Special Needs Children: Guidance for the GAL

A presentation to the *DuPage County Bar Association by*

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November, 15 2019

Wanzenberg & Associates

www.iepguardians.org

Overview of Today's Presentation

- Brief update on Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) since May 2013 and the 5th revision of the DSM
- An overview of how school-based supports are structured
- Tips to enhance your communication with schools
- Presentation will be available online at www.iepguardians.org under "Presentations"
- Our practice overview: advocacy, executive functioning instruction, therapeutic service placement and integration
- Our background as special education and general education administrators and –now-- layadvocates
- We offer free consultations to family up front to ensure our services are a good match

Some important considerations

- Clinical diagnoses (DSM-V/ICD-10 by a qualified clinician) vs. School-based educational eligibilities under and Individualized Education Program (IEP) (i.e., *does the disability present in evaluative terms in the school setting?)*
- Discussions with children and young adults
  - Consider developmental level, pacing and response, and steps/bits
  - Consider language deficits (expressive, receptive, pragmatic)
  - Model “Person Centered planning” and remembering the individual in front of the label/diagnosis, with both parents as caregivers who –in spite of their differences– must support that individual’s goals
- Support for child’s caregivers and caregiver network

Autism Spectrum Disorder (ASD)
DSM-V criteria (summarized)

- **Dimension 1- *characteristics*, over time in at least two settings**
- **Historical deficits in social communication, across multiple contexts** (one or more)
  - **Reciprocity** (functional exchange), restriction of interests (highly focal areas of interest); failure to initiate social interactions
  - **Nonverbal communication** (eye contact, reading body language and tone, gestures)
  - **Development, maintenance, and understanding of social relationships** (failure to adapt to social situations, difficulty with imaginative play, limited interest in interaction)

Autism Spectrum Disorder (ASD)
DSM-V criteria (summarized)

- **Dimension 2- *Restricted characteristics*, over time in at least two settings**
- **Stereotyped or repetitive movements or behaviors** (e.g., lining items up, echolalia, idiosyncratic phrases)
- **Insistence on routines or ritualized patterns/schedules**
- **Highly restrictive interests with strong attachment to objects**
- **Under or over-sensitivity to sensory input in environment (e.g., smells, sounds, sights, temperature, etc.)**

Autism Spectrum Disorder (ASD)
DSM-V criteria (summarized)

Dimension 3 - *severity* (see handout)

- *"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."*
- Other disabilities ruled out

Autism Spectrum Disorder (ASD)
DSM-V criteria (summarized)

Severity Level	Social Communication	Restricted, repetitive behaviors
3 *(Requiring Very Substantial Support)*	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly interfere with functioning in all spheres. Great distress/ difficulty changing focus or action.
2 *(Requiring Substantial Support)*	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/ repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/ or difficulty changing focus or action.
1 *(Requiring Support)*	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Autism Spectrum Disorder (ASD)
How is it diagnosed (clinically)?

- Rating scales (best practice indicates BOTH parents and at least one external setting)
- Self-report if appropriate
- Mental status examination (clinician to student)
- Review of records
- Speech and Language evaluations (pragmatic social communication)
- Observations in various settings
- Psychological testing (cognitive, executive functioning, achievement, projectives)

Autism Spectrum Disorder (ASD)
How is it treated (treatment modalities)?

- Behavioral (BCBA, ABA, DIR-FLOORTIME, etc.)
- Communication (pragmatic social communication, assistive/augmentative)
- Social skills groups (modeling, social stories, videos)
- Educational (IEP, Section 504 accommodations, RTI-MTSS)
- Medical including pharmacological (as prescribed by MD, DO) and dietary/nutritional
- Other therapies (occupational [fine motor], expressive, music, animal, recreational, etc.

Attention Deficit Hyperactivity Disorder (ADHD)

DSM-V criteria requires six or more

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
- Often has trouble holding attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
- Often has trouble organizing tasks and activities.
- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
- Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily distracted
- Is often forgetful in daily activities.

Attention Deficit Hyperactivity Disorder (ADHD)

DSM-V criteria: Impulsivity and Hyperactivity (requires 6 or more)

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting their turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

Attention Deficit Hyperactivity Disorder (ADHD)

DSM-V criteria: Impulsivity and Hyperactivity (all conditions must be met for hyperactivity/impulsivity)

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more settings, (such as at home, school or work; with friends or relatives; in other activities).
- The symptoms are not better explained by another mental disorder (such as a mood disorder, anxiety disorder, dissociative disorder, or a personality disorder). The symptoms do not happen only during the course of schizophrenia or another psychotic disorder.
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.

Attention Deficit Hyperactivity Disorder (ADHD)

Three Presentations

- *Combined Presentation*: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
- *Predominantly Inattentive Presentation*: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months
- *Predominantly Hyperactive-Impulsive Presentation*: if enough symptoms of hyperactivity-impulsivity, but not inattention, were present for the past six months.

Attention Deficit Hyperactivity Disorder (ADHD)

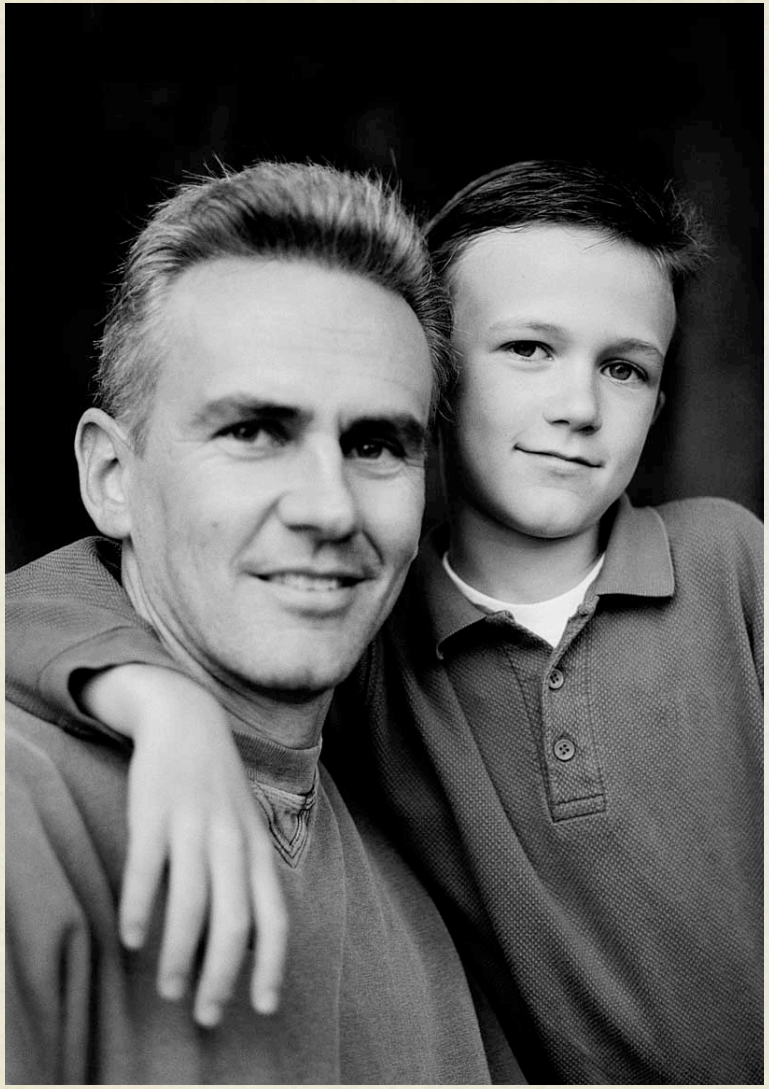
How is it treated (treatment modalities)?

- Best practice treatment: multimodal approach
- Behavioral therapy (CBT)
- Educational and environmental supports
- Pharmacological (stimulant and nonstimulant)
- Executive Functioning coaching
- Diet/nutrition
- Treatment of ADHD within other concomitant diagnoses (e.g., affective disorders, ASD, learning disabilities, etc.)

Attention Deficit Hyperactivity Disorder (ADHD)
How is it diagnosed (clinically)?

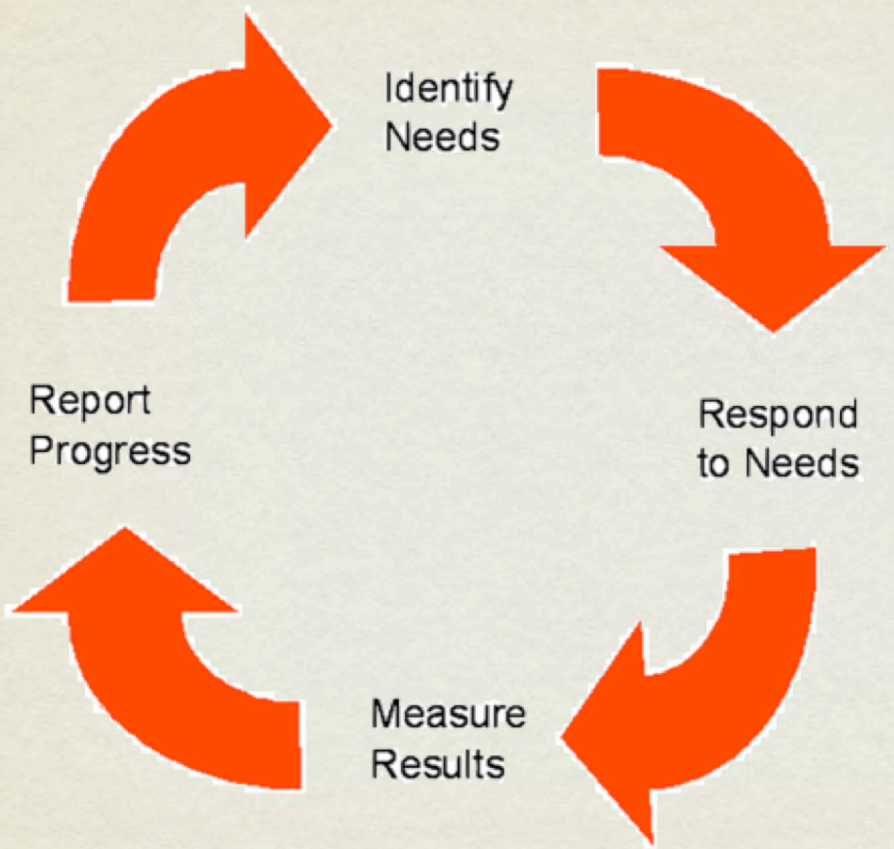
- Rating scales (best practice indicates BOTH parents and school setting)
- Self-report if appropriate
- Cognitive assessments (verbal, non-verbal, processing speed, working memory)
- Specific executive functioning assessments
- Review of records
- Speech and Language evaluations (pragmatic social communication)
- Observations in various settings

5 Important School Considerations for the GAL



- Establish consensus between parents that the focus of all meetings and conversations is student centered, well before any school staff are involved
- Establish a clear goal(s) that is measurable and focuses on positive student outcomes.
- Learn who the key players are at each school environment to avoid potential landmines.
- Advocacy is situational: measure your reaction to the context and audience
- Put your mantra (“what is best for the child?”) into practice with every connection with school staff.

What a GAL should focus on before contact with school staff is made



- Meet with parents/caregivers to establish common goal(s) and measurable student outcomes. If consensus is not possible, discuss and prioritize educational matters beforehand.
- It is imperative that parents are in collaboration that the purpose of meetings and communication with school is student centered. Schools tend to take passive approach in matters of parent disagreement.
- Agree on a set agenda and the roles of each parent and the GAL.

General Support Plan Overview: What can schools offer?

Consult handout: comparison of supports

- Response to Intervention (RTI) or Mult—Tiered System of Supports (MTSS)
- Section 504 Plan (accommodations and limited related services only)
- Individualized Education Program (IEP): need for specialized instruction to meet needs of learner
- Beyond public school

School Responsibilities for Data Collection/Progress Monitoring

- Brief overview of RTI/MTSS
- Generally 8-12 weeks per tier, but not always!
- Tier 1 (progress monitoring 3x a year)
- Tier 2 (progress monitoring 2x a month)
- Tier 3 (progress monitoring weekly)
- Interventions must be peer reviewed, research based, and effective for the population targeted
- See: “what works clearinghouse” at http://ies.ed.gov/ncee/wwc/

Escalation and De-Escalation in School Matters: A Continuum of Responses

Efforts to Escalate (more intensive, formal, timeline-oriented requests) in descending order:

GAL requests that the student be brought up at Pupil Problem Solving Team meeting to address a specific issue

GAL requests the notes from that meeting and weighs in on specific interventions/supports to be put in place

GAL requests a formal meeting 30-45 days after the intervention/supports were implemented to review data.

If the intervention/support had no impact on student GAL can request a more formal plan which can include:

Moving to a 504 plan (provide accommodations)

Open up a CSE in anticipation of obtaining an IEP

School District has 10 days to respond to such a request. At this time a meeting will be held to accept or deny the request to open up a case study evaluation or a 504 plan.

If unhappy with the results of the meeting it is now time to kick up the request to the Director of Special Education for the District.

What are signs that lead to GAL problems in school support scenarios?

- **Communication difficulty/breakdown (jargon, timelines, steps in process, RTI, data collection, rights, etc.)**
- **Team is –unknowingly– operating on faulty or outdated assumptions (e.g., "*well, that is what parent wanted/told me last year!*")**
- **Parents feel unqualified or underprepared to raise or respond to specific concerns (e.g., Parent has to triple task; at the meeting, "*I'm not going to say anything*")**
- **Meetings can be overwhelming from parent POV ("*They made me cry, so I want you to make them cry…*")**
- **Options are not fully explained to parents and parents aren't informed of what they can request ("*We don't know, what we don't know!*")**
- **Parents do not feel they are participating/collaborating meaningfully in the process**
- **Parents and school often see different versions of the student, and may have competing theories of how the child learns best**

Escalation likely needed after a meeting like this…

- **Parent had no clue what the meeting was about, who was at the table, and what was proposed**
- **Parents expected to triple task: listen, take notes, and digest new information on the fly**
- **Meeting suppressed the opinions of the staff and or the parents, and only the 1-2 staff were talking**
- **There are team members who never spoke up at the meeting… on anything**
- **Feedback and documentation broad, general, and loose, with clear pride of authorship reflected in proceedings**
- **Meeting went well over budget; staff came and went without introduction or explanation**
- **Items discussed and agreed to not summarized, and left to parent to follow up**
- **Record issued with no reflection of actual conversation**

What does a productive student support meeting look like?

- **Parent, and LEA collaborated and agreed to purpose, agenda, format, and timeline**
- **Parents had time before the meeting to review and evaluate proposed information (goals, reports, scores, etc.)**
- **Appropriate balance between elasticity (to permit team members to extend a point) and structure (meeting accomplished objective, i.e., domain for re-evaluation)**
- **Team members stop frequently and check for understanding**
- **Team members have avoided the "love-in" and disingenuous compliments**
- **Meeting did not exceed appropriate time limit**
- **Follow up items were recapped, "timelined", and issues deferred to another meeting encapsulated**
- **Ideally, additional comments were projected for parents to see or read back. Alternatively, parents were invited to contribute to proceedings under "parent concerns"**

In closing...

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DCBA CLE PROGRAM
Special Needs Children
Matthew Wanzenberg, Ph.D.
November 15, 2019
3:15p-4:00p

Note: Powerpoint presentation and resources specific to topic areas will be available for download and distribution:
http://iepguardians.org/STUFF/PRESENTATIONS/111519DCBA.pdf

OUTLINE	NOTES
1. Presentation Overview a. Focus on practical information for your clients and identification for referral b. Focus on accessing supports and services in public schools c. We always offer a free consultation with parents who are interested in learning more about our services 2. Autism Spectrum Disorder (ASD) a. Overview of current DSM-V diagnostic criteria (May, 2013) b. Autism and Social Communications Disorder c. Changes from DSM-IV and implications moving forward d. Treatment modalities for ASD: i. Behavioral (BCBA, ABA, DIR-FLOORTIME, etc.) ii. Communication (pragmatic social communication, assistive/augmentative communication, social skills groups) iii. Educational (IEP, Section 504 accommodations, RTI-MTSS) iv. Medical including Pharmacological (as prescribed by MD, DO) and dietary/nutritional v. Other therapies (occupational [fine motor] expressive, music, animal, recreational, etc.)	

vi. Complementary and alternative medicines
e. Differences between educational eligibility (Au) under an IEP and clinical diagnoses
f. Feedback for attorneys in your interaction with individuals with ASD
i. Communication tools
ii. Developmental level
iii. Language (expressive and receptive)
iv. Person centered planning, and remembering the individual in front of the label/diagnosis
v. Support for child's caregivers and caregiver network

3. Attention Deficit Hyperactivity Disorder (ADHD)
a. Overview of current DSM-V diagnostic criteria
b. Best practice treatment: multimodal approach
i. Behavioral therapy
ii. Educational and environmental supports
iii. Pharmacological (stimulant and nonstimulant)
c. Other approaches
i. Executive Functioning coaching
ii. Diet/nutrition
iii. Treatment of ADHD within other concomitant diagnoses (e.g., affective disorders, ASD, learning disabilities, etc.)

4. School Based Supports (overview, eligibilities, process)
a. General Education
b. Response to Intervention (RTI) and Multi-Tiered Systems of Support (MTSS)
c. Section 504 Plan accommodations
d. Individualized Education Program (IEP)

Links to specific diagnostic criteria:

- Autism Spectrum Disorder (source: DSM-V 299.00 F84.0; via Center for Disease Control and Prevention)
  - https://www.cdc.gov/ncbddd/autism/hcp-dsm.html
- Severity table

Severity Level	Social Communication	Restricted, repetitive behaviors
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- Social (Pragmatic) Communications Disorder (SCD) (source: DSM-V 315.39 F80.89; via Autism Speaks)
  - https://www.autismspeaks.org/dsm-5-criteria
  -
- Attention Deficit Hyperactivity Disorder (ADHD) (source: DSM-V 314.0x F90.x; via Center for Disease Control and Prevention)
  - https://www.cdc.gov/ncbddd/adhd/diagnosis.html
  - Three “types”
    - *Combined Presentation*: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
    - *Predominantly Inattentive Presentation*: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months
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IEP's, 504 plans, RTI plans, and Post-High School Supports

	K-12 Individualized Education Program (IEP)	K-12 Section 504 of Rehabilitation Act	Response to Intervention Plans (RTI)	College and Agency (Section 504 and Americans with Disabilities Act)
School accountability	The student's public school is responsible for the student's performance as long as goals are identified in the IEP	The student's public school is not held accountable for specific areas of performance	The school is required to monitor student's performance in interventions	The student is responsible for his/her own academic performance. The school or agency is only required to consider supporting documentation
Identification	Public schools have a responsibility to find and evaluate students with disabilities that impact school performance	Parents must provide supporting documentation that meet federal guidelines for accommodation	Any school member or parent can initiate a request for an intervention plan	The student provides supporting documentation for disability and need for basic accommodations which may or may not be provided by college or agency
Costs of Identification	School districts bear the responsibility for a case study evaluation	In most cases, the family bears the costs of the eligibility evaluation for 504 services	School district bears the responsibility to design, implement, and monitor the intervention plan	The student is responsible for all costs associated with eligibility for supports at the school or agency
Termination	Services terminate at graduation or day after student's 22nd birthday if still in high school.	School services terminate upon graduation, but 504 plan may generalize to adult world	Intervention plan terminates at team discretion or upon graduation from high school	504 plan terminates upon completion of program or degree
Plan development	A multidisciplinary team of specialists develop and monitor the IEP	A limited committee of school team members develops and reviews the 504 plan	No requirement for specific team member, but casemanager is designated to monitor results of interventions	Student identifies needed accommodations; school or agency committee will review and determine if these are feasible in higher education
Entitlement	Student is subject to a free and appropriate public education outlined in IEP at no cost to parent. Due process rights allow for appeal.	Student is subject to a free and appropriate public education outlined in 504 plan at no cost to parent. Due process rights allow for appeal.	No specific rights exist for student or parent	Schools and agencies may determine eligibility for services with limited due process for student
Advocacy	Family is advocate	Family is advocate	School staff are the advocates	Student is advocate and seeks out supports needed
Changes allowed to course of study	Extensive and individualized modifications to course of study are allowed	Accommodations cannot fundamentally alter the nature of the course of study	No specific requirements, only that interventions must be established in research as effective interventions	Accommodations cannot fundamentally alter the nature of the course of study **or** cause undo hardship to school, agency, or employer.
Confidentiality	Strict confidentiality limited to school staff and specialists	Strict confidentiality limited to school staff and specialists	No specific requirements relating to achievement	Confidentiality between school/agency and student under FERPA
Funding	Federal, State, and Local funds	No funding	No funding	No funding; colleges may assess a "support fee" to offset costs of supports
Generalization	Carries over each year in public schools, K-12. Yearly progress updates and a re-evaluation each three years for continued eligibility. Meetings can be called at any time, as frequently as requested by school or parent	Carries over each year in public education, K-12. A brief yearly review is required.	No specific requirement: may be short term and not subject to carry-over in public school. Plans often do not generalize from elementary to middle to high schools	Plan is reviewed by college/agency at least yearly and renewed until program is completed

Adapted from: Brinckerhoff, L.B., Shaw, S.F., & McGuire, JM (2000)