MODELIZAÇÃO DAS POLÍTICAS E DAS PRÁTICAS DE INCLUSÃO SOCIAL DAS PESSOAS COM DEFICIÊNCIAS EM PORTUGAL

THE CONTRIBUTION OF THE INTERNATIONAL CLASSIFICATION OF FUNCTIONING, HEALTH AND DISABILITY FOR CHILDREN AND YOUTH TO SPECIAL NEEDS EDUCATION

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Introduction

This paper has been prepared on request of the CRPG in response to concerns raised about the appropriateness of the International Classification of Functioning Health and Disability (ICF)[1] as an operational framework for target group identification in the field of special education. The approach taken is, in the first place, to explore the most appropriate approach that should be adopted from an inclusive educational perspective and subsequently to review the ICF against these criteria.

Assessing special educational needs and allocating resources

The debate as to the appropriateness and suitability of the ICF-CY in a special education context needs to be broached in broader terms. There is a critical question to be answered prior to addressing any reservations directly related to the classification itself. This question is:

> '*Should a bio-psychosocial approach be adopted to assessing special educational needs and planning special educational interventions?*'

If the answer to this question is positive, then it is possible to address the secondary questions relating to which is the most well developed and relevant bio-psychosocial framework to use in developing an effective system of response to special educational needs. In order to answer the primary question it is useful to consider what alternatives to a bio-psychosocial approach are available to educational policy makers.

Minority and deficit approaches to determining special educational needs

Historically, there have been two other approaches adopted. The first of these is the medical/classificatory approach in which the special educational system operates on the basis of disability categories or diagnosis. This approach is familiar to most educationists. It has many advantages including administrative convenience and simplicity in operational and financial systems. The approach is based on the premise that the diagnostic category to which a person has been designated can be used as the key to the type and level of education required[2].

The meaning of "special education" cannot be determined solely by biological traits, they are primarily shaped by social influences and circumstances.

This approach is most often in evidence in systems where distinctions are made between different types of disabilities in funding and developing services. It is also associated most strongly with a

specialized/segregated approach to delivery of special education. There are a number of sub-optimal consequences of the application of this approach:

- One characteristic of this approach is that a child needs to attract a medical diagnosis in order to be eligible for services.
- A second characteristic is that services are developed for children within a narrow band of eligibility.
- A third element is that organisations that deliver services define themselves in terms to specific diagnoses i.e. general learning disability, autism, cerebral palsy etc. A corollary of this is that when the statutory authorities are allocating funds they do so on the basis of disability categories i.e. physical, sensory, learning disabilities and the resources go directly to the service providers rather than to the person or the family.
- A fourth characteristic is that services are designed not so much around the needs of the individual but rather around the stereotyped requirements of a particular diagnostic category.

The implications of these types of approaches for the child, the family and special educational professionals are substantial:

1. The system dichotomizes children into those who are in the diagnostic net and those who are not. This means that children with borderline eligibility are denied resources until they deteriorate sufficiently in order to meet the criteria.
2. Those who are assessed as eligible are assigned a diagnostic label which brings into play the negative consequences of Stigma associated with disability.
3. Children with dual diagnosis find it very difficult to get appropriate services as they fall between 'two stools'.
4. Parents are forced to seek a diagnosis for their children in order to get services.
5. Psychologists and other allied health professionals end up acting as 'gatekeepers' of resources as assessments focus on eligibility rather than upon needs and strengths.
6. The approach tends to support and to proliferate stereotypes of disability rather than treating each learner as an individual.

<u>The inclusive education approach to special education</u>

An alternative view of disability places it in the external environment and highlights the role that attitudes, systems and services (or the lack of them) play in creating disability. The main argument

put forward for this view of disability is that if we treat people differently and educate them in a parallel system, they will develop differently and never fully integrate into the mainstream of society and society will always view them as different and stigmatized.

This approach places responsibility for the creation of disability on the very institutions originally set up to respond to special educational needs. For example, placing a young learner in a segregated educational environment ultimately means that he or she will not learn to assimilate into the mainstream, will acquire a label and a stigma, while at the same time the resources required to achieve mainstreaming are 'locked up' in the specialised segregated system. From this perspective, it is those who assign a diagnosis that create disability.

From this standpoint the role of special education needs to be radically changed and its primary goal refocused on creating mainstream educational environments in which individual differences arising from a health condition or functional impairment do not disadvantage any learner. The approach emphasizes equality of outcomes, full participation in mainstream education, independence and reasonable accommodation. The implications of this approach to special education is that resources need to be targeted at training mainstream teachers and adapting schools rather than maintaining the specialised system which is seen as the origin of much of the isolation and exclusion experienced by people with developmental disabilities.

The inclusive education approach[3] requires education systems to change and respond to the learner with special educational needs rather expecting the learners to adapt to the education system. However, there is significant concern that the concept of inclusive education will be used to disestablish the special education sector without properly resourcing the mainstream.

The inclusive education movement has developed over the past 15 years in parallel with the dissemination of the social model of disability to the point where the underpinning concepts and principles have been generally accepted in most developed economies. The dilemma is no longer about whether a deficit or an inclusive approach is the right choice for special education but how it is possible to move from a position where most systems are now deficit based to where they need to be in order to meet the ideals of the inclusive education aspiration.

Determining eligibility and documenting needs

The key issue is how the limited resources available to special education can be targeted effectively at those who most need support and interventions. Within a system structured on the basis of the deficit model, eligibility for resources is based on a recognized diagnosis and professionals act as

'gatekeepers' to resources by ensuring that all those who are given access to resources meet the eligibility criteria. It is more problematic within a system based on an inclusive education model. Firstly, resources need to be targeted at adapting the mainstream system rather than at individuals with special educational needs. Secondly, the inclusive approach is anathema to labeling learners and so it necessary to construct an alternative means of providing services to those who need them most. However, in most jurisdictions, competent authorities still allocate budgets on the basis of disability categories/ labels. Thirdly, the limited resources available within the educational system for special education would be completely absorbed if they were all allocated to making mainstream education accessible

One mechanism that has been used in a number of jurisdictions for allocating resources is Individual Educational Planning. In this approach resources are allocated on the basis of an Individual Educational Plan (IEP)[4] which is based on a Statement of Need rather than on a diagnostic label alone. Thus, someone with a general learning disability is provided with a Statement of Need which specifies the support and interventions required (either mainstream or specialised as appropriate) and on this basis an IEP is developed through a multi-disciplinary process which responds to the educational, social and health care needs of the individual. It is important that the statement of need has a statutory basis so that any resource specified in the statement has a legal mandate to be provided. One critical aspect of such a system is that the statutory body responsible for identifying needs is independent of the authority responsible for providing the resources.

The Statement and IEP system can operate alongside the development of the mainstream system through the adaptation of infrastructure and the training and continuous professional development of mainstream teachers. In some systems all schools are allocated some special education resources based on the number of children in the school based on the principle that statistically all schools will have children with needs. A second allocation of resources can be made to a school on the basis of the level of disadvantage of the pupils or the number of students with disabilities in the school. Finally, if these resources are insufficient to meet the needs of an individual learner a Statement of Needs is prepared which specifies the additional resource required.

<u>The need for a bio-psychosocial approach to documenting special educational needs</u>

The effective operation of a system based on IEPs and statements of need depends on the adoption of an appropriate model of special educational needs. If the systems is based on a deficit model then the assessment of needs will focus solely on the functional limitations of the learner and the only needs included in the statement will refer to interventions to build the capacity of the individual. If the system is based on a more social model the focus will be on changes to the

environment and the provision of supports to assist the learner in the mainstream setting. Either of these approaches will result in an unbalanced IEP. It is essential that both functional and activity limitations and environmental barriers are addressed in the statement of needs and hence in the IEP. In order to carry out a comprehensive assessment of need it is essential that it be based on a holistic model of human development. In effect, such a model is at the core of the bio-psychosocial conception of human development[5]. The application of the bio-psychosocial model in order to document profiles of functioning and disability of children is strongly recommended by many international experts in the use of the ICF.[6]

The ICF as a framework for documenting special educational needs

Once the argument in favour of a bio-psychosocial approach to the development of a system of inclusive education has been accepted, the remaining issue is which conceptual framework best reflects the principles and values of the biopsychosocial model and can provide a systematic means of documenting both individual and environmental needs and strengths. From this perspective there is no framework more appropriate and relevant than the International Classification of Functioning Health and Disability (ICF).

The ICF possesses a number of characteristics that make it an ideal framework to support the development and implementation of a comprehensive assessment of needs process in education.[7]

1. The ICF construes Disability as ***'a dynamic interaction between the person and contextual factors'***[8 9] as opposed to the static dichotomous characterisations inherent in the deficit and social models. In this regard it is ideal as a basis for identifying learner needs and strengths and the barriers and facilitators the learner's environment.
2. The ICF is an integral part of a system of classification that includes the International Classification of Disease. Thus primary and secondary diagnoses can easily be incorporated into the assessment using a combination of ICF and ICD 10.
3. The ICF provides a systematic way of documenting not only a student's functional capacity but also his or her limitations in carrying out activities. This is crucial given that learners with the same functional impairments can differ significantly in the extent they can deal with day to day life activities such as self care or communicating.
4. The ICF provides an equally systematic means of documenting the extent to which a learner's environment is assisting him or her to perform above or below her capacity. For example, the ICF allows an assessment team to document the case where a learner is communicating more effectively as a result of an assistive device than would have been possible given his or her level of functioning. Similarly, the ICF allows a team to specify the

extent to which the attitudes of a person's family are acting as a facilitator or a barrier to participation in mainstream education.

5. The language of the ICF is neutral unlike the terminology associated with many deficit based classification systems. In this regard it is more acceptable to parents and learners and easier to understand by teachers.
6. The qualifier system of the ICF allows an assessment team not simply to specify the degree of strengths, needs, barriers and facilitators but also to indicate those which are amenable to change either by the provision of capacity building interventions, providing supports or by changing the environment.
7. The ICF reflects a number of other important characteristics which make it an ideal framework for reviewing and assessing educational needs and strengths.

    a. The ICF has been designed so that it can be used to systematically describe *Human Functioning* in general and not merely *Disability*.
    b. It is based on a *Universal* model of functioning and activity and rather than a *Minority* model.
    c. It is *Integrative* in that it incorporates not merely medical aspects but also psychological and social elements of the disability process.
    d. It describes an *Interactive* process in which the relationship between function, activity and participation are not linear progressive but are amenable to change.
    e. It incorporates the concept of *Parity* in that a functional impairment that arises from an accident or developmental process is treated the same regardless of etiological causality.
    f. It is *context - inclusive* and does not ascribe impairment or disability to the person alone.
    g. It has applicability in a *culturally diverse* society because the concepts which it incorporates are not particularly based on western ideology.
    h. It is designed as an *operational* tool for policy development, research and clinical applications it is not simply theory driven.
    i. It is designed to be relevant to the *life span*. It is not solely adult driven and thus can be used to capture developmental differences.

One of the primary aims of the ICF is to provide a scientific basis for the consequences of health conditions. One of the well documented consequences of having a health condition as a child is that it very often disrupts participation in education. The ICF has the flexibility and power to document the educational consequences of a health condition in terms that are highly amenable to planning remedial and compensatory supports and interventions.

The ICF is now widely used internationally in a number of fields including health, social care, employment, social security and education. The clinical application of the ICF in terms of assessing needs, evaluating progress and planning interventions has been well accepted in most jurisdictions at this point in time. The research applications of the ICF in terms of measuring outcomes and the impact of environmental factors on activity limitations and societal participation have been widely acclaimed. It has also been used in social policy development to plan social security systems and redesign disability legislation and policy. It is also widely used statistically to collect and report data in population surveys or in administrative databases for managing systems of provision. However, it has also been proposed for use within education as a framework for assessing functioning and activity, monitoring progress and planning interventions.

The development of the ICF Children and Youth version

One of the main drawbacks to the widespread application of the ICF in the field of special education has been the lack of a child version of the framework. This was particularly problematic because the adult version could not cater for the differences in the nature and type of functioning of children compared to adults. It is not acceptable to conceptualize a child as a smaller version of an adult. Children are in a constant process of flux, change and progressions through development. In fact in most norm based assessment tools for children it is necessary to produce separate norms for every six months of age e.g. reading, IQ etc.. It is also the case that children and adolescents are very often and appropriately restricted by their environments in their participation in many major life activities e.g. drinking alcohol or gaining admission to nightclubs. The types of participation and environments are very different for younger people.

These differences were well recognized by the WHO which requested in 2002 that the ICF be adapted for universal use in health, education and social sectors for children and youth. As result a working group carried out the work between 2002 and 2004 and field trials took place in 2005 and 2006. The applicability of the ICF-CY[10] was examined using four age-group questionnaires; infancy (0-2), early childhood (3-6), middle childhood (7-12) and adolescence (13-18). As a result the ICF version for children and youth (ICF-CY) was published by WHO this year. The ICF-CY is intended to facilitate continuity in documenting functioning, activity, participation and the role of the environment across the transitions that human beings make from childhood to adulthood and to facilitate communication between professionals and between service providers and parents.

The ICF-CY has the potential to overcome some of the challenges currently facing assessment and intervention in special education. Firstly, given its structure it can highlight functional differences between children with the same diagnosis. Secondly, it can emphasise functional similarities between children with different diagnoses. Thirdly, it can bridge the chasm between assessment

and intervention. Fourthly, it can be used to document changes as a result of interventions not only in the performance of the child but also in the child's environment[11].

The main modifications to the adult version of the ICF were:[12]

a. Modifying or expanding descriptions of existing codes
b. Assigning new content to unused codes
c. Modifying inclusion and exclusion criteria of existing codes
d. Expanding the qualifier system to include developmental aspects.

Basically, the ICF-CY is consistent with the organisation and structure of the adult version, expanded to cover the essential aspects of functioning and environment of childhood and adolescence. Some 237 changes have been made to ICF codes particularly in the area of activities and participation. For example, code *d1200* – mouthing, touching, smelling, tasting captures a particular developmental stage as do the codes *d1330-d1332* which cover acquiring single words or meaningful sounds, combining words into phrases and acquiring syntax.[13]

A manual has been developed by the National Institute of Special Needs Education in Japan for the use of the ICF-CY which has been approved by the WHO.

Concerns about the application of the ICF in the field of Special Education

A number of objections have been raised to the use of the ICF as an operational framework for the target group identification. It is useful explore the basis for these in light of the clear potential that the framework has in most other areas of community participation.

Firstly, it is proposed that clinical/ health and educational definitions are not appropriate for the same processes and that they are themselves insufficient to define the conditions through which special education is needed. While there is merit to this argument, the ICF is actually designed to overcome these difficulties and is an *Integrative* framework in that it incorporates not merely medical aspects but also psychological and social elements of the disability process. It is probably the only systematic classification system to bring together health, learning and social functioning in a coherent and operational system.

Secondly, it is justifiably argued that a definition is incomplete if it doesn't recognise the effects on educational performance. In this regard, the ICF approach is well designed. In fact one of the key distinctions that is at the core of the ICF, although it is not always easy to maintain in practice, is that between Capacity and Performance. From this perspective the ICF has the potential to

distinguish between a learner's diagnosis, functional impairment, activity limitations and the level of their performance in the education system.

Thirdly, a concern has been raised in relation to whether or not it is premature to use the ICF as a basis for determining eligibility for special education services. It is validly pointed out that research has yet to provide evidence that the ICF has the potential to impact positively on students with special educational needs. What needs to be clarified is how the ICF can be used in the identification process of goals and objectives for students with special educational needs, and in the specification services that the students require. There is little doubt that the ICF-CY has only recently been published by the WHO and that at this stage the main data available are from field trials but some of these have actually produced validation data and the structure of the ICF-CY appears to stand up to scrutiny. In addition, the ICF-CY has been used in educational projects previously. For example, it has been used in the US in the Georgia Early Intervention Project for children in the 0-3 year age group to carry out baseline, intermediate, and exit evaluations and the US Department of Education has included Activity and Participation codes for eligibility and documenting personal functioning in its Early Intervention Data Handbook**.**

The ICF-CY is also well capable of documenting both personal and environmental needs and linking these to services, interventions and supports. In fact there is no other framework that provides such a thorough and systematic support for comprehensive assessment and planning. Further, it is important to acknowledge that the ICF describes a universal continuum from health and wellness to impairment and disability. It is not based on a minority model nor is it derived from a deficit model both of which underpin the majority of systems for determining eligibility at present. However, it is also important to question if the current approaches to determining eligibility are not in themselves 'disabling' and whether more enabling alternatives should be sought. Ultimately, the ICF describes functioning, activity and participation and the cut off point for 'Disability' in any one jurisdiction is a socio-political decision that is based on the ideology and culture of the jurisdiction and the resources available. It has been argued earlier in this document that using the ICF-CY as a basis for a comprehensive assessment of needs and putting in place a system of Individual Educational Planning supported by legislation that uses the ICF for planning and monitoring is one way forward. In this approach those who are eligible for an IEP are by definition eligible for the supports and interventions specified in the plan. The key is the basis upon which eligibility is decided.

Fourthly, it is pointed out that ICF wasn't created as a substitute other categorisation processes, for example diagnostic labels such as "autism", but as a way of providing additional information. Once again it is important to keep in mind that the ICF is specifically designed to be used in conjunction with the ICD 10 and so it is not a question of 'either-or' but one of 'both-and'. What is important is

how the additional information provided by the ICF beyond the use of diagnostic categories can be applied to empower the process of identifying students with special educational needs. Another challenge for the application of the ICF in a special educational context is the availability of practical instruments to support its use. In a number of areas substantial development is required to produce suitable tools. Nevertheless, many current assessment tools and inventories are amenable to being reported using ICF conventions and language. An example of an Educational Psychological Report, derived from readily available assessment procedures and instruments, but presented using the ICF framework and language is included as an appendix to this document for illustrative purposes.

Fifthly, there is a question as to whether or not the ICF is appropriate for use within the education sector given that it was designed a health classification. It is important not to lose sight of one of the core aspects of the ICF - Participation. Chapter 8 of the Activity and Participation section specifies participation in major life activities, one of which is formal education. It is possible to take this as a starting point for assessment and explore the reasons why a student is being restricted in his or her participation in formal education. Each content area of the ICF-CY has relevance to this assessment but some are particularly critical to education and learning. Thus mental functioning, sensory functioning, voice and speech, learning and applying knowledge, communications, interpersonal interactions are all commonly evaluated in assessments of special educational needs. However, the ICF adds value through its systematic description of environmental factors some of which are also relevant to education including technology (assistive devices), accessible educational infrastructure, supports and relationships (including family and teachers), attitudes (including the attitudes of special educators) and services, systems and policies (including eligibility systems based on a deficit model). It is difficult to support the view that the ICF-CY is not relevant to education given that participation in education is one of the most important aspects of life in the community for young people.

Sixthly, there is concern that because Portugal is one of the first jurisdictions to attempt to apply the ICF in a comprehensive way in education, it may not be properly applied. This reservation is based on a presumption that the application of the ICF-CY framework to special education will unsupported by proper consultation, research, monitoring and evaluation. If this were the case the use of the ICF would be insupportable. However, the adoption of the principles underpinning the ICF i.e. a focus on human functioning rather than disability; a universal rather than a minority model; an integrative approach; acknowledgement of the interactive nature of the disability process; acceptance of the parity of function; and a context-inclusive model which is culturally diverse and life span compatible, is surely worthy of consideration. What is required is that the same careful action research approach is employed in the gradual implementation of the ICF-CY to special education as has been used in other jurisdictions in the realms of social security, employment and social exclusion.

Finally, a question has been raised as to the value that ICF-CY (Children and Youth) will have for children given its Health orientation. It is difficult to discern the basis upon which such an observation can be made given that participation in education and learning are so central to the framework.

Summary and conclusions

It is clear that the WHO definition of health is not limiting in its meaning and that it is intended to include a state of complete physical, mental and social well-being rather than simply the absence of disease. From any standpoint education is a major life activity especially for children, adolescents and young adults and as such is an important aspect of social well being and participation in the community. It is patently on a par with social security, employment, economy and social policy as a legitimate field of application for the ICF.

At a recent meeting of WHO Collaborating Centres for the Family of International Classifications, it was acknowledged that:

> "*…the child's mastery of skills, personal independence, social integration and developmental or academic transitions would constitute outcomes of special education consistent with ICF Participation codes."*[14]

Further the ICF has been applied in other jurisdictions in the field of education including the US and Hungary[15].

The ICF had been widely welcomed by the educational community in Italy.

> "…*things are currently changing for the better, and this positive change is mainly due to the introduction of World Health Organization's ICF, the International Classification of Functioning, Disability and Health, occurred in 2002. This system, specifically designed to comprehend, interpret, describe and share the person's functioning, was welcomed by the school professionals and those health professionals more sensitive to a comprehensive bio-psycho-social conceptualization of health and functioning.*"[16]

In Italy, it has been used has a reference for measuring disability and in the development of policies in the employment sector to promote the vocational integration of people with disabilities. New legislation derived from the framework has also been introduced covering the long-term care of people with severe chronic disabling conditions and, using ICF and ICD 10, a multidisciplinary

individual assessment of need to monitor the progress of children against the educational curriculum[17].

One proposal for the use of the ICF-CY is as a framework for intervention and outcome markers in education.[18] The North American Collaborating Centre for the ICF in its feedback from its 10th Annual Conference specifically references special education as an example of a relevant application of the ICF.[19]

Within the scope of the "Multidisciplinary Research Network on Health and Disability in EU" project, the ICF is being used as the conceptual foundation to explore the lived experience of people with disabilities and to provide a common language that links together clinical and rehabilitative services, population data collection and other health-related services, such as education and employment[20].

In Switzerland, procedures based on ICF are being developed to assist in the identification of learners with special educational needs during early years education.[21] This involves a practice-oriented diagnostic process for the allocation of pupils to special educational procedures at elementary schools[22].

In the UK, a national classification framework is used which is based on multiple dimensions of educationally relevant functional impairments, learning activity limitations and learning participation restrictions. This was designed on the basis of the ICF scheme.
The standardisation of identification and monitoring procedures based on ICF scheme is useful in to containing parental pressures for increased identification and to inform curriculum and pedagogic planning[23].

The National Institute of Special Needs Education in Japan has also launched a research project into the application of the ICF –CY in the development of educational policy.[24]

The National Institute for Disability Research and Rehabilitation is the US has embraced the ICF.[25] The Centre for Special Education Finance has also acknowledged the applicability of the ICF to educational issues.[26]

In Australia, the ICF was being evaluated as a framework for 'assessment for support' procedures in education and curriculum design.[27]

There is general acceptatnce that a bio-psychosocial model is the most appropriate model upon which to build an inclusive education system. There is also wide international acceptance that the ICF, which is based on a bio-psychosocial construction of disability, is the most comprehensice,

systematic and detailed framework for documenting functioning, activity and participation. It has been cioted by many experts in the field of special education as an important step forward. It has been recognized as having a contribution to make not only at the level of poloicy and national statistics but at an operational level and there are a number of projects exploring the application of the ICF to special education. The publication of the ICF-CY brings the ICF framework much closer in practical terms to being operational for younger people. The time is right to being to integrate ICF-CY in policy and practice in the field of special education. Some concerns have been raised about its application but these can be addressed by adopting a systematic research oriented and consultation driven implementation process.

Finally, in combination with a Statementing/IEP procedure the ICF-CY in combination with ICD 10 can act as the primary point of reference in developing an operational framework for target group identification in the field of special education.

Appendix 1

Case Study using the ICF as Framework for Reporting Special Educational Needs

Individual Statement of Needs and Behaviour Support Plan

Demographic Information:
Name: John
Gender: Male
Address: Dublin 11
Date of Birth: 20/03/1994
Medical Diagnosis: None

Profile: John comes from an economically vibrant family in which both parents work. Hs is the third and youngest child with one brother (15) and one sister (23). His father is an information technologist with an international company which requires him to be away from home for extended periods of time. Nevertheless he when he is present he tries to give the children as much time as they need. His mother works as a dental secretary in a city centre firm but has negotiated flexi-time to help her cope with John's difficulties.

Reason for Referral: John was referred for assessment to determine his special educational needs. He had difficulty making the transition from primary to secondary school and has recently become disruptive in class and during recreation. The immediate reason for the referral was that John had played truant for a number of days. His learning support teacher reports that he finds the activities in literacy classes too childish for him and that he has begun to disrupt the learning of the other students.

Functioning:
Mental:

Intellectual: WISC FS – 105
VSIQ – 120
PSIQ – 90

Memory: Short Term Memory: - Digit Span – 5

Attention: Teacher Report – Moderate impairment in concentrating in formal settings
Parent Report - Difficulties in following instructions, keeping personal possessions, participating in family games and watching TV

Student Report - John is not aware of these issues and blames adults for not having a sense of humour.

Orientation: John had difficulty in distinguishing left from right and demonstrated cross laterality being left handed and using the right foot

Parent Report - John has difficulty with directions and has on occasions got lost when the family were on outings.

Emotional: John presented as an aggressive boy who challenged the assessment and saw it as punishment for his behaviour. It took substantial effort to establish rapport but cooperation was established at a satisfactory level.

Perceptual: John had difficulty with all tests involving visual perception. His auditory discrimination was adequate.

Language: John's performance on the Vocabulary and Similarities subtest were exceptional (SS 15 & 14 respectively). His social comprehension was slightly below the rest of his verbal scores. He came across as an eloquent teenager during the assessment.

Sensory Functions:

No assessment of John's hearing or vision has been carried out.

Neuromusculoskeletal and Movement:

Control of voluntary movement functions:

Simple movement: John developed slowly in terms of motor coordination. He was slow to learn to dress himself and to tie his shoes

Complex movement: John had a very uncharacteristic pencil grip which involved his thumb and index finger. Even allowing for his left handedness it could be described as clumsy.

Coordination: John had a moderate difficulty in coordinating visually directed movements

Activity limitations & Participation Restriction:

Learning and Applying Knowledge:

Listening: On the basis of his Mother's report John's ability to listen to stories as a child was moderately impaired. She reported that he does not listen to music nor spend much time watching TV.

Learning to read: On standard word recognition test his standard score was 65.

Learning to write: His handwriting was immature and his spelling was characterised by transpositions and simple errors. On a standard spelling test his standard score was 60.

Learning to calculate: John's arithmetic attainments was in the high average range of attainment

Solving problems: John had moderate difficulties in solving orally presented arithmetic word problems.

General task and demands:

Undertaking multiple tasks: On the basis of both parental and teacher reports, John has moderate difficulty in organising himself to carry out anything other than simple tasks.

Communications:

Receiving:

Spoken messages – John was had no difficulty understanding oral instructions given in a systematic and ordered way

Non-verbal messages – John was very sensitive to body language and modulated his response during testing to the body language of the assessor.

Speaking: John was a very coherent and exceptionally eloquent teenager who, once relaxed, was quite capable of explaining his dilemmas

Conversation – After an initial period during which John acted with suspicion his conversational skills emerged as one of his strengths.

Interpersonal Interactions and Relationships:

Complex Interpersonal Interactions: John is having difficulty with his parents and his teachers. He believes that he is being persecuted because he is an artist. His logic is that because he is different the system can't handle him. Once he warmed up he come over as very persuasive.

Relating with strangers – John initially was very suspicious in his interactions but became relatively relaxed when he perceived no threat from the situation.

Formal relationships: John has a mild difficulty in relating to authority figures. During his time in formal education his mother has been called into school on a regular basis to speak to the teachers. He has avoided being suspended but there is little doubt that John is uncomfortable in formal situations.

Informal relationships: John is a popular and adventurous individual with his school friends. He continues to have friends from his primary school even though they are at different secondary schools.

Family relationships – John has severe difficulty relating to his father. It takes very little time after his father arrives home for a row to break out. His siblings tend to goad him to get a rise out of him. Despite his outbursts his mother is very patient with him.

Major Life Areas:

School education: John is having significant difficulty in adapting to secondary school. He is disruptive in class, has played truant on a number of occasions and is at risk of being suspended.

Community, Social and Civic Life:

Recreation and Leisure: John is a very physical individual who enjoys getting involved in active sports. Unfortunately he is not particularly agile and his performance has not being adequate for him to be picked for any team sport. On the advice of a family friend his mother got him involved in the Scouts. While he enjoys going to Scouts he is at risk of being asked not to attend on the basis of his disruptive behaviour.

Environmental:

Products & technology:

For personal use: John has access to a range of IT solutions to his literacy problems. His father has got him his own laptop with a voice activated word processing software package. John like the status of having the computer but has yet, after 12 months, failed to get the package to work.

Support & Relationships:

Immediate family: John's main family relationship is with his mother. He has great difficulty relating top his father and his siblings.

Friends – John has no close friends but many good acquaintances

People in position of authority – Even in primary school John had difficulty with his teachers. Since moving to secondary school his problems have multiplied and he is at risk of being suspended

Health professionals – John has attended an OT who has been working with him on motor coordination exercises.

Other Professionals: John has been in receipt of learning support for most of this educational career. His current learning support teacher believes he has potential to adapt to an academic curriculum

Attitudes:

Immediate family: John's father is at a loss as to how to handle John. He is motivated to find a way but knows that his relationship with John is fraught. His mother is very stressed because she is beginning to see that John's behaviour may

jeopardise her capacity to continue to work. She is very anxious to find a solution that will allow her to further her career.

Friends: John has no close friends but lots of acquaintances.

Services, Systems and Policies:

Education and training services systems and policies: John has been in receipt of learning support from a very early age. He has attended special reading classes since he was eight years old. His parents have provided him with extra tuition outside of school through the Dyslexia Association. The current referral is on the basis that an Individual Statement of Need and a Behaviour Support Plan may avert the possibility that John will become an early school leaver.

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