

UNIT- III : IDENTIFICATION AND ASSESSMENT

Identification and Assessment of persons with Physical Disability- VI/HI/PH; Intellectual Disability- LD/ASD/ID; Mental Behaviour (MI); Chronic Neurological Conditions; Blood Disorders; Multiple Disabilities; Screening, Diagnostic, Functional and Educational assessment and referral.

UNIT- III IDENTIFICATION AND ASSESSMENT

Disability is a complex and multifaceted concept. The concept and meaning of disability differs across territories along numerous associated legal, political and social constructs. It is generally viewed as a physical or mental condition(s), or both, that limit(s) an individual's movements, activities and sense perceptions. Persons with disabilities are forced to face a lot of discrimination due to prejudices and biases in society. The most vulnerable area that falls prey to the discrimination is "Education". Disabilities are often incurable, however early identification and intervention may facilitate optimum management and also prevent exacerbating the consequent conditions.

The early and appropriate identification of condition/s of disability facilitates special attention for implementation of required educational intervention. This in turn can bring a meaningful difference in the lives of children with disabilities. Need based interventions that are implemented in inclusive educational settings, as early as possible helps children to grow with confidence and self-respect. As a result, children with disabilities can purposefully engage with society.

Identification and Assessment of persons with Visual Impairment

Vision plays a vital role in school learning and it is essential that teachers understand the visual abilities of their students. Serious vision

problems are not common in Papua New Guinea schools but there are some students who have serious vision loss or who are blind. Many students who have mild to moderate vision impairments are not identified as such, so teachers have an important role in detecting vision impairment.

As is the case with hearing impairment and some other disabilities, students with vision impairment can sometimes be mistaken for students with intellectual disability or learning difficulties, so when a teacher finds that a student is struggling at school, they should always check the student's vision and hearing. When vision impairment is not addressed at school, it can lead to learning difficulties and even behavioral problems, as the student misses important information, struggles to keep up with other students, loses confidence and becomes frustrated.

The World Health Organization uses the following classifications of visual impairment. When the vision in the better eye with best possible glasses correction is:

- ✓ 20/30 to 20/60 is considered mild vision loss, or near-normal vision
- ✓ 20/70 to 20/160 is considered moderate visual impairment, or moderate low vision
- ✓ 20/200 to 20/400 is considered severe visual impairment, or severe low vision.

In the United States, a person with

- ✓ 20/200 in the BETTER eye is considered legally blind.
- ✓ 20/500 to 20/1,000 is considered profound visual impairment, or profound low vision
- ✓ less than 20/1,000 is considered near-total visual impairment, or near total blindness no light perception is considered total visual impairment, or total blindness.

The International Classification of Diseases 11 (2018) classifies vision impairment into two groups, distance and near presenting vision impairment. Distance vision impairment:

- ✓ Mild – presenting visual acuity worse than 6/12
 - ✓ Moderate – presenting visual acuity worse than 6/18
 - ✓ Severe – presenting visual acuity worse than 6/60
 - ✓ Blindness presenting visual acuity worse than 3/60
- Near vision impairment

Presenting near visual acuity worse than N6 or M.08 with existing correction. Globally, it is estimated that at least 2.2 billion people have a vision impairment or blindness, of whom at least 1 billion have a vision impairment that could have been prevented or has yet to be addressed.

These 1 billion people include those with moderate or severe distance vision impairment or blindness due to unaddressed refractive error (123.7 million), cataracts (65.2 million), glaucoma (6.9 million), corneal opacities (4.2 million), diabetic retinopathy (3 million), and trachoma (2 million), as well as near vision impairment caused by unaddressed presbyopia (826 million).

The term “early intervention” has a literal meaning—intervening in a child’s development to provide support at an early time in his or her life. Under the Individuals with Disabilities Education Act (IDEA), infants and toddlers with disabilities who are eligible for early intervention, and their families, can receive early intervention services from the time the child is born until 3 year of age.

Physical signs of vision problems include eyelids drooping over one or both eyes, or eyelids that do not completely cover the eyes when the child closes them. If a child has a clear squint, has jerky eye movements, or has eyes that do not move together, parents should see a pediatric ophthalmologist. Other signs include:

- ✓ Not looking at others in the eyes

- ✓ Reaching in front of or beyond an object
- ✓ Holding objects very close or very far to see them
- ✓ Turning or tilting his head when he uses his eyes
- ✓ Continuously pushing or poking his eyes
- ✓ Looking above, below or off to one side of an object, rather than directly at it
- ✓ Bumping into objects and having a lot of trouble seeing at night
- ✓ Feeling for objects on the ground instead of looking with her eyes

Early intervention may be helpful in preventing children from displaying blindish behaviors. A qualified teacher should arrange an early education program to help develop accurate and effective use of the child's senses. The parents should also be included in such programs together with their visually impaired children as most parents are unaware of techniques used to teach visually impaired.

- ✓ Holds objects and books too close or too far.
- ✓ Rubs eyes extensively / watery eyes.
- ✓ Take help from peers to copy from the blackboard.
- ✓ Blinks more frequently / regular headaches.
- ✓ Not able to write in the prescribed space/line.
- ✓ Feel difficult to identify objects/people at a distance.
- ✓ Not able to follow moving objects.
- ✓ Poor eye-hand coordination.
- ✓ Depending too much on oral information.
- ✓ Not able to identify/match the colours.
- ✓ Unable to recognize the actions and facial expressions.
- ✓ Not able to read in poor lighting conditions.
- ✓ Covers one eye and tilts the head forward
- ✓ Holds objects and books close to the eyes.
- ✓ Asks other children when taking notes from the blackboard
- ✓ Squints eyelids together
- ✓ Bumps into people or objects
- ✓ Unable to participate in games requiring distance vision

- ✓ Excessive sensitivity to light
 - ✓ Crossed eyes
 - ✓ Red rimmed, encrusted or swollen eyelids
 - ✓ Inflamed eyes
 - ✓ Eyes itch, burn or feel scratchy
 - ✓ Blurred or double vision.
- ✓ The disabilities occurring or developing in childhood should be identified as early as possible to have a better habilitation process. The fact that infancy and early childhood are critical periods in the development of an individual itself substantiates the essentiality of the process of early intervention.

Identification and Assessment of persons with Hearing impairment

Children can have communication problems for a variety of reasons. In many cases, a communication problem is the result of another disability, such as intellectual disability, severe learning difficulties, physical disability (e.g., cerebral palsy, cleft lip or palate), deafness or moderate hearing loss, or an emotional or psychological disorder. In other cases, and for no obvious reason, children have difficulty learning, understanding or expressing language.

There are three types of communication problems:

- ✓ **Expressive problems** are the most obvious communication problems. Children may be unable to sequence sentences properly so they use incorrect word order or grammar, or just speak in one-word sentences.
- ✓ Children may have articulation problems, where they cannot physically produce certain sounds or words, or where they stutter. Some children speak too softly or too loudly and others speak in a monotone, without using expression.
- ✓ **Problems with interacting** Some children lack good social and conversational skills. They don't know how to take turns when talking,

they don't know how to begin or end a conversation, or PD they might not make eye contact or use appropriate body language. Some children also cannot pick up the subtle expressions and emphases in language.

Receptive problems Difficulties with the comprehension and understanding of spoken language -receptive problems, are less obvious than other speech problems and more difficult to identify than other problems. Nevertheless, they can have serious consequences for children's learning and development. Children with receptive problems struggle with the meanings of words and the meanings of sentences. They often have difficulty with the subtleties of language and with abstract concepts. They can have problems making predictions and inferences in language. Sometimes they appear to have appropriate expressive skills but this is often just meaningless chatter.

Students with hearing impairments will benefit from front-row seating. An unobstructed line of vision is necessary for students who use interpreters and for those who rely on lip-reading and visual cues. If an interpreter is used, the student's view should include the interpreter and the lecturer.

- ✓ Do not speak facing the blackboard
- ✓ Whenever possible, utilize circular seating arrangements as they offer Deaf or hard-of-hearing student the best opportunity to see all class participants
- ✓ Be aware of the fact that hands, books, or microphones in front of your face can add to the difficulties of lip readers
- ✓ Keep your face within view of the student and speak in a natural tone
- ✓ When an interpreter is being used, speak directly to the student, not to the interpreter
- ✓ Recognize the brief amount of extra processing time that it takes for the interpreter to translate a message from its original language into another language because this will cause a delay in the student's receiving information, asking questions, and/or offering comments

- ✓ Repeat the questions or remarks of others in the room-Acknowledge who has made the comment so that the hard-of-hearing student can focus on the speaker
- ✓ Use visual aids to reinforce spoken presentations whenever possible
- ✓ Whenever possible, provide the student with class outlines, lecture notes, lists of new technical terms and printed transcripts of audio and audio-visual materials
- ✓ Do not hesitate to communicate with the student in writing when conveying important information such as assignments, scheduling and deadlines
- ✓ Whenever possible, try not to speak when the person is writing.
- ✓ Do not shout!!
- ✓ Be amenable to wearing a microphone transmitter for use with an assisted listening device if asked
- ✓ If there is a break in the class, be sure to get the hard-of-hearing student's attention before resuming the lecture
- ✓ Be flexible: allow a Deaf student to work with audio-visual material independently and for a longer period of time
- ✓ Allow the student the same anonymity as other students (i.e. avoid pointing out the student or their accommodations to the rest of the class)

Hearing impairment is a latent disability. Hearing loss can manifest in many different ways. Depending on the degree or severity of the hearing loss, symptoms can range from occasional difficulty understanding words to inability to communicate with others and socialization.

- ✓ The child experiences difficulties following oral presentations and directions.
- ✓ Watches the lips of teachers/speakers very closely.
- ✓ Often asking people to repeat.
- ✓ Turns head and leans towards the speaker.
- ✓ Child cannot localize sound (tell where sound is coming from).

- ✓ Use limited vocabulary.
- ✓ Uses speech sounds poorly.
- ✓ Child does not startle when a loud sound is present.
- ✓ Often does not respond when called from behind.
- ✓ Shows delayed speech and language development.
- ✓ Generally inattentive during oral presentations and the perception those others are mumbling.
- ✓ Constantly turns the volume up on radio or television or has discharge.
- ✓ Complains of earaches, frequent colds, or ear infections.
- ✓ A learning disability diagnosis, poor performance in school.

Hearing impairment is a hidden disability, and the symptoms can be classified based on the severity of the hearing loss. Due to hearing loss, not only normal verbal communication but also psychological feelings also affect.

Children with mild or moderate hearing loss can have difficulties in learning and developing the necessary speech and language skills that help them to foster self-esteem and the ability to succeed at school and gain employment. If not detected early, hearing loss can change the way children speak, learn and interact with others.

Soon after born, through neonatal hearing screening, the child's hearing abilities should be assessed. This gives enough time to the hearing health professionals to manage a young child's hearing loss with effective habilitation.

Cognitive impairments are varied, but may be categorized as memory, perception, problem-solving, and conceptualizing disabilities. Memory problems include difficulty getting information from short-term storage, and long-term and remote memory. This includes difficulty recognizing and retrieving information.

Perception problems include difficulty taking in, attending to, and discriminating sensory information. Difficulties in problem-solving include recognizing the problem identifying, choosing, implementing solutions, and evaluating of outcomes. Conceptual difficulties can include problems in sequencing, and generalizing previously.

Identification of Speech Impairment:

Various techniques are used but one such technique is to know the behavioral clues to detect speech defects.

- ✓ Faulty articulation or pronunciation-substitution (Cree for tree) omission (ate for gate); distortions (ship for sip).
- ✓ voice quality-nasality, (too much sound through nose hoarseness, harshness Notes (irritation), breathiness.
- ✓ Defective voice-too high or too low; too loud or too soft; monotonous voice.
- ✓ Stuttering, cluttering.
- ✓ Difficulty in understanding the meaning of spoken words/sentences.
- ✓ Difficulty in formatting oral sentences. Speech is defective when it deviates so from the speech of other people that it calls attention to itself, interferes with communication, or causes the possessor to be maladjusted.

Language problems should be considered significant if they interfere with communication if they cause the speaker to maladjusted or if they cause problems for the listener

Teachers will want to reduce unnecessary classroom noise as much as possible. This helps the child focus without contending with the extraneous noises which assist understanding and comprehension.

- ✓ Be sure to be near the student when giving vocal instructions and ask the student to repeat the instructions and prompt when necessary. Provide verbal clues often.
- ✓ Provide a quiet spot for the student to work whenever possible.
- ✓ Speak slowly and deliberately.

- ✓ Provide visual cues - on the blackboard or chart paper.
- ✓ Focus on the student frequently and provide step-by-step directions - repeating when necessary.
- ✓ Use gestures that support understanding.
- ✓ Avoid correcting speech difficulties - this will lead to weaker self-esteem much more important to model correct speech patterns.
- ✓ Touch base with the speech/language pathologist to ensure the correct accommodations are in place. The learning environment needs to be positive.
- ✓ Capitalize on the student's strengths as much as possible.
- ✓ Be patient when the child is speaking, rushing a child with difficulties magnifies the frustration level.

More specifically the regular classroom teacher has to discharge certain responsibilities. He has to:

- ✓ Refer the pupil to a speech therapist.
- ✓ Integrate speech and language activities throughout the school day with whatever subject is being taught.
- ✓ Provide a good speech and language model.
- ✓ To improve comprehension use short phrases, sentences, and questions when speaking to pupils.
- ✓ Use concrete experiences and role-playing the meaning of words, sentences, and stories.
- ✓ Provide visual clues such as pictures.
- ✓ Give them enough time to gather their thoughts before they speak out.
- ✓ Give verbal directions, riddles, and display interesting pictures and ask them to express or describe.
- ✓ Read stories aloud and ask questions about the story.
- ✓ Repeat words in sentences, and use analogies (A dog is to cat as a tree is to).
- ✓ Have pupils tell how these are alike or different

Identification and Assessment of persons with Physical Disability

Physical disabilities place some limitations on a person's ability to move about, use their limbs or hands or control their own movement. Physical disabilities are the most obvious disabilities, as a rule, although there are some conditions that limit movement and mobility in less obvious or inconsistent ways (e.g., epilepsy, cystic fibrosis, diabetes). Students with more severe physical disabilities often have related health problems and, of course, physical disabilities are often a symptom of health problems.

Identifications of Orthopaedic Impaired Children:

Identification of orthopedically children is very easy in comparison with other disabilities like partial sightedness and hearing impairment etc. There are some children who have problems of a mild degree which may be overlooked. For these cases, identification can be made with the help of the following checklist on behavioral manifestations. The orthopedic impaired children can be identified by putting the following questions:

- ✓ Poor motor control or coordination. The child is unable to coordinate two or more muscle groups for performing any task.
- ✓ Walks awkwardly or with a limp.
- ✓ Shows signs of pain during physical exercise.
- ✓ Difficulty in picking holding and putting in some place.
- ✓ Move in a shaky fashion.
- ✓ Falls frequently.
- ✓ These children have poor motor control and coordination.
- ✓ These children show signs of pain during physical exercise.
- ✓ Deformity in fingers, legs, hands, spine, neck.
- ✓ Frequent pain in joints.
- ✓ Jerking movement in walking.
- ✓ Amputated limbs and

- ✓ Difficulty in sitting, standing, walking.

The orthopedically handicapped children are identified due to the following significant reasons:

- ✓ The orthopedically handicapped children have poor motor control or co-ordination.
- ✓ They move in a Shakey fashion.
- ✓ They show postural and writing defects due to skeletal deformities.
- ✓ Due to less strength and vitality they show low ability in school work.
- ✓ They walk awkwardly or with a limp.
- ✓ They show signs of pain during physical exercise.
- ✓ They lack either completely or partially, the power of manipulation or locomotion.
- ✓ The Crippled child: The crippled child normally complains in his limbs, muscles and joints. Crippling may also occur due to the congenital reasons, accident or the effect of diseases. The white house conference gives a definition of a crippled child as the crippled child in the orthopedic sense, is a child that has a defect which causes a deformity or an interference with normal function of the bones, muscles or joints. His condition may be congenital or due to disease or accident. It may be aggravated by neglect or by ignorance.

As with most students with disabilities, the classroom accommodations for students with orthopedic impairments will vary dependent on the individual needs of the student. Since many students with orthopedic impairments have no cognitive impairments, the general educator and special educator should collaborate to include the student in the general curriculum as much as possible. In order for the student to access the general curriculum the student may require these accommodations:

- ✓ Special seating arrangements to develop useful posture and movements.
- ✓ Instruction focused on development of gross and fine motor skills.
- ✓ Securing suitable augmentative communication and other assistive devices.
- ✓ Awareness of medical condition and its affect on the student (such as getting tired quickly). Because of the multi-faceted nature of orthopedic impairments, other specialists may be involved in developing and implementing an appropriate educational program for the student. These specialists can include:
 - ✓ Physical Therapists who work on gross motor skills (focusing on the legs, back, neck and torso).
 - ✓ Occupational Therapists who work on fine motor skills (focusing on the arms and hands as well as daily living activities such as dressing and bathing).
 - ✓ Speech-Language Pathologists who work with the student on problems with speech and language.
 - ✓ Adapted Physical Education Teachers, who are specially trained PE teachers who work along with the OT and PT to develop an exercise program to help students with disabilities.
 - ✓ Other Therapists (Massage Therapists, Music Therapists, etc.).

Identification and Assessment of persons with Learning Disabilities

The term 'specific learning disability' means a disorder in 1 or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations.

Disorders Included.—Such term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia

Disorders Not Included.—Such term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage."

According to RCI : "Specific Learning Disabilities means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, speak, read, spell or to do mathematical calculations.

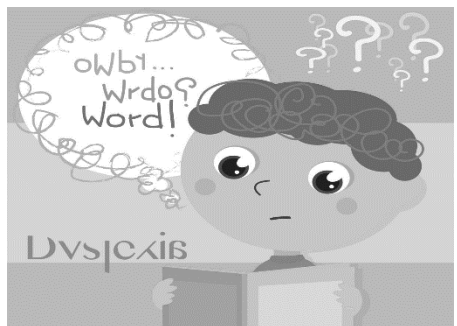
Underneath the learning disability umbrella, many disabilities are categorized into one of three types: dyslexia, dysgraphia, and dyscalculia.

Dyslexia

Dyslexia is a language-processing disorder that impacts reading, writing, and comprehension. Dyslexics may exhibit difficulty decoding words or with phonemic awareness, identifying individual sounds within words. Dyslexia often goes undiagnosed for many years and often results in trouble with reading, grammar, reading comprehension, and other language skills.

Reading difficulties are by far the largest area of learning difficulties, with over 80% of students with learning difficulties having reading difficulties as their particular area of need (Vaughn et al, 2000). Particular areas of need are likely to be:

- ✓ difficulties remembering sight words and patterns
- ✓ difficulties identifying the separate sounds in spoken words
- ✓ difficulties blending sounds
- ✓ confuses similar letters and words (e.g., b and d; man and name)
- ✓

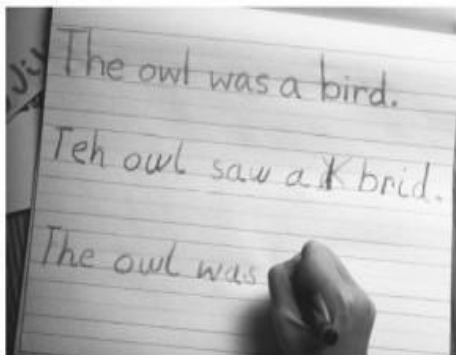


difficulties decoding words (i.e., working out how written words sound and what they might mean)

Dysgraphia

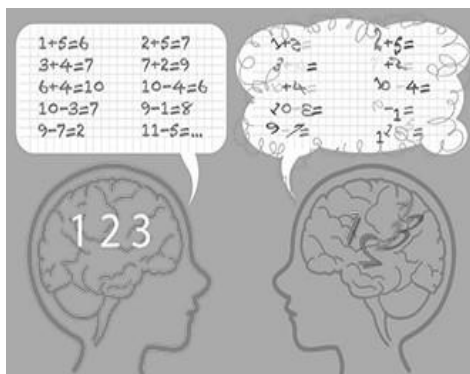
Those with dysgraphia have trouble converting their thoughts into writing or drawing. Poor handwriting is a hallmark of dysgraphia but is far from the only symptom. Sufferers struggle to translate their thoughts into writing, whether in spelling, grammar, vocabulary, critical thinking, or memory. Individuals with dysgraphia may exhibit difficulty with letter spacing, poor motor planning, and spatial awareness, and trouble thinking and writing simultaneously.

Many children have difficulty forming letters, holding a pencil correctly, tracing shapes with fingers, recognizing shapes, copying from the blackboard, drawing, and so on. In many cases, this is the only particular difficulty that the student has. Teachers need to be careful not to assume that students with poor handwriting have other difficulties. Teachers also need to judge whether the student has difficulty understanding what or how to write, or physically forming the letters.



Dyscalculia

Dyscalculia encompasses learning disabilities related to mathematical calculations. Individuals with dyscalculia struggle with math concepts, numbers, and reasoning. Sometimes referred to as having “math dyslexia,” individuals



might have difficulty reading clocks to tell time, counting money, identifying patterns, remembering math facts, and solving mental math.

If mathematics is the only area of difficulty, this area of difficulty is sometimes (but rarely) called dyscalculia (meaning can't do math's!).

Students with mathematics difficulties often have

- difficulty with counting and sorting groups of objects to match numbers
- difficulty remembering number facts (e.g., addition facts, times tables)
- difficulties with arithmetic operations.

Sometimes students develop difficulties in the early primary years but this is often a result of problems they are having with reading and comprehension. Understanding the order in equations, number sentences and so on, is also an area where students frequently experience difficulty.

People with learning disabilities are of average or above-average intelligence but still struggle to acquire skills that impact their performance in school, at home, in the community and in the workplace. Learning disabilities are lifelong, and the sooner they are recognized and identified, the sooner steps can be taken to circumvent or overcome the challenges they present.

Identification and Assessment of persons with autism spectrum disorder

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social

interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).

Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

Intellectual disability and autism spectrum disorder frequently co-occur; to make co morbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Diagnostic Criteria

A Persistent difficulty in the social use of verbal and nonverbal communication as manifested by all of the following:

Pervasive developmental disorders

A group of disorders characterized by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, activities. These qualitative abnormalities are a pervasive feature of the individual's functioning in all situations.

Childhood Autism

A type of pervasive developmental disorder that is defined by:

(a) the presence of abnormal or impaired development that is manifest

before the age of three years, and

(b) the characteristic type of abnormal functioning in all the three areas of psychopathology:

- ✓ reciprocal social interaction,
- ✓ communication, and restricted,
- ✓ stereotyped, repetitive behaviour.

In addition to these specific diagnostic features, a range of other nonspecific problems are common, such as phobias, sleeping and eating disturbances, temper tantrums, and (self-directed) aggression.

Autistic disorder Infantile: • autism

A type of pervasive developmental disorder that differs from childhood autism either in age of onset or in failing to fulfil all three sets of diagnostic criteria. This subcategory should be used when there is abnormal and impaired development that is present only after age three years, and a lack of sufficient demonstrable abnormalities in one or two of the three areas of psychopathology required for the diagnosis of autism (namely, reciprocal social interactions, communication, and restricted, stereotyped, repetitive behaviour) in spite of characteristic abnormalities in the other area(s).

Atypical autism arises most often in profoundly retarded individuals and in individuals with a severe specific developmental disorder of receptive language. •

Overactive disorder associated with mental retardation and stereotyped movements an ill-defined disorder of uncertain no so logical validity. The category is designed to include a group of children with severe mental retardation (IQ below 35) who show major problems in hyperactivity and in attention, as well as stereotyped behaviours.

They tend not to benefit from stimulant drugs (unlike those with an IQ in the normal range) and may exhibit a severe dysphoric reaction (sometimes with psychomotor retardation) when given stimulants. In adolescence, the over activity tends to be replaced by under activity (a pattern that is not usual in hyperkinetic children with normal intelligence).

This syndrome is also often associated with a variety of developmental delays, either specific or global. The extent to which the behavioural pattern is a function of low IQ or of organic brain damage is not known.

Asperger syndrome A disorder of uncertain nosological validity, characterized by the same type of qualitative abnormalities of reciprocal social interaction that typify autism, together with a restricted, stereotyped, repetitive repertoire of interests and activities.

It differs from autism primarily in the fact that there is no general delay or retardation in language or in cognitive development. This disorder is often associated with marked clumsiness. There is a strong tendency for the abnormalities to persist into adolescence and adult life.

Speech and Language Problems:

Most children with an ASD have slower language development than their peers. It is not only expressive language that may show problems, receptive language may also appear delayed in young children, and children may appear to be less responsive to their own name.

Some children with autism also appear to lose words that they had previously learnt. This regression is described in approximately 25% of children with classic autism, and is usually a gradual process where a child fails to learn new words, and may stop using previously learnt words altogether.

ADHD:

ADHD is the most common psychiatric disorder to occur alongside an ASD and there are clinical benefits from receiving a dual diagnosis. Children are likely to benefit from receiving treatment aimed specifically at their ADHD symptoms, as well as having both impairments recognized by parents and teachers.

DCD:

Developmental Co-ordination Disorder (or Dyspraxia) describes the motor co-ordination problems and clumsiness typical in AS. Such

difficulties may benefit from intervention from an Occupational Therapist or Physiotherapist.

Tics and Tourette's syndrome:

Several reports have documented the co-occurrence of tics in Asperger's Syndrome. Tourette's syndrome has also been observed in children with autism. Tics may be verbal or motor.

Feeding and Eating Problems:

Problems with food including food refusal, selective eating, hoarding, pica and overeating have all been observed among children with an ASD. Some children have difficulties coping with mixed textures, may eat their food in a certain order and may even ask for their food on different plates.

Assessment

A general assessment should cover the following areas: · The child's developmental history.

- ✓ Observations of the child in structured and semi-structured situations.
- ✓ Nursery/School report.
- ✓ Assessment of cognitive level.
- ✓ Assessment of problem behaviours.
- ✓ Speech and language assessment.
- ✓ Audiology and visual tests if indicated.

Chromosomal screen is needed if there are dysmorphic (abnormal) features. Physical investigations may be specifically indicated in some cases including the need for an EEG, or screening for Fragile X and other chromosomal abnormalities. It is still debatable as to whether these investigations are worth performing routinely as the yield of positive results is relatively low.

Identification and Assessment of persons with - ID-Intellectual Disability

The term 'intellectual disability' refers to a group of conditions caused by various genetic disorders and infections. Intellectual disability is usually identified during childhood, and has an ongoing impact on an

individual's development.

Intellectual disability can be defined as a significantly reduced ability to understand new or complex information, learn new skills and to cope independently including social functioning. As with all disability groups, there are many types of intellectual disability with varying degrees of severity. These include considerable differences in the nature and extent of the intellectual impairments and functional limitations, the causes of the disability, the personal background and social environment of the individual.

Some people have genetic disorders that impact severely on the intellectual, social and other functional abilities. Others with mild intellectual impairment may develop adequate living skills and are able to lead relatively independent adult lives. Approximately 75 per cent of people with intellectual disability are only mildly affected, with 25 per cent moderately, severely or profoundly affected.

Children can start preschool at any age, usually around age two or three, usually finishing up around age four or five. While there is usually only three years difference between the youngest preschool child and the oldest preschool child, they are three important, critical years for all different types of growth — think about what is "normal" for a 2-year-old and what is "normal" for a 5-year-old, from basic academics to physical capabilities, from emotional growth to social skills.

To offer assistance, guidance, and a baseline for teachers, parents, guardians, pediatricians, and any other medical or education professionals that your preschooler may encounter, many preschools often conduct internal preschool assessments.

And while there are standard tests available to preschool teachers and early childhood development experts, many preschools and day cares have their own assessments and qualifiers that includes

✓ Fine motor skills

- ✓ Eye-hand coordination
- ✓ Recognition of letters
- ✓ Recognition of shapes
- ✓ Recognition of numbers
- ✓ Recognition of colors
- ✓ Speaking skills including articulation and how well the child expresses him or herself
- ✓ Social skills, including the ability to cooperate, take turns, make friends.
- ✓ How a child is able to transition between activities
- ✓ Knowledge of personal information, including address, phone number, and names of parents and/or care givers

Depending on the method used, the assessment can be formal or informal, but in most cases, your child won't notice anything different going on as they are usually conducted in the course of classroom activities.

Early childhood educators need to become aware of children's individual interests and strengths and find ways to engage and expand them. They can do so by arranging for a rich variety of learning experiences that appeal to all the senses — visual, auditory, and physical — and by alternating individual, partnered, small group, and large group activities so that children experience various kinds of social interaction.

In early childhood programs, assessment takes place by observing children in daily activities and taking note of their skills, understandings, interests, vocabulary, and attitudes toward various tasks. It includes communicating with families regularly to learn about the circumstances that may affect classroom behaviors or interactions, such as personal or family illness, injury, and child-rearing beliefs and practices.

While children exhibit a broad range of individual differences and personal interests, assessment should ensure that both boys and girls have opportunities to participate in a range of activities, from block

building to musical, artistic, or dramatic play, in order to stimulate the development of spatial, artistic, musical, and verbal abilities in all children.

Students with intellectual disability may need particular adjustments to assessment tasks. Once you have a clear picture of how the disability impacts on learning, you can consider alternative assessment strategies. In considering alternative forms of assessment, equal opportunity is not a guaranteed outcome, it is the objective.

You are not expected to lower standards to accommodate students with disability but rather are required to give them a reasonable opportunity to demonstrate what they have learned:

Allow extensions to assignment deadlines

Use technology to record students work, e.g. digital photography, tape and video.

Students may take longer to organise thoughts and sequence material. They will benefit from discussing their outlines, with particular attention being paid to appropriate relationships and connections between points.

Encourage the student to submit an early draft of assignments to allow the opportunity for feedback to the student as a formative process. Students with an intellectual disability will need extra time in an examination for reading and analysing questions and for planning their answers.

Some students will request that examination questions be read to them. Some students may prefer to dictate their answers to a scribe. They will need a venue which is quiet and distraction-free.

Keep short your written examination instructions and sentences within examination questions. Questions using bullet points, lists or distinct parts are more likely to be correctly interpreted.

Students may benefit from an exam timetable that features a number of days between exams to assist in exam preparation.

Many students with intellectual disability are chronic mis spellers

and use dictionaries only with great difficulty.

Assessment for individuals with ID involves multiple professionals due to the varying and far-reaching needs across developmental domains. Team models may be multidisciplinary, interdisciplinary, or transdisciplinary.

Identification and Assessment of persons with - Mental Behaviour (MI)

American Association on Mental Retardation (1992) : Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning existing concurrently with related limitations in two or more of the following adaptive skill areas:

- ✓ Communication
- ✓ Self-care
- ✓ Home living 199
- ✓ Social skills
- ✓ Community use
- ✓ Self-direction
- ✓ Health and safety
- ✓ Functional academics
- ✓ Leisure and work
- ✓ Mental retardation manifests before the age of 18

Many systems have been proposed for the classification of mentally retarded children. In 1963 Gel of reported that 23 different classification systems were in use in English speaking countries. But the three phrases used most by the educators to classify mentally retarded children are the following.

- ✓ Educable Mentally Retarded (E M R)
- ✓ Trainable Mentally Retarded (T.M.R)
- ✓ Severely or profoundly mentally Retarded (P.M.R).

Educable or mild retarded

Mild retarded children are often referred to by educators as educable mentally retarded children comprise those who lie at the upper end of the mentally retarded category. Their mental handicap is regarded as minimal as their measure intelligence falls in the I.Q range of 50/55 to 70/75.

School programmes of mildly retarded children stress the basic academic subjects reading writing and arithmetic during the elementary years. The emphasis shifts to vocational training and work-study programmes in the middle and high school stage. Mildly retarded adult develops social and communication skill similar to those of their nonretarded persons and many of them are not recognized as retarded outside of school or after they finish the school.

Trainable or moderate retarded

Moderate retarded are sometimes referred to as trainable mentally retarded. These children fall at the lower end of the mentally retarded range and their I.Q usually lie between 30/35 to 50/55. The trainable group usually demonstrate their intellectual deficit at a fairly age through their slowness in overtaking the normal developmental steps and difficulties generally in the area of adaptive behaviour.

Normally placed in special day schools T.M.R children need training in self care activities and language development and many cases are able to acquire only rudimentary academic skills. Most of them are capable of limited economic usefulness, perhaps in a sheltered workshop. As adults some may ultimately have to live in community or institutional residential settings when parents or relatives are no longer able to provide for them.

Severe or profound Retarded

Severe or profoundly retarded children are almost identified at

birth or shortly afterwards. Their IQ usually lies below 30. These children are for the most part totally dependent on others for their existence and are institutionalized quite early in life. Most of them have significant cerebral nervous damage and many have other handicapping conditions.

Traditionally they have not been considered for special education. Training for the severely retarded consists of self care skills, toileting, dressing, eating, drinking and language development. A profoundly retarded person may not be able to care for his or her personal needs and may be confined to a bed.

According to A.A.M.D system mental retarded children are classified in the following way.

- ✓ Mild Retarded IQ = 55-70
- ✓ Moderate retarded IQ = 40-55
- ✓ Severe retarded IQ = 25-40
- ✓ Profound retarded IQ less than 25

Identification of educable mentally retarded

When it is suspected that a child is an educable mental retarded, it is the collective efforts of the parents, teachers, medical officers, psychologists and social workers to help in identifying the child. It is essential that their degree of retardation should be ascertained, so that necessary action can be taken from the very beginning otherwise more difficult problems may be created in the future.

Remedial Programmes of the educable mentally retarded

The educable mentally retarded children are capable of making progress in the normal school subjects of reading, writing and counting up to a functional level if the curriculum and methodology of teaching these subjects is specially designed to meet the limitations of their nature.

The standards aimed at and the methods used should be functionally oriented. All the school activities should serve practical realistic and reliable aims for these children. The most important

objective of the teacher would be to help the mentally retarded children to develop these attributes which will enable them to become self-sufficient and accepted members of the community in which they live.

The primary concern of education should be to promote not so much the three R's but the three A's personal adequacy social adequacy and occupational adequacy personal adequacy refers to the ability to take care of one's ordinary everyday needs.

Personal adequacy for the mentally retarded is concerned as much with self-respect as self-care.

Social adequacy refers to helping the child to behave and conduct himself generally in ways that will make him acceptable to his fellow men both in the work and in leisure time activities.

Occupational adequacy is essentially practical oriented. The aim occupational adequacy is to impart to the child those skills which will help him setting employment and become economically independent.

In lower occupations a friendly co-operative disposition, good manners, punctuality and perseverance are important factors than knowledge of a specific skill in securing a job keeping in view of these things for developing occupational competency that the tool subjects of reading, writing and counting should be emphasized as they are required to certain occupations.

The ultimate purpose of placement of the educable mentally retarded is to help the child in positive and realistic way to make him secured in the community as a wage earner and a complete citizen.

Remedial measures for the educable mentally retarded may be assigned both to the parents at home and teachers at school. The role of the parents to understand their mentally retarded children is as important the role of the teachers at school

Identification and Assessment of persons with Chronic Neurological Conditions;

Identification and Assessment of persons with Blood Disorders;

Identification and Assessment of persons with Multiple Disabilities;

Multiple disabilities - “concomitant impairments (such as mental retardation-blindness, mental retardation-orthopedic impairment, etc.) the combination which causes such severe educational needs that they cannot be accommodated in programs solely for one disability. (IDEA)

According to the act “Multiple Disabilities” means a combination of two or more disabilities as defined in clause (i) of section 2 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996).

Disabilities under the National Trust Act are in fact Developmental Disabilities caused due to insult to the brain and damage to the central nervous system. These disabilities are Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities. These are neither diseases nor contagious nor progressive. They cannot be cured by drugs or surgery. But early detection and training improve outcome. This is done using the services of Physio-Occupational and Speech Therapists, Community Based Rehabilitation Workers and Special Educators.

The disability occurs in the child, what is known as the ‘age of onset’, may also range from birth to a few days after birth, from early childhood till late teens. Sometimes children are born with one disability but acquire the second or third disabling conditions during childhood. The characteristics and the needs of the children depend on the nature of combination of the disabilities, the age of onset and the opportunities that have been available to a child in his environment.

Multiple Disability refers to a combination of two or more disabling conditions that have a combined effect on the child's communication, mobility and performance of day-to-day tasks.

We can say that just as every child is different, similarly every child with MD is different. However, there are some things that this group of children have in common.

- ✓ It affects the all-round development of the child
- ✓ Need regular help in simple day-to-day activities such as wearing a shirt, opening a door,
- ✓ Finding a chair to sit down and so on.
- ✓ A highly structured educational / rehabilitation programme helps in their training.

Characteristics Of Children with Multiple disabilities

Children with Multiple disabilities show some of the following characteristics:

Vision Problems:

As children grow, some of them appear to always squeeze their eyes together to look at something closely, or keep looking at their moving fingers/paper, bump into things while walking, complain of too much light all the time. Their eyes may also look different from 'normal' eyes.

Hearing Problems:

A child with a hearing problem may respond to only particular sounds. They may take a long time and repeated training to develop speech. And mostly they may only repeat what they hear. They may also learn to adapt to their routine environment by 'guessing' the conversations going around, but may actually face a lot of difficulty in a new place with unknown people. Sometimes deaf children also show difficulty in balancing their body or walking in a straight line.

Learning Problems:

Due to the combined loss of two or more disabilities, the rate and speed of learning of the children is very slow. Learning often becomes

repetitive and meaningless, unless special care is taken to make the child feel safe about exploring the world around him. Multi handicapped children also have very limited ideas to play with toys or things around them.

Communication:

Communication is probably the one area that is most significantly affected in children with multiple disabilities. The children are unable to see or hear or follow the different ways in which their brother and sister play with each other, elders are greeted, standing in a line to get a ticket or passing a bottle of water around a dining table.

Posture and Mobility:

Our sight, hearing and body movements help us to move around, without bumping into things, remember the way to reach places or even to use our own hands to hold and look at things. Presence of Cerebral Palsy, locomotor disabilities and balance difficulties makes it hard for the child to manage his own body movements sometimes and so it becomes very difficult to use his body to move from one place to another.

Odd Behaviours:

Most children with multiple disabilities show strange behaviours that are called 'self-stimulating' behaviours. Some of these are moving one's body repeatedly, shaking head side to side, moving fingers in front of eyes, hitting or slapping the ears, swinging in one place and so on. The children mostly do this due to lack of anything else to do. Sometimes it is important for them to continue doing it from time to time as it helps them get some information about the world around them in their own special way. Sometimes these children also show disturbed sleep patterns.

Medical Conditions:

Most multi-handicapped children also suffer from other medical conditions such as epilepsy, frequent eye and ear infections, respiratory disorders, muscular degeneration frequent surgeries and so on. Such medical conditions lead to frequent hospitalizations and the child again misses out on a lot of exposure and learning from the environment.

Various Combinations Of Multiple disabilities

Impairments can be associated in various ways. Their functional impact varies according to the child development, and the primary disability risk may be aggravated to become secondary disabilities, which are pre dominant in the prognosis and for which several treatments are available.

- ✓ difficulty locating in space and time;
- ✓ weakness of new memories (memory);
- ✓ problems or in ability to reason or relate situations to one another;
- ✓ lack of language skills or rudimentary language.

However, the ability to express feelings is often preserved, as well as contact with the environment, and gain in independence are achieved by children receiving proper treatment based on skills rather than defects/deficiencies.

There can be many types of multiple disabilities, depending on combination of disabilities with wide range of characteristics exhibited, as follows

Characteristics:

- ✓ Poor short / long term memory
- ✓ Problem processing information Inability to organize / problemsolving responses
- ✓ Communication is affected
- ✓ May have speech characterized by substitution, omissions
- ✓ Lacks high level thinking and comprehension skills
- ✓ Temper tantrums
- ✓ Trouble in abstract thinking Problems in carrying out ADL / self -care skills
- ✓ Difficulty in mobility Poor in learning (education is affected)Interaction with people is limited
- ✓ Usually dependent on others
- ✓ Tendency to withdraw from society

- ✓ May become fearful, angry and upset in the face of forced or unexpected changes
- ✓ May execute self-injurious behaviour
- ✓ Displays immature behaviour not at par with their chronological age
- ✓ Exhibit impulsive behaviour
- ✓ Medical problems may accompany severe disabilities (include seizures, sensory loss, hydrocephalus, sclerosis)
- ✓ Physically clumsy and awkward
- ✓ Difficulty participating in games involving motor-skills
- ✓ Experience fine-motor deficits
- ✓ Forgets skills through disuse
- ✓ Trouble generalizing skills from one situation to another
- ✓ Poor in problem-solving skills
- ✓ Poor test taker due to limiting factors of disabilities
- ✓ May have difficulty locating sound direction
- ✓ Difficulty learning about objects and their relationships

Deaf blindness:

Deaf blindness is a combination of hearing and visual impairments causing severe communication, developmental / educational problems like

- ✓ Moderate to profound hearing and significant visual impairments;
- ✓ Moderate to profound hearing and significant visual impairments and other significant disabilities;
- ✓ Central processing problems of vision and hearing domains;
- ✓ Progressive sensory impairments or significant visual impairment;
- ✓ Possible loss of auditory processing mechanisms (associated with severe physical disability or severe cognitive disability) and severe communication delay. (RPWD

Act, 2016

Characteristics:

- ✓ Difficulty bonding with caregivers and establishing / maintaining interpersonal relationships Feelings of vulnerability: generally (learner feels safer in a seated position)

- ✓ Difficulty in communication skills Trouble learning object permanence
- ✓ Delayed understanding that there are consequences to actions
- ✓ Inconsistent responses to sounds / visual inputs Distorted perception of world (typically perceive time differently - time seems to pass much more slowly)
- ✓ Unusual responses via the impact senses (e.g., tactile sensitivity or tactile defensiveness, particularly around face)
- ✓ An overactive startle response
- ✓ Difficulty interacting with things in environment in a meaningful way / generalizing information Stereo-typical responses (because of fear/confusion / sensory deprivation)
- ✓ Delayed motor skills, such as crawling and reaching; difficulties interpreting movement; problems in maintaining and restoring balance

Planning For Needs-Based Educational supportive Service Educational Placement:

As far as possible, every child with special needs should be placed in regular schools, with needed support services.

Aids and Appliances: All children requiring assistive devices should be provided with aids and appliances, obtained as far as possible through convergence with the Ministry of Social Justice and Empowerment, State Welfare Departments, National Institutions or NGOs.

Support Services:

Support services like physical access, resource rooms at cluster level, special equipment, reading material, special educational techniques, remedial teaching, curricular adaptation or adapted teaching strategies could be provided.

Teacher Training:

Intensive teacher training should be undertaken to sensitize regular teachers on effective classroom management of children with special needs. These trainings should be recurrent at block /cluster levels

and integrated with the on-going in-service teacher training schedules in SSA.

Resource Support:

Resource support could be given by teachers working in special schools.

Where necessary, specially trained resource teachers should be appointed,

particularly for teaching special skills to children with special needs. Wherever this option is not feasible, long term training of regular teachers should be undertaken.