9 is 2 SDs above the mean (5 + 2 + 2). Conversely, a stanine of 3 is 1 SD below the mean (5 – 2) and a stanine of 1 is two SDs below the mean (5 – 2 – 2).

There is a child in our school that we feel needs to be evaluated for a possible disability. The parents refuse to give consent. Do we need their consent?

The district by law needs the parent's or guardian's consent for an evaluation. A request for an evaluation should not be misinterpreted as an automatic decision that the student has a disability. When the district asks for the parent's or guardian's consent, it is a means of ensuring that the parents or guardians have full knowledge of the district's actions. For the district to involve the parents or guardians in the decision making is part of due process. The parent or guardian will need to fully understand the reasons for an individual evaluation for special education. Parents and guardians have the right to request an informal conference if they have any questions about the purpose or type of evaluation proposed or if they do not want their child evaluated. This conference may be held with the committee chairperson, building principal, or any other professional who will be part of the assessment team. The parent or guardian may even contact the board of education. The parent or guardian or the school may withdraw the IEP Committee referral within a specified period of time if the parent or guardian and the referring party agree to another plan that better suits the student's needs. If, however, they do not reach agreement on the student's evaluation, due process options are available.

I keep hearing about all the kids with ADHD. Bottom line, how many kids are actually diagnosed with ADHD? Is it really so many more boys than girls?
ADHD is one of the most commonly diagnosed behavioral disorders of childhood.

The disorder is estimated to affect between 3 to 7 out of every 100 school-aged children (American Psychiatric Association, 2000). In the United States, an estimated 1.46 to 2.46 million children (3 percent to 5 percent of the student population) have ADHD. Although for years it was assumed to be a childhood disorder that became visible as early as age 3 and then disappeared with the advent of adolescence, the condition is not limited to children. It is now known that while the symptoms of the disorders may change as a child ages, many children with ADHD do not grow out of it (Mannuzza, Klein, Bessler,
Malloy, & LaPadula, 1998). Boys are four to nine times more likely to be diagnosed, and the disorder is found in all cultures, although prevalence figures differ.

What classification of disability has the largest disparity between boys and girls in special education?

Males are significantly more likely than females to fall within each major disability group. The largest disparity is within the category of emotionally disturbance, where boys comprise some 80 percent of the population. Among the general population of students in grades 1 to 8, there are more boys with emotional disturbance (7 percent of all boys in special education are classified as emotionally disturbed) than girls (4 percent of all girls in special education are so classified). Sources document that boys outnumber girls at about five to one (Hallahan & Kauffman, 2003; Hardman et al., 2005; Heward, 2006; Turnbull et al., 2004).

Is it true that African American males are overrepresented in the special education classification of Emotional Disturbance?

According to Turnbull et al. (2004), African American males are overrepresented in the category of emotional or behavioral disorders. The special education community faces three challenges in terms of this high identification rate: (1) unavailability of culturally appropriate assessment instruments, (2) concern about teacher expectations regarding appropriate behavior, and (3) building respectful family-professional partnerships that may prevent identification. Ethnically diverse groups are more likely to experience stressors such as `poverty, discrimination, violence, violent death, drug and alcohol abuse, and teenage pregnancy' that can contribute to mental health problems (p. 144).
Although African Americans comprise 14.8 percent of the school population, they comprise nearly 27 percent of the students who receive special education services as having and emotional disturbance (U.S. Department of Education, 2004).

Administrators in our school have been talking about "high risk" students. Yet, there is no such term as a special education category? What does it mean to be a "high risk" student?

The determination of who will receive a comprehensive assessment for a suspected disability is a process that normally begins with the local school. In most states, each school will have a committee called the Child Study Team (Pupil Personnel Team, School Based Support Team etc.) which reviews children who are considered high risk. A high risk child is any child who is experiencing social, academic, emotional, medical, language, perceptual, or environmental turmoil that prevent him/her from performing up to his/her ability in school. As a result of this intense turmoil, many symptoms are generated in a dynamic attempt to alleviate the anxiety. They can show up in many different behavior patterns. Some of the more common ones that can be exhibited by either elementary or secondary students while in school are:

- A history of adequate or high first quarter grades followed by a downward trend leading to failures in the final quarter.
- A history of excessive absences.
- A history of excessive lateness.
- Frequently cannot separate from parent at the start of the school day. While this can be normal behavior in very young children, it becomes a more serious symptom after age 6 or 7.
- High achievement scores and high school abilities index with a history of low academic performance.
- Consistent failure in two or more quarters of at least two subjects.
- A history of parent "coverage" for inappropriate behavior, poor work performance, poor attitude, failures, or absences.
- Students wandering the halls after school with no direction or purpose.
- A history of constant projection onto others as a reason for a lack of performance, handing in work, failures, or cutting.
- A history of feeling powerless in the student's approach to problems.
- Recent stress related experiences i.e. divorce, separation, death of a parent or parent's loss of employment.
- A history of constant visits to the nurse.
- Social withdrawal from peers with an emphasis on developing relationships with adult

We use the word “hyper” all the time to describe an active child. Yet, I know that a child with ADHD will often have “hyperactivity.” How is “hyperactivity” different from just boys being boys or kids with just more energy than others?

Excessive activity is the most visible sign of ADHD. Studies show that these children are more active than those without the disorder, even during sleep. The greatest differences are usually seen in school settings (Barkley, 2000). Many parents find their toddlers and preschoolers quite active. Care must be given before labeling a young one as hyperactive.

At this developmental stage, a comparison should be made between the child and his or her same-age peers without ADHD. In young children, usually the hyperactivity of ADHD will come across as "always on the go" or "motor driven." You may see behaviors such as darting out of the house or into the street, excessive climbing, and less time spent with any one toy. In elementary years, children with ADHD will be more fidgety and squirmy than their same-age peers who do not have the disorder. They also are up and out of their seats more. Adolescents and adults feel more restless and bothered by quiet activities. At all ages, excessive and loud talking may be apparent. (APA, 2000).

Hyperactive children always seem to be "on the go" or constantly in motion. They dash around touching or playing with whatever is in sight, or talk incessantly. Sitting still at dinner or during a school lesson or story can be a difficult task. They squirm and fidget in their seats or roam around the room. Or they may wiggle their feet, touch everything, or noisily tap their pencil. Hyperactive teenagers or adults may feel internally restless. They often report needing to stay busy and may try to do several things at once.