

Issues in Multidisciplinary Assessments for Special Education:
A Position Paper

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Among the many roles of psychologists are assessing abilities of clients, especially in schools. In some states, they have been historically employed as persons who give intelligence tests and other evaluations to children who are in trouble academically and behaviorally. They are seen as the one who gives the IQ tests. This is both a valued part of what is seen as necessary in schools and needs a thorough examination. A detailed look at the role of school psychologists as multidisciplinary team members is given here.

One of the major tenets of the Individuals with Disabilities Education Improvement Act of 2004 is the concept of a multidisciplinary assessment. History is filled with cases studies of persons who were identified as disabled by a physician or a psychologist and placed in special education or even an institution for education or treatment. This too many times has been a one way street, getting into programs and never getting out. This occurred when assessments were given at initial identification but not followed up with re-evaluations. Congress recognized this as IDEA was written and added to the law a full multidisciplinary diagnosis to be identified as disabled and required a re-evaluation every three years to remain labeled and disabled and to stay in special education.

This has been chipped away with IDEA revisions over the years, sometimes at the cry of psychologists who tire of being considered as just the guy or lady with the test kit and certainly at the complaint of state departments of education and school districts who see first this assessment as expensive and filled with meetings and paperwork and unnecessary because of a feeling that children with disabilities do not change much anyway and new assessments do not reveal any unknown or new information, often looking just like the old evaluations.

I suggest this is not a good idea for multiple reasons, Re-evaluations are a check on misdiagnosis in the first place, second children do change over time and often disorders once had no longer manifest or they worsen. Speech and language should improve with age, vision may deteriorate, and behavior changes for better or worse as one develops socially and becomes involved with new and more sophisticated peer groups over the years. A third reason re-evaluations should be done is that our educational programming should be having an effect and we need summative checks on this growth (multidisciplinary assessments) as well as formative evaluations by service providers (teachers and therapists) as the child is learning.

There are seven domains of a thorough multidisciplinary evaluation to identify a child for special education. First we check the child's input and output systems, for obvious reasons. We want to know how to communicate with each child evaluated and how he or she might communicate with us. We initially then evaluate sensory information. While there are many sensory systems, more than the five taught in elementary school (vision, hearing, touch, smell and taste), such as the vestibular system, the proprioceptive system, the measurement of how well one can perceive humidity, temperature (internal and external), how well one can sense his need for food (hunger) or water (thirst), most of these sensory measurements are not needed to determine if the child can process information of the world about him and communicate with it.

Hearing and vision are extremely useful to a multidisciplinary assessment and are the first two domains one should assess. If one cannot hear or has impairments in hearing, this clearly redirects the remainder assessment battery. One would not give tests that require hearing to measure achievement or intelligence when the child has an uncorrectable hearing impairment. Assessment in a visual mode might work or assessment through sign language interpretation could happen if this occurs. The same concerns exist about vision. If on vision tests we find a child with a significant vision loss uncorrectable with glasses, the child should not be assessed with standard procedures where vision matters. Either large print material or assessment in Braille or auditory ways to measure achievement or cognition should be used.

Third we should determine the speech and language capacities of a child before we proceed with testing. Does he speak? If not how does he communicate? If he speaks, is it in English, and if not what is his native language? We are required to either assess in the child's native language or use language free tests so we do not have an evaluation that discriminates against a child in an inappropriate manner. Some non-language or language free tests exist to measure intelligence and basic achievement in pre-academic learning. Academic learning almost always occurs in a linguistic context, in some language. So before we assess academics or intelligence we need to know how children function in speech and language.

The fourth and last domain that measures input and output is health and motor. If the child is motorically impaired (has missing limbs, has severe cerebral palsy, spinal muscular atrophy, muscular dystrophy, cannot sit up, etc.) or problems with stamina (a weak heart, trouble breathing, sickle cell anemia, etc.) this is also important to know before we expect more of him or her than can be delivered. One could think when the child shuts down that the child is not knowledgeable when in actuality he or she is just exhausted and may need more rest or time to be assessed. Children with other health problems (diabetes, infectious diseases, compromised immune systems, etc.) should have these examined thoroughly before they are tested as well.

Once we understand and have accommodated for the way the child obtains information, can communicate with others and use the skills they have, then we need to plan the cognitive assessment (intelligence levels and how well one uses intelligence through adaptive behavior). There are many standardized individual intelligence tests. Group tests are not to be used for purposes of special education identification, for we need to know one-on-one how a child performs with an examiner. The major tests used are the Stanford-Binet Scales of Intelligence (currently the 5th edition) and the Weschler tests of intelligence of which there are three major ones: Weschler Adult Intelligence Scale (WAIS), the Weschler Intelligence Scale for Children (WISC) and the Weschler PreSchool and Primary Scale of Intelligence (WPPSI). Each is in its fourth edition. The WAIS is for persons 16-90 years old, the WISC for those 6 to 16 and the WPPSI from age 2.5 to 7 years and three months. Wechsler also publishes a nonverbal scale and a quick screening device. Other less prominent general use individual instruments that can measure intelligence are the Kaufman Assessment Battery for Children (KABC), the Kaufman Adolescent and Adult General Intelligence Test, and the Woodcock-Johnson Test of Cognitive Abilities.

There are a fairly length array of tests for populations with differences that can be found with hearing, vision, motor skills, developmental limits, etc. For example the Leiter International Performance Scale-Third Edition (authored by Gail Roid, who wrote the current Stanford-Binet) is a nonverbal test of intelligence used for nonverbal children, non English speaking children (since the test is given with no spoken words by either the examiner or the child), deaf children, children with severe expressive and receptive language impairments and children with autism. Always there is a language deficit inherent in this disability. Another test that purports to make this measurement is the UNIT (Universal Nonverbal Intelligence Test). The TONI-3 (Test of Nonverbal Intelligence) is another of these. The Cattell Culture Fair tests are also used to measure children's ability nonverbally.

The Haptic Intelligence Test for the Adult Blind can be adapted for children and the Williams Intelligence Test for Children with Defective Vision is designed for youngsters who are blind and partially sighted. The Das-Naglieri Cognitive Assessment System measures cognitive processes rather than ability.

A measure that is good for children with limited physical ability is the Pictorial Test of Intelligence-2, the second edition of the French Pictorial Test of Intelligence. Also useful for this group of children is the Columbia Mental Maturity Scale-3. These tests show children pictures and one can respond by nodding, with eye blinks, or if possible by touching the stimulus drawings after a verbal prompt.

The Bayley Scales of Infant Development and the Battelle Developmental Inventory are both designed for very young children. The Bayley has items that can be given after the first three days of life and multiple measures for the first ten days. About 100 items are normed for children less than one year old. It stops at 30 months. The Battelle has items from birth to age seven.

Last to be discussed among this group is the Callier Azusa Scale, which comes in a form G and H. Both measure multiple skills with G the measure of ability including cognition, and H measuring language skills. The value of the Callier Azusa is a focus on very low functioning or young children. There are multiple items that can be given in multiple domains. One of the things that make the Callier Azusa valuable is the directions permit third party administration when a child is not cooperative. One can ask a reliable informant who knows the child well (teacher, parent, teacher assistant, etc.) and credit the child with items even if the psychologist does not see the child perform them as long as it is indicated this is done in the report written about the assessment. The reader is forewarned and should beware if the reporter's reliability is biased or questioned.

Many of these instruments do not give IQ scores but developmental ages, from which, if one knows the child's birthdate, a deviation IQ can be computed if one is desired. It is not necessary to obtain an IQ score to get an intellectual assessment, but often one needs some standard score from which to make a comparison to a norm group.

Adaptive behavior measures are given to contrast with ability measures. One's cognitive assessment is a comparison of tested ability (IQ or developmental level) compared to how one uses this ability (adaptive behavior). How smart is the child and does this ability help one get in out of the rain. Some folks have average or high ability and no common sense. But if one has average adaptive behavior and a low tested intellectual level, likely the intelligence or developmental test is not accurate. If one is smart adaptively, one most generally is smart intellectually, and if the score is low, then somehow in the hour or so the psychologist took to test the child, the child did not perform typically or the wrong test was used that looked through a clouded window. For example a child with a hearing impairment with good adaptive behavior would likely score low on a verbal IQ test. This would not give a clear but a cloudy view of intellectual ability, for such ability would be masked by one not hearing the questions well, or not understanding the expected performance.

Once adaptive abilities are compared to intellectual skills, one tests achievement, the sixth domain. In school aged children this is most often with individually administered achievement tests. The Woodcock Johnson Reading Mastery Test, the Key Math test, the Kaufman Achievement Test are but a few of these. Paper and pencil tests can be given, but these must be administered individually where the examiner can observe if the child shuts down and does not try. One cannot take group administered achievement tests and use them as the sole measure of achievement to put a child into special education. They can be considered, but individual tests must be given as well. For younger children developmental tests can be measures of achievement. How well one walks, can do simple tasks, etc., can be measured on the Brigance Inventories or other one-on-one tests of developmental levels.

Finally, following achievement tests, one should be evaluated socially and emotionally. Sometimes this is just a screening...if the child seems normal and has lots of appropriate friends. But it can be that tests such as the Burks Behavior Rating Scale 2 or the Conners Comprehensive Behavior Rating Scale 3 can be used to determine how well one is adjusted socially. Socio-grams can be used and interviews held. If children show psychiatric problems, measures of autism, psychological adjustment, psychoses, etc. can be done in this domain.

This being a multidisciplinary assessment who should do each part? Vision, hearing, and health and motor are generally the purview of the school nurse. She may do the vision screen with a Snellen Chart or a Keystone Telebinocular. If problems are found, the nurse refers the parents to an ophthalmologist or optometrist for a better evaluation and possible glasses or treatment. Hearing tests can be done by the nurse or the speech language pathologist (SLP). If a problem is identified, the child should be referred to an audiologist for a full hearing test. It is obvious that the speech/language pathologist should be doing the diagnostics in the speech and language domain. Screenings can be done by teachers or parents or other professionals, but the evaluation is the purview of the SLPs. The psychologist gives the intelligence test and most often the teacher or psychologist administers the adaptive behavior scale to the parents and may fill one out as well to get a comparison of how the child is seen at school to at home. Teachers give generally achievement tests, and last psychologists most often do social and emotional evaluations.

There are a number of issues regarding multidisciplinary assessments that are important to consider. First to be multidisciplinary, the evaluation must be conducted by more than one discipline. Second this is best done (even if the law no longer specifies this) by more than one examiner. This prevents conflicts between the child and the single examiner that might arise getting a child labeled and placed in special education because these two do not see eye to eye. Third this examination must be by law with more than one test. One cannot make a child eligible for special education because he bombed just one test. This leads to the fourth area that should be considered, the examination should be done at best on more than one day. If the child has a bad day, he then will not end up in special education because of it. Last this examination should be done in more than one setting. Kids may freak out in a test room at school, especially young ones and those low functioning or having little experience with these type of assessments. They may need to be seen in their classrooms, on the playground, in a testing room and even at home if possible. I conclude this section with the following powerful summative sentence. **A multidisciplinary assessment should be more than one test from more than one discipline given by more than one examiner on more than one day in more than one setting.**

There are other issues in assessment that should be noted. Since the time of Alfred Binet in France over 100 years ago and the first intelligence test, these

assessments have been mostly paper and pencil tests best given one to one with a client. Today with the advent of technology, wifi, and the internet, with the use of iPads and tablet like devices, they can be given in Q-interactive formats, without test kits, mostly without paper and pencil and with two iPads, one with the child and one with the examiner. The examiner ask the child a question, the child selects the answer on his iPad. It is immediately scored and calculated on the examiner's iPad. The session goes on until criterion is reached, which will be indicated on the examiner's iPad when the child misses the requisite number. When the date is entered correctly (dates of assessments and birthdates) the test looks up norms and reports scores correctly and instantaneously. While this looks like a great improvement, no materials to arrange or misplace, no test materials (other than the iPad, to be tossed), the stimulus items and prompts just pop up when needed. The problem with this is often new directions were just written to do this without re-norming the test. Tests were originally normed the old fashioned way and this change in protocol is just assumed to be the same when making comparisons to other kids in the norm group. This is not necessarily so. We could be comparing apples to oranges as we compare Q-interactive scores to those from paper and pencil tests, despite the company who sells it protestations to the contrary.

Next there are changes in legal expectations and requirements of tests today compared to the near distant past. IDEA no longer requires re-evaluations of children (as of 2004). Parents can be and most often are asked to waive the re-evaluation. If they do, statements are made that there appears to be no change in the child's level of functioning in areas not assessed. While there is a point to doing this that makes sense, reducing paper work, more wise use of too few psychologists and assessment team time, parents are not equals in the room where this decision is made way too often. They are talked out of a re-evaluation that may be needed and/or desired by the parents. Children do change (that is the point of a special education, to get them to grow and develop), and if we do not document that with an assessment, all too often this change is not noted.

There is continual pressure to use group testing especially in achievement instead of individual achievement tests. This is exacerbated by the presence of plenty of state and federal mandated high stakes test results. Why not use this data instead of individual tests, the question is asked. For we do not know the child put in his best effort, and all assessments have an inherent assumption that the test results are the child's best effort. When this is not so, the test is invalid, not measuring what it was supposed to measure. How will we know that if we do not watch him as he takes the test and if he goes to sleep or starts gazing off into space, redirect him? This cannot be done on state or federal high stakes tests.

A recent federal court case has indicated that a multidisciplinary evaluation can be done by one examiner, in violation of principles written about above. If the examiner holds credentials in more than one dimension. I for example am a licensed school psychologist, a licensed special educator and a licensed general educator. What if I was a nurse too, and a trained and licensed speech/language pathologist?

Could I not then do the entire evaluation? This is, in my opinion, inviting a law suit as soon as a child is misdiagnosed because only one person put eyes on the child.

Permission to test is required by parents when the evaluation does something to the child not done to every child. Without this permission, we legally cannot give the child most individual evaluations. What then happens when we have a child with a disability, we then are unable to assess, then label, then serve the child. IDEA says we must serve every known child, but if some mom says no, we are in a quandary. The solution is to due process the parents for permission to test. Schools are reticent to do this because of the cost of due process and because this sets up a confrontational and adversarial relationship with the parent. So they often let it slide, saying "He is your child." Problem is that later the parent may get a lawyer and get "religion" and sue us for not testing her child over her objection. The law would favor her because we are the smart ones who are required to know the law and she is "just a parent" fumbling in the dark and not knowing any better. Courts in this situation have said over and over again that we must act in the best interest of the child, not in a manner to keep peace with the parents. Try to talk them into an assessment. If not they must be taken to due process to get permission to test. This is not so simple however, for if they lose due process, they can pull the child out of school, move to an adjoining district, or home school the child, all delaying or negating the order to test the child that the hearing officer has written.

It is important to note that parents have the right to a second opinion at district expense also if they disagree with your assessment and ask for it. We must tell them where they can obtain qualified examiners for this second opinion and we must pay for it, unless we go to due process to prove our original assessment is correct and valid. While we likely could do this since we did our work right the first time, I would hope, often this is not practical for the cost of due process far exceeds the cost of an independent evaluation. Once parents know this they can wear us out with such requests. Our control over this is to do our exams well the first time to cut down on those requests and to have excellent public relations with parents so we can charm them and convince them our evaluations are accurate and in the best interest of their child. If parents persist in a second opinion request, offer to do the exam over with another test and with another psychologist or team from the school, where you can control the costs.

In the case a truly independent educational evaluation is demanded, schools should be sure our examiners are equally qualified as the ones chosen by the parent. If the disagreement that leads to the request for an independent evaluation goes to court or due process, there is a presumptive bias to agree with the most qualified examiners.

Last today, the requirement for identification of children with disabilities, especially those with learning disabilities (LD), is shifting. The federal law states that LD assessments can be done by Response To Intervention (RTI) methods. In some states this is mandated as the method of labeling children with a learning

disability. Some have it as an option. RTI as an assessment method is to respond to a referral with asking the teacher or referring agent to change the way the child is being taught to see if he/she responds well to a different intervention. If the child starts learning as desired, then the child is not likely disabled but there was a mismatch between how the child was being taught and how one was learning. RTI methods ask teachers to teach children at least three different ways within the classroom (tier one interventions), then if one does not respond properly, experts (reading specialists, special educators, behavior specialists, etc.) can be brought in to identify other ways to teach the child. If he learns in this tier two intervention, then he is not labeled. Only when tier 3 interventions are needed and used, placing the child into special education, is the child given a label as a child with a disability. This is part of the formal evaluation then given, the multidisciplinary evaluation.

In conclusion, the requirement for a multidisciplinary evaluation is today a moving target in federal requirements and in how it is viewed by schools and parents as well as hearing officers and courts. We should understand them thoroughly and completely and conduct them with utmost care and skill. Children will benefit and schools will save much in money, energy and good will with parents.