Unit : 3 ❐ Assessment at Pre-school and School Level

Structure

3.1 Introduction :

Assessment methods and tools are very much essential for educational purpose. It may vary with age group because with the age the sensory motor coordination, social, perceptional emotional, communicational skills also varies which affect the learning outcome of a child.

3.2 Objectives :

After going through this unit the reader should be able to -

1. Understand the importance of assessment at preschool and school level.
2. Understand the developmental and adaptive behaviour assessment.
3. Explain and demonstrate tools at preschool level Upanayan, Aarambh Portage, MDPS. FACP and school level (MDPS, BASIC-MR, GLAD SIS).

4. Understand documentation of assessment result interpretation and report writing implication of class level assessment & its relation to inclusion with resource support.

3.3 Importance of assessment at preschool and school level

Preschool children

This group usually comprises of children from birth to six years. Though there are special programmes in India to target this group, currently there are no State policies or standard guidelines on assessment and intervention programmes. In this scenario, it is justified to look-up at the best practices available worldwide. The Individual with Disabilities Education Act (1997) of US require that every child identified to have disabilities at this stage will be assessed by a multidisciplinary team to establish relative strengths and needs in all the areas of development and identify appropriate services; secondly, a family directed assessment of resources, priorities, and concerns of the family and identification of resources and support system to meet them. Further the assessment should be able to predict the expected outcome for both the child and family, and precisely state what intervention programmes are required to achieve the outcome. In this context it is pertinent to note that preschool assessment should gather information on both the child and the family. Within the existing resources, early childhood assessment can be conducted if the teacher had the following competencies :

- Basic understanding of causes and prevention of disabilities in general and mental retardation in particular.
- Knowledge of human growth and development including the stages of development, facilitating factors,inhibiting factors, hazards of development, and intervention.
- Knowledge of existing developmental, (e.g. GDS, DST etc.), educational (e.g. Arambh) and other assessment tools (e.g. Portage, Upanayan) meant for this group.
- Knowledge of family functioning models and relevant assessment scales (Persha & Rao, 2003; Peshawaria et. at., 1995).
- Awareness about existing Policies, Provisions and Service Providers as applicable to the region to which the child belongs.

School level

This group comprises of children between 6 to 15 years. Hence assessment is required on the following :-

1. Intelligence assessment on standardized scales. This information will be helpful from the point of diagnosing mental retardation, estimating disability so that appropriate social benefits are extended to.
2. Adaptive behaviour assessment on norm-referenced scales (preferably, on VSMS) and / or criterion scales (e.g. MDPS).
3. A detailed educational assessment, preferably based on the functional approach (e.g. the functional assessment checklists for programming).
4. Assessment of problem behaviours, as indicated (e.g. BASIC-MR, BASAL-MR).
5. Depending on the need and educational setting, assessment can be conducted formally (e.g. grade level assessment tool by Narayan, 1994) or informally (e.g. teacher made curriculum-based tests).

At school level, particularly when it comes for placement in regular schools, the assessment should go beyond the individual with disabilities. It is also important to understand the environmental variables such as, attitudinal barriers, physical barriers, peer support, attitude and enthusiasm of the teachers and administrators.

3.4 Developmental and Adaptive Behaviour Assessment

From the information about the pattern of development of any individual, early identification can be possible. Sereening tools are also helpful to identify person with a specific condition within a large population. The screening procedure is less costly and less time consuming to determine the pattern of development in a child within his developmental stage or not. More over it is important to note that being positive on screening does not necessarily mean that the same result should come on assessment. Suppose developmental screening has indicated general developmental delay suggestive of mental retardation but the same result may not come up on IQ assessment.

There are several screening tools meant for identification of mental retardation, which are as follows :-

NIMH development screening schedule : This tool was developed by Saroj Arya (1991) to screen preschool children for disabilities in general and mental retardation in

particular. The schedule consists of ten key items on development that are passed by 90% of the children between the specified age group. The tool is established to have sound validity, reliability, and predictive power. The tool is meant for use in rural areas as as well as in urban setting.

NIMH screening schedules (National Institute for the Mentally Handicapped, 1989) : There are three schedules under this group meant for age group below 3 years, 3 to 6 years, and 7 years and above. The number of items / questions on which information has to be obtained varies from 8 to 13 per schedule. Administration of each schedule may not take more than five minutes. Though the psychometric properties particularly the predictive power of these schedules is not known, they are widely used in mass screening and the feedback is satisfactory.

Developmental screening test (DST) : This test was developed by Bharatraj (1977). This provides a measure of mental development based on social adaptive behavioural skills, communicative skills and motor skills from birth to 15 years. This can also be used with any age group of suspected cases of mental retardation. This tool shows good correlation with standardized IQ measures; therefore it is used whenever standard intelligence testing is not possible. Administration of this screening takes thorough training, and is primarily used by psychologists and developmental therapists.

Gessell's drawing test : Verma et al. (1972) adapted this test in Indian setting. This test consists of some simple geometrical shapes, which the student has to draw. This test is applicable from 1½ year to 8 years. Very recently some more items have been added which has enhanced its applicability up to the age of 12 years (Venkatesan, 2002). It takes about ten minutes to apply and interpret the test provided the child is cooperative

Developmental assessment tools

Other than the screening tools, early identification can be done by acquiring information about the development pattern of the individual. We know that development follows a specific pattern, which means that there is an expected age range for every developmental task. When we compare the individual's development with that of the expected norms, we can answer the following questions : whether development was normal, or any deviations were indicated; if the developmental deviation was specifically restricted to one area or generalized. This information can be attained by observation of the child, and also by interviewing the parents. Some of the important developmental milestones are shown in Table 1.

Table 1 : Normal Milestones of Development

S. No.	Developmental Milestone	Mean are by which it is attained
1.	Smiles at others	4 months
2.	Holds head erect	4 months
3.	Puts objects into mouth	4 months
4.	Rolls from back on to stomach	6 months
5.	Makes sounds "anna", "da da da" etc.	7 months
6.	Sits without support	8 months
7.	Responds to name	10 months
8.	Stands by holding on to an object	10 months
9.	Holds object with thumb and index finger	10 months
10.	Stands without support	10 months
11.	Walks without support	15 months
12.	Tells own name	18 months
13.	Drinks by self from glass	21 months
14.	Shows body parts when named	24 months
15.	Speaks in small sentences	30 months
16.	Unbuttons clothes	36 months
17.	Differentiates big and small	36 months
18.	Can button clothes	40 months
19.	Combs hair	48 months

Source : National Institute for the Mentally Handicapped, Secunderabad.

A careful analysis of the developmental tasks will indicate that whether the child is having specific delay or a generalized delay suggestive of mental retardation. However, sometimes it may more areas of development it usually suggests mental retardation. However, sometimes it may not be possible to remember all necessary milestones hence we may miss some while observing of interviewing. Therefore, it is better to use developmental scales for they contain all necessary questions about development and also provide normative comparisons. Besides the developmental scales mentioned above, Developmental Assessment Scales for Indian Infants (DASII), an Indian adaptation of Bailey's Infant Scales for Development by Pramila Pathak (1970; 2009), are also widely used for assessment and intervention.

Developmental assessment is mandatory in assessing mental status because it is one of the criteria of any diagnostic system. That is, it is essential for both intellectual and adaptive behavioural deficits should be during the the developmental period (i.e. before the age of 18 years). Further, intelligence testing cannot be done accurately at younger age groups (i.e. below age 3 years), and in very severely and profoundly retarted children. Sometimes, sensory-motor, communication deficits, lack of formal training and education etc. will also interfere with intelligence testing. Therefore, it is a common practice that wherever intelligence testing is not applicable or feasible, developmental assessment is done to estimate developmental quotients did interpreted the same way as intelligence quotient (IQ) to ascertain the severity of mental retardation. Another reason why developmental assessment is preferred that developmental tasks are not influenced by formal education or lack of it unlike the tasks given under intelligence testing. Lastly need for developmental assessment is also indicated by the fact that internationally the construct of mental retardation is changing to reflect it also as a developmental and intellectual disability. However, it must be noted that developmental assessment is not a substitute to intelligence testing, as both depend on entirely different assumptions.

Assessment of adaptive behaviours :-

Adaptive behaviour is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group (Grossman, 1983, P-159). This expectation differ from age to age.

According to the American Association on Mental Retardation (AAMR) the deficits in adaptive behaviour during the childhood years may reflect deficit in academic learning, judgement and reasoning in dealing with the environment and social skills in group activities and interpersonal relationship. So it can be considered as a feature of mental retardation.

Classification of persons with mental retardation based on the support system required with reference to the adaptive behaviour deficits is an emerging trend globally. Therefore, assessment of social and adaptive behaviour is an important aspect in assessment of mental retardation. Similarly, behavioural problems and communication deficits are common to mental retardation. Therefore, assessment of all these aspects is important for a comprehensive plan.

AAIDD recognizes adaptive behaviour as a collection of three skill areas explained below, and a significantly sub average functioning in the following three areas is necessary identify mental retardation (Luckasson et. al. 2002) :

- Conceptual skills - language and literacy; money, time and number concepts; and self-direction.
- Social skills - interpersonal skills, social responsibility social problem solving and the ability to obey laws and to avoid being victimized.
- Practical skills - activities of daily living (personal care), occupational skills, healthcare, travel/transportation schedules/routines safety, use of money, use of the telephone.

Assessment of adaptive behavior to determine the support system is not common in India, where IQ levels are transformed into disability percentages. But now globally the trend is to define support system based on the extent of deficits in adaptive behaviors. Then the question comes what are supports? Supports are resources and strategies necessary to promote the development, education, interests, and personal well being of a person with intellectual disability. Supports can be provided by a parent, friend, teacher, psychologist, doctor, or by any appropriate person or agency. The AAIDD views that providing individualized supports can improve personal functioning, promote self-determination, and enhance the well being of a person with intellectual disability. Supports also lead to community inclusion abilities. Focusing on supports as the way to improve education, employment, recreation, and living environments is an important part of a person-centered approach to provide care to people with intellectual disability. To extend the support system, an individual's need for supports be analyzed in at least nine key areas, which are human development, teaching and education, home living, community living, employment, health and safety behavior, social behavior and protection and advocacy. Between intelligence problems and adaptive behaviour deficits, credit is given to the latter in conceptualizing mental retardation as it directly reflects quality of independent living.

To Give the importance of adaptive behaviour as a diagnostic criterion and its role in independent living, assessment is done to obtain two questions : 1) whether the adaptive behaviour is significantly below average? 2). If yes, what are the relative strengths and deficits of the individual? Answer to the first question comes from norm-referenced assessment, while criterion - references and behavioural tools are for the other. Answer to the second question emphasizes the fact that measurement of adaptive behaviour is a nonbiased assessment of culturally different students, as it recognizes cultural and ecological influences on daily living activities. Some of the commonly used scales are listed in Table 2.

Table 2 : The adaptive behaviour scales used in India

S. No.	Name of the Scale	Approach	Age Group	Remarks
1.	Vineland Social Maturity Scale (VSMS; Malin, 1968; Bharatarj, 1992)	Normative	Applicable for 0-15 years; But is used with any age group of suspected cases of mental retardation	Yields social quotient (SQ) Provide a profile of adaptive behariour domains. Indicates just the target areas
2.	Madras Developmental Programming System (Jeyachandran & Vimala, 1975)	Criterion	Not defined from age the point of view of age but appears to be applicable for age 3 years & above, as the items reflect content from preprimary level and upwards.	One of the first tests of its kind in India. Useful for individualized programme plan

Adaptive behaviour scales / Tools for assessment of adaptive behaviour

The adaptive behavior, which projects our behavior in the personal and social areas, reflects our ability to respond to the environment. Thus adaptive behaviors come under the broad domains of functional independent skills, personal and social responsibility, and independent living skills. These elements combine to form an organized behavioral pattern of the individual. Some of the popular adaptive behavior scales used for assessing the mentally retarded persons are :-

The Adaptive Behaviour Scales (ABS) : The scale was developed in 1969 by Nihira et. al. to be used for client assessment and individual program planning and assessing the total programming needs of groups of clients for research purposes. It can be used to make assessment of mentally retarded, emotionally maladjusted and developmentally disabled persons of all ages from childhood for adulthood. It is divided into two parts : Part-I, is concerned with matters described as adaptive behaviour and comprises ten domains with a total of 66 items. The domains are independent functioning, physical development, number and time, domestic activity, vocational activity, self direction, responsibility, and socialization, Part-II of the scale is concerned with what are called maladaptive behaviours. These are grouped into 14 domains. They include violent and destructive behaviour, untrustworthy behaviour, withdrawal, stereotyped behaviour, inappropriate interpersonal manners, unacceptable vocal habits, unacceptable

habits, self abusive behaviour, hyperactive tendencies, sexually aberrant behaviour, psychological disturbances and use of medication. . The ABS is designed for use by someone who knows the individual being assessed. Thus it can, for example, be completed by a case worker or teacher. The assessor records responses to the item on the questionnaire, and no special training is necessary to complete it.

The Vineland Social Maturity Scale (VSMS) : This was developed by Edgar A. Doll in 1935, and has been revised several times since its first publication. It was intended to be used for program evaluation and research. The scale was designed to assess the social competence of individuals of ages from birth to 25 years and above. The Indian adaptation of VSMS, by Fr. A. J. Malin, has an age range of birth to 15 years. There are eight domains with 89 items, grouped age wise self-help general; self help eating, self help dressing, self direction, occupation, communication, locomotion, and socialization. The information is collected by a trained examiner from an informant who is familiar with the client. Scoring of the items gives the information on social age from which the social quotient could be calculated.

3.5 Assessment Tools at preschool level :

The age of three to four years is the time when the child attends a preschool, thus, a mentally retarded child with higher chronological years may educationally fall in the preschool years (3-4 years). The child is showing skills exhibited by a pre schooler and, therefore, needs educational instruction appropriate for a pre schooler.

There are several assessment tools available at pre school level.

a) Upanayan

Upanayan is a systematic, structured, early-intervention programme for the training of children with developmental delays and / or mental retardation. It was developed at Madhuram Narayanan Centre for Exceptional Children, Chennai. The programme was developed and designed to suit the Indian socio-economic conditions and cultural milieu. The programme has been developed considering diverse needs of children with any developmental delay besides mental retardation. This approach provides early intervention irrespective of the diagnostic labeling. Upanayan programme are designed for two groups of children : (1) birth to two-years; (2) two-years to six-years. Upanayan enables the family members particularly the mother to be the trainer or educator of the child. Another unique feature of this programme is that it combines traditional wisdom of child-care from India and other parts of the world with intervention.

Programme for babies from birth to two-years of age comprises five developmental

areas; motor, self-help, language, cognition, and socialization. Under each of the above areas, 50 discrete behavioral skills have been identified as the optimal ones to cover the daily activities of a child of this age group. The activities have been planned to train children in the various skills in the household setting of an average Indian home. Programme for children from two to six years includes advanced skills set under each of the 12 areas, which are as follows : gross motor, fine motor, mealtime activities, dressing, grooming, toileting, receptive language, expressive language, socialization, reading, writing and number work. As part of the Upanayan Programme the centre has also developed a computer-aided programme of development training for children with mental retardation (0 to 2 years) in making friends, reaching out teaching how to clap, learning to blow, learning to balance and standing on one's own legs.

b) Aarambh

Current research on education of persons with mental retardation indicates that children with mental retardation can be part of the inclusive education system provided curriculum adaptation, evaluation methods are compatible to the individual needs. Even when the resources are available, children with special needs do not adjust to the inclusive setting they are not prepared for it. By the time it is realized valuable time, which was important for preparing base for future learning, is lost. Research directed towards early detection and intervention confirms that early-learning is very influential on later-learning. Precisely in this backdrop, "Arambh", a package for inclusive education at preschool level was developed at The National Institute of Mentally Handicapped (NIMH) (Rao & Narayan, 2002) with funding support from UNICEF. It provides a customized curriculum, instruction for adaptation in teaching method each content and disability at preschool level. This package is meant to provide early childhood special educational inputs between 3 to 6 years i.e. before entering into the school system. The package consists of the following :-

1. Curriculum calendar
2. Teacher manual
3. Policy maker booklet
4. Activity cards

The curriculum calendar specifies what objectives of learning to be involved in its monthly activities. Teacher manual helps the teacher to make programme plan in regular school so that the existing infrastructure and resources are well utilized.

An information booklet for the policymakers is added to draw a roadmap for making the inclusive model of covering the children with special needs. There are 225 activity cards to cover the knowledge required daily; and information for a child to interact with parents, family members and the community. The cards indicate the process of various activities through conversation, games, songs, story-telling, creativity and finally prepare the child for skill demonstration. Field studies indicate that this scale is being widely used in early childhood special education in India.

c) Portage Guide

David EL Shearer found the Portage Project in 1969 to provide services to young children identified with disabilities within a rural community (Shearer and Shan; 1972). By early 70's the project offered home-based services that supported parents as their children's first, most valuable an influential teacher. This family-guided model supports parents and family in implementing an individualized educational plan and through basic routines and activities that the parent and child engage in on a daily basis. Specific play-based activities offered and utilized to meet child's goals and to improve parent-child interactions. Developmental assessment tools are also used for targeting skills, behaviors and progress. The outcomes ultimately helped children to prepare for school and overall success. The ultimate goal of this project is to create and enhance quality programme which promote the development of education of all children with disabilities and their families through a home or relationship-based early intervention programme. This project is guided by the following four core values :-

1) Strengh-Based : a focus on the strengths of children, families, and programms.
2) Ecological : consideration of the larger environment in which children, families and programs exist.
3) Family Focused : families and programs are the decision makers.
4) Relationship Based : most effective work is through relationships based upon trust that supports each individual and forms the basis of the program implementation (CESA 5, 2003).

This project has been adapted widely across the developing countries including India. Commonly known as Portage, "The Portage Basic Training Course for Early Stimulation of Preschool Children in India" was adapted in India by Tehal Kohli in 1987. This adaptation is an outcome of UNICEF supported pioneering project of its kind titled, "impact of home-centre based training programmes to

reduce developmental deficits of disadvantaged young children under ICDS scheme in Chandigarh". Portage as a tool provides age norm references besides giving the flexibility to choose programme as per the child's condition. Components of the Portage Material are as followed :-

1) Portage Checklist by Bluma et al (1976) lists sequential behaviours from birth to six years of life. The Indian version, adapted by Kohli, contains 575 checklist items encompassing infant stimulation, socialization, language, self-help cognitive and motor domains.

2) Curriculum cards to observe each of the behaviours on the checklist. Each card includes a behavioural description of skill and suggests material and curriculum ideas for teaching it.

3) Activity charts.

4) Reactions of mothers towards portage training : It notes the mothers' satisfaction level with the programme.

d) Madras Developmental Programming Systems (MDPS)

This scale earlier know as "Madras Scale" was developed by Jeyachandran and Vimala (1968). It underwent three editions including a revision before it acquired its present form and the name, "Madras Developmental Programming Systems" (MDPS) in 1975. The scale was revised five more times till 1992. The scale is first of its kind in India in individualized programme planning in training persons with mental retardation. It consists of 18 domains with each containing 20 times. The 18 domains encompass the following broad areas :-

Motor	:	(Gross Motor, fine motor)
Self-helf skills	:	(Eating, dressing, grooming, toileting)
Communication skills	:	(Receptive language, expressive language)
Social interactions		
Functional academic skills	:	(Reading, writing, arithmetic, time, money)
Domestic behavior		
Community orientation		
Recreation and leisure time activities		
Vocational activities		

Each item is scored with alphabetic code ('A' means performs; 'B' means yet to perform), and a colour code ('Blue' means performs; 'Red' means yet to perform). Specific patterns are also used to indicate if a skill, which was not performed at baseline, is achieved after training. The patterns vary depending on which quarter the assessment was done. Being a criterion-referenced scale it provides scope for periodic assessments and evaluation. Items from each domain are also identified to represent different educational levels including preprimary, primary, secondary and prevocational. Some salient features of the scale are as following :-

- Item selection is based on developmental stages and life situations.
- All the 360 items are positive statements which are observable and measurable.
- All the items have functional relevance.
- The items proceed from simple to complex.
- The scale has sound psychometric properties such as reliability, validity and practicality.

e) Functional assessment checklist for programming (FACP)

Latest among the approaches to curriculum development, the functional approach emphasizes that educational goals should be functional, age appropriate and community - referenced. Need for his approach arises in the context that curricular content, at times, does not provide a meaningful link between learning situation and practical situation. Functional curriculum ensures that the activity taught is directly applicable in real situation. Suppose a teacher may decide to teach spellings only for those words that require reading and writing in general correspondence. Accordingly, the teacher shall teach the spellings for name of the student, grocery items, sign boards than typically beginning with alphabet. Similarly, training for holding food is done with real food than holding beads and blocks. Thus, a functional programming aims at leading the student towards reduced dependence on others and provide maximum personal, social and occupational competency. The following checklists, based on functional curriculum, are extensively used in India in both individualized training and group teaching :-

Functional Assessment Checklists for Programming (Narayan et. al., 1994)

This checklist is developed by the Department of Special Education, NIMH. There are separate checklists for different age groups - Preprimary (3-6 years), Primary-I (7-10 years), Primary-II (9-14 years), Secondary (11-14 years). Prevocational-I and Prevocational-II (both 15-18 years), and Care Group (those who are profoundly retarded). The items vary from one checklist to another. The domains covered are, personal, social,

academics, occupation and recreational. The checklist provides the guidelines as how to promote children from one class to another. If the curriculum is mastered the individual will have necessary competency to undergo vocational training and function independently in adult life.

3.6 Assessment Tools at school age :

The years between five to ten are the years of primary schooling. During this period, significant changes in the sphere of physical, intellectual, emotional and social aspects takes place. Language, communication, reasoning thinking, problem solving capacities develops rapidly.

The various assessment tools at this age are :-

i) **MDPS - Mentioned earlier**

ii) **BASIC MR - The Behavioural Assessment Scales for Indian Children with Mental Retardation (BASIC-MR)** are used for assessing the current level of bahaviour and for programme planning with children between 3-18 years of age. BASIC-MR comprises two parts - Part A and B. Part A has 280 items which provide information regarding the current level of skill behaviours in seven functional areas - motor skills, activities of daily living, language, reading-writing, number-time, domestic-social and prevocational-money. With respect to each item, one has to see whether or not the child can do the task as specified in the item independently; if not, what sort of help he needs. Depending upon the child's performance, the child is given a score as described below :-

Each child with retardation may show different levels of performance on the items of the BASIC-MR, PART A. The six possible levels of performance under which each item can be scored are as follows. The record booklet is used to enter the scores obtained by the child on each item.

Level One : Independent (Score 5) - If the child performs the listed behaviour without any kind of physical or verbal help, it is marked as 'independent' and given a score of 5.

Level Two : Clueing (Score 4) - If the child performs the listed behaviour only with some kind of verbal hints, it is marked as 'clueing' and given a score of 4.

Level Three : Verbal Prompting (Score 3) - If the child perform the listed behaviour with some kind of accompanying verbal statements, it is marked as 'verbal prompting' and given a score of 3.

Level Four : Physical Prompting (Score 2) - If the child performs the listed behaviour only with any kind of accompanying physical or manual help, it is marked as 'physical prompting' and given a score of 2.

Level Five : Totally dependent (Score 1) - If the child does not perform the listed behaviour at present, although he can be trained to do so; it is marked as 'totally dependent' and given a score of 1.

Level Six : Not applicable (Score 0) - Some children may not be able to perform the listed behaviour at all, owing to sensory or physical handicaps. Wherever an item is marked "not applicable", it gets a score of 0.

Part B has 75 items which provide information regarding the current level of problem behaviour in the child. With respect to each behaviour, it is noted whether the child never shows the behaviour (0), shows it occasionally (1) or frequently (2).

Table 3 : Showing domains of BASIC-MR

	BASIC-MR
Part A : Skill bahaviour domains	1. Motor 2. Activities of daily living 3. Language 4. Reading-writing 5. Number-time 6. Domestic-social 7. Prevocational-money 8. Social-communication
Part B : Problem	1. Violent and destructive behaviours 2. Temper tantrums 3. Misbehaves with others 4. Self-injurious behaviours 5. Repetitive behaviours 6. Odd bahaviours 7. Hyperactivity 8. Rebellious behaviours 9. Antisocial behaviours 10. Fears

iii) **GLAD - Grade level assessment device for children with learning problems in schools** (Narayan, 1994) : This tool was the first of its kind in India, which was developed in the backdrop that there were no wholesome scales to assess the learning problems. Even those existing did not meet the variation across State and Central schools syllabi. Some of the main objectives with which this tool was developed are as following :-

- Development of a schedule for assessing children to find out their class equivalence in academic performance in India.
- Developing a manual for use by the teacher.

The tool has two formats : Format-I and Format-II. Format-I contains test booklets of class I to IV given in the form of worksheets. Each class contains worksheets in Hindi, English and Mathematics. Item include tasks requiring verbal and written responses to questions. Analysis of students performance gives clue to the teacher regarding the student's style of learning and problem solving. The salient feature of this scale is that the test items are based on minimum levels of learning (MLL) prescribed by the National Council on Educational Research and Training (NCERT). Further, items have the uniform endorsement of syllabi of various Central Boards and a State Board where MLL was taken the standard. But wherever MLL were not prescribed as in the case of LKG and UKG, item endorsed by different boards, and published books were considered in the same order. Thus this tool satisfies the assessment needs of children coming from different school syllabi across India. Since the test items reflect the standard curricula, it is also an example for curriculum based assessment tool. The tool has established criterion validity, content validity face validity, test-retest reliability.

Format-II is meant for teacher's observation regarding the student's performance on Format-I and certain personal details of the student. It contains three sections. Section-I deals with personal details, family history, school history etc. Section-2 requires the teacher to note information on sensory-motor skills, which will be useful for medical referral. Section-3 indicates the possible errors for each subject so that when they are noted the teacher can undentand the processing deficits involved in specific subject.

Finally the summary sheet provides for a brief overall picture of the child, which includes matrix that shows the child's class of functioning in terms of independent, functional and frustration levels. Coding facilities are provided so that the class levels in which the student is tested can be noted in terms of his or her performance. The salient features are as follows :-

- Overall information can be used to identify learning problems with reference to curriculum.
- It is possible to ascertain the grade levels in Hindi, English and Mathematics.
- Information obtained can be used in diagnosis and management of specific learning disabilities in primary class levels.
- It is reliable, valid, and easy to administer and interpret.
- Has relevance to all parts of India, as it is based on MLL, and also the Central and a State Board Syllabi.

iv) **Support Intensity Scale :-**

It is a unique scientific assessment tool designed to measure the level of practical support required by the people with mental retardation in order to lead a normal, independent life in society.

The scale has two components :-

- A manual explains how to administer the instrument.
- A set of pre printed forms rate the respondent on the intensity of supports required in medical, behavioural and life activity areas.

The support means resources and strategies - including individuals, money or tangible assets, assistive devices, of environments that enable people with developmental disabilities live normal lives in regular community settings.

The Supports Intensity Scale measures supports required by an individual in75 life activities in the areas of home living; community living; life-long learning; employment, health and safety; social interaction; and protection and advocacy.

The Supports Intensity Scale also measures 15 exceptional medical needs and 13 behavioural support needs of the individual being tested. The rationale here is that certain medical conditions and challenging behariours predict that a person will require increased levels of support, regardless of his or her relative intensity of support needs in other life areas.

The Supports Intensity Scale is conducted as a semi-structured interview by a qualified interviewer with preferably two or more respondents that know the individual well. The interviewer should be a professional who has completed at least three months and have had recent opportunities to observe the person function in one or more environments for substantial periods of time.

The Supports Intensity Scale has been normed on a sample of 1306 people between the ages of 16 and 70+ identified with mental retardation or other developmental disabilities. The SIS sample was drawn from 33 states and 2 Canadian provinces and the data was collected between spring 1999 and fall of 2002.

Benefits of SIS Scale :-

- Provides direct, reliable, and valid measurement of supports requirements in 57 life activities.
- Ranks results by frequency, daily support time, and types of support needed.
- Evaluates impact of 15 medical and 17 behavioural conditions on overall support needs.
- Presents percentile ranking of persons needs based on national field test data.
- Provides graphic plot of information recorded, including visual display of areas of high intensity vs. low intensity of supports needs.
- Supplements adaptive behavior measures by revealing exactly what practical supports are required to perform a task (Adaptive measures identify the skills of an individual has to do a task).

The authors of the Supports Intensity Scale are :-

James R. Thompson, Brian Bryant, Edward M. Camplell, Ellis M. (Pat) Craig, Caroyln Hughes.

3.7 Documentation of Assessment, Result Interpretation and Report writting :

Implication of class level assessment and its relation to inclusion with resources support.

Different assessments can be used for further recommendation and further action. There are various assessment result which alone or combinations of different result is needed for decision making.

The comprehensive report leads to evaluative purpose.

- Writting report for administrative decisions alike.
  - Diagnosis and certification.
  - IQ assessment.

- Placement in appropriate school.
- Eligibility to various benefits and concessions.
- Establishing rights.
- Access to suitable adaptive devices for independent mobility, communication and learning.

➢ Writing reports for educational programming.

The teacher must remember following points for writting educational programming :-

- Objectivity
- Use
- Clearity
- Authencity
- Unbaised
- Uptodate
- Simplicity
- Precise
- Provision of support documents where applicable.

➢ **Writting report for referral :-**

- Referral at the time of initial assessment
- Referral during the educational programme
- Referral for admission to regular / special school
- Referral on completion of school educational.

Interpretation of educational assessment has two major purposes :-

- Placement decision
- Programme planning

Placement decision :-

Due to intellectual impairments coping in regular classes is difficult. In the light of inclusive education, placement of the child should be with the childs pear and be based on chronological age.

According to Salvia and Ysseldyke (2007), general educators believe that children with developmental delay needs more support or special assistance to achieve desired outcome with the help of class level assessment or grade level assessment, - the teacher has to take into account the consistency of responses over a period of time and select the right recommendations for referral and amount and nature of support needed.

Programme Planning :-

The assessment by the teacher is continuous and it reflects current level of functioning at a given time and progress as a result of instruction.

Recently the model of class level assessment or curriculum based assessment for monitoring progress is response to instruction (Horner, Sugai and Horner 2000). It basically focuses on effective instruction. In inclusive settings, it helps the teacher to decide, how much the student benefits from core instruction (which is provided to all students), how much enhanced instruction is needed in addition to the core instruction and in what near intensive instruction is to be planned.

The assessment data which will include - preliminary assessment, specific assessment to plan annual god, individualized educational programme (IEP), date of behaviour analysis, record of parent teacher meetings, visits to inclusive classes as a resource teacher, team meeting with principal, detail information of the students profile like learning style, rate of learning, interests, needs, supportive classmates or teachers give a clear picture of the student in the class.

So, to achieve the goal of education, perfect recording of assessment, supporting parents, cooperation of teachers, proper referral, modified instructions, innovative teaching strategies, alternative evaluation system can be used as a support system for the child in inclusive set up.

3.8 ''Check Your Progress''

(i) What are the importance of assessment at preschool and school level?

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(ii) Why developmental assessment is necessary in mental retardation?

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(iii) What is adaptive behavior? Reason out the importance of assessment of adaptive behariour in the field of mental retardation?

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(iv) Describe two important assessment tools in preschool level.

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(v) Describe one curriculum based assessment tool used in school level assessment. Define its importance in inclusive educational set up.

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3.9 Let Us Sum Up

The needs of individual vary with the age thus different methods of assessment are needed. During preschool age the basic skills such as cognitive, motor, sensory perceptual skills develop at rapid speed. So, the pre-requisites for most of the adaptive behaviours and conceptual skills are still in progress. The assessment tools should be like that to evaluate these pre-requisites of a child.

The assessment of school level is to impart for diagnosis and placement in proper educational set up. So the tools at this level are to assess the overall academic and adaptive skills which are necessary for independent living.

Developmental assessment is an important aspect of early identification of mental retardation. Assessment of adaptive behavior is needed to define effectiveness of the person to meets the standards of personal independence and social responsibility expected according to the age and culture.

Assessment tools used in preschool level are Upanayan, Arambh, Portage, MDPS, FACP and assessment tools in school level is MDPS, BASIC-MR, GLAD and Support Intensity Scale.

Documentation of assessment is important for evaluative purpose, educational programming purpose and referral purpose. The educational assessment has two major purpose – placement decision and programme planning.

So, for overall development of a child depends upon had perfectly the date of assessment is used through analysis and what types of modification is needed for his educational upliftment in inclusive educational system.

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